I. Policy: Laser Treatment of Acne

II. Purpose/Objective:
To provide a policy of coverage regarding Laser Treatment of Acne

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: Acne (Acne Vulgaris) is a multifactorial disease that involves the pilosebaceous unit, which is composed of the hair follicle and the sebaceous gland. Inflammation generally occurs when excess oil, dirt and/or bacteria blocks the gland ducts. The pulsed dye laser is thought to cause thermal coagulation of the sebaceous lobule and associated hair follicle thus resulting in reduced sebaceous gland secretions and a reduction in the inflammatory lesions.

Photodynamic Therapy involves the application of aminolevulinic Acid (ALA) that is absorbed and metabolized intracellularly. When activated by light, oxygen radicals are released which are believed to target and destroy acne-associated bacterium which results in a decrease in sebum production.

EXCLUSIONS:
The Plan does NOT provide coverage for pulsed dye laser as a treatment for Acne Vulgaris because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does NOT provide coverage for photodynamic therapy for the treatment of Acne Vulgaris because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

Note: Photodynamic Therapy for the treatment of head and neck cancer is addressed in MP179.

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: Pulsed Dye Laser for Treatment of Acne

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>17000</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettlement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion</td>
</tr>
<tr>
<td>17003</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettlement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; second through 14 lesions, each (List separately in addition to code for first lesion)</td>
</tr>
<tr>
<td>17004</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettlement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, 15 or more lesions</td>
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<tr>
<td>S8948</td>
<td>Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes</td>
</tr>
<tr>
<td>96567</td>
<td>Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session</td>
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LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede 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: 10/05
Revised: 10/06, 11/08 (coding)