PROVIDER POLICIES & PROCEDURES

OFFICE-BASED TARGETED EXCIMER 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 office-based, targeted excimer 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.

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.

CLINICAL GUIDELINE

Coverage guidelines for office-based, targeted excimer 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:

Psoriasis

Office-based, targeted excimer laser therapy is typically considered medically necessary for the treatment of localized, plaque psoriasis refractory to conservative management with topical agents and/or phototherapy.

Vitiligo

Initial

Office-based, targeted excimer laser therapy is typically considered medically necessary for the initial treatment (up to 12 weeks) of vitiligo after a failed consecutive two-month trial of conservative treatment with topical agents.

Ongoing

Office-based, targeted excimer laser therapy is typically considered medically necessary for the ongoing treatment of vitiligo when there is a documented, beneficial clinical response to treatment.

All Other Indications

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

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 office-based, targeted excimer 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 office-based, targeted excimer laser therapy:

1. Fully completed authorization request via on-line web portal; and
2. Documentation from the requesting physician supporting medical necessity.

EFFECTIVE DATE
This policy for the prior authorization for office-based, targeted excimer laser therapy for individuals covered under the HUSKY Health Program is effective May 1, 2023.

LIMITATIONS
Not Applicable

CODES:

Code	**Description**
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. **HUSKY Plus Physical Program (or HUSKY Plus Program):** A supplemental physical health program pursuant to Conn. Gen. Stat. § 17b-294, for medically eligible members of HUSKY B in Income Bands 1 and 2, whose intensive physical health needs cannot be accommodated within the HUSKY Plan, Part B.
8. **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.
9. **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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PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	March 2023	Approved at the March 8, 2023, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
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