PROVIDER POLICIES & PROCEDURES

LASER THERAPY

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for laser therapy. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Laser treatment for skin conditions use concentrated beams of light and varying wavelengths to stimulate the skin's own natural healing process. There are a variety of laser treatment options aimed at treating specific conditions and results can span from improvement of texture, appearance, and tone, to improving pliability and alleviating scar related dysfunction.

Excimer laser is a form of ultraviolet laser proposed for the treatment of various dermatologic conditions including psoriasis and vitiligo. Excimer lasers are monochromatic 308 nm xenon chloride lasers used to treat small, focused areas of the body. The number of treatments required depends on multiple factors including the condition being treated, the severity of the condition, skin type, and response to treatment.

Fractional carbon dioxide laser treatment delivers a variety of microbeams that remove columns of skin, thereby leaving the skin around each column intact. The body then produces collagen and elastic to aid in healing resulting in smoother and more pliable skin. Fractional carbon dioxide laser treatment reduces healing time and subsequent damage or dyspigmentation to the treated areas.

The pulsed dye laser is commonly used for the treatment or removal of several types of vascular malformations of the skin. The device uses bright light that is absorbed by the abnormal blood vessels and uses heat to destroy those blood vessels without damaging the surrounding skin.

A picosecond laser is a type of laser that delivers ultra-short pulses of light to create a precise and controlled disruption in the targeted tissue which breaks up pigment in the skin. Due to the shorter pulses there is less heat generation leaving the surrounding cells intact and undamaged.

CLINICAL GUIDELINE

Coverage guidelines for laser therapy are made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Office-based, Targeted Excimer Laser Therapy

Office-based, targeted excimer laser therapy is typically considered medically necessary for the treatment of either of the following conditions:

A. Localized, plaque psoriasis refractory to conservative management with topical agents and/or phototherapy; or
B. Nonsegmental vitiligo involving 10 to 40 percent of the body surface area; or
C. Vitiligo involving less than 10 percent of the body surface area after a failed, consecutive two-month trial of conservative treatment with topical agents.

Initial authorization for office-based targeted excimer laser therapy treatment will be approved for five (5) sessions per week for a six (6) month authorization period.

Reauthorization

Continued office-based targeted excimer laser treatment may be considered medically necessary when:

A. The above criteria are met; and
B. There is a documented, beneficial response to treatment.

Note: Reauthorization of office-based, targeted, excimer laser therapy will be reviewed for medical necessity until the lesions are resolved or when maximum efficacy has been achieved as evidenced by submitted medical documentation.

Not Medically Necessary

Office-based, targeted excimer laser therapy is typically considered experimental/investigational and NOT medically necessary for all other indications including, but not limited to:

- Alopecia areata
- Atopic dermatitis
- Cicatricial alopecia
- Vesicular dyshidrotic eczema
- Lichen planus
- Onychomycosis
- Psoriatic nail disease
- Uremic pruritis

Fractional Carbon Dioxide Laser Treatment

Fractional carbon dioxide laser treatment for hypertrophic burn scars may be considered medically necessary when:

A. There is documentation of failed attempts of conventional treatments; and
B. There is documentation of scar tension that limits function or has caused contractures; and
C. There is no documentation of the individual having any of the following contraindications:
    1. Open wounds or lesions at or around treatment site; or
    2. An active infection at or around the treatment site; or
    3. Prior radiation therapy to the treatment site.

Initial authorization for fractional carbon dioxide laser treatment will be approved for a six (6) month period with no more than twelve (12) sessions per authorization period.

Reauthorization

Continued fractional carbon dioxide laser treatment may be considered medically necessary when:

A. The above criteria are met; and
B. There is a documented, beneficial response to treatment.

Note: Reauthorization of fractional carbon dioxide laser therapy will be reviewed for medical necessity until the lesions are resolved or when maximum efficacy has been achieved as evidenced by submitted medical documentation.

Not Medically Necessary
Fractional carbon dioxide laser treatment is typically considered experimental/investigational and NOT medically necessary for all other indications including, but not limited to:

- Actinic keratoses
- Vulvar lichen sclerosis
- Vaginal atrophy and dyspareunia
- Cutaneous manifestations of amyloidosis
- Keratoacanthoma

Fractional carbon dioxide laser treatment is typically considered cosmetic and NOT medically necessary for all other indications including, but not limited to:

- Facial rejuvenation
- Acne scar treatment
- Sun damage repair
- Wrinkles, lines, or other signs of aging
- Striae distensae (stretch marks)
- Postinflammatory hyperpigmentation
- Rosacea

Pulsed Dye Laser Treatment
Pulsed dye laser treatment may be considered medically necessary when the individual has:

A. Port wine stains/birthmark; or
B. Infantile hemangiomas; or
C. Pyogenic granuloma or the face or neck; or
D. Hypertrophic burn scars or keloids when:
    1. There is documentation of failed attempts of conventional treatments; and
    2. There is documentation of scar tension that limits function or has caused contractures.

Initial authorization for pulsed dye laser treatment will be approved for a six (6) month period with no more than twelve (12) sessions per authorization period.

Reauthorization
Continued pulsed dye laser treatment may be considered medically necessary when:

A. The above criteria are met; and
B. There is a documented, beneficial response to treatment.

Note: Reauthorization of pulsed dye laser therapy will be reviewed for medical necessity until the lesions are resolved or when maximum efficacy has been achieved as evidenced by submitted medical documentation.

Not Medically Necessary
Pulsed dye laser treatment is typically considered experimental/investigational and NOT medically necessary for all other indications including, but not limited to:

- Acne Vulgaris
- Granuloma faciale

Pulsed dye laser treatment is typically considered cosmetic and NOT medically necessary for all other indications including, but not limited to:

- Rosacea
- Telangiectasias
- Striae distensae (stretch marks)
- Post-acne scarring
- Facial redness or hyperpigmentation

Pico Laser Treatment
Requests for picosecond laser (e.g., PicoSure, PicoPlus, PicoCare) treatment will be reviewed using the Cosmetic Surgery Policy coverage guidelines available **here**

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization for laser therapy is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for medical procedures. Coverage determinations are based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for laser therapy:

1. Fully completed authorization request via on-line web portal;
2. A signed prescription, written within the past 3 months, from the treating physician, advanced practice registered nurse (APRN), or physician assistant (PA) enrolled in the Connecticut Medical Assistance Program (CMAP); and
3. Documentation from the treating provider, written within the past 3 months, as outlined in the *Clinical Guideline* section of this policy, supporting the medical need.

EFFECTIVE DATE

This policy for the prior authorization for laser therapy for individuals covered under the HUSKY Health Program is effective May 1, 2025.

LIMITATIONS

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

Not Applicable

CODES

Code	Description
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
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4)

not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

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