KAISER PERMANENTE®

**Kaiser Foundation Health Plan of Washington**

# *Clinical Review Criteria*

## Dermatology Services

Cosmetic vs Medical for the following:

- Alopecia, Keloids, Laser Treatments, Benign Lesions
- Broad Band UVB Therapy
- Excimer Laser for Vitiligo
- Home Narrow Band UVB Therapy for Psoriasis
- Narrow Band UVB Therapy
- PUVA Therapy
- UV Lights



## Criteria

### For Medicare Members

| Source | Policy |
|---|---|
| CMS Coverage Manuals | None |
| National Coverage Determinations (NCD) | Laser Procedures (140.5)<br>Treatment of Psoriasis (250.1)<br>Treatment of Actinic Keratosis (AKs) (250.4)<br>Durable Medical Equipment Reference List (280.1)--*(for home phototherapy requests outside of **psoriasis diagnosis** please defer to Kaiser Permanente Medical Policy below)* |
| Local Coverage Determinations (LCD) | Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979)<br>Plastic Surgery (L37020)<br>Mohs Micrographic Surgery (L35704) |
| Local Coverage Article | Local Coverage Article: Additional Information Required for coverage and pricing for Category III CPT® Codes A55681- RETIRED<br>06/30/2020 Noridian retired **Local Coverage Article (LCA A55681).** These services still need to meet medical necessity as outlined in the LCA and will require review. LCAs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Decision (NCD), a coverage provision in a CMS interpretative manual or an LCD. Most LCAs are not retired because they are incorrect. The criteria should be still referenced when making an initial decision. However, if the decision is appealed, the retired LCD cannot be specifically referenced. Maximus instead looks for "medical judgment" which could be based on Kaiser Permanente commercial criteria or literature search.<br>***includes CPT 0479T, 0480T*** |



Back to Top

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| Kaiser Permanente Medical Policy | For home UVB phototherapy requests other than Psoriasis (see above) such as Eczema, as well as other dermatological conditions:<br><br>Due to the absence of a NCD, LCD, or other coverage guidance, Kaiser Permanente has chosen to use their own Clinical Review Criteria, **for in office or home UVB Phototherapy use Phototherapy, Skin (KP-0255 v2) MCG** for medical necessity determinations. |

## For Non-Medicare Members

1) The following treatments are considered cosmetic and are therefore not covered:
   a. Botulinum injections for treatment of wrinkles and facial imperfections (for covered indications for botulinum injections see the pharmacy prior authorization criteria)
   b. Tattoo removal (CPT 15783)
   c. Laser treatment of pigmented lesions, rosacea, superficial leg and face veins, cherry angiomas, telangiectasias, spider angiomas, or spider veins/venous ectasias
   d) Chemical peel (CPT 15788, 15789, 15792, 15793, 17360)
   e) Micro-dermabrasion (No codes specific for this service)
   f) Dermabrasion (CPT 15780, 15781, 15782, 15783, 15786)
   g) Acne scar repair (CPT 15780)
   h) Tattooing, depigmentation, and melanocyte transplant for vitiligo

2) The following treatments are covered and are not considered cosmetic when conditions are met:
   a. ***Alopecia treatment*** (applicable codes HERE) when the alopecia results from **ONE of the following**:
      - Infection (treatment is for the infection)
      - Autoimmune disorder
      - Discoid lupus
      - Low iron stores
      - Folliculitis decalvans

      Laser treatment services described in 2b no longer require medical necessity review (CPT: 17000, 17003, 17004, 17106, 17107, 17108, 17110, 17111, and 17250)
   b. **Laser treatment** for **ONE of the following**:
      - Port wine stain on head or neck
      - Telangiectasias scarring when caused by removal of skin cancer or radiation therapy
      - Facial angiofibroma secondary to tuberous sclerosis
      - Vascular lesions with history of spontaneous bleeding as documented in the patient's medical record
      - Actinic Keratoses (AK) for chemo sensitive agents

   c.

