Intense Pulsed Light Therapy

Policy # 00167
Original Effective Date: 05/23/2005
Current Effective Date: 10/11/2021

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc.(collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: This medical policy does not apply to pulsed dye laser treatment.

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company has determined that the use of intense pulsed light (IPL) therapy to treat rosacea or lesions of the vascular system is **investigational.***

When Services Are Not Covered

Based on review of available data, the Company has determined that the use of intense pulsed light (IPL) therapy to treat conditions of small veins or for the removal of hair is **not eligible for coverage.****

Treatment of telangiectasia, spider veins or other small vein conditions and hair removal is determined to be cosmetic in nature and therefore excluded from coverage under most member contracts.

IPL sources are filtered xenon flashlamps that release pulses of noncoherent polychromatic light. They are less powerful than lasers. Light emitted from IPL devices usually falls in the visible to near infrared range (400 to 1200 nm). The broad range of emitted light makes IPL sources versatile devices, allowing for treatment of both vascular and pigmented lesions. The primary use of IPL devices is for photo rejuvenation. Because the delivered light energy is spread over a broad range of wavelengths, a greater number of treatment sessions is usually required for treatment with an IPL device than for treatment with lasers. Pulse durations are similar to the pulsed lasers.

IPL is similar to laser technology, but the devices produce a broad spectrum of light (wavelengths) with computer-controlled parameters of energy to target specific tissue components of the skin. In

the case of lesions of the vascular system, such as spider veins of the face or legs, vascular birthmarks, small varicose veins, prominent facial and neck veins, and blood vessel lesions of the trunk, the target tissue is hemoglobin in the blood. A computer is then used to selectively pulse the light source in a specific wavelength range, heating visible blood vessels, while sparing all the surrounding normal skin. This technique controls depth of penetration, and degree of heating, eliminating the need for tedious and potentially painful needle vein sclerosis, and eliminating the need for electric spark cautery which can leave scars. This technique is effective for most patients, but must not be used in patients with recently tanned skin, or those with darker complexions, due to cross-reactivity with the skin's natural melanin pigment.

Pulsed light sources used for the removal of hair use the conversion of light into heat as it passes through the skin and is absorbed in the target pigment melanin found in the hair follicle. When the temperature reaches a high enough level in a hair follicle during its active phase, the targeted hair structures are disabled, thus inhibiting hair re-growth. In clinical trials to date using a number of different lasers and IPL hair removal systems, some test sites remained hair-free for up to two years.

Pulsed light delivery devices differ by level or type of penetration of light energy. PhotoDerm™‡ devices include the PhotoDerm VL (vascular lesions), PhotoDerm PL (pigmented lesions), PhotoDerm HR (hair removal) and PhotoFacial™‡. Other pulsed light therapy devices identified include; EpiLight™‡, and Advanced Pulsed Light™‡ (APL).

Rationale/Source

The treatment of small veins and hair removal are considered to cosmetic services. Subscriber contracts often exclude coverage for cosmetic services.

The determination that the use of IPL therapy to treat rosacea or lesions of the vascular system is investigational is based on lack of scientific evidence demonstrating:

- Conclusions concerning the effect of the technology on health outcomes have been addressed;
- The technology improves the net health outcome;
- The technology is at least as beneficial as any established alternatives and improvement is attainable outside the investigational settings.

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References

1. Lask G, et al. The Role of laser and intense light sources in photo-epilation: a comparative evaluation. J Cutaneous Laser Therapy 1999, Jan; 1(1):3-13.
2. Elman M, Lask G. The Role of pulsed light and heat energy (LHE) in acne clearance. J Cosmet Laser Ther. 2004, Jun; 6(2):91-5.
3. http://www.facialplasticsurgery.net
4. Sadick NS, Weiss R, Kilmer S, Bitter P. Photorejuvenation with intense pulsed light: results of a multi-center study. J Drugs Dermatol 2004; 3:41.
5. Alster TS, Tanzi EL, Welsh EC. Photorejuvenation of facial skin with topical 20% 5-aminolevulinic acid and intense pulsed light treatment: a split-face comparison study. J Drugs Dermatol 2005; 4:35.

Policy History

Original Effective Date: 05/23/2005
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05/03/2005	Medical Director review
05/17/2005	Medical Policy Committee review
05/23/2005	Managed Care Advisory Council approval
07/07/2006	Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
04/04/2007	Medical Director review
04/18/2007	Medical Policy Committee approval. No change to coverage eligibility.
04/02/2008	Medical Director review
04/16/2008	Medical Policy Committee approval. No change to coverage eligibility.
04/02/2009	Medical Director review
04/15/2009	Medical Policy Committee approval. No change to coverage eligibility.
04/08/2010	Medical Policy Committee approval
04/21/2010	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/07/2011	Medical Policy Committee approval
04/13/2011	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/12/2012	Medical Policy Committee approval

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04/25/2012	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
05/02/2013	Medical Policy Committee approval
05/22/2013	Medical Policy Implementation Committee approval. Coverage eligibility unchanged
09/04/2014	Medical Policy Committee review
09/17/2014	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/03/2015	Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
09/03/2015	Medical Policy Committee review
09/23/2015	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/08/2016	Medical Policy Committee review
09/21/2016	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
09/07/2017	Medical Policy Committee review
09/20/2017	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/06/2018	Medical Policy Committee review
09/19/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/05/2019	Medical Policy Committee review
09/11/2019	Medical Policy Implementation Committee approval. Added a Note before the coverage section that this policy does not apply to pulsed dye laser treatment. Coverage eligibility unchanged.
09/03/2020	Medical Policy Committee review
09/09/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/02/2021	Medical Policy Committee review
09/08/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 09/2022

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Coding

The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines is with Blue Cross and Blue Shield of Louisiana and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	17106, 17107, 17108, 17110, 17111
HCPCS	No codes
ICD-10 Diagnosis	D18.00-D18.09, L71.0-L71.9

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into

standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and 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 that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.