

Policy: MP019

Section: Medical Benefit Policy

Subject: Laser Treatment of Cutaneous Vascular Lesions

Applicable line of business:

| | | | |
|-------------------|----------|-----------------|----------|
| Commercial | x | Medicaid | x |
| Medicare | x | ACA | x |
| CHIP | x | | |

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.

Commercial

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

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

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- 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)
- Port wine stain on the trunk or extremities associated with recurrent bleeding or painful nodules

For the treatment of any of the following conditions:

- Vascular hamartomas
- Kaposi's sarcoma
- Hereditary hemorrhagic telangiectasia
- Pyogenic granuloma
- Rosacea, severe refractory

And the lesion is affecting a vital structure (e.g., nose, eyes, ears, lips, or larynx) or results in any of the following:

- Pain
- Bleeding
- Ulceration
- Repeated infection
- Difficulty eating or swallowing

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**.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

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.

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL.

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.

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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, 12/23 (expand indications)

Reviewed: 8/03, 9/04; 9/07, 9/08, 9/09, 9/10, 1/14, 1/15, 1/16, 1/17, 12/17, 12/18, 12/19, 12/20, 12/21, 12/22, 12/24

CMS UM Oversight Committee Approval: 12/23, 02/25

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.