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|---|
| **Effective Until August 1st, 2025**<br>**Excimer Laser** (CPT code 96920, 96921, 96922) is covered when ALL of the following are met:<br>1. Member must have ONE of the following conditions:<br>a. Vitiligo: vitiligo on the face, neck or hands.<br>b. Psoriasis: scalp, face, neck or hands<br>2. There must be documentation of the failure of medical management with topical therapy |
| **Effective August 1st, 2025**<br>**Excimer Laser** (CPT code 96920, 96921, 96922) is covered when **ONE of the following** are meet:<br>1. Psoriasis involving the scalp, face, neck or hands and documented treatment and failure of at least **TWO** of the following topical treatments over a consecutive 12-week period, one of which should be a high potency corticosteroid unless contraindicated, or contraindication/intolerance to ALL remaining treatment options:<br>• High-potency corticosteroid (e.g., clobetasol propionate, betamethasone dipropionate or fluocinonide);<br>• Topical calcineurin inhibitor (i.e., tacrolimus or pimecrolimus 0.1%)<br>• Vitamin D derivatives (calcipotriene) |


Back to Top

- Retinoids (e.g., tazarotene)
- Tar preparations
- Anthralin
- Keratolytic agents (e.g., lactic acid, salicylic acid, and urea

2. Vitiligo involving the face, neck or hands and failure of BOTH of the following, unless contraindicated or not tolerated, over at least 12-week consecutive trial:
   a. Topical corticosteroid
   b. Topical calcineurin inhibitor (i.e., tacrolimus or pimecrolimus 0.1%)

d. **Scar/keloid revision**: Kaiser Permanente has elected to use the Scar Revisions (KP-0495) MCG* for medical necessity determinations. (applicable codes HERE)

e. **Fractional Laser for burns and traumatic scars:** *Currently not covered due to lack of efficacy per the published medical literature (0479T, 0480T).*

f. Removal of **benign skin lesions** (seborrheic keratoses, skin tags, milia, molluscum contagiosum, sebaceous (epidermoid) cysts, moles (nevi), acquired hyperkeratosis (keratoderma) and viral warts) are medically necessary and not cosmetic and are covered when **ONE or more of the following** criteria are met (applicable codes HERE):
   1. The clinical diagnosis is uncertain, particularly where malignancy is a realistic consideration based on lesion appearance (non-responsive to conventional treatment or change in appearance).
   2. The lesion has **ONE or more of the following** characteristics:
      - Bleeding
      - Intense itching
      - Pain
      - Has physical evidence of inflammation (purulence, oozing, edema, erythema, etc.)
      - Clinically restricts an orifice or vision
      - Is in an anatomical region subject to recurrent physical trauma and there is documentation of resulting pain, itching, or bleeding

g. **Laser/intense pulse light treatment** is covered for hair removal when the excess hair is a result of a documented endocrine abnormality confirmed by blood test. (commonly submitted with CPT 17999)

h. **PUVA:** Kaiser Permanente has elected to use the Skin Phototherapy (PUVA) (KP-0253) MCG* for medical necessity determinations. (CPT code 96912, 96913)

i. **UVA:** Kaiser Permanente has elected to use the Phototherapy, Skin (KP-0255 v2) MCG* for medical necessity determinations. (CPT code 96900, 96910)

j. **Home narrowband UVB phototherapy** (E0691, E0692, E0693, E0694, A4633) is covered for qualifying conditions per Phototherapy, Skin (KP-0255 v2) MCG* when:
   - The member has durable medical equipment coverage
   - The light is ordered by a dermatology provider
   - Home phototherapy requires initial support/teaching for frequency, dose of treatment to avoid over or undertreatment as well as follow up on a regular basis to ensure correct treatment, as arranged by the ordering provider

**Related criteria:**
**Electronic Brachytherapy for non-melanoma skin cancer**
**Dermal Fillers for Facial Lipoatrophy**

*** MCG Manuals are proprietary and cannot be published and/or distributed**. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed using these criteria, you may request a copy of the criteria by calling the Kaiser Permanente Clinical Review staff at 1-800-289-1363.

For access to the MCG Clinical Guidelines criteria, please see the MCG Guideline Index through the

 Back to Top

provider portal under Quick Access.

