Medicare Medical Policy

Hemangioma and Vascular Malformation Laser Treatment

MEDICARE MEDICAL POLICY NUMBER: 381

Effective Date: 3/1/2023

Last Review Date: 2/2023

Next Annual Review: 2/2024

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, Providence Plan Partners, and Ayin Health Solutions 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
Medicare Guidance Notes	The Noridian LCA for *Billing and Coding: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)* (A57162) states, "CPT codes 17106, 17107 and 17108 describe treatment of lesions that are usually cosmetic. When using these CPT codes the clinical records should clearly document the medical necessity of such treatment and why the procedure is not cosmetic." Neither this LCA A57162, nor any other Medicare policy provide specific coverage criteria to be used to determine whether laser treatment of vascular lesions may be considered cosmetic or reconstructive. In the absence of such NCD, LCD, or other Medicare policy, Company policy criteria below is applied for medical necessity decision-making.
Laser Therapy for Vascular Skin Lesions *Example:* • *Port wine stains* • *Hemangiomas*	Company medical policy for Hemangioma and Vascular Malformation Laser Treatment I. This service may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. This service is considered **cosmetic** for Medicare when the Company medical policy criteria are not met. *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

- Cosmetic and Reconstructive Procedures, MP232

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

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
  - History
  - Physical examination

COSMETIC VS. RECONSTRUCTIVE SURGERY

Cosmetic surgery is statutorily excluded by Medicare, and thus, is not a covered Medicare benefit.

> *Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10)(4):*
>
> "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member."

General Medicare guidance regarding cosmetic and reconstructive procedures is as follows:

> *Medicare Benefit Policy Manual, Chapter 16, §120:*
>
> "Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose."

In addition, the Noridian LCD for *Plastic Surgery* (L37020) calls out several key points regarding cosmetic vs. reconstructive procedure decision-making.

MEDICARE COVERAGE

In order to determine if coverage is available for a procedure, review may be required to determine if the procedure is cosmetic or reconstructive in nature.

Medicare and Medical Necessity

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)*.

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.) which addresses the medical necessity of a given medical service, 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)*

BACKGROUND

Hemangiomas

Hemangiomas are benign tumors made up of blood vessels. They can be found anywhere on the body, but commonly appear on the face, scalp, chest, or back. Hemangiomas rarely become malignant and usually fade and shrink over time, and therefore they are not commonly treated. Some may treat hemangiomas when the tumor interferes with vision, breathing, or may potentially cause disfigurement. Treatment may involve beta blockers, steroids, compression, embolization, and laser treatment.

Port Wine Stains (PWS)

Port wine stains (nevus flammeus) are capillary malformations occurring from vascular anomalies that cause discoloration of the skin. Present at birth, port wine stains (PWS) are most commonly singular in occurrence. They are distinct from infantile hemangiomas. Rarely, they occur as part of a larger constellation of malformation syndromes. As a child grows, the pink to red patches grow in proportion to the child's growth, the red color deepens, and the area thickens. Capillary malformations occur in 0.1 to 2 percent of newborns. The etiology is unknown.

Laser Treatment of Hemangiomas and Port Wine Stains (PWS)

Laser treatment of hemangiomas and PWS in its macular stage (childhood) may prevent the development of the hypertrophic component of the lesion. The pulsed dye laser was developed specifically to treat cutaneous vascular lesions. Laser treatment diminishes the existing blood vessels, making them smaller and fewer in number, reducing the progression of these lesions. Laser treatment can be administered in an outpatient setting, usually in multiple sessions.

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.

BILLING GUIDELINES AND CODING

CODES*		
CPT	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
HCPCS	None	

***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
2. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services; Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
3. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage; Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf

4. Medicare Claims Processing Manual, Chapter 16 - Laboratory Services; Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf
5. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners; Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
3/2023	New Medicare Advantage medical policy