Medical Policy

Whole Body Integumentary Photography

Policy Number: OCA 3.702
Version Number: 9
Version Effective Date: 01/01/16

Product Applicability

☐ All Plan+ Products

Well Sense Health Plan
☐ New Hampshire Medicaid
☐ NH Health Protection Program

Boston Medical Center HealthNet Plan
☒ MassHealth
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Senior Care Options ◊

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

Generally, the Plan considers whole body integumentary photography (with or without dermatoscopy) to be experimental and investigational for 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. 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 policy, Experimental and Investigational Treatment (policy number OCA 3.12), for the product-specific definitions of experimental or investigational treatment.
Description of Item or Service

**Whole Body Photography/Total Body Photography:** Whole body integumentary photography is a procedure where the entire surface of a patient is photographed for the purpose of providing a reference source of skin lesions over time. The pictures may be taken with a traditional/digital camera or with a computer-based optical imaging device or dermatoscope. The purpose of this procedure is to obtain a visual record of the patient’s skin with the hope of being able to compare with future examinations to assist in the identification of new or changed skin lesions. Digital images may be stored electronically. This technique has been proposed as a tool in the management of patients at high risk for skin cancer.

Medical Policy Statement

The Plan considers whole body integumentary photography experimental and investigational for any indication.

Limitations

The Plan considers this service experimental and investigational.

Definitions

**Dermatoscopy:** Also known as dermoscopy or epiluminescence microscopy, dermoscopy refers to the technique of analyzing morphological structures of the skin using a device that both magnifies and illuminates the skin surface. The technique involves a light source and may include the application of a liquid to the surface of the skin to change the skin refraction and/or translucence to make underlying structures visible. Dermoscopy is usually used following unaided-eye examination of suspect lesions. Digitization of images, typically after initial visual assessment, permits storage and facilitates their retrieval, often used for comparison purposes if a lesion is being followed up over time.

**Dysplastic Nevi:** Dysplastic nevi are atypical moles whose appearance is different from that of common moles. Dysplastic nevi are generally larger than ordinary moles and have irregular and indistinct borders. Their color frequently is not consistent and may range from pink to dark brown. These nevi are usually flat, but parts may be raised above the skin surface. Dysplastic nevi can be found anywhere, but are most common on the trunk in men and on the calves in women.

**Dysplastic Nevus Syndrome:** Also called atypical mole syndrome, dysplastic nevus syndrome is an autosomal dominant hereditary disorder of the skin characterized by the presence of many mole-like tumors (nevi). People with this syndrome often have more than 100 moles, at least some of which are atypical in size, color, and structure.

**Melanoma:** Melanoma is a malignant tumor of the skin that originates in melanocytes, the cells which produce the pigment melanin that colors the skin, hair, and eyes.
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 States 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). Because 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.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation 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 the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

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<th>CPT Code</th>
<th>Description: Code Considered Experimental and Investigational</th>
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<tr>
<td>96904</td>
<td>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</td>
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Clinical Background Information

Melanoma is the most aggressive of the three types of skin cancer and accounts for the majority of all skin cancer related deaths. The treatment of melanoma is highly successful if it is diagnosed early. Excision of suspected lesions with examination under a microscope for diagnosis is the gold standard for the evaluation of pigmented skin lesions because the sensitivity and specificity of this method is nearly 100%. The early phase of malignant melanoma may be difficult to diagnose because malignant melanomas of the skin can share many clinical features with atypical birthmarks, moles, or other benign skin lesions. Individuals with atypical mole syndrome (i.e., dysplastic nevus syndrome) are at greater risk for the development of cancer of the skin in the form of malignant melanoma.

At the current time there is limited available published evidence in the peer reviewed medical literature indicating that photographic imaging improves patient outcomes by reducing the frequency of unnecessary biopsies or improving early detection of malignant melanoma. Additional studies are

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needed to establish patient selection criteria and long-term efficacy and safety. Therefore, based on the available evidence in the peer-reviewed literature, whole body photography is considered investigational and experimental for the monitoring and screening of patients with dysplastic nevus syndrome, a history of dysplastic nevi, patients with a personal or family history of melanoma, or any other indication.

References


<table>
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<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>02/01/09 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC, Utilization Management Committee (UMC), and QIC</td>
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<td>Internal Approval: 10/14/08: MPCTAC 10/28/08: UMC 11/18/08: QIC</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12

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<th>Policy Revisions History</th>
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<tbody>
<tr>
<td>Review Date</td>
<td>Summary of Revisions</td>
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<tr>
<td>11/01/10</td>
<td>Updated references.</td>
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<td>11/01/11</td>
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<tr>
<td>08/01/12</td>
<td>No changes to applicable code list. Updated references and removed</td>
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**Policy Revisions History**

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<th>Description</th>
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<th>Effective Date</th>
<th>Authorizing Entity</th>
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<tr>
<td>08/01/13</td>
<td>Review for effective date 10/01/13. Updated references.</td>
<td>10/01/13</td>
<td>08/21/13: MPCTAC 09/19/13: QIC</td>
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<td>09/01/14</td>
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<td>11/01/14</td>
<td>09/17/14: MPCTAC 10/08/14: QIC</td>
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<tr>
<td>09/01/15</td>
<td>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.</td>
<td>11/01/15</td>
<td>09/16/15: MPCTAC 10/14/15: QIC</td>
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<td>11/25/15</td>
<td>Review for effective date 01/01/16. Revised language in the Applicable Coding section.</td>
<td>01/01/16</td>
<td>11/25/15: MPCTAC (electronic vote) 12/09/15: QIC</td>
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**Last Review Date**

11/25/15

**Next Review Date**

09/01/16

**Authorizing Entity**

QIC

**Other Applicable Policies**

Medical Policy – *Experimental and Investigational Treatment*, policy number OCA 3.12

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**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.