**If requesting this service, please send the following documentation to support medical necessity:**

- Last 6 months of clinical notes from requesting provider &/or specialist (dermatology, surgery notes)

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage

## Background

Dermatology services include a wide array of therapies. Some therapies are purely cosmetic, others are considered from a benefits standpoint to be "medically necessary" and relate to function and/or have an impact on an individual's physical, social and/or mental well-being.

The purpose of expanding the criteria set is to distinguish between dermatology services that are considered purely cosmetic versus those which are seen as medically necessary and are covered in part or whole. The creation of the criteria set incorporated what was previously found in coverage policy and other reference documents.

## Medical Technology Assessment Committee(MTAC)

***Home Narrowband UVB Phototherapy***

BACKGROUND

Psoriasis is a chronic skin disease that affects 1-3% of the population. With psoriasis, the life cycle of skin cells is shortened from about a month to a few days. Consequently, cells build up rapidly on the outer layer of skin, forming thick erythematous plaques that are often pruritic. (Mayoclinic.com; BMJ clinical evidence). Treatments for psoriasis include: 1) self-care: baths, avoidance of alcohol, moisturizer; 2) topical medications: corticosteroids, vitamin D analogues, anthralin, retinoids; 3) oral medications: retinoids, methotrexate, azathioprine, cyclosporin, immunomodulator drugs (biologics); 4) phototherapy; 5) combination therapy e.g. phototherapy and oral medications. Phototherapy is one of the more commonly used treatments for psoriasis. The rationale behind phototherapy is that it causes photochemical reactions of endogenous absorbing molecules results in reduction of DNA synthesis that leads to a treatment effect. The therapy was first proposed in the 1920s by Dr. Goeckerman at the Mayo clinic who found a beneficial effect of natural sunlight in combination with coal tar. In the 1970s, it was shown that broadband ultraviolet B (UVB) radiation alone could treat milder clinical forms of psoriasis. After experimentation with different wavelengths, it was found that wavelengths between 311-313 nm were best at balancing the clearing of psoriasis while at the same time minimizing the adverse effect of erythema. The first well-designed lamp that emitted narrow-band radiation at 311-313 nm, the Phillips TL-01 fluorescent lamp, was introduced in 1984 (Kist, 2005; Honigsmann, 2001). The main treatment- limiting side effect of narrowband UVB is erythema, reported by 10-94% of patients depending on treatment regimen and definition of erythema. Other short-term side effects include dry skin with pruritis, blistering, and increased frequency of recurrent herpes simplex outbreaks. Long-term side effects, as with other types of phototherapy, include photo ageing and skin cancer. However, the incidence of skin cancer in patients with psoriasis treated with narrowband UVB is not well known (Kist et al., 2005, Naldi et al., 2005). The recommended initial treatment dose of narrowband UVB is 50-80% of a patient's minimal erythema dose (MED), established through phototesting. This is followed by increases of 10-40%, depending on the aggressiveness of the treatment and the patient's response (Kist, 2005; Honigsmann, 2001). The American Academy of Dermatology guidelines recommend giving up to 20-25 treatments of narrowband UVG, 2-3 times a week (Menter et al., 2008).

**10/06/2008: MTAC REVIEW**
**Home Narrowband UVB Phototherapy**

**Evidence Conclusion:** There is insufficient evidence to draw conclusions about the safety and effectiveness of home narrowband UV-B phototherapy for patients with psoriasis. There are no published randomized or non-randomized trials that use modern home phototherapy equipment. Findings from an RCT are expected to be published within the next 3-6 months.

**Articles:** A 2006 review article (Koek et al., 2006) on home ultraviolet B phototherapy for psoriasis identified 7 empirical clinical studies, 5 of which were published in English. 3 of the 5 studies in English were published between 1979-1983, before the introduction of the Phillips TL-01 fluorescent lamp. Thus, they did not use currently available phototherapy technology. Both of the more recent studies (Cameron et al., 2002; Feldman et al., 1996) were case series with fewer than 25 patients. One of the 3 older studies (Paul et al., 1983) had a


