Pulsed Dye Laser Therapy for Cutaneous Vascular Lesions

Last Review Date: May 12, 2017  Number: MG.MM.SU.46aC5

Definitions
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.

Guideline
See also Cosmetic 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).

Medical Guideline Disclaimer

Property of EmblemHealth. All rights reserved. The treating physician or primary care provider must submit to EmblemHealth the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. EmblemHealth 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). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program 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 EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary. If there is a discrepancy between this guideline and a member’s benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication. EmblemHealth Services Company LLC, (“EmblemHealth”) has adopted the herein policy in providing management, administrative and other services to HIP Health Plan of New York, HIP Insurance Company of New York, Group Health Incorporated and GHI HMO Select, related to health benefit plans offered by these entities. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.
Limitations/Exclusions

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

Applicable Procedure Codes

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>17106</td>
<td>Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm</td>
</tr>
<tr>
<td>17107</td>
<td>Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm</td>
</tr>
<tr>
<td>17108</td>
<td>Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm</td>
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</tbody>
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Applicable ICD-10 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D18.01</td>
<td>Hemangioma of skin and subcutaneous tissue</td>
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<tr>
<td>Q82.5</td>
<td>Congenital non-neoplastic nevus</td>
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</tbody>
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References

Specialty-matched clinical peer review.