MEDICAL COVERAGE POLICY	
SERVICE:	**Laser Treatment of Skin Lesions**
Policy Number:	**099**
Effective Date:	**05/01/2025**
Last Review:	**04/14/2025**
Next Review:	**04/14/2026**

SERVICE: Laser Treatment of Skin Lesions

PRIOR AUTHORIZATION: Required

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details. Not all plans may cover this therapy.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination) NCD 140.5 Laser Procedures. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid Provider Procedures Manual | TMHP (TMPPM). If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

BSWHP may consider laser therapy medically necessary for ONE or more of the following conditions:

- Keloids or other hypertrophic scars which are secondary to an injury or covered surgical procedure and 1 or more of the below is met:
  - Causes significant pain requiring chronic analgesic medication
  - Results in significant functional impairment

- Mild to moderate localized plaque psoriasis when ALL of the following criteria are met:
  - Affects 10% or less of their body area AND
  - Have failed to adequately respond to 3 or more months of topical treatments

- Port Wine Birthmark (Stain)
  - On the face and/or neck in members ≤ 18 years of age
  - On the face and/or neck of members > 18 years of age when symptomatic (bleeding, infection, pain, ulceration), or produces functional impairment
  - On the trunk or extremities when symptomatic (bleeding, infection, pain, ulceration), or produces functional impairment

- Infantile hemangiomas (IH) in children, when decisions are made in consultation with a hemangioma specialist, and 1 or more of the following criteria are met:
  - Life-threatening complication (e.g., airway obstruction, liver IH with high output CHF and severe hypothyroidism)
  - Functional impairment - periocular IH (≥ 1 cm); IH involving the nose, lip, or oral cavity

- Ulceration - any size, involving any of the lips, columella, superior helix of ear, gluteal cleft and/or perineum, perianal skin, other intertriginous areas (neck, axillae, inguinal region)
- Structural anomalies - segmental IH of face, scalp, lumbosacral or perineal area (e.g., in PHACE syndrome or LUMBAR syndrome)
- Potential for permanent disfigurement (scarring or permanent skin change) - facial IH of nasal tip or lip (any size); or any facial location >2cm (>1cm if </=3 months of age); scalp IH >2cm

Laser therapy is considered cosmetic for the following conditions (list is NOT inclusive):

- Dyschromia
- Removal of hair for pseudofolliculitis barbae or follicular cysts
- Removal of spider angiomata
- Removal of telangiectasias in adults
- Rosacea
- Acne
- Granuloma faciale
- Rhinophyma
- Genital warts
- Granuloma faciale
- Superficial glomangiomas
- Pyrogenic granuloma
- Verrucae

Pulsed Dye Laser therapy is considered experimental and investigational for all other indications.

BACKGROUND:
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 a cut, a burn or seal of tissue.

Many skin lesions are considered cosmetic and thus treatment is not a benefit for many plans.

MANDATES: Reconstructive Surgery for Craniofacial Abnormalities in a Child TIC §1367.153
A health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

CODES:

Important note:
Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

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 to 50.0 sq cm 17108 – Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm
CPT Codes Not Covered	
ICD-10 Codes	D18.00 - D18.09 - Hemangioma L40.0 - Psoriasis vulgaris (plaque psoriasis) L91.0 - Hypertrophic scar (keloid) Q82.5 - Congenital non-neoplastic nevus (Port wine stain)
ICD-10 Codes Not Covered	

POLICY HISTORY:

Status	Date	Action
New	11/1/2010	New policy
Reviewed	10/18/2011	Reviewed.
Reviewed	10/04/2012	Reviewed.
Reviewed	9/05/2013	Added CMS language, ICD10 codes. Updated references
Reviewed	5/22/2014	No changes
Reviewed	5/28/2015	Revised criteria
Reviewed	6/09/2016	No changes
Reviewed	05/16/2017	No changes
Reviewed	04/03/2018	Coverage criteria modified
Reviewed	06/27/2019	Updated codes. Expanded criteria for children
Reviewed	05/28/2020	Reviewed and aligned for FirstCare and SWHP
Reviewed	01/28/2021	No changes except to correct erroneous CPT code.
Reviewed	01/27/2022	No changes
Reviewed	12/01/2022	Revised criteria for Port Wine stains and Infantile hemangiomas
Reviewed	01/02/2024	Formatting changes and added hyperlinks to NCD and TMPPM, beginning and ending note sections updated to align with CMS requirements and business entity changes
Reviewed	04/14/2025	Changed to Port Wine Birthmark in accordance with AAP; added additional covered criteria under IH in accordance with AAP recommendations; added description of Reconstructive Surgery for Craniofacial abnormalities
Updated	08/11/2025	Removed, “Medicare NCD or LCD specific InterQual criteria may be used when available.”

