NO. 91456

SKIN CONDITIONS

Effective: 09/01/2026
Committee Review: 08/12/2026
Last Updated: 08/12/2026

Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This medical policy addresses the evaluation and treatment of selected skin conditions

Related policies:

- Cosmetic and Reconstructive Surgery Procedures No. 91535
- Gender Affirming Surgery No. 91612
- Platelet Rich Plasma/Platelet Rich Fibrin Matrix/ Autologous Blood-Derived Products/ BMAC No. 91553

I. MEDICAL NECESSITY CRITERIA

A. Selected Nonmalignant Skin Conditions Limited to Office Visits and Prescription Drug Therapy

Inclusions:

Services for the following skin conditions associated with the listed diagnosis codes and related subgroups are limited to:

1. Office visits
2. Prescription drug therapy, when clinically appropriate and subject to pharmacy benefit

Applicable ICD-10-CM Codes:

L57.3	Poikiloderma of Civatte
L63.0 – L63.9	Alopecia areata
L64.0 – L64.9	Androgenic alopecia
L65.0 – L65.9	Other nonscarring hair loss
L66.0 – L66.9	Cicatricial alopecia [scarring hair loss]
L70.0 - L70.9	Acne
L71.1 - L71.9	Rosacea
L73.0	Acne keloid
L81.0 – L81.9	Other disorders of pigmentation
L84	Corns and callosities
L85.1	Acquired keratosis [keratoderma] palmaris et plantaris
L95.8	Other vasculitis limited to the skin
L95.9	Vasculitis limited to the skin, unspecified
L98.8	Other specified disorders of the skin and subcutaneous tissue
L98.9	Disorder of the skin and subcutaneous tissue, unspecified

Limitations:

The following limitations apply:

1. Services for the above skin conditions associated with the listed diagnosis codes and related subgroups are limited to office visits and prescription drug therapy, unless separate medical necessity criteria are specified elsewhere in this policy.
2. All services are subject to member-specific benefit plan documents, pharmacy benefits, prior authorization requirements, and applicable plan limitations.
3. In the event of a conflict between this policy and a member's benefit plan, the benefit plan will govern.

B. Dermatologic Conditions and Treatments

1. Acne Vulgaris

Inclusions:

The following treatments for acne vulgaris are considered medically necessary:

a. Management of acne vulgaris is limited to the services described in **Section A. Skin Conditions Limited to Office Visits and Prescription Drug Therapy**

Exclusions:

The following treatments for acne vulgaris are considered not medically necessary:

a. Acne Extraction Procedures including:
   i. Marsupialization
   ii. Removal or extraction of milia, comedones, cysts, or pustules

b. Skin Resurfacing Procedures including:
   i. Facial Dermabrasion for active acne or acne scars
   ii. Chemical Peels for active acne or acne scars

c. Light-Based and Laser Therapies including:
   i. Phototherapy
   ii. Photochemotherapy
   iii. Excimer Laser Therapy
   iv. Other laser or light-based treatments

d. Other acne treatments, including but not limited to:
   i. Cryotherapy
   ii. Salabrasion

2. Alopecia

Inclusions:

The following treatments for alopecia are considered medically necessary:

a. Management of alopecia is limited to the services described in **Section A. Skin Conditions Limited to Office Visits and Prescription Drug Therapy**.

Exclusions:

The following treatments for alopecia are not medically necessary, including but not limited to:

a. Pharmacologic and topical therapies

b. Hair Prostheses (e.g., wigs, hair systems, scalp prostheses)

c. Hair transplantation procedures (e.g., punch grafting, follicular unit transplantation or extraction)

d. Phototherapy
e. Photochemotherapy
f. Laser and light-based therapies (e.g., laser therapy, low level light therapy)
g. Other services or treatments intended to promote hair growth, prevent hair loss, or improve appearance, (e.g., scalp cooling devices, scalp cooling therapy during chemotherapy)

3. Premalignant Skin Lesions and Early Keratinocyte Carcinomas

Inclusions:

Treatment of premalignant skin lesions and early keratinocyte carcinomas may be medically necessary when clinically appropriate as noted below:

a. Chemical Peels

Inclusions:

Medium and/or deep chemical peels are medically necessary when **ALL** of the following criteria are met:

i. The treatment is for actinic keratoses (AK) or other pre-malignant skin lesions; **and**
ii. Lesion burden is extensive or diffusely distributed, making lesion-directed therapy impractical; **and**
iii. Conventional therapies (e.g., topical treatment with 5-fluorouracil (5-FU)) are not feasible, contraindicated, or have failed.

Exclusions:

Chemical peels are not medically necessary for the following:

i. Treatment of non-malignant (simple) lesions.
ii. Active acne
iii. Acne scarring
iv. Skin wrinkling
v. Other cosmetic purposes
vi. Skin rejuvenation
vii. Hyperpigmentation
viii. Individuals with actinic cheilitis
ix. Invasive cutaneous squamous cell carcinoma (excluding cSCC in situ)
x. High-risk or invasive basal cell carcinoma

b. Facial Dermabrasion

Inclusions:

Dermabrasion is considered medically necessary when **ALL** of the following criteria are met:

i. Treatment is for the removal of superficial basal cell carcinomas and pre-cancerous actinic keratoses; **and**
ii. Conventional methods of removal (e.g., cryotherapy, curettage, excision, topical 5-FU (Efudex) are impractical due to the number and distribution of the lesions.

Exclusions:

Dermabrasion is not medically necessary for conditions including but not limited to:

i. Removal of acne scars
ii. Active acne
iii. Benign or non-premalignant skin lesions
iv. Invasive cutaneous squamous cell carcinoma (excluding cSCC in situ)
v. High-risk or invasive basal cell carcinoma

Limitations:

i. Chemical peels and dermabrasion are not considered first-line treatment for premalignant skin lesions.
    a) These procedures are reserved for cases involving treatment-refractory disease, non-surgical candidates, or when standard therapies are not feasible, contraindicated, or have failed.
ii. Surgical excision remains the preferred treatment for most basal cell carcinomas (BCC) and invasive cutaneous squamous cell carcinomas (cSCC).

c. Photodynamic Therapy (PDT)

Inclusions:

Photodynamic Therapy is considered medically necessary when **ONE** of the following diagnoses is present **and** the applicable clinical criteria are met:

i. Actinic keratoses (AK) or Field Cancerization; **and**
   a) Lesion burden is extensive, diffuse, multifocal, or within a contiguous treatment field; **or**
   b) Conventional lesion-directed therapies (e.g., topical therapies, cryotherapy, curettage) are contraindicated, not tolerated, impractical, or have failed.

ii. Cutaneous squamous cell carcinoma (cSCC) in situ (Bowen disease); **and**
   a) Lesion burden is extensive, diffuse, multifocal, or within a contiguous treatment field; **or**
   b) Conventional therapies (e.g., topical agents, cryotherapy, curettage, surgical excision) are contraindicated, not tolerated, impractical, or have failed.

iii. Low Risk Superficial Basal Cell Carcinoma (sBCC); **and**
   a) The lesion is clinically and histologically consistent with superficial BCC without evidence of dermal invasion; **and**
   b) Surgical excision or radiation therapy is contraindicated or impractical.

d. <u>Exclusions:</u>

Photodynamic Therapy is not medically necessary for the following conditions:

i. Actinic cheilitis
ii. Psoriasis
iii. Invasive cutaneous squamous cell carcinoma (excluding cSCC in situ)
iv. High-risk or invasive basal cell carcinoma
v. Benign skin lesions
vi. Individual, few, or isolated actinic keratoses treatable with lesion-directed therapy
vii. Skin cancer prophylaxis

4. Cosmetic Skin Conditions

<u>Exclusions:</u>

The following exclusions apply to cosmetic skin conditions:

a. Treatment of cosmetic skin conditions (including but not limited to those listed above) is not medically necessary.

i. Priority Health defines a cosmetic condition as a condition that, if left untreated, would not result in an adverse medical outcome.

5. Keloid Formation

Inclusions:

Removal of keloids is considered medically necessary when at least **one** of the following criteria is met:

- **a.** Keloid formation is due to complications arising from a medically necessary service and treatment of the complication is clinically indicated (e.g., development of lesions following major surgery such as organ transplantation or to host vs. graft syndrome).
- **b.** Excision of the lesion is required for restoration of body form and/or function following an accidental injury
- **c.** Keloid formation is a result of medically necessary treatment of neoplastic disease (e.g. hypertrophic keloid scar formation due to radiation therapy).
- **d.** Keloid formation is secondary to burn scars
- **e.** The lesion is suspicious for malignancy and requires diagnostic evaluation or excision.
- **f.** The lesion causes functional impairment or clinically significant complications, including but not limited to:
  - i. Infection
  - ii. Bleeding
  - iii. Inflammation
  - iv. Restriction of movement

Exclusions:

Removal of keloids is considered not medically necessary when performed for:

- **a.** Keloid formations due to body piercings or tattoos
- **b.** Improvement of appearance, without documentation of functional impairment or clinically significant complications.
- **c.** The following treatments for keloids are considered experimental, investigational, unproven, and are not medically necessary:
  - **i.** Platelet-rich plasma (PRP) therapy
  - **ii.** Stem cell–based or regenerative medicine therapies, including but not limited to:
    - **a)** Stromal vascular fraction
    - **b)** Stem cell–conditioned media

iii. Botulinum toxin injections (e.g., onabotulinumtoxinA [Botox®])
iv. Laser-assisted drug delivery (LADD)
v. Chemical peels
vi. Dermabrasion
vii. Massage therapy or manual scar manipulation as a standalone treatment

6. Rosacea

Inclusions:

The following treatments for rosacea are medically necessary:

a. Management of rosacea is limited to the services described in **Section A. Skin Conditions Limited to Office Visits and Prescription Drug Therapy**

Exclusions:

The following treatments for rosacea are not medically necessary:

a. Surgical treatment of rosacea
b. Light-based or energy-based therapies used primarily for cosmetic indications, including but not limited to:
i. Broadband light therapy
ii. Intense pulsed light (IPL)
iii. Laser therapies for erythema or telangiectasia

C. Vulvar and Labial Surgical Procedures

Inclusions:

Vulvar and/or labial surgical procedures (e.g., vulvectomy) may be considered medically necessary when performed for clinically indicated conditions, including but not limited to:

1. Malignancy (e.g., vulvar cancer).
2. Premalignant diseases including but not limited to:
   a. Vulvar intraepithelial neoplasia
   b. Vulvar dysplasia
3. Gender-affirming surgery:
   a. Refer to Priority Health's Gender Affirming Surgery Medical Policy No. 91612 for medical necessity criteria.

Exclusions:

Vulvar and/or labial surgical procedures, including vulvectomy, labiaplasty, and excision of excessive skin and subcutaneous tissue are not medically necessary for the following indications:

1. Hypertrophy of the labia.
2. Cosmetic purposes or non-medical indications.

D. Other Investigational and Not Medically Necessary Services

<u>Exclusions</u> (Not Medically Necessary / Experimental and Investigational):

The following services are considered experimental, investigational, unproven, and/or not medically necessary due to insufficient evidence demonstrating improvement in net health outcomes:

1. Salabrasion
2. Total Body Photography (e.g., Vectra WB360) when used for documentation, screening, or monitoring of skin lesions
3. Reflectance confocal microscopy (RCM) and other emerging skin imaging technologies when used as a substitute for standard clinical evaluation and management.
4. Molecular fluorescent imaging of suspicious nevi and other emerging imaging technologies when used for routine screening, diagnosis, or monitoring of skin lesions.

E. Photochemotherapy and Phototherapy:

Phototherapy modalities may include but are not limited to:

1. Narrowband ultraviolet B (NB-UVB)
2. Broadband ultraviolet B (BB-UVB)
3. Psoralen plus ultraviolet A (PUVA)
4. Targeted phototherapy (e.g., excimer laser, excimer lamp)

<u>Inclusions:</u>

Phototherapy and photochemotherapy are considered medically necessary when **all** of the following criteria are met:

1. The member has failed, is intolerant to, or has a contraindication to conventional medical management; **and**
2. Treatment is for **one** of the following conditions:
    a. Atopic dermatitis (atopic eczema)
    b. Connective tissue diseases involving the skin (e.g., cutaneous graft-versus-host disease (GVHD), localized scleroderma, lupus erythematosus)
    c. Cutaneous T-cell Lymphoma (CTCL) (e.g., Mycosis fungoides)

d. Grover's disease (transient and persistent acantholytic dermatosis)
e. Lichen disorders (e.g., Lichen planus)
f. Photodermatoses (e.g., polymorphic light eruption, actinic prurigo, chronic actinic dermatitis)
g. Pityriasis
h. Chronic plaque psoriasis (refer to Section F. Psoriasis)

Exclusions:

Phototherapy and photochemotherapy are considered not medically necessary for conditions **not** listed above, including but not limited to:

1. Alopecia (hair loss)
2. Cosmetic indications
3. Other conditions for which sufficient evidence of clinical benefit has not been established

Limitations:

The following limitations apply:

1. Treatment must be prescribed and monitored by a qualified healthcare professional.
2. Additional criteria may apply to specific phototherapy modalities as outlined elsewhere in this policy.
3. Home tanning beds and other non-medical ultraviolet light devices are not considered equivalent to medically supervised phototherapy and are not medically necessary.

