



**Subject:** *Pulsed Dye Laser Treatment*

**Number:** *200309-0009*

Effective date: 10/28/2003

Revision date(s): 06/2000; 09/30/2003

**Important note**

Even though this policy may indicate that a particular service or supply is considered 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* 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 and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this Medical Policy and Criteria Statement. Medicare and Medicaid policies will only apply to benefits paid for under Medicare or Medicaid rules, and not to any other health benefit plan benefits. The Centers for Medicare and Medicaid's *Coverage Issues Manual* can be found on the following Web site: <http://www.cms.hhs.gov/manuals/pub06pdf/pub06pdf.asp>

**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 either a cut, burn or seal of tissue.

Laser procedures are classified into 3 categories:

1. **Substantially equivalent laser procedures:** are generally accepted surgical procedures in which the laser merely serves as a substitute for the traditional surgical instrument, such as a scalpel or knife.
2. **Generally accepted new laser procedures:** Laser procedures for which there is no equivalent, conventional, surgical approach, but which has been determined by the plan to meet our technology assessment guidelines.
3. **Experimental/ investigative laser procedures:** Laser procedures which have been determined by the plan to not meet our technology assessment guidelines.

**Policy and criteria**

**NOTE:** These services require prior authorization by the plan medical director.

**When services are covered:**

We cover **pulsed dye laser** as treatment for **port wine stain(s) or other hemangioma(s)** WHEN they are:

- on the face or neck; OR
- on other parts of the body *and* a functional impairment exists.

**When services are not covered:**

We **do not cover** services when the above criteria are not met *or* for any procedures or devices not listed above.

We **do not cover** pulsed dye laser treatment, surgery or services related to treatment of the following cosmetic indications:

- Rosacea with or without rhinophyma
- Spider angiomas or vein(s)
- Telangiectasias

We **do not cover** laser treatment of **psoriasis** because there is inadequate evidence in the peer-reviewed published medical literature of its effectiveness for this indication. Therefore, laser treatment of psoriasis is deemed investigational and experimental.

**Codes:**

Codes	Number	Description
CPT	17106 -17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique) code range [for deforming hemangiomas/port wine stain(s).]
HCPCS	None	

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**FCHP products to which this policy applies:**

- ⊕ FCHP Direct and FCHP Select Care (HMO)
- ⊕ FCHP Flex Care Direct and Select (POS)
- ⊕ Fallon Preferred Care (PPO)
- ⊕ FCHP MassHealth
- ⊕ Non-Group: FCHP Independent Care, Direct enrollment and Bill-at-home

Medicare plan – *reminder* to refer to CMS for policy and criteria

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### **Mandated benefit/Regulatory issues**

- Ø Federal
- Ø Commonwealth of Massachusetts
- Ø Medicare – National Policy
- Ø Medicare – Local Medical Review Policy
- ⊕ Not applicable

### **Committee review dates:**

**Technology Assessment Committee:**

**Utilization Management Committee:** 06/2000; 06/2003

Approved by: Signature on file 10/28/2003  
 Dennis A. Batey, M.D. Vice President and Chief Medical Officer Date