Back to Top

comparison group, the others were case series. The Paul et al. study, which included 40 patients, compared the efficacy of a Metec-Helarium unit emitting low-intensity selective UV phototherapy (LISUP) at home to 3 times/week in-office UVB therapy. In-office UVB therapy was found to be more effective than home LISUP treatment; 90% (18/20) of patients in the UV-B group experienced clearing of psoriasis compared to 40% (8/20) of patients in the home LISUP group. No additional completed studies were identified that compared home UVB phototherapy to in-office UVB phototherapy or to a different type of treatment. A published protocol for an RCT was identified (Koek et al., 2006). This trial, called the PLUTO study, is a multi-center trial comparing home UVB treatment to in-center UV-B phototherapy in 196 patients with psoriasis. The home phototherapy treatments is Waldmann UV-100 unites with TL-01 lamps. According to the lead author (personal communication), a manuscript on the study outcomes is currently under review by the BMJ.

The use of Home narrowband UVB phototherapy in the treatment of psoriasis does not meet the *Kaiser Permanente Medical Technology Assessment Criteria.*

**10/05/2009: MTAC REVIEW**
**Home Narrowband UVB Phototherapy**
**Evidence Conclusion:** PLUTO study (Koek 2009) on home versus outpatient ultraviolet B phototherapy for psoriasis randomized 196 patients (in the Netherlands) with mild to severe psoriasis and clinically eligible for narrowband ultraviolet B phototherapy, to receive the treatment at home or in an outpatient setting. The trial had valid methodology and design as a noninferiority study. The patients and providers were not blinded, however assessment of the severity of and extent of the disease were evaluated by an independent research nurse blinded to the treatment arms. The results of the trial indicate that home phototherapy was not inferior to that provided in outpatient department, mainly for the self-administered psoriasis area and severity index (SAPASI) 50, 75, and 90 (i.e. proportion of patients achieving at least 50%, 75%, or 90% decline of baseline SAPASI at the end of therapy) as well as the psoriasis area and severity index (PASI) 90. However, the possible inferiority of home ultraviolet phototherapy to that provided in an outpatient setting, could not be entirely excluded for the primary outcome of PASI 50, or PASI 75, as the lower limits of the 95% confidence intervals were slightly lower than -15% preset noninferiority margin. The differences observed in SAPASI and PASI results may indicate a bias in the patient's self-assessment. The results of the trial also showed that patients in the home therapy group had a significantly higher mean number of irradiations, but an insignificantly higher cumulative dose at the end of therapy. 87% of the all participants had at least one occurrence of mild erythema, 58% a burning sensation, and 39% severe erythema with no significant differences between the two study groups. No significant differences were observed in the disease specific or generic quality of life among patients treated on outpatient setting or at home. The home therapy however, was associated with a lower burden of treatment and greater patient satisfaction.
**Articles:** A study on home versus outpatient ultraviolet B phototherapy for psoriasis was recently published in BMJ in 2009. Koek MB, Buskens E, vanWeelden H, et al. Home versus outpatient ultraviolet B phototherapy for mild to severe psoriasis: pragmatic multicenter randomized controlled non-inferiority trial (PLUTO study). *BMJ* 2009; 338: b1542 doi 10.1136/bmj. b1542

The use of Home narrowband UVB phototherapy in the treatment of psoriasis does meet the *Kaiser Permanente Medical Technology Assessment Criteria.*

## Hayes Technology Assessment

Fractional carbon dioxide ($CO_2$) and erbium-doped yttrium aluminum garnet (Er:YAG) lasers are commonly used for treatment of excessive scarring. Laser therapy may be used to improve erythema, texture, pliability, and pain associated with burn and traumatic scars. Fractional laser ablation refers to the process in which a laser beam is split into hundreds of microbeams, which create small thermal injuries to the skin. It is believed that the injury caused by laser induces collagen formation and tissue remodeling. As opposed to ablative lasers, nonablative lasers induce coagulation only and do not cause epidermal injury and tissue vaporization.