F. Psoriasis

1. Conventional Therapy

Inclusions:

The following conventional therapies for psoriasis may be considered medically necessary when clinically appropriate:

a. Systemic non-biologic therapies
b. Topical therapies
c. Biologic therapies
d. Small molecule therapies
e. Combination therapy, including but not limited to:
   i. Topical therapy with phototherapy
   ii. Phototherapy with systemic therapy
   iii. Combination systemic and topical therapy

f. Intralesional corticosteroid injections for localized lesions resistant to topical therapy.
g. Phototherapy and photochemotherapy

Limitations:

The following limitations apply:

a. Treatment selection should be based on:
  i. Disease severity (mild, moderate, severe)
  ii. Body surface area (BSA)
  iii. Special site involvement (face, hands, genitals)
  iv. Impact on quality of life
b. Escalation of therapy should follow a stepwise approach consistent with clinical guidelines
c. Use of systemic therapies and biologic agents are subject to pharmacy benefit management requirements (e.g., formulary status, prior authorization).
d. Intralesional corticosteroids are limited to localized, treatment-resistant (topical therapy) lesions.
e. Oral PUVA is contraindicated in those younger than 10 years; pregnant patients; nursing mothers; and those with a personal history of melanoma, lupus erythematosus, or xeroderma pig mentosum.

2. Office-Based Phototherapy (UVB)

Inclusions:

Office-based or on-site phototherapy (UVB) treatment for psoriasis is medically necessary when **all** of the following criteria are met:

a. Ordered and managed by a dermatologist; **and**
b. The member has severe disabling psoriasis (greater than 10% of body surface area involvement [BSA]); **and**
c. Conventional treatment has failed, is contraindicated, or is not tolerated.

Exclusions:

Office-based phototherapy is NOT medically necessary when:

a. The member does not have documentation of severe, disabling psoriasis (greater than 10% BSA involvement) that has failed conventional treatment.
b. The member's disease is adequately controlled with topical therapy alone

3. **Home Phototherapy (UVB)**

Inclusions:

Home UVB phototherapy is medically necessary when **all** of the following criteria are met:

- **a.** Ordered and managed by a dermatologist; **and**
- **b.** The member has severe disabling psoriasis (greater than 10% of body surface area involvement [BSA]) that is unresponsive to conventional treatment; **and**
- **c.** The member is unable to travel for office-based treatment due to serious medical or physical conditions (e.g. confined to the home; severity and frequency of flares); **and**
- **d.** The member has documented history of frequent psoriasis flares requiring immediate treatment to control; **and**
- **e.** Treatment has been continuous, long term (greater than 1 year), and has demonstrated clinical effectiveness; and is expected to continue long term; **and**
- **f.** The UVB home device requested is the smallest size appropriate for the treatment area (e.g., hand wand for hand).

Exclusions:

Home UVB treatments are considered experimental, investigational, and not medically necessary for:

- **a.** Any indications other than psoriasis including vitiligo.

Limitations:

The following limitations apply:

- **a.** Medicaid members: Home phototherapy is not a covered benefit.
- **b.** Home tanning beds are not a covered benefit.
- **c.** Subject to prior authorization and DME requirements, where applicable.
- **d.** All services are subject to member-specific benefit plans, which govern in the event of a conflict with this policy.

4. **Laser Therapy for Psoriasis**

   a. **Pulsed dye laser (PDL)**

   Inclusions:

Pulsed dye laser (PDL) may be considered medically necessary for the following:

i. Treatment of nail psoriasis

Exclusions:

PDL is not medically necessary for the following:

i. Conditions other than those listed above.

b. Targeted Phototherapy (Excimer Laser or Excimer Lamp)

Inclusions:

Adult Members (≥18 Years of Age)

Targeted ultra-violet B (UVB) phototherapy including excimer laser (308 nanometers [nm]), and excimer light (308nm) is medically necessary when **all** of the following criteria are met:

i. Treatment is for symptomatic localized, plaque psoriasis involving the hands, feet, knees, elbows, scalp or face.
ii. Member has chronic, stable, mild to moderate plaque psoriasis.
iii. Disease involves less than 10% body surface area (BSA)
iv. Psoriasis has proven refractory to at least a two-month trial of conservative treatment of topical agents and/or non-laser phototherapy.
v. Conventional treatments with at least three of the following treatment categories have failed:
    a) Topical therapies
    b) Phototherapy
    c) Systemic therapies
    d) Combination therapies
    e) Intralesional corticosteroid injections
vi. Lesions have previously demonstrated responsiveness to UVB treatment.

Pediatric Members (12-17 Years of Age)

Inclusions:

Use of excimer laser therapy (308 nanometers [nm]) or excimer lamp therapy may be considered medically necessary when ALL of the following criteria are met:

i. The member meets all adult medical necessity criteria listed above; and.
ii. Documentation of prior treatment history and response is provided; and
iii. Clinical rationale supporting the request is provided.; and
iv. A specific treatment plan and expected outcomes (goals) are documented.

Exclusions:

Excimer laser therapy is not considered medically necessary for the following:

i. History of photosensitivity disorder.
ii. Psoriasis is adequately controlled and responds to standard therapies.
iii. Plaque-type psoriasis involvement ≥ 10 % body surface area.
iv. Non-plaque psoriasis subtypes.
v. Phototherapy utilized as first-line treatment of mild psoriasis.
vi. Members less than 12 years of age.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)
NCD - Scalp Hypothermia During Chemotherapy to Prevent Hair Loss (110.6)
NCD - Laser Procedures (140.5)
NCD - Treatment of Psoriasis (250.1)
NCD - Treatment of Actinic Keratosis (250.4)

Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	LCD - Removal of Benign Skin Lesions (L34200) LCD - Cosmetic and Reconstructive Surgery (L39506)
First Coast Service Options, Inc.	LCD - Cosmetic and Reconstructive Surgery (L38914)
Wellpoint Federal (formerly National Government Services, Inc.)	None identified
Noridian Healthcare Solutions	LCD - Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L34233)
Novitas Solutions, Inc.	LCD - Removal of Benign Skin Lesions (L34938) LCD - Cosmetic and Reconstructive Surgery (L35090)
Palmetto GBA	LCD - Removal of Benign and Malignant Skin Lesions (L33445) LCD - Cosmetic and Reconstructive Surgery (L33428) LCD - Scalp Cooling for the Prevention of Chemotherapy-Induced Alopecia (L39573)
WPS Insurance Corporation	LCD - Removal of Benign Skin Lesions (L35498) LCD - Cosmetic and Reconstructive Surgery (L39051)

III. BACKGROUND

The skin is composed of an outer layer, the epidermis, a thicker inner layer, the dermis, and subcutaneous tissue, The epidermis contains keratinocytes, melanocytes, and Merkel's cells (touch-sensitive cells), while the dermis contains connective tissue, collagen, elastic fibers, blood and lymphatic vessels, nerves (those that sense heat and cold, texture, pressure and trauma), sebaceous glands, and sweat glands. Many

dermatologic conditions addressed in this policy involve inflammatory, premalignant, neoplastic, cosmetic, or functional changes of these structures.

Acne Vulgaris
Acne vulgaris is a chronic inflammatory disorder of the pilosebaceous unit characterized by comedones, papules, pustules, nodules, and possible scarring. The 2024 American Academy of Dermatology (AAD) acne guideline recommends evidence-based topical and systemic pharmacologic therapies, including benzoyl peroxide, topical retinoids, topical antibiotics, oral doxycycline, hormonal therapies, and isotretinoin for severe, scarring, psychosocially burdensome, or treatment-refractory disease (Reynolds et al., 2024). The guideline also emphasizes multimodal topical therapy, limiting systemic antibiotic use, combining systemic antibiotics with benzoyl peroxide and topical therapy, and judicious use of intralesional corticosteroids for larger inflammatory lesions (Reynolds et al., 2024; AAD, 2026a).

Procedural and device-based acne treatments, including extraction, chemical peels, dermabrasion, phototherapy, laser/light-based therapies, cryotherapy, and salabrasion, are not central components of guideline-directed routine acne management. The AAD specifically recommends against the addition of pneumatic broadband light to adapalene 0.3% gel, supporting that device-based interventions are not routinely recommended as standard acne treatment (AAD, 2026a).

A comprehensive systematic review of modern procedural therapies for acne vulgaris found that although certain modalities may provide clinical improvement, outcomes are highly variable with respect to efficacy, safety, tolerability, and relapse rates and are limited by heterogeneity in study design, short follow-up durations, and inconsistent durability of response (Pour Mohammad et al., 2025). Additional systematic reviews and clinical studies similarly report small sample sizes, variability in treatment protocols, inconsistent outcome measures, and limited long-term data, supporting the adjunctive rather than primary role of these interventions (Ishii et al., 2025; Trinh et al., 2026).

Randomized and comparative studies demonstrate that while some laser-, light-, and photodynamic therapy-based treatments may provide incremental or short-term improvement, established pharmacologic treatments, particularly isotretinoin for moderate-to-severe disease, provide more consistent and durable outcomes and remain the standard of care (He et al., 2025; Zhang et al., 2023).

Many procedural interventions are also commonly performed to improve cosmetic outcomes, including reduction of mild acne lesions, post-inflammatory erythema, post-inflammatory hyperpigmentation, and acne scarring, and are frequently utilized as elective or self-pay services rather than essential medical management.

Overall, current clinical practice guidelines and available evidence support office-based evaluation and evidence-based pharmacologic treatment as the standard management

approach for acne vulgaris. Procedural and device-based interventions have not demonstrated consistent improvement in net health outcomes compared with established medical therapies and are therefore considered adjunctive, cosmetic, investigational, unproven, and/or not medically necessary for the routine treatment of acne vulgaris (Reynolds et al., 2024; Pour Mohammad et al., 2025; Ishii et al., 2025; Trinh et al., 2026).

Atopic Dermatitis and Other Phototherapy-Responsive Dermatoses
Atopic dermatitis is a chronic, relapsing inflammatory skin disorder characterized by immune dysregulation, skin barrier dysfunction, pruritus, and recurrent eczematous lesions. Current American Academy of Dermatology (AAD) guidelines recommend a stepwise treatment approach that includes moisturizers, topical anti-inflammatory therapies, systemic therapies, and biologic agents when clinically appropriate (Sidbury et al., 2023; Davis et al., 2026).

Phototherapy and photochemotherapy have an established role in the management of selected dermatologic conditions when conventional therapies are insufficient, contraindicated, or not tolerated. The AAD guideline for atopic dermatitis recognizes phototherapy as a treatment option for appropriately selected patients with disease that is not adequately controlled with standard medical management (Sidbury et al., 2014).

Ultraviolet-based therapies, including narrowband ultraviolet B (NB-UVB), broadband ultraviolet B (BB-UVB), psoralen plus ultraviolet A (PUVA), and targeted phototherapy, are used in the treatment of a variety of inflammatory, lymphoproliferative, and photodermatologic disorders. Conditions for which phototherapy may provide clinical benefit include atopic dermatitis, cutaneous T-cell lymphoma, graft-versus-host disease involving the skin, localized scleroderma, lichen disorders, photodermatoses, pityriasis disorders, and psoriasis (Elmets et al., 2019; Sidbury et al., 2014).

Treatment selection should be individualized based on diagnosis, disease severity, extent of involvement, prior treatment response, safety considerations, and the specific phototherapy modality utilized. Because therapeutic response and risk profiles vary among conditions and treatment modalities, phototherapy should be prescribed and monitored by a qualified healthcare professional experienced in its use (Elmets et al., 2019; Sidbury et al., 2014).

Alopecia
Alopecia encompasses a group of disorders characterized by hair loss, most commonly androgenetic alopecia (AGA) and alopecia areata. AGA is a common, chronic condition driven by androgen-mediated follicular miniaturization and primarily affects appearance and quality of life rather than causing direct physical morbidity (Asfour et al., 2023; Hurrell et al., 2026). Available treatments for AGA, including topical minoxidil and oral finasteride, may provide modest improvement in hair growth but generally require ongoing use, and treatment response is variable (Adil & Godwin, 2017).

In contrast, alopecia areata is an autoimmune disorder characterized by non-scarring hair loss with variable severity and disease course. Management may include topical, intralesional, and systemic corticosteroids, as well as targeted therapies such as Janus kinase (JAK) inhibitors, which have demonstrated clinically meaningful hair regrowth in randomized controlled trials; however, relapse following treatment discontinuation is common and long-term durability remains uncertain (Abarca et al., 2025; King et al., 2022). International consensus recommendations and society guidelines emphasize individualized treatment based on disease severity, extent of hair loss, and patient impact, while acknowledging variability in treatment response and limitations in the evidence base (Meah et al., 2020; Harries et al., 2025).

