Laser Treatment of Acne and Rosacea

Policy # 00162
Original Effective Date: 03/07/2005
Current Effective Date: 10/12/2020

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: Light Therapy for Psoriasis is addressed separately in medical policy 00131.

Note: Light Therapy for Vitiligo is addressed separately in medical policy 00699.

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 considers laser treatment of active acne to be **investigational.***

Based on review of available data, the Company considers laser treatment of rosacea to be **investigational.***

Note: *The use of laser therapy, electrosurgery, cryosurgery, and chemosurgery (i.e., epidermal/dermal chemical peels) for the treatment of acne scarring or effects associated with rosacea (e.g. erythema, teleangiectasia, scarring) is not covered by the Company because it is considered a cosmetic service.*

Background/Overview

Acne

Acne is a very common disorder of the pilosebaceous follicles that primarily affects adolescents and young adults and may be classified as inflammatory or noninflammatory. Acne is characterized by comedones, nodules and eruptions of papules, pustules and nodulocystic lesions. Lesions are found in areas with the greatest concentration of sebaceous glands, i.e., the face, neck and upper part of the trunk. The four causal factors of acne are androgen-mediated sebaceous gland hyperplasia and excess sebum production; abnormal follicular keratinization, which results in plugging of the follicles, and comedo formation; proliferation of propionibacterium acnes (*P. acnes*) and

inflammation resulting from the chemoattractant and proinflammatory byproducts of *P. acnes*. Genetic factors, diet and stress may also contribute to the development and severity of acne. Treatment of active acne usually consists of good skin care regimen, benzoyl peroxide, antibiotics and retinoids. Active acne is distinct from acne scarring, which may occur from tissue damage after inflammatory lesions subside.

Pulsed dye laser has been used in the treatment of acne scarring; however, more recently, lasers have been investigated for the treatment of active inflammatory acne. Laser therapy at various irradiation levels or fluences (e.g., low- and mid-level irradiation lasers and long-pulse diode lasers) has been used to destroy active acne lesions and enlarged sebaceous glands. Lasers are believed to improve active acne lesions by reducing the presence of *P. acnes*, which contain porphyrins that are destroyed by exposure to light of specific wavelengths (i.e., blue light of 405–420 nm). Lasers may also have anti-inflammatory effects (i.e., red light of 660 nm) that may improve active acne. Low-fluence pulsed dye lasers are less ablative and purpuric and may be preferred in active acne treatment to limit tissue damage and potential treatment-related scarring. Laser treatment of active acne lesions may also reduce potential acne scarring that can occur in severe cases.

Rosacea
Rosacea is a chronic, inflammatory skin condition that cannot be cured; the goal of treatment is symptom management. Nonpharmacologic treatments, including laser and light therapy, dermabrasion, and others, are proposed for patients who do not want to use or are unresponsive to pharmacologic treatments.

Rosacea is characterized by episodic erythema, edema, papules, and pustules that occur primarily on the face but may also be present on the scalp, ears, neck, chest, and back. On occasion, rosacea may affect the eyes. Patients with rosacea have a tendency to flush or blush easily. Since rosacea causes facial swelling and redness, it is easily confused with other skin conditions, such as acne, skin allergy, and sunburn.

Rosacea affects mostly adults with fair skin between the ages of 20 and 60 years and is more common in women, but often most severe in men. Rosacea is not life-threatening, but if not treated, may lead to persistent erythema, telangiectasias, and rhinophyma (hyperplasia and nodular swelling and congestion of the skin of the nose). The etiology and pathogenesis of rosacea is unknown but may be a result of both genetic and environmental factors. Some of the theories as to the causes of rosacea

include blood vessel disorders, chronic *Helicobacter pylori* infection, demodex folliculorum (mites), and immune system disorders.