**Conclusion**

An overall very-low-quality body of evidence is insufficient to draw regarding the efficacy and safety of CO2 fractional laser ablation or Er:YAG fractional treatment of burn or traumatic scars for functional improvement. Although most of the reviewed studies reported improved scar pliability following fractional laser treatment, this represents a surrogate outcome that does not directly address the primary Key Question. There is a large body of evidence on fractional laser ablation of hypertrophic scars and keloids; however, it primarily addresses cosmetic outcomes. The literature evaluating the impact of fractional laser treatment on functional outcomes is wholly

 Back to Top

comprised of case reports, which only supply anecdotal information. Large, well-designed trials of fractional laser treatment that directly address improvement of functional outcomes associated with scarring as a result of burns or trauma are needed.

**Hayes Rating:** D² --Insufficient Evidence: For carbon dioxide ($CO^2$) fractional laser ablation for functional improvement related to burn or traumatic scars. D² --Insufficient Evidence: For Erbium-doped yttrium platinum garnet (Er:YAG) fractional laser treatment for functional improvement related to burn or traumatic scars.

Hayes. Hayes Technology Assessment. *Fractional Laser Treatment of Burn and Traumatic Scars for Functional Improvement.* Dallas, TX: Hayes; May 11, 2021. Retrieved February 03, 2023, from https://evidence.hayesinc.com/report/htb.fractionallaser4442

## Applicable Codes

**Considered Medically Necessary when criteria in the applicable policy statements listed above are met (unless otherwise noted):**

**Alopecia Treatment**

| CPT® or HCPC Codes | Description |
|---|---|
| **15775** | Punch graft for hair transplant; 1 to 15 punch grafts |
| **15776** | Punch graft for hair transplant; more than 15 punch grafts |
| **96902** | Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality |
| **With Diagnosis Codes** | |
| **L63.0** | Alopecia (capitis) totalis |
| **L63.1** | Alopecia universalis |
| **L63.2** | Ophiasis |
| **L63.8** | Other alopecia areata |
| **L63.9** | Alopecia areata, unspecified |
| **L64.0** | Drug-induced androgenic alopecia |
| **L64.8** | Drug-induced androgenic alopecia |
| **L64.9** | Androgenic alopecia, unspecified |
| **L66.2** | Folliculitis decalvans |
| **L66.8** | Other cicatricial alopecia |
| **L66.9** | Cicatricial alopecia, unspecified |

**Benign Skin Lesions**

| CPT® or HCPC Codes | Description |
|---|---|
| **11200** | Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions |
| **11201** | Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure) |
| **11400** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less |
| **11401** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm |
| **11402** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm |
| **11403** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm |
| **11404** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm |
| **11406** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm |
| **11420** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less |


Back to Top

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|---|---|
| **11421** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm |
| **11422** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm |
| **11423** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm |
| **11424** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm |
| **11426** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm |
| **11440** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less |
| **11441** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm |
| **11442** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm |
| **11443** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm |
| **11444** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm |
| **14446** | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm |
| **11450** | Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair |
| **11451** | Excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair |
| **11462** | Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair |
| **11463** | Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with complex repair |
| **11470** | Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair |
| **11471** | Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with complex repair |
| **17110** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions |
| **17111** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions |
| **With Diagnosis Code** | |
| **L82.0** | Inflamed seborrheic keratosis |
| **L82.1** | Other seborrheic keratosis |

**Excimer Laser (Vitiligo & Psoriasis)**

| CPT® or HCPC Codes | Description |
|---|---|
| **96920** | Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm |
| **96921** | Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm |
| **96922** | Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm |

**Home Narrowband UVB Phototherapy**

***Note: Code E0691 can be ordered more than once (e.g., scalp and hand/foot device) or billed with codes E0692-E0694.**

| CPT® or HCPC Codes | Description |
|---|---|
| **E0691** | Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft or less |
| **E0692** | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 ft panel |
| **E0693** | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 ft panel |


Back to Top

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| **E0694** | Ultraviolet multidirectional light therapy system in 6 ft cabinet, includes bulbs/lamps, timer, and eye protection |
| **A4633** | Replacement bulb/lamp for ultraviolet light therapy system, each |

**Fractional Laser for burns and traumatic scars**
**Medicare – Considered not medically necessary**
**Non-Medicare – Considered not medically necessary**

| CPT® or HCPC Codes | Description |
|---|---|
| **0479T** | Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children |
| **0480T** | Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure) |