Emerging and adjunctive therapies for alopecia, including laser and energy-based devices, platelet-derived products, growth factor injections, regenerative medicine approaches, and hair restoration procedures, have demonstrated improvements in hair density and patient-reported outcomes in some studies. However, systematic reviews and meta-analyses consistently report substantial heterogeneity in study design, treatment protocols, patient selection, outcome measures, and duration of follow-up, with insufficient evidence to establish long-term efficacy, safety, or durability of benefit (Alahmadi et al., 2026; Alali et al., 2026; Behrangi et al., 2026; Chen et al., 2026).

Current evidence indicates that most therapies for alopecia are directed toward improving hair growth, appearance, and quality of life rather than preventing functional impairment, morbidity, or disease progression. Available treatments often require ongoing use, demonstrate variable effectiveness, and may be associated with relapse after discontinuation (Meah et al., 2020; Harries et al., 2025; National Alopecia Areata Foundation [NAAF], n.d.). Accordingly, office-based evaluation and evidence-based pharmacologic management remain the cornerstone of treatment, while hair prostheses, hair transplantation, regenerative medicine therapies, and other cosmetic or investigational interventions have not demonstrated sufficient evidence of durable clinical benefit to establish routine medical necessity.

Premalignant Skin Lesions and Early Keratinocyte Carcinomas

Actinic keratoses (AKs) are common premalignant keratinocytic lesions that arise on chronically sun-exposed skin and may progress to cutaneous squamous cell carcinoma (cSCC) if left untreated. Current American Academy of Dermatology (AAD) guidelines support treatment of AKs and recognize both lesion-directed and field-directed treatment strategies. Strong recommendations are made for ultraviolet protection, cryotherapy, topical 5-fluorouracil (5-FU), and topical imiquimod, while photodynamic therapy (PDT) is conditionally recommended as an effective field-directed treatment option (Eisen et al., 2022). Field-directed therapies are particularly useful for patients with multiple lesions, diffuse actinic damage, or field cancerization, in which clinically visible lesions are accompanied by subclinical keratinocytic dysplasia within contiguous areas of photodamaged skin (Eisen et al., 2021).

Cutaneous squamous cell carcinoma (cSCC) is the second most common skin cancer and carries a risk of local invasion and metastasis. Management is guided by lesion-specific risk stratification, with surgical excision and Mohs micrographic surgery remaining the preferred treatment modalities for most invasive tumors (NCCN, 2026). For select cases of cSCC in situ (Bowen disease), nonsurgical therapies including topical fluorouracil, topical imiquimod, and photodynamic therapy may be considered; however, cure rates are generally lower than those achieved with surgical treatment (NCCN, 2026).

Basal cell carcinoma (BCC) is the most common human malignancy. Surgical excision remains the cornerstone of management because it provides the highest cure rates and histologic margin assessment (NCCN, 2026). Nonsurgical treatment modalities, including topical therapies and photodynamic therapy, may be considered for carefully selected low-risk superficial basal cell carcinomas, particularly when surgery or radiation therapy is contraindicated, impractical, or otherwise undesirable. These approaches generally demonstrate lower cure rates than surgical management and are typically reserved for tumors that are clinically and histologically consistent with superficial BCC without evidence of dermal invasion (NCCN, 2026).

Photodynamic therapy involves the application of a photosensitizing agent followed by exposure to a specific light source, resulting in selective destruction of dysplastic and neoplastic cells. Current AAD guidelines support PDT as a field-directed treatment option for AKs, particularly in patients with extensive, diffuse, multifocal, or contiguous areas of photodamaged skin. NCCN guidelines also recognize PDT as a treatment option for select cases of cSCC in situ and low-risk superficial BCC when appropriate clinical circumstances exist (Eisen et al., 2022; NCCN, 2026).

Chemical peels and dermabrasion are resurfacing techniques that may be used as field-directed or ablative therapies in select cases of premalignant skin disease. Chemical peels induce controlled epidermal and dermal injury through application of chemical agents, while dermabrasion mechanically removes epidermal and superficial dermal layers. These modalities may reduce lesion burden and improve the appearance of chronically sun-damaged skin; however, available evidence is limited by heterogeneous treatment protocols, variable outcome measures, and limited long-term comparative data relative to established therapies such as cryotherapy, topical agents, and photodynamic therapy (Paradisi et al., 2025; Gualdi et al., 2026).

Accordingly, current evidence and guideline-based practice support chemical peels and dermabrasion as adjunctive or second-line treatment options that may be considered for extensive actinic damage, field cancerization, or diffuse premalignant disease when lesion-directed therapies are impractical because of lesion number, distribution, patient tolerance, or other clinical considerations. Established lesion-directed and field-directed therapies, including cryotherapy, topical 5-FU, topical imiquimod, and PDT, remain the

preferred first-line management options for most patients with premalignant keratinocytic lesions (Eisen et al., 2022).

Overall, current evidence and professional society guidelines support lesion-directed and field-directed therapies as the foundation of treatment for premalignant skin lesions and early keratinocyte carcinomas. Procedural resurfacing approaches such as dermabrasion and chemical peels may have a role in selected patients with extensive disease but are not routinely recommended for cosmetic skin rejuvenation, benign lesions, or other non-oncologic indications.

Keloid Formation

Keloids are fibroproliferative scars that result from abnormal wound healing and are characterized by excessive collagen deposition that extends beyond the boundaries of the original injury. Keloids may be associated with pain, pruritus, inflammation, recurrent irritation, bleeding, secondary infection, cosmetic deformity, or functional impairment depending on their size and location. Current consensus recommendations and professional society guidance emphasize individualized management based on lesion characteristics, symptom burden, anatomic location, and risk of recurrence, with multimodal therapy generally favored over single-modality treatment (Gold et al., 2014a, 2014b; Ogawa et al., 2019).

Commonly utilized treatment modalities include intralesional corticosteroid injections, silicone gel sheeting, pressure therapy, cryotherapy, laser therapy, surgical excision with adjuvant therapy, and combination treatment approaches. Surgical excision alone is associated with high recurrence rates and is generally not recommended without adjunctive treatment. Evidence suggests that multimodal regimens, particularly those incorporating corticosteroid-based therapies, are associated with improved outcomes and lower recurrence rates compared with monotherapy (Gold et al., 2014b; Bailey et al., 2024; Sanchez Cruz et al., 2026).

Despite widespread clinical use, the quality of evidence supporting many keloid interventions remains variable. Systematic reviews and meta-analyses have identified substantial heterogeneity in study design, treatment protocols, outcome measures, and duration of follow-up. Available evidence demonstrates variable effectiveness and inconsistent durability of response across treatment modalities, particularly for laser therapies, silicone gel sheeting, and other adjunctive interventions (Leszczynski et al., 2022; Tian et al., 2023; Jackson et al., 2025; Shen et al., 2026).

Emerging therapies including platelet-rich plasma (PRP), autologous fat grafting, stromal vascular fraction, stem cell-derived products, conditioned media, botulinum toxin, laser-assisted drug delivery, and other regenerative medicine approaches have shown preliminary promise in some studies. However, current evidence is limited by small sample sizes, lack of standardized protocols, short follow-up periods, and insufficient long-term efficacy and safety data. Consequently, these therapies have not been

established as standard of care and remain investigational (Abu Alqam et al., 2024; Bernabe et al., 2024; Jafarzadeh et al., 2024).

Overall, current evidence supports an individualized, symptom-driven, and multimodal approach to the management of keloids. Treatment is generally directed toward reducing symptoms, preventing progression, improving function, and minimizing recurrence, while cosmetic concerns alone are insufficient to establish medical necessity. Emerging regenerative and investigational therapies lack sufficient evidence to demonstrate durable clinical benefit and are therefore considered experimental, investigational, unproven, and/or not medically necessary.

Cosmetic Skin Conditions

Cosmetic skin conditions are conditions for which treatment is intended primarily to improve appearance and would not be expected to prevent, diagnose, treat, or ameliorate a disease, injury, functional impairment, or adverse medical outcome if left untreated. Treatments directed at aesthetic enhancement, correction of normal anatomic variation, or improvement of appearance generally do not meet accepted standards of medical necessity.

Examples of cosmetic skin conditions and services include, but are not limited to, treatment of wrinkles, photoaging, benign skin lesions, acne scarring, post-inflammatory skin changes, dyspigmentation, hair loss, tattoo removal, skin resurfacing for aesthetic purposes, and other appearance-related concerns. Such interventions are commonly performed to improve cosmetic appearance, self-image, or patient satisfaction rather than to treat a disease process or restore physiologic function.

Professional society guidance and clinical practice standards distinguish medically necessary treatment of disease from procedures performed primarily for cosmetic or aesthetic purposes. While cosmetic treatments may improve appearance and quality of life, improvement in appearance alone is not sufficient to establish medical necessity. Accordingly, services intended primarily for cosmetic enhancement are not medically necessary unless a separate medically necessary indication is specifically identified elsewhere in this policy (ACOG, 2020; Perelmuter, 2024).

Vulvar and Labial Surgical Procedures

Vulvar and labial surgical procedures encompass a range of interventions, including labiaplasty, vulvectomy, and other reconstructive or excisional procedures performed for functional, reconstructive, oncologic, or cosmetic indications.

Vulvar surgical procedures may be medically necessary when performed for clinically indicated conditions, including malignancy, premalignant disease, vulvar intraepithelial neoplasia (VIN), dysplasia, symptomatic functional impairment, trauma, congenital abnormalities, or other medically necessary reconstructive indications. NCCN guidelines

support surgical management as a primary treatment modality for vulvar malignancies and selected premalignant lesions when clinically appropriate (NCCN, 2026).

Professional society guidance from the American College of Obstetricians and Gynecologists (ACOG) defines female genital cosmetic surgery as procedures performed to alter genital appearance or function in the absence of a clinically indicated medical condition. ACOG states that these procedures are generally not medically indicated, lack sufficient high-quality evidence demonstrating safety and effectiveness, and may be associated with complications including pain, bleeding, infection, scarring, altered sensation, dyspareunia, dissatisfaction with outcomes, and the need for revision surgery (ACOG, 2020, reaffirmed 2026). ACOG further recommends evaluation for underlying functional disorders, psychological concerns, and non-surgical management options before consideration of surgical intervention.

Systematic reviews and meta-analyses evaluating labiaplasty and related cosmetic genital procedures generally demonstrate high patient-reported satisfaction rates; however, the available evidence is derived primarily from observational studies and is limited by lack of control groups, heterogeneity in surgical techniques, inconsistent outcome measures, and limited long-term follow-up (Escandón et al., 2022; Géczi et al., 2024; Zulfikaroglu et al., 2026). Although reported complication rates are generally low, adverse events including bleeding, wound dehiscence, infection, asymmetry, altered sensation, dyspareunia, and the need for revision procedures have been documented (Escandón et al., 2022; Sorice-Virk et al., 2020).

Additional literature highlights substantial variation in normal vulvar anatomy and cautions against pathologizing normal anatomic diversity. Perceived labial hypertrophy may represent normal physiologic variation rather than disease, and the growing utilization of cosmetic vulvar procedures has been accompanied by ongoing concerns regarding inconsistent terminology, variable clinical indications, and a lack of standardized outcome measures (Perelmuter, 2024; Togo et al., 2026).

Overall, current evidence and guideline-based practice distinguish medically necessary vulvar and labial procedures performed for oncologic, reconstructive, or functional indications from cosmetic or elective genital procedures performed primarily to alter appearance. Cosmetic vulvar and labial procedures have not demonstrated sufficient evidence of improvement in net health outcomes and are therefore not considered medically necessary. This includes procedures performed solely for labial hypertrophy, aesthetic enhancement, or other appearance-related concerns in the absence of a clinically significant medical condition.

Psoriasis

Psoriasis is a chronic, immune- mediated inflammatory disease characterized by dysregulation of multiple inflammatory pathways, including (IL)-17 and IL-23 signaling. The disease may occur at any age and presents in several clinical forms. There are

multiple clinical subtypes of psoriasis. The most common form of psoriasis is chronic plaque psoriasis is the most common subtype, while other major forms include guttate, pustular, erythrodermic, scalp, palmoplantar and nail psoriasis.

Treatment selection is individualized and depends on disease severity, extent of involvement, symptoms, impact on quality of life, comorbid conditions, and prior treatment response. Therapeutic options include topical therapies, phototherapy, photochemotherapy, systemic non-biologic agents, biologic therapies, combination therapy, intralesional corticosteroid injections, and select laser- based treatments (Elmets et al., 2019; Menter et al., 2020).

