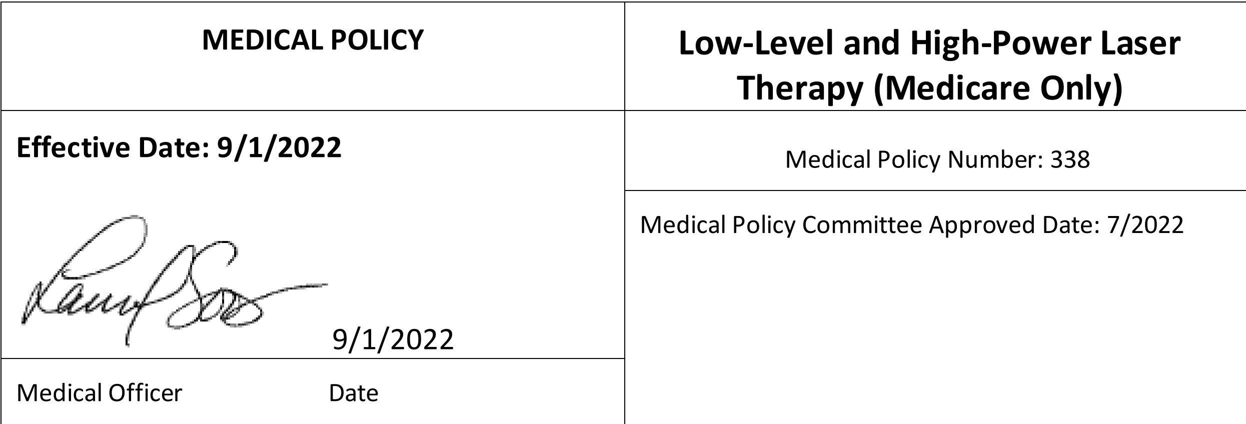

MEDICAL POLICY	Low-Level and High-Power Laser Therapy (Medicare Only)
Effective Date: 9/1/2022	Medical Policy Number: 338
9/1/2022	Medical Policy Committee Approved Date: 7/2022
Medical Officer Date	

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Low-Level Laser Therapy (LLLT) *High-Power Laser Therapy*	Company medical policy for Low-Level and High-Power Laser Therapy (All Lines of Business Except Medicare) I. These procedures are considered **not medically necessary** for Medicare Plan members based on the Company medical policy. *"Investigational" services are considered not medically necessary for Medicare Plan members. See Policy Guidelines below.*

POLICY GUIDELINES

Medicare and Medical Necessity

The Company 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)*

The Medicare National Coverage Determination (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." Since our Medicare Administrative Contractor (MAC) – Noridian – does not address either low-level or high-powered laser therapy, the Plan Commercial criteria will apply.

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

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)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. *(Medicare Claims Processing Manual, Ch. 23, §30 A)*

BILLING GUIDELINES

CPT code 0552T 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

0552T 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." HCPCS code S8948 is not covered as indicated in the relevant Company coding policy, *(Coding Policy 22.0 HCPCS S-Codes and H-Codes)*.

CPT/HCPCS CODES

Medicare Only	
No Prior Authorization Required Note: Inclusion of a code in this section does not guarantee reimbursement or coverage. The following codes do not require routine review for medical necessity, but they may be subject to audit or benefit denial.	
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
Not Covered	
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then it will be **denied as not covered.**	
97039	Unlisted modality (specify type and time if constant attendance)
97799	Unlisted physical medicine/rehabilitation service or procedure

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

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.

U.S. Food and Drug Administration (FDA)

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)47
• GRT LITE™ PRO-8A (GRT Solutions, Inc.)48
• LightStream™ Low Level Laser (RJ Laser Canada Corp.) 49
• TouchOne™ (OTC)50

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)51
• ALT Laser (Avicenna Laser Technology, Inc.)52
• ESPT-3X (Lighthouse Technical Innovations, Inc.)53

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

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