

Skin Treatment, Services and Procedures

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[Instructions for Use](#)

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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 Psoriasis (NCD 250.1)

Coverage Guidelines

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 titled [Durable Medical Equipment \(DME\), Prosthetics, Corrective Appliances/Orthotics \(Non-Foot Orthotics\) and Medical Supplies Grid](#).

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.

Refer to the [National Coverage Determination \(NCD\) for Treatment of Psoriasis \(250.1\)](#). (Accessed February 8, 2021)

Hemorheograph Services

The hemorheograph is a diagnostic instrument which is safe and effective for determining the adequacy of skin perfusion prior to the performance of minor surgical procedures on the extremities, including minor podiatric procedures, and as an adjunct to the evaluation of patients suspected of having peripheral vascular disease.

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. Refer to the [NCD for Hemorheograph \(250.2\)](#). (Accessed February 8, 2021)

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. The destruction of actinic keratoses is covered without restrictions based on lesion or patient characteristics. Refer to the [NCD for Treatment of Actinic Keratoses \(250.4\)](#). (Accessed February 8, 2021)

Skin Substitutes

Skin substitutes may be covered when criteria are met. Refer to the Coverage Summary titled [Wound Treatments](#).

Infrared Therapy Services

Refer to the Coverage Summary titled [Wound Treatments](#).

Intravenous Immunoglobulin (IVIG)

Refer to the Coverage Summary titled [Medications/Drugs \(Outpatient/Part B\)](#).

Debridement Services

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Debridement Services](#).

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. Refer to the [NCD for Treatment of Decubitus Ulcer \(270.4\)](#). (Accessed February 8, 2021)

Supporting Information

Important Note: When searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Debridement Services				
Accessed October 27, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L34032 (A56459)	Debridement Services	Part A and B MAC	CGS Administrators, LLC	KY, OH
L37166 (A55818)	Wound Care	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L33614 (A56617)	Debridement Services	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY RI, VT, WI
L34199 (A57460)	Treatment of Ulcers and Symptomatic Hyperkeratoses	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY

Debridement Services

Accessed October 27, 2021

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L34243 (A57459)	Treatment of Ulcers and Symptomatic Hyperkeratoses	Part A and B MAC	Noridian Healthcare Solutions, LLC	CA, AS, GU, HI, MP, NV
L35125 (A53001)	Wound Care	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L37228 (A55909)	Wound Care	Part A MAC	Wisconsin Physicians Service Insurance Corporation	AK*, AL, AR*, AZ*, CA*, CO*, CT*, DE*, FL*, GA, HI*, IA, ID*, IL*, IN, KS, KY*, LA*, MA*, MD*, ME*, MI, MO, MS*, MT*, NC, ND*, NE, NH*, NJ*, NM*, NV*, OH*, OK*, OR*, PA*, RI*, SC, SD*, TN, TX*, UT*, VA, VT*, WA*, WI*, WV, WY* Note: States notated with an asterisk (*) should follow the other available state-specific LCD/LCA listed in this table. This WPS LCD/LCA only applies to states without asterisk.
L37228 (A55909)	Wound Care	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE

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Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update <ul style="list-style-type: none"> Reformatted policy; transferred content to new template
02/16/2021	Supporting Information <ul style="list-style-type: none"> Updated Local Coverage Determination (LCD)/Local Coverage Article (LCA) Availability Grid to reflect the most current reference links

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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 are 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](#)).

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