Keystone First
Community HealthChoices

Dermatology

Reimbursement Policy ID: RPC.0112.72KF

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

Policy addresses billing and/or payment of certain dermatology procedures, including lesion removal, excisions, shavings, wound repairs and biopsies.

Exceptions

Cosmetic procedures are not reimbursable.

Reimbursement Guidelines

The health plan covers skin lesions, excisions, shavings, wound repairs and biopsies for the treatment of certain skin conditions, or cancers, when such treatment is recommended by the member's physician.

All procedures discussed in this policy must be reported with the correct modifier, if applicable, including any/all anatomical modifiers for reimbursement.

Excision(s)
Excisional lesion removals are categorized by type, benign (CPT 11400-11471) or malignant (CPT 11600-11646), body area (e.g., trunk, arms, legs) and size in centimeters. Excisions include margins and single layer closure using sutures, chemical, or electrocauterization. Excision codes are used to reflect “full thickness” (through dermis) removal of a lesion. Refer to the CPT Manual for instructions on correct coding (procedure codes and modifiers) of specifics such as lesion size, body area, complexity, and associated procedures such as suturing.

The below are covered procedures by the health plan.

Shaving
Removal of epidermal or dermal skin growths by shaving (CPT 11300-11313) does not require suturing. Control of bleeding by chemical or electrical cauterization is included in these codes and not separately reimbursable.

Debridement
Debridement (CPT codes 11000-11044) is a surgical excision to remove dead, damaged or contaminated skin not associated with fractures or dislocations (see CPT codes 11010-11012).

Wound repairs
Wound repairs are categorized into three types of repairs (simple, intermediate, or complex), body area (e.g., scalp, neck, extremities) and length in centimeters. Simple repairs (12001-12021) include superficial lacerations and minor repairs Intermediate repairs include deeper or more complex lacerations with deep subcutaneous or layered repairs.

Biopsy
Biopsy codes (11102-11107) may be reimbursable when the procedure is performed for the specific purpose of obtaining tissue samples for diagnostic examination. The physician removes a biopsy sample of skin or subcutaneous tissue for the purpose of performing a diagnostic histopathologic study under a microscope.

Biopsies performed on separate sites or separate lesions on the same date of service may be separately reimbursable but must be reported with only one primary biopsy code regardless of how many different techniques are used when performed on the same lesion and during the same session.

Separately identifiable evaluation and management services may be reimbursable if they are above and beyond the pre- and post-operative work of the procedure and are performed by the same physician on the same day as a covered minor surgical service is performed.

Multiple Procedures payment reduction
The health plan reimburses multiple dermatology procedures by paying the highest valued procedure at 100% of the highest allowable, and 25% for the second highest, no other payment will be made for additional procedures after the second unless provider has a specific rate in their contract. Modifier 51 must be reported to receive payment for more than one procedure performed on the same date of service and by the same physician. Add-on codes are not subject to payment reduction.

The following services are bundled into the payment for the primary procedure performed:
- Anesthesia when provided by the surgeon or dermatologist, including conscious sedation.
- Simple closures when performed in conjunction with another procedure.
- Miscellaneous supplies (e.g., surgical trays).

- Evaluation and management services.

Minor Surgical Procedures
A minor surgical procedure is a procedure with a 0- or 10-day global period. The global period for a surgical procedure considers services routinely performed by the surgeon or by members of the same group with the same specialty during the preoperative, intra-operative, and post-operative time periods. Claims for services considered to be directly related to the pre-procedure, intra-procedure, and post-procedure work are included in the global reimbursement and will not be paid separately. Minor surgical procedures are not separately reimbursable as an evaluation and management service. However, if a significant and separately identifiable evaluation and management service unrelated to the decision to perform the minor surgical procedure is documented and unrelated to the decision to perform the minor surgical procedure, appropriate modifier is required.

If a minor surgical procedure is performed on a new patient, the same rules for reporting evaluation and management services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an evaluation and management service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles. Both the medically necessary minor surgical procedure and the evaluation and management service must be appropriately and sufficiently documented by the provider in the member’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

Please check with the health plan website for any prior authorization requirements.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. Corresponding Clinical Policies.
VII. Applicable Medicaid Fee Schedule(s).
VIII. American Academy of Dermatology Association, https://www.aad.org/

Attachments

N/A

Associated Policies

RPC.0033.72KF Multiple Procedure Payment Reduction
RPC.0009.72KF Significant-Separately Identifiable Evaluation and Management service (Modifier 25)
RPC.0010.72KF Distinct Procedural Service (Modifier 59, X {EPSU})
RPC.0012.72KF Global Surgical Package and Split Surgery

Policy History

09/2026	• Removed the next review date

	• Replaced the plan name with “the health plan”
07/2026	Reimbursement Policy Committee Approval
06/2026	Annual review • No major changes
07/2025	Reimbursement Policy Committee Approval