Joint American Academy of Dermatology-National Psoriasis Foundation (AAD-NPF) guidelines support the use of phototherapy, including narrowband ultraviolet B (NB-UVB), broadband ultraviolet B (BB-UVB), psoralen plus ultraviolet A (PUVA), and targeted phototherapy, as effective treatment options for appropriately selected patients with psoriasis. Phototherapy may be used alone or in combination with topical or systemic therapies and remains an important treatment modality for patients with moderate-to-severe disease or disease that is inadequately controlled with topical therapies alone (Elmets et al., 2019).

Biologic therapies and targeted systemic agents have significantly improved clinical outcomes for patients with moderate-to-severe psoriasis and are recommended for patients whose disease is not adequately controlled with conventional therapies. Although these agents demonstrate high levels of efficacy and durability, treatment selection must consider disease heterogeneity, comorbidities, patient-specific factors, long-term safety considerations, monitoring requirements, and cost (Menter et al., 2019; Menter et al., 2020).

Current guideline-based management emphasizes a stepwise approach to therapy and recognizes phototherapy, systemic therapies, and biologics as evidence-based treatment options for appropriately selected patients. Treatment decisions should be individualized based on disease severity, body surface area involvement, lesion location, symptom burden, and patient-specific needs (Elmets et al., 2019; Menter et al., 2019; Menter et al., 2020).

Phototherapy, Photochemotherapy, and Psoriasis
Phototherapy involves the controlled therapeutic use of ultraviolet (UV) light, including ultraviolet A (UVA), ultraviolet B (UVB), or combinations of UVA and UVB. Photochemotherapy combines a photosensitizing agent, most commonly psoralen, with (UVA) exposure and is commonly referred to as psoralen plus ultraviolet A (PUVA). Available phototherapy modalities include narrow band ultraviolet B (NB-UVB), broadband ultraviolet B (BB-UVB), PUVA, targeted phototherapy, and other specialized UV- based treatments (Elmets et al., 2019).

Phototherapy and photochemotherapy are established treatment modalities for a variety of inflammatory, lymphoproliferative, and photodermatologic disorders, including psoriasis, atopic dermatitis, cutaneous T-cell lymphoma, lichen disorders, photodermatoses, pityriasis disorders, localized scleroderma, and cutaneous graft-versus-host disease. Selection of treatment modality depends on the underlying diagnosis, disease severity, extent of involvement, prior treatment response, patient-specific factors, and safety considerations (Elmets et al., 2019; Sidbury et al., 2014).

Psoriasis is a chronic immune-mediated inflammatory disease characterized by dysregulation of multiple inflammatory pathways, including interleukin (IL)-17 and IL-23 signaling. Chronic plaque psoriasis is the most common clinical subtype, although guttate, pustular, erythrodermic, scalp, palmoplantar, and nail psoriasis may also occur. Current management includes topical therapies, phototherapy, systemic non-biologic therapies, biologic therapies, combination therapy, targeted small molecule agents, intralesional corticosteroids, and selected laser-based treatments (Elmets et al., 2019; Menter et al., 2019; Menter et al., 2020).

Joint American Academy of Dermatology-National Psoriasis Foundation (AAD-NPF) guidelines support the use of NB-UVB, BB-UVB, and PUVA as effective treatment options for appropriately selected patients with psoriasis. NB-UVB is generally preferred because of its favorable safety profile, convenience, and effectiveness, although PUVA may be appropriate in selected circumstances. Phototherapy may be used alone or in combination with topical or systemic therapies and remains an important treatment option for patients with moderate-to-severe disease or disease inadequately controlled with topical treatments alone (Elmets et al., 2019).

Home NB-UVB phototherapy may be appropriate for selected patients when office-based treatment is impractical and ongoing phototherapy is clinically indicated. AAD-NPF guidance recognizes home phototherapy as a reasonable alternative to office-based treatment for appropriately selected patients with generalized plaque psoriasis, provided adequate patient education, monitoring, and follow-up are maintained (Elmets et al., 2019). Recent evidence has demonstrated comparable effectiveness between home and office-based NB-UVB phototherapy when appropriate patient selection and oversight are utilized (Gelfand et al., 2024).

Targeted phototherapy, including excimer laser and excimer lamp therapy, delivers focused UVB radiation to affected skin while minimizing exposure to surrounding uninvolved tissue. Current guidelines support its use for localized plaque psoriasis, particularly when disease involves less than 10% body surface area or affects difficult-to-treat areas such as the scalp, hands, feet, elbows, knees, and palmoplantar surfaces (Elmets et al., 2019). Pulsed dye laser (PDL) therapy has also demonstrated clinical benefit in selected patients with nail psoriasis and may be considered in that setting (Elmets et al., 2019).

Evidence supporting other light-based modalities is more limited. The AAD-NPF guideline does not recommend topical aminolevulinic acid (ALA) or methyl aminolevulinate (MAL) photodynamic therapy (PDT) for localized psoriasis, palmoplantar psoriasis, or nail psoriasis. Similarly, insufficient evidence exists to support routine use of grenz ray therapy, visible light therapy, or other non-established light-based modalities for psoriasis management. These technologies have not demonstrated sufficient evidence of improvement in net health outcomes compared with established therapies and therefore remain investigational or not medically necessary when used for psoriasis (Elmets et al., 2019).

Overall, current evidence and professional society guidelines support phototherapy, photochemotherapy, home NB-UVB phototherapy, and targeted UVB therapies as effective treatment options for appropriately selected patients with psoriasis and certain other dermatologic disorders. Treatment selection should be individualized based on disease characteristics, prior treatment response, safety considerations, and patient-specific factors, with modalities lacking sufficient evidence of clinical benefit reserved as investigational or not medically necessary.

Rosacea

Rosacea is a chronic inflammatory disorder that primarily affects the central face and is characterized by persistent erythema, flushing, papules, pustules, telangiectasia, phymatous changes, and, in some patients, ocular manifestations. The disorder is chronic and relapsing, with periods of exacerbation and remission, and may result in progressive changes in appearance and reduced quality of life if left untreated (Schaller et al., 2020; Thiboutot et al., 2020).

Current consensus recommendations have transitioned from a subtype-based classification system to a phenotype-based approach, with treatment tailored to the specific clinical manifestations present in each patient (Schaller et al., 2020). Evidence-based management includes topical therapies such as metronidazole, azelaic acid, ivermectin, and other anti-inflammatory agents, as well as oral tetracycline-class antibiotics for inflammatory papules and pustules. Oral isotretinoin may be considered in selected patients with refractory or severe disease (Del Rosso et al., 2020; Thiboutot et al., 2020).

Treatment is directed toward controlling inflammation, reducing disease activity, minimizing symptoms, preventing progression, and improving quality of life. Although rosacea is not curable, most patients experience meaningful symptom control with appropriate medical management. Current guideline-supported therapies primarily focus on pharmacologic treatment of inflammatory and ocular manifestations, with long-term management often required due to the chronic nature of the disorder (Thiboutot et al., 2020; Schaller et al., 2020).

Device-based therapies, including vascular lasers and intense pulsed light (IPL), have demonstrated improvement in persistent erythema and telangiectasia in selected patients. However, these treatments are primarily directed toward reducing visible vascular changes and improving appearance rather than treating underlying disease activity. Available evidence is limited by heterogeneity in rosacea phenotypes, treatment protocols, outcome measures, and comparative effectiveness data across modalities (Thiboutot et al., 2020; Del Rosso et al., 2020).

Overall, current evidence and professional society recommendations support office-based evaluation and evidence-based pharmacologic therapy as the foundation of rosacea management. While laser and light-based therapies may improve vascular manifestations, these interventions are generally directed at cosmetic or appearance-related outcomes and are not considered medically necessary.

Home Phototherapy (UVB) for Vitiligo

Vitiligo is a chronic acquired pigmentary disorder characterized by the loss of functional melanocytes, resulting in well-demarcated depigmented macules and patches. Narrowband ultraviolet B (NB-UVB) phototherapy is considered a cornerstone of treatment for patients with widespread or progressive disease and is commonly administered in the office setting under physician supervision (Mohammad et al., 2017; Seneschal et al., 2023).

Home NB-UVB phototherapy has emerged as a potential alternative to office-based treatment because it may improve treatment accessibility and adherence.
The International Vitiligo Task Force noted that home phototherapy may provide comparable, repigmentation outcomes and improved convenience for selected patients; however, important challenges remain regarding optimal patient selection. optimal patient selection. treatment protocols, safety monitoring, and long-term management (Seneschal et al., 2023).

The Vitiligo Working Group has also emphasized the absence of universally accepted protocols for NB-UVB administration in vitiligo, with significant variability in treatment schedules, dosing approaches, and monitoring practices (Mohammad et al., 2017) A systematic review of randomized controlled trialsevaluating home-based phototherapy with institution-based phototherapy for vitiligoidentified conflicting findings regarding treaetment effectiveness and reported no significant differences in repigmentation rates when compared with comparator groups. Although treatment adherence was generally higher home-phototherapy groups, adverse effects occurred more frequently, and long-term term = maintenance of treatment response was not adequately evaluated (Ashraf et al., 2022).

Overall, while NB-UVB phototherapy remains an established treatment option for vitiligo, current evidence regarding home-based phototherapy is limited by inconsistent treatment protocols, variability in patient selection, insufficient long-term outcome data,

and ongoing concerns regarding safety monitoring. Additional high-quality studies are needed to better define the role of home phototherapy in the management of vitiligo (Ashraf et al., 2022; Mohammad et al., 2017; Seneschal et al., 2023).

Total Body Photography and Emerging Skin Imaging Technologies
Total-body photography (TBP) is a noninvasive imaging technology that captures high-resolution images of the skin surface to assist with longitudinal monitoring of pigmented lesions and skin cancer surveillance. Both two-dimensional (2D) and three-dimensional (3D) systems are available, and many platforms incorporate digital dermoscopy, lesion mapping, automated lesion tracking, artificial intelligence (AI) image analysis, and other software-based tools intended to support lesion detection and monitoring of high-risk populations (Cerminara et al., 2023; Garbe et al., 2025). Although professional guidelines acknowledge that TBP and sequential digital dermoscopy may serve as adjunctive tools in selected high-risk individuals, these technologies are not a substitute for comprehensive skin examination, dermoscopy, biopsy, or histopathologic evaluation, which remain the foundation of melanoma diagnosis and surveillance (Garbe et al., 2025)

Interest in TBP has increased with the development of AI-assisted image analysis and advanced three-dimensional imaging systems. Early studies suggest that these technologies may improve lesion visualization and support serial monitoring; however, available evidence demonstrates variability in diagnostic performance, differences in sensitivity and specificity across platforms, challenges with automated lesion identification and counting, and uncertainty regarding integration into routine clinical practice. Recent studies and expert commentary have also noted concerns regarding false-positive findings, increased biopsy rates of benign lesions, workflow implications, and unclear effects on long-term clinical outcomes and cost-effectiveness (Cerminara et al., 2023; Ferris & Adamson, 2025; Soyer et al., 2025).

Reflectance confocal microscopy (RCM) is a noninvasive imaging technology that provides near-histologic visualization of the epidermis and superficial dermis and may assist in the evaluation of selected pigmented and non-pigmented skin lesions. Although RCM has demonstrated utility in lesion characterization and may reduce unnecessary biopsies in specialized settings, current evidence supports its use as an adjunct to clinical examination, dermoscopy, and histopathologic assessment rather than as a replacement for standard diagnostic approaches. Limitations include operator dependence, specialized training requirements, restricted imaging depth, variability in interpretation, limited availability, and uncertainty regarding its impact on long-term clinical outcomes and net health benefit (Ho et al., 2024; Deussing et al., 2025; Deußing et al., 2025; Moscarella et al., 2024).

Molecular fluorescent imaging and other emerging skin imaging technologies are being investigated as noninvasive tools to assist in the detection and characterization of suspicious pigmented lesions. Preliminary studies have demonstrated promising

diagnostic performance; however, available evidence remains limited to early validation studies and has not established improvement in melanoma detection rates, clinical decision-making, patient outcomes, or cost-effectiveness compared with standard evaluation methods (Grossman et al., 2026). Current melanoma guidelines continue to emphasize clinical examination, dermoscopy, biopsy, and histopathologic assessment as the diagnostic standard, and these technologies have not been incorporated into routine diagnostic recommendations (AAD, 2026; Garbe et al., 2025).

Professional guidelines continue to support comprehensive skin examination, dermoscopy, biopsy when indicated, and histopathologic evaluation as the foundation of melanoma diagnosis and surveillance. While TBP, AI-assisted lesion analysis, RCM, molecular fluorescent imaging, and other advanced skin imaging technologies may serve as adjunctive tools in selected clinical settings, current evidence has not consistently demonstrated improvement in net health outcomes when used for routine screening, diagnosis, monitoring, or surveillance. Additional high-quality studies are needed to establish their clinical utility, optimal patient selection, long-term outcomes, and cost-effectiveness (AAD, 2026; Garbe et al., 2025; Ho et al., 2024).

