MEDICAL COVERAGE POLICY	
SERVICE:	Laser Treatment of Skin Lesions
Policy Number:	099
Effective Date:	03/01/2021
Last Review:	01/28/2021
Next Review Date:	01/28/2022

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 Summary Plan Description (SPD)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: Laser Treatment of Skin Lesions

PRIOR AUTHORIZATION: Required

POLICY: Plans may exclude coverage for this therapy. Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

For Medicare plans, please refer to appropriate Medicare LCD (Local Coverage Determination). If there is no applicable LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

Laser therapy may be considered medically necessary for ONE or more of the following conditions:

- Keloids or other hypertrophic scars which are secondary to an injury or covered surgical procedure and 1 or more of the below is met:
  - Causes significant pain requiring chronic analgesic medication
  - Results in significant functional impairment
- Mild to moderate localized plaque psoriasis when ALL of 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 1 or more of the following criteria are met:
  - they compromise vital structures,
  - are symptomatic (bleeding, painful, ulcerated, infected)
  - 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.

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

SUPPORTING DATA:

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.

CPT Codes:	17106 - Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm 17107 - Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm 17108 - Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm
CPT Not Covered:	
ICD10 codes:	D18.00-D18.09 Hemangioma L40.0 Psoriasis vulgaris (plaque psoriasis) L91.0 Hypertrophic scar (keloid) Q82.5 Congenital non-neoplastic nevus (Port wine stain)
ICD10 Not covered:	

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.

POLICY HISTORY:

Status	Date	Action
New	11/1/2010	New policy
Reviewed	10/18/2011	Reviewed.
Reviewed	10/04/2012	Reviewed.
Reviewed	9/05/2013	Added CMS language, ICD10 codes. Updated references
Reviewed	5/22/2014	No changes
Reviewed	5/28/2015	Revised criteria
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
Reviewed	05/28/2020	Reviewed and aligned for FirstCare and SWHP
Reviewed	01/28/2021	No changes except to correct erroneous CPT code.

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan 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.

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4. Dover JS, Arndt KA, Dinehart SM, et al. Guidelines of care for laser surgery. American Academy of Dermatology, Guidelines/Outcomes Committee. J Am Acad Dermatol. 1999;41(3 Pt 1):484-495.
5. Griffiths CEM, Clark CM, Chalmers RJG, et al. A systematic review of treatments for severe psoriasis. Health Technol Assess. 2001; 40(4):125.
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15. Ross BS, Levine VJ, Nehal K, et al. Pulsed dye laser treatment of warts: An update. Dermatol Surg. 1999;25(5):377-380.
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18. Neuhaus IM, Zane LT, Tope, WD. Comparative Efficacy of nonpurpuragenic pulsed dye laser and intense pulsed light for erythematotelangiectatic rosacea. Dermatol Syrg. 2009 June;35(6):920-8. Epub 2009 Apr 6.
19. Larson AA, Goldman MP. Recalcitrant rosacea successfully treated with multiplexed pulsed dye laser. J Drugs Dermatol. 2007 Aug;6(8):843-5.
20. Tan SR, Tope WD. Pulsed dye laser treatment of rasacea improves erythema, symptomatology and quality of life. J Am Acad Dermatol. 2004 Oct;51(4):592-9.
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22. 2020 TMPPM, Section 1.12 Texas Medicaid Limitations and Exclusions