Overview
Laser Skin therapies encompass a wide array of treatments aimed at multiple skin conditions. Excimer lasers utilize ultraviolet lights in order to treat a variety of dermatological conditions utilizing a 308- nm (nanometer) wavelength to treat a small, focused area. The use of Excimer therapy over standard therapies can lead to a more rapid response to treatment.

Policy
Fallon Health requires Prior Authorization for Excimer Laser Skin Therapy, the below criteria must be met. Medical records from the primary care physician and other providers who have diagnosed or treated the symptoms prompting this request are also required.

We will cover treatment for the diagnosis moderate to severe psoriasis and vitiligo when the below criteria has been met:
1. The psoriasis must be localized plaque psoriasis affecting 10 % or less of the body area.
2. The member must have tried and failed a minimum 3 months longer of conservative treatments with one or more of the below
   - Topical application of steroids or other drugs; or
   - Ultraviolet light (actinotherapy); or
   - Coal tar alone or in combination with ultraviolet B light (Goeckerman treatment).

Treatment for any other condition is either considered cosmetic or experimental/investigational and will not be covered.

Exclusions
- Any use of Excimer Laser Skin Therapy other than listed above
- Excimer Laser Skin Therapy for cosmetic reasons

Codes

<table>
<thead>
<tr>
<th>Code type</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPT</td>
<td>96920</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm</td>
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<tr>
<td></td>
<td>96921</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm</td>
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<tr>
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<td>96922</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm</td>
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References

2. CMS National Coverage Determination (NCD) 250.1 Treatment of Psoriasis.

Policy History

Origination date: 10/01/2017
Approval(s): Technology Assessment Committee: 09/27/2017 (approved new policy), 08/22/2018 (updated references), 09/10/2019 (updated references)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member’s particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product’s Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member’s benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates 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. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.