Policy: MP019
Section: Medical Benefit Policy
Subject: Laser Treatment of Cutaneous Vascular lesions

I. Policy: Laser Treatment of Cutaneous Vascular Lesions

II. Purpose/Objective:
To provide a policy of coverage regarding Laser Treatment of Cutaneous Vascular Lesions

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Cutaneous vascular lesions are the most common pediatric birthmarks. They are classified as either hemangiomas or vascular malformations. Pulsed Dye Lasers are most commonly used to treat hemangiomas and vascular malformations. Pulsed dye lasers use a yellow light beam with wavelengths ranging from 585nm-600nm. The superficial laser penetrates between .75 mm-1.5mm into the skin and is absorbed by the blood vessels and the abnormal ones are destroyed leaving the surrounding skin unharmed.

INDICATIONS: Pulsed dye laser treatment of cutaneous vascular lesions: e.g. port-wine stain, complicated hemangioma, spider angioma with a feeder arteriole is considered medically necessary when any of the following conditions apply:

For treatment of Hemangiomas:
- The hemangioma is compromising vital structures (e.g., nose, eyes, ears, lips or larynx).
- The hemangioma is symptomatic (e.g., bleeding, painful, ulcerated, subject to recurrent infection).
- The hemangioma is associated with Kasabach-Merritt Syndrome.
- The hemangioma is pedunculated.

For treatment of Port Wine Stains:
- The lesion results in bleeding or painful nodules.
- The patient is at risk for development of glaucoma (e.g., Sturge-Weber Syndrome, lesions that are located on the eyelids or the forehead)

EXCLUSIONS:
For members over age 18 years, initiation of laser treatment of cutaneous vascular lesions that do not interfere with physical body function or without manifestation of complications such as hypertrophy and pyogenic granuloma formation is considered cosmetic and is NOT COVERED.

In the absence of impairment of physiologic function, laser treatment of Rosacea is considered cosmetic and therefore NOT COVERED.

Laser treatment of telangiectasia is considered cosmetic and therefore not covered.

The treatment of cutaneous vascular lesions from which no significant improved physiologic function is achieved is considered cosmetic and is NOT COVERED.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Laser Treatment of Cutaneous Vascular Lesions
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

CPT Codes
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- 50.0 sq. cm.
17108 Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq. cm.

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy. For PA Medicaid Business segment, this policy applies as written.
REFERENCES:


This policy will be revised as necessary and reviewed no less than annually.

Devised: 1/94
Revised: 5/95, 8/02, 9/05 (Clarified Criteria); 9/06, 8/11, 1/12 (added exclusions), 1/13
Reviewed: 8/03, 9/04; 9/07, 9/08, 9/09, 9/10, 1/14, 1/15, 1/16, 1/17, 12/17