**Laser/Intense Pulse Light Treatment for hair removal**

| CPT® or HCPC Codes | Description |
|---|---|
| No specific codes – ***c**ommonly submitted with CPT code 17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue* | |

**PUVA**

| CPT® or HCPC Codes | Description |
|---|---|
| **96912** | Photochemotherapy; psoralens and ultraviolet A (PUVA) |
| **96913** | Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings) |

**Scar/Keloid Revision**

| CPT® or HCPC Codes | Description |
|---|---|
| **15002** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children |
| **15003** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) |
| **15004** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children |
| **15005** | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) |
| **23921** | Disarticulation of shoulder; secondary closure or scar revision |
| **24149** | Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure) |
| **24925** | Amputation, arm through humerus; secondary closure or scar revision |
| **25907** | Amputation, forearm, through radius and ulna; secondary closure or scar revision |
| **25922** | Disarticulation through wrist; secondary closure or scar revision |
| **25929** | Transmetacarpal amputation; secondary closure or scar revision |


Back to Top

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| **26121** | Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft) |
| **26123** | Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); |
| **26125** | Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft); each additional digit (List separately in addition to code for primary procedure) |
| **27594** | Amputation, thigh, through femur, any level; secondary closure or scar revision |
| **27884** | Amputation, leg, through tibia and fibula; secondary closure or scar revision |
| **31830** | Revision of tracheostomy scar |
| **67343** | Release of extensive scar tissue without detaching extraocular muscle (separate procedure) |
| **With Diagnosis Codes** | |
| **L73.0** | Acne keloid |
| **L91.0** | Hypertrophic scar |
| **L90.5** | Scar conditions and fibrosis of skin |

**UVA**

| CPT® or HCPC Codes | Description |
|---|---|
| **96900** | Actinotherapy (ultraviolet light) |
| **96910** | Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B |

## Considered not medically necessary:

**Botulinum Injections**

| CPT® or HCPC Codes | Description |
|---|---|
| **64611** | Chemodenervation of parotid and submandibular salivary glands, bilateral |
| **64612** | Chemodenervation of parotid and submandibular salivary glands, bilateral |
| **64615** | Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine) |
| **64616** | Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis) |
| **64617** | Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed |
| **64642** | Chemodenervation of one extremity; 1-4 muscle(s) |
| **64643** | Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure) |
| **64644** | Chemodenervation of one extremity; 5 or more muscles |
| **64645** | Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure) |
| **64646** | Chemodenervation of trunk muscle(s); 1-5 muscle(s) |
| **64647** | Chemodenervation of trunk muscle(s); 6 or more muscles |

**Tattoo Removal**

| CPT® or HCPC Codes | Description |
|---|---|
| **15783** | Dermabrasion; superficial, any site (eg, tattoo removal) |

**Chemical Peel**

| CPT® or HCPC Codes | Description |
|---|---|
| **15788** | Chemical peel, facial; epidermal |
| **15789** | Chemical peel, facial; dermal |


Back to Top

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|---|---|
| **15792** | Chemical peel, nonfacial; epidermal |
| **15793** | Chemical peel, nonfacial; dermal |
| **17360** | Chemical exfoliation for acne (eg, acne paste, acid) |

**Micro-dermabrasion**

| CPT® or HCPC Codes | Description |
|---|---|
| **No Specific Codes** | |

**Dermabrasion**

| CPT® or HCPC Codes | Description |
|---|---|
| **15780** | Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) |
| **15781** | Dermabrasion; segmental, face |
| **15782** | Dermabrasion; regional, other than face |
| **15783** | Dermabrasion; superficial, any site (eg, tattoo removal) |
| **15786** | Abrasion; single lesion (eg, keratosis, scar) |
| **15787** | Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) |

