Medicare Medical Policy

Hemangioma and Vascular Malformation Laser Treatment

MEDICARE MEDICAL POLICY NUMBER: 381

Effective Date: 3/1/2025

Last Review Date: 2/2025

Next Annual Review: 2/2026

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”).

☒ 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.

Note: For the treatment of hypertrophic or keloid scars caused by accidental injury, burns, or a prior surgical procedure, see the separate Medicare Cosmetic and Reconstructive Procedures medical policy (see Policy Cross References below).

Service	Medicare Guidelines
Laser Therapy for Hemangiomas	Local Coverage Determination (LCD): Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979) **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." • While hemangiomas are not called out specifically in the LCD, they **are** included as a medically necessary diagnosis in the companion LCA. • Therefore, when the coverage criteria in the LCD are met, treatment of hemangiomas may be considered medically necessary. • Congenital non-neoplastic nevus (e.g., port wine stains) are not included as a covered indication in the billing/coding LCA. However, because the Company internal coverage criteria allow for coverage of these lesions using similar coverage criteria to what is found in the above LCD, the Plan's Company criteria will be applied.
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 laser treatment of vascular lesions in a coverage manual. • **National Coverage Determination (NCD):** The 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, neither the above Noridian LCD, nor Noridian LCA A57162, provide specific coverage criteria to determine whether laser treatment of a port wine stain may be considered cosmetic or reconstructive, and therefore, is not considered "fully established." • Therefore, in the absence of **fully established** Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance, 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)].*
Laser Therapy for Port Wine Stains	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. Cosmetic procedures are member benefit exclusions. *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

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.

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:*
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> "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.

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." While hemangiomas are not called out specifically in the LCD, they **are** included as a medically necessary diagnosis in the companion LCA. Therefore, the coverage criteria in the LCD are applied to treatment of hemangiomas. Congenital non-neoplastic nevus (e.g., port wine stains) are **not** included as a covered indication in the billing/coding LCA. However, because the Company internal coverage criteria allow for coverage of these lesions using similar coverage criteria to what is found in the above LCD, the Plan's Company criteria will be applied.

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)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, 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.

Since there are not fully established coverage criteria for laser treatments of port wine stains available in applicable Medicare statutes, regulations, NCDs or LCDs, then Company medical policy criteria will be applied. See the Medicare Coverage Criteria table above for more information regarding the use of internal coverage criteria when Medicare coverage criteria are not fully established.

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

GENERAL

See associated local coverage articles (LCAs) for related billing and coding guidance, as well as additional coverage and non-coverage scenarios and frequency utilization allowances and limitations:

- LCA: Billing and Coding: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (A57162)

CPT codes 17106-17108 are used for the destruction of vascular proliferative lesions. If a lesion is not considered a "vascular proliferative lesion," or if the lesion is not destroyed, then the treatment should not be reported using these codes. In the absence of a more specific CPT code, an unlisted code (e.g., 17999) would be used instead.

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

None

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
3/2023	New Medicare Advantage medical policy
3/2024	Annual review; no criteria change
3/2025	Annual review; add use of Noridian LCD for laser treatment of hemangiomas