Important note:
Unless otherwise indicated, this policy will apply to all lines of business. Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS’s Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Pulsed Dye Laser Treatment

PRIOR AUTHORIZATION: Required.

POLICY:
Laser therapy may be considered medically necessary for the following conditions:

- Keloids or other hypertrophic scars which are secondary to an injury or covered surgical procedure and either criterion below is met:
  - Causes significant pain requiring chronic analgesic medication; OR
  - Results in significant functional impairment
- Mild to moderate localized plaque psoriasis when the following criteria are met
  - affects 10% or less of their body area AND
  - have failed to adequately respond to 3 or more months of topical treatments
- Port wine stains and other vascular lesions in children when they compromise vital structures, are symptomatic (bleeding, painful, ulcerated, infected), or cause documented functional impairment.

Laser therapy is considered cosmetic for the following conditions (list is NOT inclusive):

- Dyschromia
- Removal of hair for pseudofolliculitis barbae or follicular cysts
- Removal of spider angiomata
- Removal of telangiectasias in adults
- Rosacea
- Acne
- Granuloma faciale
- Rhinophyma
- Genital warts
- Granuloma faciale
- Superficial glomangiomas
- Pyrogenic granuloma
- Verrucae
Pulsed Dye Laser therapy is considered experimental and investigational for all other indications.

For Medicare lines of business see LCD referenced below.

OVERVIEW: Laser is an acronym for light amplification by stimulated emission of radiation. A laser creates orderly beams of intense light of one color. These instruments concentrate the light to produce a cut, a burn or seal of tissue.

Many skin lesions are considered cosmetic and thus treatment is not a benefit for many plans.

MANDATES: Reconstructive Surgery for Craniofacial abnormalities in a child TIC §1367.153

CODES:

Important note: CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17106-17108</td>
<td>Destruction of cutaneous vascular proliferative lesions (e.g., laser technique)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD10 codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D18.00-D18.09</td>
<td>Hemangioma</td>
</tr>
<tr>
<td>L40.0</td>
<td>Psoriasis vulgaris (plaque psoriasis)</td>
</tr>
<tr>
<td>L91.0</td>
<td>Hypertrophic scar (keloid)</td>
</tr>
<tr>
<td>Q82.5</td>
<td>Congenital non-neoplastic nevus (Port wine stain)</td>
</tr>
</tbody>
</table>

CMS: NCD Manual Section Number 140.5: Medicare recognizes the use of lasers for many medical indications. Procedures performed with lasers are sometimes used in place of more conventional techniques. In the absence of a specific non-coverage instruction, and where a laser has been approved for marketing by the Food and Drug Administration, contractor discretion may be used to determine whether a procedure performed with a laser is reasonable and necessary and, therefore, covered.

The determination of coverage for a procedure performed using a laser is made on the basis that the use of lasers to alter, revise, or destroy tissue is a surgical procedure. Therefore, coverage of laser procedures is restricted to practitioners with training in the surgical management of the disease or condition being treated.

No specific LCD for Pulsed Dye Laser Treatment. However, LCD L35090 addresses cosmetic and reconstructive surgery, and LCD L34938 addresses removal of benign skin lesions.

POLICY HISTORY:

<table>
<thead>
<tr>
<th>Status</th>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>11/1/2010</td>
<td>New policy</td>
</tr>
<tr>
<td>Reviewed</td>
<td>10/18/2011</td>
<td>Reviewed.</td>
</tr>
<tr>
<td>Reviewed</td>
<td>10/04/2012</td>
<td>Reviewed.</td>
</tr>
<tr>
<td>Reviewed</td>
<td>9/05/2013</td>
<td>Added CMS language, ICD10 codes. Updated references</td>
</tr>
<tr>
<td>Reviewed</td>
<td>5/22/2014</td>
<td>No changes</td>
</tr>
<tr>
<td>Reviewed</td>
<td>5/28/2015</td>
<td>Revised criteria</td>
</tr>
</tbody>
</table>
MEDICAL COVERAGE POLICY

SERVICE: Laser Treatment of Skin Lesions

Policy Number: 099

Effective Date: 09/01/2019

Last Review: 06/27/2019

Next Review Date: 06/27/2020

Reviewed 6/09/2016 No changes
Reviewed 05/16/2017 No changes
Reviewed 04/03/2018 Coverage criteria modified
Reviewed 06/27/2019 Updated codes. Expanded criteria for children

REFERENCES:
The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.


Hayes Rating:

Vascular lesions:

B  For pulsed dye laser (PDL) or cryogen spray cooled pulsed dye laser (CPDL) treatment of port-wine stain (PWS) in children and adults requiring definitive treatment to alleviate or prevent medical or psychological complications.

B  For PDL or CPDL treatment of superficial hemangiomas or the superficial component of mixed hemangiomas in infants or children requiring definitive treatment to alleviate or prevent medical or psychological complications.

B  For PDL or CPDL treatment of postinvolutional hemangiomas and telangiectasia in infants or children requiring definitive treatment to alleviate or prevent medical or psychological complications.

D1  For PDL or CPDL treatment of low-risk hemangiomas in infants or children when spontaneous resolution is possible and no immediate medical or psychological complications are evident.

D2  For PDL or CPDL treatment of deep hemangiomas, and the deep component of mixed hemangiomas in infants or children.

Psoriasis:

C  For excimer laser or PDL therapy for adult patients with chronic, stable, localized, plaque psoriasis. This Rating is based on positive but low-quality evidence that these laser therapies may provide some treatment benefit in this patient population. However, outstanding questions remain regarding the type of laser therapy that is most effective, the comparative effectiveness versus standard therapy, patient selection, long-term effectiveness and safety, as well as optimal treatment/testing parameters.

D2  For excimer laser and PDL therapy for patients with other types of psoriasis. This Rating is based on insufficient evidence pertaining to the efficacy and safety of these laser therapies for adult patients with types of psoriasis other than plaque psoriasis.

D2  For ultraviolet 1 (UVA1) laser therapy for patients with any type of psoriasis. This Rating is based on the paucity of evidence pertaining to the efficacy and safety of this type of laser therapy.

D2  For laser therapy for children and pregnant and lactating women with psoriasis. This Rating is based on the paucity of studies evaluating laser therapy in this patient group.

Rosacea:

C  For the use of laser and light therapies for the treatment of facial rosacea, including erythematotelangiectatic and papulopustular rosacea. This Rating reflects promising but weak preliminary evidence regarding the efficacy of laser and light therapies.

D  For the use of laser and light therapies in patients with evidence of rhinophyma, phymatous, ocular, variant manifestations of rosacea, or in patients with non-rosacea telangiectasia. This Rating reflects the paucity of evidence that use of laser and light therapies is safe and efficacious in these disease subtypes.