Accordingly, total-body photography, three-dimensional total-body photography, artificial intelligence-assisted lesion analysis, reflectance confocal microscopy, molecular fluorescent imaging, and similar emerging skin imaging technologies remain investigational because their impact on clinical management and health outcomes has not been fully established (AAD, 2026; Garbe et al., 2025).

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
Joint American Academy of Dermatology (AAD)-National Psoriasis Foundation (NPF)	Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures (2021) Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies (2020) Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics (2019) Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the

	management and treatment of psoriasis with phototherapy (2019) Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis in pediatric patients (2019)
European Dermatology Forum (EDF)	EuroGuiDerm Guideline for the Systemic Treatment of Psoriasis Vulgaris (2023)
National Comprehensive Cancer Network (NCCN)	NCCN Guidelines- Squamous Cell Skin Cancer (2026) NCCN Guidelines- Basal Cell Skin Cancer (2026) NCCN Guidelines- Vulvar Cancer (2026)
The Alopecia Areata Consensus of Experts (ACE)	The Alopecia Areata Consensus of Experts (ACE) study: Results of an international expert opinion on treatments for alopecia areata (2020)
The National Alopecia Areata Foundation (NAAF)	Available Treatments - National Alopecia Areata Foundation | NAAF (n.d.)
British Association of Dermatologists	British Association of Dermatologists living guideline for managing people with alopecia areata 2024
American Academy of Dermatology (AAD)	Guidelines of care for the management of acne vulgaris (2024) Guidelines of care for the management of atopic dermatitis in adults with topical therapies (2023) Guidelines of care for the management of atopic dermatitis with phototherapy and systemic agents (2014) Guidelines of care for the management of atopic dermatitis in pediatric patients (2026) Guidelines of care for the management of basal cell carcinoma (2018)

	Guidelines of care for the management of cutaneous squamous cell carcinoma (2018) Guidelines of care for the management of primary cutaneous melanoma (2018)
International Advisory Panel on Scar Management	Updated international clinical recommendations on scar management: part 2--algorithms for scar prevention and treatment (2014)
American Medical Association (AMA)	Evidence-Based Clinical Practice Guidelines for Laser-Assisted Drug Delivery (2022)
American Acne & Rosacea Society (AARS)	Update on the Management of Rosasea from the American Acne and Rosacea Society (AARS) (2019)
Global ROSacea COnsensus (ROSCO) panel	Recommendations for rosacea diagnosis, classification and management: update from the global ROSacea Consensus 2019 panel
National Rosacea Society (NRS)	All About Rosacea: Signs & Symptoms and Treatment
National Rosacea Society Expert Committee	Standard management options for rosacea: The 2019 update by the National Rosacea Society Expert Committee
American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice	ACOG Committee Opinion Number 795, January 2020. Elective Female Genital Cosmetic Surgery. (Replaces Committee Opinion Number 378, September 2007. Reaffirmed 2026) Vaginal Rejuvenation, Labiaplasty, and Other Female Genital Cosmetic Surgery
European Dermatology Forum (EDF)	European consensus-based interdisciplinary guideline for melanoma. Part 1: Diagnostics - Update 2024

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Decision date
Fractional CO2 Laser Therapy System (EXFU CO2)	K242183	10/23/2024
UltraPulse Alpha CO2 Laser System	K220467	05/18/2022
JOULE System	K180508	05/18/2018
Candela (Syneron) CO_2RE Laser System	K181523	07/11/2018
Quanta System Spa	K173002	12/13/2017
Palomar (Cynosure) ICON	K110907	06/22/2011
eCO2 Plus, DENTA III, DENTA III+, and SP III Laser Systems	K100610	01/20/2011
FRAXEL RE:PAIR (FRAXEL III SR) LASER SYSTEM	K080915	07/01/2008

VI. CODING

See also:
Priority Health Removal of Benign Skin Lesions Billing Policy No. 093

A. Treatment of Skin Conditions

1. PUVA and UVB Treatment

ICD-10 Codes: *These diagnoses support medical necessity of the procedures listed below:*

B36.0	Pityriasis versicolor
C84.00 - C84.09	Mycosis fungoides
C84.10 - C84.19	Sezary disease
C86.6	Primary cutaneous CD30-positive T-cell proliferations
D89.810 - D89.813	Graft-versus-host disease
L11.1	Transient acantholytic dermatosis [Grover]
L20.0 - L20.9	Atopic dermatitis
L28.0 - L28.2	Lichen simplex chronicus and prurigo
L29.0 - L29.9	Pruritus ani
L30.5	Pityriasis alba
L40.0 – L40.9	Psoriasis
L41.0 – L41.9	Parapsoriasis

L42	Pityriasis rosea
L43.0 - L43.9	Lichen planus
L44.0 - L44.9	Other papulosquamous disorders
L45	Papulosquamous disorders in diseases classified elsewhere
L56.0 - L56.9	Other acute skin changes due to ultraviolet radiation
L66.1	Lichen planopilaris
L80	Vitiligo
L90.0	Lichen sclerosus et atrophicus
L94.0	Localized scleroderma [morphea]
L94.1	Linear scleroderma
L94.3	Sclerodactyly
L94.5	Poikiloderma vascular atrophicans
L98.1	Factitial dermatitis
T86.00 - T86.09	Complications of bone marrow transplant

CPT/HCPCS Codes:

96900	Actinotherapy (ultraviolet light)
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photo responsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings)

2. Home Phototherapy

ICD-10 Codes: These diagnoses may support medical necessity of the devices listed below:

L40.0 - L40.4	Psoriasis
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified
L41.0 - L41.9	Parapsoriasis

CPT/HCPCS Codes:

E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four-foot panel
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six-foot panel
E0694	Ultraviolet multidirectional light therapy system in six-foot cabinet,

includes bulbs/lamps, timer and eye protection

3. **Premalignant Skin Lesions**

ICD-10 Codes: This diagnosis supports medical necessity of the CPT/HCPCS codes listed below:

L57.0 Actinic keratosis

CPT/HCPCS Codes:

96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day
96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
96574	Debridement of premalignant hyperkeratotic lesion(s) (i.e., targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
J7308	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7345	Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg

ICD-10 Codes: *The procedures listed below are medically necessary for these diagnoses only:*

C44.00 - C44.99	Other and unspecified malignant neoplasm of skin
D48.5	Neoplasm of uncertain behavior of skin
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
L57.0	Actinic keratosis

CPT/HCPCS Codes:

15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face

15782	Dermabrasion; regional, other than face

ICD-10 Codes: *The procedures listed below are medically necessary for these diagnoses only:*

C44.00 - C44.99	Other and unspecified malignant neoplasm of skin
D48.5	Neoplasm of uncertain behavior of skin
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
L57.0	Actinic keratosis

CPT/HCPCS Codes:

15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal

4. Laser Therapy

ICD-10 Codes: *These diagnoses support medical necessity of the procedures listed below:*

L40.0 - L40.4	Psoriasis
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified

CPT/HCPCS Codes:

96920	Excimer laser treatment for psoriasis; total area less than 250 sq cm
96921	Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm
96922	Excimer laser treatment for psoriasis; over 500 sq cm
15793	Chemical peel, nonfacial; dermal

5. Not Medically Necessary

ICD-10 Codes: *Services billed with these diagnoses are not medically necessary for treatment.*

L57.3	Poikiloderma of Civatte
L63.0 – L63.9	Alopecia areata
L64.0 – L64.9	Androgenic alopecia
L65.0 – L65.9	Other nonscarring hair loss
L66.0 – L66.9	Cicatricial alopecia [scarring hair loss]
L70.0 - L70.9	Acne
L71.1 - L71.9	Rosacea

L73.0	Acne keloid
L81.0 – L81.9	Other disorders of pigmentation
L95.8	Other vasculitis limited to the skin
L95.9	Vasculitis limited to the skin, unspecified
L98.8	Other specified disorders of the skin and subcutaneous tissue
L98.9	Disorder of the skin and subcutaneous tissue, unspecified

CPT/HCPCS Codes:
Evaluation & Management codes for new or established patients are allowed when billed with the diagnoses above.

Treatment services are not medically necessary for the diagnoses above include but are not limited to:

- Medicine services including injections
- Medication used in treatment except that which is subject to pharmacy coverage
- Minor or major surgical procedures including but not limited to:

10040	Extraction (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site, (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq. cm
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq. cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq. cm

17340	Cryotherapy (CO_2 slush, liquid N_2) for acne
17360	Chemical exfoliation for acne (e.g., acne paste, acid)

6. Vulvar and Labial Surgical Procedures

Inclusions:
ICD-10 Codes:

C51.0	Malignant neoplasm of the labium majus
C51.1	Malignant neoplasm of the labium minus
C51.2	Malignant neoplasm of the clitoris
C51.8	Malignant neoplasm of overlapping sites of vulva
C51.9	Unspecified malignant neoplasm of the vulva or external female genitalia
D07.1	Carcinoma in situ of the vulva
N90.0	Mild vulvar dysplasia
N90.1	Moderate vulvar dysplasia

CPT/HCPCS Codes:

56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56630	Vulvectomy, radical, partial
56631	Vulvectomy, radical, partial; with unilateral inguinofemoral lymphadenectomy
56632	Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy
56633	Vulvectomy, radical, complete;
56634	Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy
56637	Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy
56640	Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy

Exclusions:

ICD-10 Codes: *Services billed with this diagnosis are not* medically necessary

N90.60	Unspecified hypertrophy of vulva
N90.61	Childhood asymmetric labium majus enlargement

N90.69	Other specified hypertrophy of vulva

Services are considered cosmetic/ not medically necessary when billed with the diagnoses listed below:

15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
56620	Vulvectomy simple; partial

7. Other Not Medically Necessary Procedures and Items.

CPT/HCPCS Codes:

E1399	Durable medical equipment, miscellaneous (Explanatory notes must accompany claims billed with unlisted codes.)
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
17380	Electrolysis epilation, each 30 minutes
0700T	Molecular fluorescent imaging of suspicious nevus; first lesion
0701T	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion
96934	Reflectance confocal microscopy (RCM) for cellular and sub-

cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)

96935 Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)

96936 Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)

8. Other Benign Conditions:

Removal of skin tags

11200 Removal of skin tags, multiple fibro cutaneous tags, any area; up to and including 15 lesions

11201 Removal of skin tags, multiple fibro cutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)

Seborrheic Keratosis

ICD-10 Diagnosis:

L82.0 Inflamed seborrheic keratosis

L82.1 Other seborrheic keratosis

Professional or facility treatment services for the diagnoses above include but are not limited to:

- Anesthesia
- Minor or major surgical procedures
- Not covered for Medicaid

Vitiligo

ICD-10 Diagnosis:

L80 Vitiligo

Professional or facility treatment services for the diagnoses above include but are not limited to:

- Anesthesia
- Medical procedures and services
- Limitations do not include treatments mentioned elsewhere in this policy

Treatment of Lipoma

ICD-10 Diagnosis:

D17.0	Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck
D17.1	Benign lipomatous neoplasm of skin and subcutaneous tissue of trunk
D17.20 0 D17.24	Benign lipomatous neoplasm of skin and subcutaneous tissue of limb
D17.30 – D17.39	Benign lipomatous neoplasm of skin and subcutaneous tissue of other and unspecified sites
D 17.9	Benign lipomatous neoplasm, unspecified

Professional or facility treatment services for the diagnoses above include but are not limited to:

- Anesthesia
- Minor or major surgical procedures

B. Suspicious Lesions:

From Principles of CPT Coding: “When an excised lesion is a neoplasm of uncertain morphology (i.e. benign vs. malignant), choosing the correct CPT code relates to the manner in which the lesion was approached rather than the final pathologic diagnosis, since the CPT code should reflect the knowledge, skill, time, and effort that the physician invested in the excision of the lesion. Therefore, an ambiguous but low-suspicion lesion might be excised with minimal surrounding grossly normal skin/soft tissue margins, as for benign lesion codes. An ambiguous but moderate-to high-suspicion lesion would be excised with moderate to wide surrounding grossly normal skin/soft tissue margins as for malignant lesions codes” (American Medical Association, 2017).

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

Society and Professional Guidelines

1. American Academy of Dermatology. Acne clinical guideline [Internet]. Rosemont (IL): American Academy of Dermatology; 2026 [cited 2026 Jul 22]. Available from: https://www.aad.org/member/clinical-quality/guidelines/acne
2. American Acne & Rosacea Society (AARS). Consensus Recommendations from the American Acne & Rosacea Society on the Management of Rosacea. 2013–2014. Accessed June 28, 2026. Available at URL address: https://acneandrosacea.org/rosacea-medical-management-guidelines/
3. American College of Obstetricians and Gynecologists (ACOG), Committee on Gynecologic Practice. ACOG Committee Opinion No. 795. Elective Female Genital Cosmetic Surgery. Jan 2020 (reaffirmed 2026). Accessed June 29, 2026. Available from: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/elective-female-genital-cosmetic-surgery
4. American College of Obstetricians and Gynecologists (ACOG). Vaginal Rejuvenation, Labiaplasty, and Other Female Genital Cosmetic Surgery. Last reviewed: August 2025. https://www.acog.org/womens-health/faqs/vaginal-rejuvenation-labiaplasty-and-other-female-genital-cosmetic-surgery
5. American Medical Association. Principles of CPT Coding. 9th ed. Chicago (IL): American Medical Association; 2017.

