



MASSACHUSETTS

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Medical Policy

Ultrasonographic Evaluation of Skin Lesions

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Policy Number: 303

BCBSA Reference Number: 2.01.59A (For Plan internal use only)

NCD/LCD: NA

Related Policies

Dermatoscopy, #[519](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Ultrasonographic evaluation of skin lesions is [INVESTIGATIONAL](#).

Ultrasonographic evaluation as a technique to assess photo-aging or skin rejuvenation techniques is considered cosmetic in nature, and therefore is [NOT MEDICALLY NECESSARY](#).

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

| | Outpatient |
|---------------------------------------|---------------------------------------|
| Commercial Managed Care (HMO and POS) | This is not a covered service. |
| Commercial PPO and Indemnity | This is not a covered service. |
| Medicare HMO Blue SM | This is not a covered service. |
| Medicare PPO Blue SM | This is not a covered service. |

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's

contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

Description

Ultrasonographic evaluation of skin lesions refers to the use of ultrasound to determine the margins and depth of surface tumors or inflammatory skin conditions. Ultrasound transducers of at least 20 MHz are used.

The following applications of ultrasonographic evaluation have been proposed:

- To assess the margins and depth of melanoma and non-melanoma skin cancers to aid in surgical planning,
- To assess actinic keratoses to determine if cryosurgery is an appropriate therapeutic option,
- To follow the course of connective diseases of the skin (i.e., scleroderma) by evaluating the amount and location of collagen in the dermis, and
- To assess inflammatory skin diseases, such as allergic reactions or psoriasis.

Examples of ultrasonographic evaluations of skin lesions include the Episcan® I-200 Ultrasound System from Longport, Inc. and the DermaScan™ C Ultrasonic System from Cortex Technology. All ultrasonographic evaluations of skin lesions are considered investigational or not medically necessary regardless of the commercial name, the manufacturer or FDA approval status.

Summary

The evidence is insufficient for determining whether the use of ultrasound leads to improved health outcomes in patients with skin lesions. No identified study examined whether the use of ultrasonography preoperatively resulted in improved health outcomes, such as lower rates of disease recurrence or increased survival. Given the lack of sufficient high-quality evidence on the impact of ultrasound skin imaging on patient management, this technology is considered investigational. In addition, due to the cosmetic nature of the application, ultrasound skin imaging is considered not medically necessary to assess photoaging or skin rejuvenation techniques.

Policy History

| Date | Action |
|----------------|---|
| 11/2022 | Annual policy review. Policy updated with literature review through October 2022. No references added. Policy statements unchanged. |
| 2/2020 | Policy updated with literature review through February 1, 2020, no references added. Policy statements unchanged. |
| 11/2011-4/2012 | Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements. |
| 1/12/2011 | New policy, effective 1/12/2011 describing ongoing non-coverage. |

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

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