Coverage Summary

Skin Treatment, Services and Procedures

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<th>Policy Number: S-010</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 02/18/2009</th>
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<tr>
<td>Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 02/19/2019</td>
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Related Medicare Advantage Policy Guidelines:

- Infrared Therapy Devices (NCD 270.6)
- Intravenous Immune Globulin (IVIG)
- Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases (NCD 250.3)
- Treatment of Actinic Keratosis (NCD 250.4)
- Treatment of Decubitus Ulcers (NCD 270.4)
- Treatment of Psoriasis (NCD 250.1)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

INDEX TO COVERAGE SUMMARY

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   2. Hemorheograph Services
   3. Destruction of Actinic Keratosis
   4. Skin Substitutes
   5. Infrared Therapy Services
   6. Intravenous immunoglobulin (IVIG)
   7. Debridement Services
   8. Treatment of Decubitus Ulcers

II. DEFINITIONS

III. REFERENCES

IV. REVISION HISTORY

V. ATTACHMENTS

I. COVERAGE

Coverage Statement: Skin treatment, services and procedures are covered when Medicare coverage criteria are met.
**DME Face to Face Requirement:** Effective July 1, 2013, Section 6407 of the Affordable Care Act (ACA) established a face-to-face encounter requirement for certain items of DME (including ultraviolet light therapy system and ultraviolet multidirectional light therapy system). For DME Face to Face Requirement information, refer to the Coverage Summary for Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.

**Guidelines/Notes:**

1. **Treatment of Psoriasis**

Psoriasis is a chronic skin disease, for which several conventional methods of treatment have been recognized as covered. These include topical application of steroids or other drugs; ultraviolet light (actinotherapy); and coal tar alone or in combination with ultraviolet B light (Goeckerman treatment).

A newer treatment for psoriasis uses a psoralen derivative drug in combination with ultraviolet A light, known as PUVA. PUVA therapy is covered for treatment of intractable, disabling psoriasis, but only after the psoriasis has not responded to more conventional treatment. The contractor should document this before paying for PUVA therapy.

*See the NCD for Treatment of Psoriasis (250.1). (Accessed January 25, 2019)*

2. **Hemorheograph Services**

Hemorheograph services coverage is limited to those services employing the hemorheograph which are performed for preoperative and postoperative diagnostic evaluation of suspected peripheral artery disease.

*Note: This instrument is not a plethysmograph and is not considered as such. A plethysmograph measures and records changes in the size of a body part as modified by the circulation of blood in that part. The hemorheograph, on the other hand, measures surface blood flow in the skin; it does not measure total blood flow in a digit or limb. See the NCD for Hemorheograph (250.2) (Accessed January 25, 2019)*

3. **Destruction of Actinic Keratoses**

Actinic keratosis (AKs), also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have the potential to become a skin cancer. Destruction of actinic keratoses is covered without restrictions (on the form of treatment) based on lesion or patient characteristics. *See the NCD for Treatment of Actinic Keratoses (250.4) (Accessed January 25, 2019)*

4. **Skin Substitutes**

Skin substitutes may be covered when criteria are met. *See the Coverage Summary for Wound Treatments.*

5. **Infrared Therapy Services;** see the Coverage Summary for Wound Treatments.

6. **Intravenous immunoglobulin (IVIG);** see the Coverage Summary for Medications/Drugs (Outpatient/Part B).

7. **Debridement Services;** Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment A). (Accessed November 18, 2019)
8. **Treatment of Decubitus Ulcers**

Hydrotherapy (whirlpool) treatment for decubitus ulcers is covered when treatment is reasonable and necessary. Some other methods, the safety and effectiveness of which have not been established, are not covered. Examples include ultraviolet light, low intensity direct current, topical application of oxygen, and topical dressings with Balsam of Peru in castor oil. See the NCD for Treatment of Decubitus Ulcer (270.4). (Accessed January 25, 2019)

**II. DEFINITIONS**

**III. REFERENCES**

See above

**IV. REVISION HISTORY**

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<th>Date</th>
<th>Update Details</th>
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| 04/01/2019 | Updated policy introduction; added language to clarify:  
- There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)  
- In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5) |
| 02/19/2019 | Annual review with no updates. |
| 09/18/2018 | Updated Local Coverage Determination (LCD) Availability Grid; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy) |
| 02/20/2018 | Annual review with no updates. |
| 01/16/2018 | Re-review with the following update: Guideline 7 (Debridement Services) - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline. |
| 02/14/2017 | Annual review; no updates |
| 02/16/2016 | Annual review; no updates to the guideline content; updated reference link(s) of the applicable LCDs to reflect the condensed link. |
| 03/24/2015 | Annual review with the following updates: Guideline 3 (Destruction of Actinic Keratoses): Added definition of Actinic keratosis (AKs) from Definition section  
Guideline 4 [Bilaminate Skin substitutes (Apligraf®)]: Changed to Skin Substitutes  
Guideline 5 (Infrared Therapy Services): Replaced coverage guidelines with reference link to the Coverage Summary for Wound Treatment.  
Guideline 6 [Intravenous immunoglobulin (IVIG)]: Replaced coverage guidelines with |
reference link to the *Coverage Summary for Medications/Drugs (Outpatient/Part B)*.

Guideline 7 (Debridement Services): Removed guidelines in the coverage summary; added a statement that LCDs exist.

Removed the definition of:
- Psoriasis (already included in Guideline 1)
- Actinic Keratosis (moved to Guideline 3)
- Phototherapy (not addressed in the coverage summary)
- Infrared Therapy Services (definition addressed in the Coverage Summary for Wound Treatment)
- Pressure Ulcer Stages (not addressed in the coverage summary)

10/21/2014  Removed detailed DME Face-to-Face Requirement information and replaced with a reference link to the DME, Prosthetics, Corrective Appliances/Orthotic and Medical Supplies Grid.

02/18/2014  Annual review; deleted reference to the UnitedHealthcare Home Infusion Coverage document

08/20/2013  Added a note pertaining to the DME Face-to-Face Requirement in accordance with Section 6407 of the Affordable Care Act as defined in the 42 CFR 410.38(g)

02/19/2013  Annual review; no updates

02/27/2012  Annual review; no updates

01/01/2012  The UHC Home Infusion Part B Coverage Criteria Grid (Attachment B) was updated to include Gammagard and Gamunex under the Therapeutic Class “Immune Globulin Subcutaneous”

08/24/2011  Updated Guidelines #7 Debridement Services; replaced L13081 with L13705 as default LCD for states with no LCDs (L13081 retired for SC Palmetto #00880 effective 6/17/2011; L13705 added to SC Palmetto #11202 effective 6/18/2011 per scheduled J11 implementation); no change in coverage guidelines. The LCD Availability Grid was also reviewed and updated

02/21/2011  Annual review; Updated Guidelines #7 Debridement Services using the standard Coverage Summary language format and using L13081 guidelines for states with no LCDs for Debridement Services

**V. ATTACHMENTS**

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<tr>
<th>LCD ID</th>
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<td>A and B MAC</td>
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<td>First Coast Service Options, Inc.</td>
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## Attachment A - LCD Availability Grid

### Debridement Services

CMS website accessed November 18, 2019

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End of Attachment F