6. Centers for Medicare & Medicaid Services (CMS). National coverage determination (NCD) for treatment of keloids and other skin lesions (250.4) [Internet]. Baltimore (MD): CMS; [cited 2026 Jun 30]. Available from: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=129
7. Davis DMR, Alikhan A, Bercovitch L, Cohen DE, Darr JM, Drucker AM, Eichenfield LF, Frazer-Green L, Paller AS, Schwarzenberger K, Silverberg JI, Singh AM, Wu PA, Sidbury R. Guidelines of care for the management of atopic dermatitis in pediatric patients. J Am Acad Dermatol. 2026 Jul;95(1):121.e1-121.e26. doi: 10.1016/j.jaad.2026.02.113. Epub 2026 Apr 7. PMID: 41949508.
8. Del Rosso JQ, Tanghetti E, Webster G, Stein Gold L, Thiboutot D, Gallo RL. Update on the Management of Rosacea from the American Acne & Rosacea Society (AARS). J Clin Aesthet Dermatol. 2020 Jun;13(6 Suppl):S17-S24. Epub 2020 Jun 1. PMID: 33282106; PMCID: PMC7710291.
9. Eisen DB, Asgari MM, Bennett DD, Connolly SM, Dellavalle RP, Freeman EE, Goldenberg G, Leffell DJ, Peschin S, Sligh JE, Wu PA, Frazer-Green L, Malik S, Schlesinger TE. Guidelines of care for the management of actinic keratosis. J Am Acad Dermatol. 2021 Oct;85(4):e209-e233. doi: 10.1016/j.jaad.2021.02.082. Epub 2021 Apr 2. PMID: 33820677; PMCID: PMC12255292.
10. Eisen DB, Dellavalle RP, Frazer-Green L, Schlesinger TE, Shive M, Wu PA. Focused update: Guidelines of care for the management of actinic keratosis. J Am Acad Dermatol. 2022 Aug;87(2):373-374.e5. doi: 10.1016/j.jaad.2022.04.013. Epub 2022 Apr 18. PMID: 35439607.
11. Elmets CA, Korman NJ, Prater EF, Wong EB, Rupani RN, Kivelevitch D, Armstrong AW, Connor C, Cordoro KM, Davis DMR, Elewski BE, Gelfand JM, Gordon KB, Gottlieb AB, Kaplan DH, Kavanaugh A, Kiselica M, Kroshinsky D, Lebwohl M, Leonardi CL, Lichten J, Lim HW, Mehta NN, Paller AS, Parra SL, Pathy AL, Siegel M, Stoff B, Strober B, Wu JJ, Hariharan V, Menter A. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol. 2021 Feb;84(2):432-470. doi: 10.1016/j.jaad.2020.07.087. Epub 2020 Jul 30. PMID: 32738429.
12. Elmets CA, Lim HW, Stoff B, Connor C, Cordoro KM, Lebwohl M, Armstrong AW, Davis DMR, Elewski BE, Gelfand JM, Gordon KB, Gottlieb AB, Kaplan DH, Kavanaugh A, Kiselica M, Kivelevitch D, Korman NJ, Kroshinsky D, Leonardi CL, Lichten J, Mehta NN, Paller AS, Parra SL, Pathy AL, Farley Prater EA, Rupani RN, Siegel M, Strober BE, Wong EB, Wu JJ, Hariharan V, Menter A. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy. J Am Acad Dermatol. 2019 Sep;81(3):775-804. doi: 10.1016/j.jaad.2019.04.042. Epub 2019 Jul 25. Erratum in: J Am Acad Dermatol. 2020 Mar;82(3):780. doi: 10.1016/j.jaad.2019.11.024. PMID: 31351884.
13. Gold MH, Berman B, Clementoni MT, Gauglitz GG, Nahai F, Murcia C. Updated international clinical recommendations on scar management: part 1--evaluating the evidence. Dermatol Surg. 2014 Aug;40(8):817-24. doi: 10.1111/dsu.0000000000000049. PMID: 25068543.

14. Gold MH, McGuire M, Mustoe TA, Pusic A, Sachdev M, Waibel J, Murcia C; International Advisory Panel on Scar Management. Updated international clinical recommendations on scar management: part 2--algorithms for scar prevention and treatment. Dermatol Surg. 2014 Aug;40(8):825-31. doi:10.1111/dsu.0000000000000050. PMID: 25068544.
15. Labadie JG, Ibrahim SA, Worley B, Kang BY, Rakita U, Rigali S, Arndt KA, Bernstein E, Brauer JA, Chandra S, Didwania A, DiGiorgio C, Donelan M, Dover JS, Galadari H, Geronemus RG, Goldman MP, Haedersdal M, Hruza G, Ibrahimi OA, Kauvar A, Kelly KM, Krakowski AC, Miest R, Orringer JS, Ozog DM, Ross EV, Shumaker PR, Sobanko JF, Suozzi K, Taylor MB, Teng JMC, Uebelhoer NS, Waibel J, Wanner M, Ratchev I, Christensen RE, Poon E, Miller CH, Alam M. Evidence-Based Clinical Practice Guidelines for Laser-Assisted Drug Delivery. JAMA Dermatol. 2022 Oct 1;158(10):1193-1201. doi: 10.1001/jamadermatol.2022.3234. PMID: 35976634.
16. Menter A, Strober BE, Kaplan DH, Kivelevitch D, Prater EF, Stoff B, Armstrong AW, Connor C, Cordoro KM, Davis DMR, Elewski BE, Gelfand JM, Gordon KB, Gottlieb AB, Kavanaugh A, Kiselica M, Korman NJ, Kroshinsky D, Lebwohl M, Leonardi CL, Lichten J, Lim HW, Mehta NN, Paller AS, Parra SL, Pathy AL, Rupani RN, Siegel M, Wong EB, Wu JJ, Hariharan V, Elmets CA. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019 Apr;80(4):1029-1072. doi: 10.1016/j.jaad.2018.11.057. Epub 2019 Feb 13. PMID: 30772098.
17. Nast A, Spuls PI, Dressler C, et al. EuroGuiDerm guideline for the systemic treatment of psoriasis vulgaris. Updated February 2025. Available at: https://www.guidelines.edf.one
18. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology: basal cell skin cancer and squamous cell skin cancer (non-melanoma skin cancers) [Internet]. Version 2026. Plymouth Meeting (PA): NCCN; 2026 [cited 2026 Jun 29]. Available from: https://www.nccn.org/professionals/physician_gls/pdf/nmsc.pdf
19. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology: squamous cell skin cancer [Internet]. Version 2026. Plymouth Meeting (PA): NCCN; 2026 [cited 2026 Jun 29]. Available from: https://www.nccn.org/professionals/physician_gls/pdf/squamous.pdf
20. National Comprehensive Cancer Network (NCCN). NCCN clinical practice guidelines in oncology: vulvar cancer (squamous cell carcinoma) [Internet]. Version 2026. Plymouth Meeting (PA): NCCN; 2026 [cited 2026 Jun 29]. Available from: https://www.nccn.org/professionals/physician_gls/pdf/vulvar.pdf
21. Ogawa R, Akita S, Akaishi S, Aramaki-Hattori N, Dohi T, Hayashi T, Kishi K, Kono T, Matsumura H, Muneuchi G, Murao N, Nagao M, Okabe K, Shimizu F, Tosa M, Tosa Y, Yamawaki S, Ansai S, Inazu N, Kamo T, Kazki R, Kuribayashi S. Diagnosis and Treatment of Keloids and Hypertrophic Scars-Japan Scar Workshop Consensus Document 2018. Burns Trauma. 2019 Dec 27;7:39. doi: 10.1186/s41038-019-0175-y. PMID: 31890718; PMCID: PMC6933735.
22. Reynolds RV, Yeung H, Cheng CE, Cook-Bolden F, Desai SR, Druby KM, Freeman EE, Keri JE, Stein Gold LF, Tan JKL, Tollefson MM, Weiss JS, Wu PA, Zaenglein AL, Han JM, Barbieri JS. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol. 2024 May;90(5):1006.e1-1006.e30. doi: 10.1016/j.jaad.2023.12.017. Epub

2024 Jan 30. Erratum in: J Am Acad Dermatol. 2026 Apr 11:S0190-9622(26)00546-3. doi: 10.1016/j.jaad.2026.04.009. PMID: 38300170.
23. Sidbury R, Alikhan A, Bercovitch L, Cohen DE, Darr JM, Drucker AM, Eichenfield LF, Frazer-Green L, Paller AS, Schwarzenberger K, Silverberg JI, Singh AM, Wu PA, Davis DMR. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. J Am Acad Dermatol. 2023 Jul;89(1):e1-e20. doi: 10.1016/j.jaad.2022.12.029. Epub 2023 Jan 12. PMID: 36641009.
24. Schaller M, Almeida LMC, Bewley A, Cribier B, Del Rosso J, Dlova NC, Gallo RL, Granstein RD, Kautz G, Mannis MJ, Micali G, Oon HH, Rajagopalan M, Steinhoff M, Tanghetti E, Thiboutot D, Troielli P, Webster G, Zierhut M, van Zuuren EJ, Tan J. Recommendations for rosacea diagnosis, classification and management: update from the global ROSacea COnsensus 2019 panel. Br J Dermatol. 2020 May;182(5):1269-1276. doi: 10.1111/bjd.18420. Epub 2019 Oct 16. PMID: 31392722; PMCID: PMC7317217.
25. Sidbury R, Davis DM, Cohen DE, Cordoro KM, Berger TG, Bergman JN, Chamlin SL, Cooper KD, Feldman SR, Hanifin JM, Krol A, Margolis DJ, Paller AS, Schwarzenberger K, Silverman RA, Simpson EL, Tom WL, Williams HC, Elmets CA, Block J, Harrod CG, Begolka WS, Eichenfield LF; American Academy of Dermatology. Guidelines of care for the management of atopic dermatitis: section 3. Management and treatment with phototherapy and systemic agents. J Am Acad Dermatol. 2014 Aug;71(2):327-49. doi: 10.1016/j.jaad.2014.03.030. Epub 2014 May 9. PMID: 24813298; PMCID: PMC4410179.
26. Thiboutot D, Anderson R, Cook-Bolden F, Draelos Z, Gallo RL, Granstein RD, Kang S, Macsai M, Gold LS, Tan J. Standard management options for rosacea: The 2019 update by the National Rosacea Society Expert Committee. J Am Acad Dermatol. 2020 Jun;82(6):1501-1510. doi: 10.1016/j.jaad.2020.01.077. Epub 2020 Feb 7. PMID: 32035944.

Acne Vulgaris

1. He SX, Wang Y, Wang J, Tang L, Yang L, Ye FL. Isotretinoin Combined Laser/Light-Based Treatments Versus Isotretinoin Alone for the Treatment of Acne Vulgaris: A Meta-Analysis. J Cosmet Dermatol. 2025 Jan;24(1):e16639. doi: 10.1111/jocd.16639. Epub 2024 Nov 7. PMID: 39509291; PMCID: PMC11743250.
2. Ishii L, Deoghare S, Boen M. Light and laser-based therapy in treatment of acne vulgaris: A clinical review. J Am Acad Dermatol. 2025 Oct;93(4):1058-1064. doi: 10.1016/j.jaad.2025.06.046. Epub 2025 Jun 21. PMID: 40550334.
3. Pour Mohammad A, Seirafianpour F, Jafarzadeh A, Ghahari S, Noroozi E, Nazerian AH, Jamshidi Naeini A, Shokraee K, Mashayekhi F, Mortaja M, Azmi A, Goodarzi A. A comprehensive systematic review on the efficacy, safety, tolerability, and relapse rates of modern procedural therapies for inflammatory and non-inflammatory acne vulgaris. Lasers Med Sci. 2025 Sep 25;40(1):383. doi: 10.1007/s10103-025-04640-3. PMID: 40993442.
4. Trinh T, Petit N, Najmi M, Koch RS, Parekh P, Ramakrishnan S. A systematic review of efficacy and adverse events of various laser treatments for acne vulgaris in diverse skin

types. J Am Acad Dermatol. 2026 Apr 27:S0190-9622(26)02525-9. doi: 10.1016/j.jaad.2026.04.1930. Epub ahead of print. PMID: 42055294.
5. Zhang L, Yang Y, Wang B, Zhao Y, Wang P, Liu J, Yang J, Wu Y, Lv T, Wei Z, Liu X, Wang R, Wong H, Ju Q, Shi L, Wang X. Modified red light 5-aminolevulinic acid photodynamic therapy versus low-dose isotretinoin therapy for moderate to severe acne vulgaris: A prospective, randomized, multicenter study. J Am Acad Dermatol. 2023 Dec;89(6):1141-1148. doi: 10.1016/j.jaad.2023.07.1023. Epub 2023 Aug 7. PMID: 37558093.

