Medicare Medical Policy

Low-Level and High-Power Laser Therapy

MEDICARE MEDICAL POLICY NUMBER: 338

Effective Date: 1/1/2026

Last Review Date: 12/2025

Next Annual Review: 7/2026

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
Post-Operative Low-Level Laser Therapy (CPT 97037)	National Coverage Determination (NCD): Infrared Therapy Devices (270.6) **RATIONALE:** According to Final Rule CMS-1784-F, Medicare finalized "non-covered status (Procedure Status "N") for CPT code 97037 because NCD 270.6 states: The use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy, is non-covered for the treatment, including the symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues. Thus, it is noncovered by Medicare."

Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below*)

- **Medicare Coverage Manuals:** Medicare does not have criteria for low-level laser therapy (LLLT) or high power laser therapy in a coverage manual.
- **National Coverage Determination (NCD):** With the exception of services noted above addressed by an NCD, NCDs for other low-level and high level laser procedures are limited. The Medicare NCD for *Laser Procedures* (140.5) states, "In the absence of a specific noncoverage instruction, and where a laser has been approved for marketing by the Food and Drug Administration, Medicare Administrative Contractor discretion may be used to determine whether a procedure performed with a laser is reasonable and necessary and, therefore, covered." This NCD is considered "not fully established" under CFR § 422.101(6)(i)(B) as it provides explicit flexibility for coverage decisions beyond the NCD.
- **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, three Medicare Administrative Contractors (MACs) have LCDs which consider **low-level laser therapy** to be non-covered (CGS Admin, National Government, Palmetto). (**Photobiomodulation [PBM] therapy** is also known as low-level laser therapy.) However, none of these MACs have jurisdiction over the plan service area. The local MAC

Noridian does not have an applicable LCD or LCA. No MACs have an LCD for **high-powered laser therapy**.

- Therefore, in the absence of fully established Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan's service area, Company criteria below are applied for medical necessity decision-making. In this case, Medicare coverage criteria are considered "not fully established" as defined under CFR § 422.101(6)(i)(B) as the available Medicare coverage policies provide flexibility for coverage decisions beyond the NCD and LCD.
- ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*

Low-Level Laser Therapy (LLLT) *High-Power Laser Therapy* *Photobiomodulation Therapy of the Retina (Code 0936T)*	Company medical policy for Low-Level and High-Power Laser Therapy I. These procedures are considered **not medically necessary** for Medicare Plan members based on the Company medical policy. *See Policy Guidelines below.*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

MEDICARE AND MEDICAL NECESSITY

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Plan's Medicare policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Since there are not fully established coverage criteria for low-level laser therapy (LLLT) or high power laser therapy available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy criteria for these services will be applied.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

Low-Level Laser Therapy

The FDA has approved several low-level laser therapy devices including, but not limited to, the following:

- MicroLight ML830® (MicroLight Corporation of America)
- GRT LITE™ PRO-8A (GRT Solutions, Inc.)
- LightStream™ Low Level Laser (RJ Laser Canada Corp.)
- TouchOne™ (OTC)

Additional low-level laser therapy devices can be found by searching the FDA Devices Database for product code NHN.

High-Power Laser Therapy

The FDA has approved several high-power laser therapy devices including, but not limited to, the following:

- LCT-1000 (LiteCure,LLC)
- ALT Laser (Avicenna Laser Technology, Inc.)
- ESPT-3X (Lighthouse Technical Innovations, Inc.)

Additional high-power laser therapy devices can be found by searching the FDA Devices Database for product code ILY.

BILLING GUIDELINES AND CODING

GENERAL

CPT codes 0552T and 1011T may be considered medically necessary if reported with one of the following diagnosis codes:

- C00.0 – C17.9
- C22.0 – C96.9
- K12.30 – K12.39

CPTs 0552T and 1011T will be denied as not medically necessary if billed with any other diagnosis codes.

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by Medicare[1], indicates HCPCS code S8948 has been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." In addition, all S-codes codes, including S8948, are not recognized as valid codes for claim submission as indicated in the relevant Company Coding Policy *(HCPCS S-Codes and H-Codes,* 22.0*).* Providers need to use alternate available CPT or HCPCS codes to report for the service. If no specific CPT or HCPCS code is available, then an unlisted code may be used. Note that unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. Thus, if an unlisted code is billed related to a non-covered service addressed in this policy, it will be denied as not covered.

The *NPFSRVF* also indicates CPT code 97037 has been assigned a Status Indicator of "N," which is defined as "Non-covered Services." This is a statutorily excluded service based on NCD 270.6.

CODES*		
CPT	0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
	0936T	Photobiomodulation therapy of retina, single session
	1011T	Photobiomodulation (PBM) therapy of oral cavity, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device
	97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction *(CMS-assigned Status "N" code – See above billing guidelines)*

	97039	Unlisted modality (specify type and time if constant attendance)
	97799	Unlisted physical medicine/rehabilitation service or procedure
HCPCS	S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes *(CMS-assigned Status "I" code – See above billing guidelines)*

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
9/2022	New Medicare Advantage medical policy (converted to new format 2/2023)
10/2023	Annual review; no criteria changes but language revision due to Company policy change from "Investigational" to "not medically necessary"
1/2024	Q1 2024 code updates
8/2024	Annual review; Add criteria for post-operative low-level laser therapy. No criteria changes for other services
1/2025	Q1 2025 code updates
8/2025	Annual review; no criteria changes
1/2026	Q1 2026 code updates