**Tattooing, Depigmentation, and Melanocyte Transplant for Vitiligo**

| CPT® or HCPC Codes | Description |
|---|---|
| No specific codes | |

**Acne Scar Repair**

| CPT® or HCPC Codes | Description |
|---|---|
| **11400** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less |
| **11401** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm |
| **11402** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm |
| **11403** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm |
| **11404** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm |
| **11406** | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm |
| **15786** | Abrasion; single lesion (eg, keratosis, scar) |
| **15787** | Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) |
| **With Diagnosis Code** | |
| **L70.0** | Acne vulgaris |
| **L70.1** | Acne conglobata |
| **L70.2** | Acne varioliformis |
| **L70.3** | Acne tropica |
| **L70.4** | Infantile acne |
| **L70.5** | Acne excoriee |
| **L70.8** | Other acne |
| **L70.9** | Acne, unspecified |

**Medical Necessity Review not required:**
**Laser treatment (described in 2b):**


Back to Top

| CPT® or HCPC Codes | Description |
|---|---|
| **17000** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion |
| **17003** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) |
| **17004** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions |
| **17106** | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm |
| **17107** | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm |
| **17108** | Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm |
| **17110** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions |
| **17111** | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions |
| **17250** | Chemical cauterization of granulation tissue (ie, proud flesh) |

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.



| Date Created | Dates Reviewed | Date Revised |
|---|---|---|
| 07/25/2002 | 12/07/2010[MDCRPC], 02/10/2011[MDCRPC], 12/06/2011[MDCRPC], 10/02/2012[MDCRPC] ,07/02/2013[MDCRPC], 08/06/2013[MPC], 06/03/2014[MPC], 02/03/2015[MPC], 09/01/2015[MPC], 07/05/2016[MPC], 05/02/2017[MPC], 03/06/2018[MPC], 03/05/2019[MPC], 03/03/2020[MPC], 03/02/2021[MPC], 03/01/2022[MPC], 03/07/2023 [MPC], 03/12/2024[MPC], 03/04/2025[MPC] | 03/04/2025 |

[MDCRPC] Medical Director Clinical Review and Policy Committee
[MPC] Medical Policy Committee

| Review History | Description |
|---|---|
| 05/21/2015 | Added CPT codes |
| 09/01/2015 | Excimer Laser: added scalp psoriasis as indication |
| 02/02/2016 | Home UVB Phototherapy: Add psoriasis as a covered indication |
| 08/02/2016 | Home UVB Phototherapy: Add diagnosis of eczema will be reviewed on a case-by-case basis |
| 12/19/2017 | Added Plastic Surgery LCD (L37020) |
| 06/17/2019 | Added Eczema as an indication to Home Narrowband UVB phototherapy |
| 08/06/2019 | Minor changes were made to benign skin lesions criteria to allow removal of warts |
| 12/01/2020 | MPC approved to adopt updates to the existing hybrid Phototherapy, Skin criteria, KP-0255, to expand coverage for additional indications including Granuloma annulare and Pityriasis lichenoides chronica for in-office and home phototherapy. Members must have durable equipment coverage and requires initial support/teaching by the ordering provider for home phototherapy. Requires 60-day notice, effective date 05/01/2021. |
| 04/28/2021 | Added diagnosis codes covered by Medicare for home phototherapy; removed retired LCD L35008 |
| 05/04/2021 | Laser treatment services described in 2b in criteria above, and represented by CPT codes: 17000, 17003, 17004, 17106, 17107, 17108, 17110, 17111, and 17250, will no longer require medical necessity review. Requires 60-day notice, effective date October 1, 2021. |
| 03/01/2022 | Updated applicable codes. |


Back to Top

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|---|---|
| 10/28/2022 | Updated Medicare Policy to defer to KP Non-Medicare criteria for phototherapy for skin conditions other than psoriasis. |
| 11/01/2022 | Updated Medicare Policy to defer to KP non-Medicare criteria for phototherapy for all skin conditions including home UVB. |
| 02/07/2023 | Clarified criteria for Fractional Laser Treatment of Burn and Traumatic Scars for Functional Improvement. Added Hayes Technology Assessment dated May 11, 2021, to references. |
| 04/18/2023 | Added retired Medicare Retired Local Coverage Article A55681 for supporting documentation |
| 03/04/2025 | MPC approved to adopt updated criteria for Excimer Laser Treatments to clarify and define conservative treatment; 60-day notice required. Effective Date August 1st, 2025.<br><br>Added codes listed in criteria sections for better clarity. |



Back to Top