Actinic Keratosis

1. Rubel DM, Spelman L, Murrell DF, See JA, Hewitt D, Foley P, Bosc C, Kerob D, Kerrouche N, Wulf HC, Shumack S. Daylight photodynamic therapy with methyl aminolevulinate cream as a convenient, similarly effective, nearly painless alternative to conventional photodynamic therapy in actinic keratosis treatment: a randomized controlled trial. Br J Dermatol. 2014 Nov;171(5):1164-71. Epub 2014 Oct 20. PMID: 24861492.
2. Walker JL, Siegel JA, Sachar M, Pomerantz H, Chen SC, Swetter SM, Dellavalle RP, Stricklin GP, Qureshi AA, DiGiovanna JJ, Weinstock MA. 5-Fluorouracil for Actinic Keratosis Treatment and Chemoprevention: A Randomized Controlled Trial. J Invest Dermatol. 2017 Jun;137(6):1367-1370.

Alopecia

1. Abarca YA, Scott-Emuakpor R, Tirth J, Moroz O, Thomas GP, Yateem D, Golbari R, Aphia N, Lysak Y, Narasimhan N, Siddiqui HF. Alopecia Areata: Understanding the Pathophysiology and Advancements in Treatment Modalities. Cureus. 2025 Jan 31;17(1):e78298. doi: 10.7759/cureus.78298. PMID: 40026917; PMCID: PMC11872173.
2. Alahmadi M, Alghamdi S, Albyali S, Alharbi R, Alanazi D, Altamimi A, Aldahash R, Alharithy R. Lasers and Energy-Based Devices in the Treatment of Androgenetic Alopecia: A Systematic Review and Meta-Analysis. Skin Appendage Disord. 2026 May 15. doi: 10.1159/000551411. Epub ahead of print. PMID: 42339398; PMCID: PMC13286600.
3. Alali A, Alahmadi M, Alsisi G, Alghamdi S, Elmehallawy G, Albelowi L, Altouri H, Albejawi L. The Efficacy of Growth Factor Injection in Androgenic Alopecia: A Systematic Review and Meta-Analysis. Aesthetic Plast Surg. 2026 May 13. doi: 10.1007/s00266-026-05910-3. Epub ahead of print. PMID: 42126441.
4. Asfour L, Cranwell W, Sinclair R. Male Androgenetic Alopecia. 2023 Jan 25. In: Feingold KR, Adler RA, Ahmed SF, Anawalt B, Blackman MR, Chrousos G, Corpas E, de Herder WW, Dhatariya K, Dungan K, Hamilton E, Hofland J, Jan de Beur S, Kalra S, Kaltsas G, Kapoor N, Kim M, Koch C, Kopp P, Korbonits M, Kovacs CS, Kuohung W, Laferrère B, Levy M, McGee EA, McLachlan R, Muzumdar R, Purnell J, Rey R, Sahay R, Shah AS, Sperling MA, Stratakis CA, Trence DL, Wilson DP, editors. Endotext [Internet]. South Dartmouth (MA): MDText.com, Inc.; 2000–. PMID: 25905192.
5. Behrangi E, Amiri S, Zeinali R, Goodarzi A, Roohaninasab M, Khosravi M, Jafarzadeh A. A systematic review of clinical evidence on the efficacy and safety of conditioned media, platelet-rich fibrin, stromal vascular fraction, extracellular vesicles, and stem cells in

androgenetic alopecia. Stem Cell Res Ther. 2026 Apr 15;17(1):194. doi: 10.1186/s13287-026-05016-2. PMID: 41987228; PMCID: PMC13191867.
6. Chen C, Wang S, Bi D, Wei AC, Guo S. Efficacy and Safety of Fractional Laser Therapy for Androgenetic Alopecia: A Systematic Review and Meta-Analysis. J Cosmet Dermatol. 2026 May;25(5):e70909. doi: 10.1111/jocd.70909. PMID: 42121331; PMCID: PMC13168682.
7. Harries MJ, Ascott A, Asfour L, Farrant P, Hale G, Holmes S, Johnson A, Jolliffe VML, Kazmi A, Macbeth AE, Messenger AG, Noor A, Takwale A, Thompson AR, Hashme M, Manounah L, Mohd Mustapa MF, Constantin AM. British Association of Dermatologists living guideline for managing people with alopecia areata 2024. Br J Dermatol. 2025 Jan 24;192(2):190-205. doi: 10.1093/bjd/ljae385. PMID: 39432739.
8. Hurrell Z, Vasiliou VS, Sirois FM, Thompson AR. A systematic review and meta-synthesis of qualitative studies of alopecia: Managing identity and appearance changes. Br J Health Psychol. 2026 Feb;31(1):e70048. doi: 10.1111/bjhp.70048. PMID: 41553006; PMCID: PMC12814765.
9. King B, Ohyama M, Kwon O, Zlotogorski A, Ko J, Mesinkovska NA, Hordinsky M, Dutronc Y, Wu WS, McCollam J, Chiasserini C, Yu G, Stanley S, Holzwarth K, DeLozier AM, Sinclair R; BRAVE-AA Investigators. Two Phase 3 Trials of Baricitinib for Alopecia Areata. N Engl J Med. 2022 May 5;386(18):1687-1699. doi: 10.1056/NEJMoa2110343. Epub 2022 Mar 26. PMID: 35334197.
10. Meah N, Wall D, York K, Bhoyrul B, Bokhari L, Sigall DA, Bergfeld WF, Betz RC, Blume-Peytavi U, Callender V, Chitreddy V, Combalia A, Cotsarelis G, Craiglow B, Donovan J, Eisman S, Farrant P, Green J, Grimalt R, Harries M, Hordinsky M, Irvine AD, Itami S, Jolliffe V, King B, Lee WS, McMichael A, Messenger A, Mirmirani P, Olsen E, Orlow SJ, Piraccini BM, Rakowska A, Reygagne P, Roberts JL, Rudnicka L, Shapiro J, Sharma P, Tosti A, Vogt A, Wade M, Yip L, Zlotogorski A, Sinclair R. The Alopecia Areata Consensus of Experts (ACE) study: Results of an international expert opinion on treatments for alopecia areata. J Am Acad Dermatol. 2020 Jul;83(1):123-130. doi: 10.1016/j.jaad.2020.03.004. Epub 2020 Mar 9. PMID: 32165196.
11. National Alopecia Areata Foundation (NAAF). Available treatments [Internet]. San Rafael (CA): National Alopecia Areata Foundation; [cited 2026 Jun 28]. Available from: https://www.naaf.org/navigation-toolkit/available-treatments/

Keloid Formations

1. Abu Alqam R, Alshammari AJ, Alkhwildi LA, Bamatraf MS, Khashab RM, Al Dwehji AMO, Alsuayri RA, Fadel ZT. Effectiveness of Autologous Fat Grafting in the Treatment of Scars: A Systematic Review and Meta-Analysis. Aesthetic Plast Surg. 2024 Oct;48(19):3945-3961. doi: 10.1007/s00266-024-04131-w. Epub 2024 Jul 16. PMID: 39014237.
2. Bailey J, Schwehr M, Beattie A. Management of Keloids and Hypertrophic Scars. Am Fam Physician. 2024 Dec;110(6):605-611. PMID: 39700364.
3. Bernabe RM, Choe D, Calero T, Lin J, Pham C, Dang J, Madrigal P, Yenikomshian HA, Gillenwater TJ. Laser-Assisted Drug Delivery in the Treatment of Hypertrophic Scars and Keloids: A Systematic Review. J Burn Care Res. 2024 May 6;45(3):590-600. doi: 10.1093/jbcr/irae023. PMID: 38347765.

4. Foppiani JA, Khaity A, Al-Dardery NM, Hasan MT, El-Samahy M, Lee D, Abdelwahab OA, Abd-Alwahed AE, Khitti HM, Albakri K, Lin SJ. Laser Therapy in Hypertrophic and Keloid Scars: A Systematic Review and Network Meta-analysis. Aesthetic Plast Surg. 2024 Oct;48(19):3988-4006. doi: 10.1007/s00266-024-04027-9. Epub 2024 May 17. PMID: 38760539.
5. Jackson K, Lee A, Ahmad N, Nguyen HP. Analysis of Therapeutic Interventions for Hypertrophic and Keloid Scarring: A Systematic Review. J Drugs Dermatol. 2025 Aug 1;24(8):770-776. doi: 10.36849/JDD.8895. PMID: 40773601.
6. Jafarzadeh A, PourMohammad A, Goodarzi A. A systematic review of the efficacy, safety and satisfaction of regenerative medicine treatments, including platelet-rich plasma, stromal vascular fraction and stem cell-conditioned medium for hypertrophic scars and keloids. Int Wound J. 2024 Apr;21(4):e14557. doi: 10.1111/iwj.14557. Epub 2023 Dec 21. PMID: 38126221; PMCID: PMC10961894.
7. Leszczynski R, da Silva CA, Pinto ACPN, Kuczynski U, da Silva EM. Laser therapy for treating hypertrophic and keloid scars. Cochrane Database Syst Rev. 2022 Sep 26;9(9):CD011642. doi: 10.1002/14651858.CD011642.pub2. PMID: 36161591; PMCID: PMC9511989.
8. Sanchez Cruz C, Magallanes Bajana A, de Araujo WM, Ríos CR, Mohamed Khalil MEZ, Medina J, Perozo K, Bentley A, Calderon Martinez E, Romano C. Comparative efficacy of intralesional therapies for keloid scars: a network meta-analysis. Ann Med. 2026 Dec;58(1):2619295. doi: 10.1080/07853890.2026.2619295. Epub 2026 Mar 20. PMID: 41860092; PMCID: PMC13007407.
9. Shen Y, Yang L, Feng D, Wang C, Bai Z, Wang X, Wang J, Feng Y, An A. Therapeutic methods and effect on keloid and hypertrophic scars: a systematic review. Front Med (Lausanne). 2026 Mar 11;13:1702697. doi: 10.3389/fmed.2026.1702697. PMID: 41889496; PMCID: PMC13013025.
10. Tian F, Jiang Q, Chen J, Liu Z. Silicone gel sheeting for treating keloid scars. Cochrane Database Syst Rev. 2023 Jan 3;1(1):CD013878. doi: 10.1002/14651858.CD013878.pub2. PMID: 36594476; PMCID: PMC9808890.

Molecular Fluorescent Imaging

1. Garbe C, Amaral T, Peris K, Hauschild A, Arenberger P, Basset-Seguin N, Bastholt L, Bataille V, Brochez L, Del Marmol V, Dréno B, Eggermont AMM, Fargnoli MC, Forsea AM, Höller C, Kaufmann R, Kelleners-Smeets N, Lallas A, Lebbé C, Leiter U, Longo C, Malvehy J, Moreno-Ramirez D, Nathan P, Pellacani G, Saiag P, Stockfleth E, Stratigos AJ, Van Akkooi ACJ, Vieira R, Zalaudek I, Lorigan P, Mandala M; European Association of Dermato-Oncology (EADO), the European Dermatology Forum (EDF), and the European Organization for Research and Treatment of Cancer (EORTC). European consensus-based interdisciplinary guideline for melanoma. Part 1: Diagnostics - Update 2024. Eur J Cancer. 2025 Jan 17;215:115152. doi: 10.1016/j.ejca.2024.115152. Epub 2024 Nov 28. PMID: 39700658.
2. Grossman D, Berry E, Ko JM, Sivamani R, Mraz S, Dhawan SS, Manbeck K, Shachaf A, Majmudar S, Shachaf C, Leachman S. In vivo molecular skin fluorescence imaging for noninvasive assessment of atypical nevi and melanoma: A validation trial. JAAD Int.

2025 Nov 26;24:279-286. doi: 10.1016/j.jdin.2025.11.010. PMID: 41552701; PMCID: PMC12805332.
3. Swetter SM, Tsao H, Bichakjian CK, Curiel-Lewandrowski C, Elder DE, Gershenwald JE, Guild V, Grant-Kels JM, Halpern AC, Johnson TM, Sober AJ, Thompson JA, Wisco OJ, Wyatt S, Hu S, Lamina T. Guidelines of care for the management of primary cutaneous melanoma. J Am Acad Dermatol. 2019 Jan;80(1):208-250. doi: 10.1016/j.jaad.2018.08.055. Epub 2018 Nov 1. PMID: 30392755.

