

# Clinical Policy: Laser Therapy for Skin Conditions

Reference Number: CP.MP.123

Last Review Date: 09/2022

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## Description

Targeted phototherapy utilizes non-ionizing ultraviolet radiation with therapeutic benefit. Phototherapy is an efficacious local therapy that provides several advantages to traditional and biologic systemic therapies. Excimer lasers are monochromatic 308 nm xenon chloride lasers that are approved to treat certain inflammatory skin diseases. This policy describes the medical necessity requirements for excimer laser based targeted phototherapy.

## Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that excimer laser based targeted phototherapy is **medically necessary** for the following indications after the failure of topical treatments:
  - A. Mild, moderate, or severe psoriasis with < 10% body surface area (BSA) involvement;
  - B. Vitiligo.
  
- II. It is the policy of health plans affiliated with Centene Corporation that excimer laser targeted phototherapy is considered **experimental/investigational** for the following indications:
  - A. Patients with photosensitivity disorders;
  - B. Acute dermatitis;
  - C. For the treatment of all other conditions than those specified above.

## Background

Targeted phototherapy uses a localized delivery of ultraviolet light to facilitate therapeutic relief of some conditions. Ultraviolet light is predominantly absorbed by skin DNA, leading to the generation of pyrimidine dimers, pyrimidine, and (6-4)-photoproducts which are either repaired or marked for arrest or cell death through the cell's checkpoint machinery.<sup>5</sup> Various spectra of ultraviolet A (UVA) and ultraviolet B (UVB) wavelengths are utilized to treat a varying array of inflammatory skin disorders, including narrowband, broadband, and excimer lasers, as well as combinations of UVA and UVB with topical, systemic, biologic, and chemotherapeutic regimens.<sup>1</sup> Additionally, phototherapy is cost effective and avoids the immunosuppressive effects that often accompany traditional and biologic based systemic therapies.

Excimer lasers are monochromatic 308nm xenon chloride lasers that provide a safe and selective approach to treating dermatological conditions. Excimer lasers are associated with significant T-cell depletion, alterations in apoptosis-related molecules, reductions in proliferation indices, and immunomodulatory mechanisms.<sup>6</sup> An early study by Feldman *et al* assessed the efficacy of excimer lasers for the treatment of mild to moderate psoriasis in a multicenter study. The authors noted that 84% of the patients reached the primary outcome of at least 75% improvement of their plaques within 1 month.<sup>7</sup> Another study by Rodewald *et al* compared the excimer laser to a non-intervention, placebo cohort, as well as other standard topical treatments for psoriasis.<sup>8</sup> The laser and topical calcipotriene had similar efficacies but both were more effective than

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topical tazarotene or fluocinonide and the time to achieve 75% improvement favored the excimer laser.<sup>8</sup> Therefore, laser was comparable to or more effective than other standard treatments for psoriasis.<sup>8</sup>

According to the American Academy of Dermatologists, the excimer laser is indicated for both adult and pediatric patients with mild, moderate, and severe psoriasis who have less than 10% BSA involvement.<sup>1</sup> The initial treatment dose of the excimer laser depends on the individual's skin type, plaque characteristics, and thickness, with subsequent doses adjusted in accordance to the patient's clinical response and side effects.<sup>1</sup> Treatment takes place 2-3 times per week until a patient is clear of symptoms and lasts an average of 10-12 treatments. Initial response is noted within 8-10 treatments, which depends on the protocol used, lesion characteristics, and site, and the mean remission time is 3.5-6 months.<sup>1</sup>

The European Dermatology Forum and the British Association of Dermatologists provide guidelines for the management of vitiligo.<sup>3-4</sup> The consensus of the European Dermatology Forum is that targeting phototherapy should be indicated for localized vitiligo and for small lesion of recent onset and childhood vitiligo.<sup>3</sup> Notably, Alhowaish *et al* documented the effectiveness of excimer laser treatments in vitiligo in 23 separate articles that included case studies, randomized controlled studies, retrospective analyses, randomized blinded studies, and controlled comparative studies.<sup>9</sup> Although the response time and the duration of response varied, the excimer laser therapy was generally effective across all of the studies.<sup>9</sup>

#### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	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

#### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
L40.0	Psoriasis vulgaris (plaque psoriasis)
L80	Vitiligo

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Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	07/16	08/16
References reviewed and updated.	07/17	08/17
References reviewed and updated	05/18	06/18
References reviewed and updated. Specialist review.	05/19	06/19

## References

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## Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

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policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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