BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Whole Body Integumentary Photography and Dermatoscopy

Policy Number: OCA 3.702
Version Number: 16
Version Effective Date: 12/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan ☒ NH Medicaid ☒ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth ACO ☒ MassHealth MCO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers whole body integumentary photography (with or without dermatoscopy) **experimental and investigational or NOT medically necessary** for the monitoring and screening of a member with dysplastic nevus syndrome, a history of dysplastic nevi, a personal or family history of melanoma, skin lesions suspected of malignancy, and/or any other indication. The Plan considers the use of dermatoscopy and related computer-based optical imaging analyses/devices for whole body photography or for a targeted body region to be **experimental and investigational or NOT medically necessary** for any indication, including but not limited to evaluating skin lesions suspected of malignancy for a member with dysplastic nevus syndrome, a history of dysplastic nevi, and/or a personal or family history of melanoma. Dermatoscopy techniques and related, computer-based optical imaging analyses would evaluate or monitor pigmented skin lesions and/or may be used to define peripheral margins of skin lesions prior to excision of a suspected malignancy. It will be determined during the Plan's standard prior authorization process if the service is considered experimental and investigational for the requested indication. See the Plan's *Experimental and*

Investigational Treatment medical policy, policy number OCA 3.12, for the product-specific definitions of experimental or investigational treatment.

Clinical Criteria

1. The Plan considers whole body integumentary photography (with or without dermatoscopy) experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of this method of monitoring and screening for any indication.

2. The Plan considers dermatoscopy and related computer-based optical imaging analyses/devices (for whole body photography or for a targeted body region) experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of dermatoscopy when used for any indication.

Limitations and Exclusions

1. The Plan considers whole body integumentary photography (with or without dermatoscopy) experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of this method of monitoring and screening for any indication.

2. The Plan considers the use of dermatoscopy and/or related computer-based optical imaging analyses/devices (for whole body photography or for a targeted body region) experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of dermatoscopy when used for any indication.

Plan Medical Director review is required for all requests for whole body integumentary photography and/or dermatoscopy, including the monitoring and screening of patients with dysplastic nevus syndrome, a history of dysplastic nevi, a personal or family history of melanoma, or any other indication. Applicable clinical information must be submitted to the Plan by the treating provider and will be used by the Plan Medical Director to determine the medical necessity of the service for a targeted body region. Medical record documentation must include the member's medical history (including results from prior dermatoscopy or whole body integumentary photography, when applicable), relevant family medical history (including relationship to member such as first-, second- and third-degree relatives), clinical indications for this technology as the most appropriate diagnostic technology for the member's condition, and documentation that the device is FDA approved for the specified indication. It will be determined during the Plan's standard prior authorization process if the service is considered experimental and investigational for the requested indication.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in

Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or WellSense Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

The industry-standard CPT codes used for a dermatoscopy techniques such as epiluminescence microscopy, digital epiluminescence microscopy, skin surface microscopy, skin videomicroscopy, or incidence light microscopy were deleted as of December 31, 2020 with no replacement code assigned by the CPT Editorial Panel of the AMA at the time of the Plan's most recent policy review. When utilized by the treating provider, dermatoscopy is considered an integral part of a normal evaluation of a pigmented skin lesion and is not separately billable.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Codes Considered Experimental and Investigational or NOT Medically Necessary
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma Plan note: This code is NOT covered (with whole body integumentary photography listed as a benefit exclusion) for the WellSense New Hampshire Medicaid product. When whole body photography is a covered service for the Plan member, the Plan considers the service experimental and investigational or NOT medically necessary. Plan Medical Director review is required.

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 10/14/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 10/28/08: Utilization Management Committee (UMC) 11/18/08: Quality Improvement Committee (QIC)	02/01/09 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC, UMC, and QIC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy title was *Whole Body Integumentary Photography* from 02/01/09 until 12/31/16.

Effective 01/01/17, the policy title is Whole *Body Integumentary Photography and Dermatoscopy*.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
10/27/09	No changes.	Version 2	10/27/09: MPCTAC 11/19/09: QIC
11/01/10	Updated references.	Version 3	11/23/10: MPCTAC 12/22/10: QIC
11/01/11	Updated references.	Version 4	11/16/11: MPCTAC 12/20/11: QIC
08/01/12	No changes to applicable code list. Updated references and removed duplicate text in Clinical Background Information section. Revised language in the following sections: Summary, Clinical Guideline Statement, and Applicable Coding. Included language that states service is experimental and investigation for all indications.	Version 5	08/15/12: MPCTAC 09/26/12: QIC
08/01/13	Review for effective date 10/01/13. Updated references.	10/01/13 Version 6	08/21/13: MPCTAC 09/19/13: QIC
09/01/14	Review for effective date 11/01/14. Updated references. No change made to Plan criteria or applicable code list.	11/01/14 Version 7	09/17/14: MPCTAC 10/08/14: QIC
09/01/15	Review for effective date 11/01/15. Updated list of applicable products, including removing Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Updated Summary, Description of Item or Service, Definitions, and References sections without changing criteria.	11/01/15 Version 8	09/16/15: MPCTAC 10/14/15: QIC
11/25/15	Review for effective date 01/01/16. Revised language in the Applicable Coding section.	01/01/16 Version 9	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
09/01/16	Review for effective date 01/01/17. Revised policy title. Updated the Summary, Description of Item or Service, Clinical Background Information, References, and	01/01/17 Version 10	09/21/16: MPCTAC 10/12/16: QIC

Policy Revisions History			
	References to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement and Limitations sections to include dermatoscopy used for regions of the body and/or for whole body integumentary photography. Revised the applicable code list and added Plan notes to codes. Added Well Sense Health Plan as applicable products for this policy because criteria and coding were added for dermatoscopy .		
10/01/17	Review for effective date 10/01/17. Updated the Description of Item or Service and References sections.	10/01/17 Version 11	09/20/17: MPCTAC
09/01/18	Review for effective date 10/01/18. Updated the References and Other Applicable Policies sections.	10/01/18 Version 12	09/19/18: MPCTAC
09/01/19	Review for effective date 10/01/19. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	10/01/19 Version 13	09/18/19: MPCTAC
07/01/20	Review for effective date 08/01/20. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, and References sections.	08/01/20 Version 14	07/15/20: MPCTAC
08/01/21	Review for effective date 09/01/21. Updated language in the Applicable Coding section and deleted CPT codes 0400T and 0401T to comply with industry-wide code deletions (with no industry-wide replacement codes assigned). Updated References section.	09/01/21 Version 15	08/18/21: MPCTAC
08/01/21	Review for effective date 11/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, and References sections. Removed deleted codes 0400T and 0401T to be consistent with industry-wide code deletions (with no industry-wide replacement codes assigned). Added billing guidelines in the Applicable Coding section.	11/01/21 Version 16	08/27/21: MPCTAC (electronic vote)

Policy Revisions History			
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Applicable Coding and References sections.	12/01/21 Version 17	11/17/21: MPCTAC

Next Review Date

07/01/22

Authorizing Entity

MPCTAC

Disclaimer Information:+

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.