Psoriasis

1. Anderson KL, Feldman SR. A guide to prescribing home phototherapy for patients with psoriasis: the appropriate patient, the type of unit, the treatment regimen, and the potential obstacles. J Am Acad Dermatol. 2015 May;72(5):868-78.e1. doi: 10.1016/j.jaad.2015.02.003. Epub 2015 Mar 5. PMID: 25748310.
2. Armstrong AW, Siegel MP, Bagel J, et al. From the Medical Board of the National Psoriasis Foundation: Treatment targets for plaque psoriasis. J Am Acad Dermatol 2017; 76:290.
3. Gelfand JM, Armstrong AW, Lim HW, Feldman SR, Johnson SM, Claiborne WCC, Kalb RE, Jakus J, Mangold AR, Flowers RH, Bhutani T, Durkin JR, Bagel J, Fretzin S, Sheehan MP, Krell J, Reeder M, Kaffenberger J, Kartono F, Takeshita J, Bridges AM, Fielding E, Nehal US, Schaecher KL, Howard LM, Eakin GS, Báez S, Bishop BE, Fitzsimmons RC Jr, Papadopoulos M, Song WB, Linn KA, Hubbard RA, Shin DB, Callis Duffin K. Home- vs Office-Based Narrowband UV-B Phototherapy for Patients With Psoriasis: The LITE Randomized Clinical Trial. JAMA Dermatol. 2024 Dec 1;160(12):1320-1328. doi: 10.1001/jamadermatol.2024.3897. Erratum in: JAMA Dermatol. 2025 Mar 1;161(3):342. doi: 10.1001/jamadermatol.2024.6431. PMID: 39319513; PMCID: PMC11425190.
4. Menter A, Gelfand JM, Connor C, Armstrong AW, Cordoro KM, Davis DMR, Elewski BE, Gordon KB, Gottlieb AB, Kaplan DH, Kavanaugh A, Kiselica M, Kivelevitch D, Korman NJ, Kroshinsky D, Lebwohl M, Leonardi CL, Lichten J, Lim HW, Mehta NN, Paller AS, Parra SL, Pathy AL, Prater EF, Rahimi RS, Rupani RN, Siegel M, Stoff B, Strober BE, Tapper EB, Wong EB, Wu JJ, Hariharan V, Elmets CA. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. J Am Acad Dermatol. 2020 Jun;82(6):1445-1486. Epub 2020 Feb 28. PMID: 32119894.
5. Menter A, Strober BE, Kaplan DH, Kivelevitch D, Prater EF, Stoff B, Armstrong AW, Connor C, Cordoro KM, Davis DMR, Elewski BE, Gelfand JM, Gordon KB, Gottlieb AB, Kavanaugh A, Kiselica M, Korman NJ, Kroshinsky D, Lebwohl M, Leonardi CL, Lichten J, Lim HW, Mehta NN, Paller AS, Parra SL, Pathy AL, Rupani RN, Siegel M, Wong EB, Wu JJ, Hariharan V, Elmets CA. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019 Apr;80(4):10291072. Epub 2019 Feb 13. PMID: 30772098.

Reflectance Confocal Microscopy (RCM)

1. Ho G, Gill M, Grant-Kels J, Schwartz RJ, Pellacani G, Gonzalez S, Alessi-Fox C, Guitera P. International expert recommendations on image acquisition for in vivo reflectance confocal microscopy of cutaneous tumors. J Am Acad Dermatol. 2024 Mar;90(3):537-544. doi: 10.1016/j.jaad.2023.09.086. Epub 2023 Oct 26. PMID: 37898340.
2. Deußing M, Schuh S, Thamm J, Winkler D, Schneider S, Nau T, Darsow U, Schnabel V, Ulrich M, Nguyen L, Frenzel D, Fischer C, Ruini C, Ntziachristos V, Kaatz M, Kurzen H, Kardorff B, Herbst R, Grunewald S, Sattler E, Welzel J, Hartmann D. S1 guideline for imaging diagnostics for skin diseases. J Dtsch Dermatol Ges. 2025 Dec;23(12):1616-1630. doi: 10.1111/ddg.15883. Epub 2025 Nov 16. PMID: 41243460; PMCID: PMC12697335.
3. Moscarella E, Ronchi A, Scharf C, Briatico G, Tancredi V, Longo C, Balato A, Argenziano G. Limits of Reflectance Confocal Microscopy in Melanoma Diagnosis. Dermatol Pract Concept. 2024 Jul 1;14(3):e2024205. doi: 10.5826/dpc.1403a205. PMID: 39122535; PMCID: PMC11314506.
Soglia S, Pérez-Anker J, Lobos Guede N, Giavedoni P, Puig S, Malvehy J. Diagnostics Using Non-Invasive Technologies in Dermatological Oncology. Cancers (Basel). 2022 Nov 29;14(23):5886. doi: 10.3390/cancers14235886. PMID: 36497368; PMCID: PMC9738560.

Rosacea

1. Del Rosso JQ, et al. Update on the Management of Rosacea from the American Acne & Rosacea Society (AARS). J Clin Aesthet Dermatol. 2020 Jun;13(6 Suppl):S17-S24.
2. Tan, J, MD and Thiboutot,, D, MD. All About Rosacea: Signs & Symptoms and Treatment. National Rosacea Society. https://www.rosacea.org/patients/all-about-rosacea
3. Thiboutot D, et al. Standard management options for rosacea: The 2019 update by the National Rosacea Society Expert Committee. J Am Acad Dermatol. 2020 Jun;82(6):1501-1510

Total Body Photography

1. Cerminara, S. E., et al. (2023). Diagnostic performance of augmented intelligence with 2D and 3D total body photography and convolutional neural networks in a high-risk population for melanoma under real-world conditions: A new era of skin cancer screening?. European journal of cancer (Oxford, England: 1990), 190, 112954. https://doi.org/10.1016/j.ejca.2023.112954
2. Gallo RL, Granstein RD, Kang S, Mannis M, Steinhoff M, Tan J, Thiboutot D. Standard classification and pathophysiology of rosacea: The 2017 update by the National Rosacea Society Expert Committee. J Am Acad Dermatol. 2018 Jan;78(1):148-155.
3. Garbe C, Amaral T, Peris K, Hauschild A, Arenberger P, Basset-Seguin N, Bastholt L, Bataille V, Brochez L, Del Marmol V, Dréno B, Eggermont AMM, Fargnoli MC, Forsea AM, Höller C, Kaufmann R, Kelleners-Smeets N, Lallas A, Lebbé C, Leiter U, Longo C, Malvehy J, Moreno-Ramirez D, Nathan P, Pellacani G, Saiag P, Stockfleth E, Stratigos AJ, Van Akkooi ACJ, Vieira R, Zalaudek I, Lorigan P, Mandala M; European Association of Dermato-Oncology (EADO), the European Dermatology Forum (EDF), and the

European Organization for Research and Treatment of Cancer (EORTC). European consensus-based interdisciplinary guideline for melanoma. Part 1: Diagnostics - Update 2024. Eur J Cancer. 2025 Jan 17;215:115152. doi: 10.1016/j.ejca.2024.115152. Epub 2024 Nov 28. PMID: 39700658.
4. Marchetti, M. A., et al. (2023). 3D Whole-body skin imaging for automated melanoma detection. Journal of the European Academy of Dermatology and Venereology : JEADV, 37(5), 945–950. https://doi.org/10.1111/jdv.18924
5. Soyer HP, O'Hara M, V Silva C, Horsham C, Jayasinghe D, Sanjida S, Schaider H, Aitken J, Sturm RA, Prow T, Menzies SW, Janda M. Skin cancer excisions and histopathology outcomes when following a contemporary population-based cohort longitudinally with 3D total-body photography. Skin Health Dis. 2023 Jan 22;3(2):e216. doi: 10.1002/ski2.216. PMID: 37013120; PMCID: PMC10066755.

Valvar and Labial Surgical Procedures

1. Escandón JM, Duarte-Bateman D, Bustos VP, Escandón L, Mantilla-Rivas E, Mascaro-Pankova A, Ciudad P, Langstein HN, Manrique OJ. Maximizing Safety and Optimizing Outcomes of Labiaplasty: A Systematic Review and Meta-Analysis. Plast Reconstr Surg. 2022 Oct 1;150(4):776e-788e. doi: 10.1097/PRS.0000000000009552. Epub 2022 Jul 26. PMID: 35877939.
2. Géczi AM, Varga T, Vajna R, Pataki G, Meznerics FA, Ács N, Hegyi P, Nyirády L, Pál P, Farkas N, Fazekas A, Várbíró S, Sára L. Comprehensive Assessment of Labiaplasty Techniques and Tools, Satisfaction Rates, and Risk Factors: A Systematic Review and Meta-analysis. Aesthet Surg J. 2024 Oct 15;44(11):NP798-NP808. doi: 10.1093/asj/sjae143. PMID: 38957153; PMCID: PMC11474617.
3. Perelmuter S. Labia minora hypertrophy: pathologizing diversity? Sex Med Rev. 2024 Jun 26;12(3):263-269. doi: 10.1093/sxmrev/qeae027. PMID: 38751224.
4. Sorice-Virk S, Li AY, Canales FL, Furnas HJ. Comparison of Patient Symptomatology before and after Labiaplasty. Plast Reconstr Surg. 2020 Sep;146(3):526-536. doi: 10.1097/PRS.0000000000007081. PMID: 32842103.
5. Togo JM Sr, Hurtado TM, Gonzalez P. Gynecoplastic Surgery: A Unified Terminology for Female Genital Aesthetic, Reconstructive, and Functional Procedures. Cureus. 2026 Jan 7;18(1):e101015. doi: 10.7759/cureus.101015. PMID: 41658643; PMCID: PMC12880605.
6. Zulfikaroglu E, Kurban D. Sexual function after female genital cosmetic surgery: A systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 2026 Feb 20;318:114894. doi: 10.1016/j.ejogrb.2025.114894. Epub 2025 Dec 13. PMID: 41401752.

Vitiligo

1. Ashraf AZ, et al. The effectiveness of home-based phototherapy for vitiligo: A systematic review of randomised controlled trials. Photodermatol Photoimmunol Photomed. 2022 Sep;38(5):409-417.
2. Mohammad TF, et al. The Vitiligo Working Group recommendations for narrowband ultraviolet B light phototherapy treatment of vitiligo. J Am Acad Dermatol. 2017 May;76(5):879-888.

3. Seneschal J, et al. Worldwide expert recommendations for the diagnosis and management of vitiligo: Position statement from the international Vitiligo Task Force-Part 2: Specific treatment recommendations. J Eur Acad Dermatol Venereol. 2023 Nov;37(11):2185-2195.

SUMMARY OF CHANGES

Deletions:

- Removed coding section language regarding home phototherapy (UVB) units requiring authorization when charges exceed $1,000 and not being a covered benefit for Medicaid.
- Removed specific lesion number threshold (15 lesions) for chemical peels to align with current society guidelines.
- Removed outdated phototherapy exclusions related to pregnancy/lactation and history of keloid formation.
- Removed specific medications listed for treatment of rosacea
- Removed redundant, outdated, or superseded references and policy language.

Additions:

- Added medical necessity criteria and exclusions for photodynamic therapy (PDT), including indications for actinic keratoses, cutaneous squamous cell carcinoma in situ (Bowen disease), and low-risk superficial basal cell carcinoma consistent with current NCCN guidance.
- Added medically necessary indications for vulvar and labial surgical procedures, including malignancy and premalignant disease.
- Expanded exclusions for keloid treatment, including platelet-rich plasma, regenerative medicine therapies, botulinum toxin, and laser-assisted drug delivery.

Changes:

- Converted policy to new template.
- Restructured and reorganized the policy into condition-specific sections with standardized Inclusions, Exclusions, and Limitations, consolidating previously scattered coverage limitations, non-covered services, and coding provisions into condition-specific criteria sections.
- Merged chemical peel and dermabrasion criteria into a new section addressing premalignant skin lesions and early keratinocyte carcinomas.
- Updated chemical peel criteria to align with current society guidelines by replacing topical therapy failure requirements with language stating conventional therapies are not feasible, contraindicated, or have failed.
- Updated background sections and references to reflect current literature, systematic reviews, and professional society guidelines.
- Updated “Labial Hypertrophy” section to “Vulvar and Labial Surgical Procedures.”

Clarifications:

- Clarified limitations, exclusions, and age-specific requirements for psoriasis phototherapy, office-based phototherapy, and targeted UVB therapy.
- Clarified that pulsed dye laser is medically necessary only for nail psoriasis.
- Clarified existing policy language for consistency and readability throughout the policy.

Past committee review dates: 08/2002, 02/2003, 08/2003, 07/2004, 07/2005, 06/2006, 02/2007, 08/2007, 02/2008, 02/2009, 10/2009, 04/2010, 04/2011, 04/2012, 04/2013, 05/2014,

05/2015, 05/2016, 05/2017, 05/2018, 05/2019, 05/2020, 05/2021, 05/2022, 08/2022, 08/2023, 08/2024, 08/2025, 08/2026

AMA CPT Copyright Statement: All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.