Medical Policy:
Pulse Dye Laser Therapy for Cutaneous Vascular Lesions (Commercial)

POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
MG.MM.SU.46aC12	11/8/2024	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Definitions

Pulsed Dye Laser (PDL)	Pulsed dye laser (PDL) emits a specific color or light wavelength that can be varied in intensity and pulse duration. When this light energy interacts with the hemoglobin found in accessible blood vessels comprising a cutaneous lesion, heat is generated that destroys the vessels within the targeted lesion while sparing the surrounding tissue. Refinement of the technology includes a cryogen spray cooled (CSC) that involves the application of a cryogen spurt to the skin milliseconds prior to laser irradiation. This cools the epidermis thereby reducing thermal injury during treatment.

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Guideline

See also Cosmetic and Reconstructive Surgery Procedures

Members with port wine stains and hemangiomata are eligible for PDL, with or without local topical or general anesthesia. Coverage will be considered until the lesion is gone or when maximum efficacy has been achieved.

Any of the following criteria must be demonstrated as met:

1. Presence of port wine stains in children and adults when a prescription (Rx) is required to alleviate or prevent clinical complications.
2. Presence of superficial hemangiomas or the superficial component of mixed hemangiomas in infants and children when a definitive Rx is required to alleviate or prevent clinical complications.
3. Presence of post involutional hemangiomas and telangiectasias in infants and children when a definitive Rx is required to alleviate or prevent clinical complications.

Documentation

1. Initial pre-treatment photos.
2. Post-treatment photos (for treatment requests beyond 3 cycles, or 6 months; each cycle consists of up to 2 months).

Limitations/Exclusions

Requests for cherry angiomas and pyogenic granulomas will be reviewed on a ***case by case basis***.

Applicable Procedure Codes

17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm

Applicable ICD-10 Diagnosis Codes

D18.01	Hemangioma of skin and subcutaneous tissue
Q82.5	Congenital non-neoplastic nevus

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References

Hayes Inc. Pulsed Dye Laser Therapy for Cutaneous Vascular Lesions. Hayes Medical Directory. Lansdale, Penn: Winifred S. Hayes, Inc; January 17, 2006.

Specialty-matched clinical peer review.

Revision history

DATE	REVISION
12/09/2019	Reformatted and reorganized policy, transferred content to new template