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available, and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Asawanonda P, Anderson RR, Taylor CR. Pendulaser carbon dioxide resurfacing laser versus electrodesiccation with curettage in the treatment of isolated, recalcitrant psoriatic plaques. J Am Acad Dermatol. 2000;42(4):660-666.
2. Berman B, Flores F. The treatment of hypertrophic scars and keloids. Eur J Dermatol. 1998;8(8):591-595.
3. Chang CW, Ries WR. Nonoperative techniques for scar management and revision. Facial Plast Surg. 2001;17(4):283-288.
4. Dover JS, Arndt KA, Dinehart SM, et al. Guidelines of care for laser surgery. American Academy of Dermatology, Guidelines/Outcomes Committee. J Am Acad Dermatol. 1999;41(3 Pt 1):484-495.
5. Griffiths CEM, Clark CM, Chalmers RJG, et al. A systematic review of treatments for severe psoriasis. Health Technol Assess. 2001; 40(4):125.
6. Hohenleutner S, Badur-Ganter E, Landthaler M, et al. Long-term results in the treatment of childhood hemangioma with the flashlamp-pumped pulsed dye laser: An evaluation of 617 cases. Lasers Surg Med. 2001;28(3):273-277.
7. Katugampola GA, Lanigan SW. Five years' experience of treating port wine stains with the flashlamp-pumped pulsed dye laser. Br J Dermatol. 1997;137(5):750-754.
8. Lanigan SW, Katugampola GA. Treatment of psoriasis with the pulsed dye laser. J Am Acad Dermatol. 1997;37(2 Pt 1):288-289.
9. Laughlin SA, Dudley DK. Laser therapy in the management of rosacea. J Cutan Med Surg. 1998;2 Suppl 4:S4-24-9.
10. Litt JZ. Rosacea: How to recognize and treat an age-related skin disease. Geriatrics. 1997;52:39-40, 42, 45-47.
11. Lupton JR, Alster TS. Laser scar revision. Dermatol Clin. 2002;20(1):55-65.
12. McClean K, Hanke CW. The medical necessity for treatment of port-wine stains. Dermatol Surg. 1997;23(8):663-667.
13. Rebora A. The management of rosacea. Am J Clin Dermatol. 2002;3(7):489-496.
14. Robson KJ, Cunningham NM, Kruzan KL, et al. Pulsed-dye laser versus conventional therapy in the treatment of warts: A prospective randomized trial. J Am Acad Dermatol. 2000;43(2 Pt 1):275-280.
15. Ross BS, Levine VJ, Nehal K, et al. Pulsed dye laser treatment of warts: An update. Dermatol Surg. 1999;25(5):377-380.
16. Wirth FA, Lowitt MH. Diagnosis and treatment of cutaneous vascular lesions. Am Fam Physician. 1998;57(4):765-773.
17. Zelickson BD, Mehregan DA, Wendelschfer-Crabb G, et al. Clinical and histologic evaluation of psoriatic plaques treated with a flashlamppulsed dye laser. J Am Acad Dermatol. 1996;35(1):64-68.
18. Neuhaus IM, Zane LT, Tope, WD. Comparative Efficacy of nonpurpuragenic pulsed dye laser and intense pulsed light for erythematotelangiectatic rosacea. Dermatol Syrg. 2009 June;35(6):920-8. Epub 2009 Apr 6.
19. Larson AA, Goldman MP. Recalcitrant rosacea successfully treated with multiplexed pulsed dye laser. J Drugs Dermatol. 2007 Aug;6(8):843-5.
20. Tan SR, Tope WD. Pulsed dye laser treatment of rasacea improves erythema, symptomatology and quality of life. J Am Acad Dermatol. 2004 Oct;51(4):592-9.
21. Mulliken JB, Glowacki J. Hemangiomas and vascular malformations in infants and children: a classification based on endothelial characteristics. Plast Reconstr Surg. 1982 Mar;69(3):412-22. PMID 7063565
22. 2020 TMPPM, Section 1.12 Texas Medicaid Limitations and Exclusions
23. Clinical Practice Guideline for the Management of Infantile Hemangiomas. Krowchuk DP, Frieden IJ, Mancini AJ, et al. Pediatrics. 2019;143(1):e20183475.

***Note**:*
Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs.