Laser Treatment of Congenital Port Wine Stain Hemangiomas

Archived Medical Policy

Archived medical policies are no longer subject to periodic review, are maintained for reference, and may be returned to active status if the need is identified.

Policy # 00166
Original Effective Date: 05/23/2005
Archived Date: 06/17/2009

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.

When Services Are Eligible for Coverage
Note: Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Based on review of available data, the Company may consider laser treatment of congenital port wine stain hemangiomas to be eligible for coverage.

Background/Overview
Port wine stains (PWS), also known as nevus flammeus, are congenital vascular malformations of the skin present at birth. The prevalence rate in the general population is 0.3%. Although PWS can arise anywhere on the body, they occur most often on the face, neck, arms or legs, and are of varying sizes. Initially appearing as light-pink macules, PWS can darken over time as a result of progressive vessel ectasia. Lesions tend to grow with the patient without a tendency towards regression. Overlying soft tissue or bony hypertrophy may be associated with these lesions.

Many different types of treatments have been investigated for hemangiomas and PWS, such as excision and grafting, dermabrasion, cryotherapy, sclerotherapy, tattooing and irradiation. More recently, laser treatment has been used with good results and the least amount of risk and side effects.

Laser light is highly focused light that is converted to heat when absorbed by pigmented skin lesions. The resulting damage causes gradual destruction of the lesion. Carbon dioxide and argon lasers have an increased incidence of significant scarring in children, whereas tunable dye lasers result in less scarring.

FDA or Other Governmental Regulatory Approval
U.S. Food and Drug Administration (FDA)
Several laser systems have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process for a variety of dermatologic indications, including treatment of port wine stains. Approved lasers for this indication include the Candela pulsed dye laser system (Candela Corp.; Wayland, MA), the Cynosure Photogenica pulsed dye laser (Cynosure Inc; Westford, MA), and the Cynosure Nd:YAG laser system. In addition, the Cynergy Multiplex Laser (Cynosure), a combined Nd:YAG and pulsed dye laser was approved by the FDA in 2005 for treatment of benign vascular and vascular dependant lesions, including port wine stains.
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In 2003, the Lumenis family of intense pulsed light systems was approved by the FDA; indications for use include dermatologic applications. Subsequently, the NannoLight intense pulsed light system (Global USA Distribution) was approved by the FDA in 2008 and the Mediflash3 and Esterflash3 systems (Dermeo) were approved in 2010 for indications specifically including treatment of port wine stains.

Centers for Medicare & Medicaid Services (CMS)
No national coverage determination.

Rationale/Source
This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. FDA approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, Blue Cross and Blue Shield Association technology assessment program (TEC) and other non-affiliated technology evaluation centers, reference to federal regulations, other plan medical policies and accredited national guidelines.

Coding
The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines (BCBSLAMPCG) are obtained from Current Procedural Terminology (CPT®), copyright 2008 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.

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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:

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<th>Code Type</th>
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References

Policy History
Original Effective Date: 05/23/2005
04/05/2005 Medical Director review
04/19/2005 Medical Policy Committee review
05/23/2005 Managed Care Advisory Council approval
05/03/2006 Medical Director review
05/17/2006 Medical Policy Committee approval. Format revision including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
05/02/2007 Medical Director review
05/16/2007 Medical Policy Committee approval. Coverage eligibility unchanged. CMS information added to FDA or Other Governmental Regulatory Approval.
06/13/2007 Medical Director review
06/20/2007 Medical Policy Committee approval. Rationale updated. Patient selection criteria deleted. “When services are excluded from coverage” section was deleted. Coverage eligibility statement was changed to “based on review of available data, the Company may consider laser treatment of congenital port wine stain hemangiomas to be reconstructive surgery that is eligible for coverage”.
06/04/2008 Medical Director review
06/18/2008 Medical Policy Committee approval. No change to coverage eligibility.
06/04/2009 Medical Director review
06/17/2009 Medical Policy Committee approval. No change to coverage eligibility. Archived policy.

Next Scheduled Review Date: Archived.

**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: 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.