While the clinical manifestations of rosacea do not usually impact the physical health status of the patient, there may be psychological consequences from the most visually apparent symptoms (i.e., erythema, papules, pustules, telangiectasias) that can impact quality of life. Rhinophyma, an end-stage of chronic acne, has been associated with obstruction of nasal passages and basal cell carcinoma in rare, severe cases. The probability of developing nasal obstruction or basal or squamous cell carcinoma with rosacea is not sufficiently great to warrant preventive removal of rhinophymatous tissue.

While rosacea cannot be eliminated, treatment can be effective to relieve its signs and symptoms. Treatment may include oral and topical antibiotics, isotretinoin, beta-blockers, clonidine, and anti-inflammatories. Patients are also instructed on various self-care measures such as avoiding skin irritants and dietary items thought to exacerbate acute flare-ups. To reduce visible blood vessels, treat rhinophyma, reduce redness, and improve appearance, various techniques have been used such as laser and light therapy, dermabrasion, chemical peels, surgical debulking, and electrosurgery. Nonpharmacologic therapy has also been tried in patients who cannot tolerate or do not want to use pharmacologic treatments. The various lasers used include low-powered electrical devices and vascular light lasers to remove telangiectasias, CO2 lasers to remove unwanted tissue from rhinophyma and reshape the nose, and intense pulsed lights that generate multiple wavelengths to treat a broader spectrum of tissue.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Acne

A number of laser and focused light devices have received marketing clearance for the treatment of acne via the FDA's 510(k) mechanism. These include lasers that emit light at 1320nm (Candela Smoothbeam™‡ and CoolTouch®)‡ ; intense pulsed light systems, which emit light in the range of 590 to 1200nm (Radiancy ClearTouch™‡, MED flash II and Ellispse I^2PL)‡; pulsed dye lasers (ICN Photonics NLite System); and lasers or high-intensity light devices, which emit violet or blue (around 414nm) and red (around 633nm) light (Aura™, Clearlight and Dermillume)‡ . The specific

indications for these devices vary; Candela Smoothbeam is indicated solely for the treatment of acne on the back, others are indicated for the treatment of inflammatory acne or for mild to moderate acne with no location specified. In 2006, a thermal device (ThermaClear™)‡ was cleared for marketing for the "treatment of individual acne pimples in persons with mild to moderate inflammatory acne" in both a practitioner's office environment and a consumer home-use environment.

Rosacea
Several laser and light therapy systems have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process for various dermatologic indications, including rosacea. For example, rosacea is among the indications for:

- Candela®‡ pulse dye laser system (Candela, Wayland, MA)
- Lumenis®‡ One Family of Systems IPL component (Lumenis, Santa Clara, CA)
- Harmony®‡ XL multi-application platform laser device (Alma Lasers, Israel)
- UV-300 Pulsed Light Therapy System (New Star Lasers, Roseville, CA)
- CoolTouch PRIMA Pulsed Light Therapy System (New Star Lasers, Roseville, CA).

FDA product code: GEX.

Rationale/Source

Acne
Two systematic reviews of light therapies for treatment of active acne were identified. Both reviews included studies on photodynamic therapy, as well as light and laser therapy. Neither review conducted any pooled analyses of laser treatment studies due to heterogeneity between studies (e.g. different wavelengths of light were used). The two systematic reviews had similar assessments of the literature. Hamilton and colleagues identified 10 randomized controlled trials (RCTs) comparing light therapy to placebo and 3 RCTs comparing light therapy to topical treatment of acne. The authors commented that studies of light therapy tended to be small (all had fewer than 50 participants), of short duration and of variable quality, and that a few compared light therapy to conventional treatment. They concluded: "our review found only limited or no benefit is given by light therapies alone…Further trials comparing light therapy with usual treatment, using a larger effect size in the power calculations, would be helpful to determine the usefulness of light therapy in treating acne." The other systematic review by Haedersdal and colleagues included 11 RCTs on light treatments (other than photodynamic therapy) and stated that that most of the studies had

suboptimal methods. For example, few studies described their randomization method and most had large losses to follow-up without intention to treat analysis. The authors state, "Based on the present best available evidence, we conclude that optical treatments with lasers, light sources and PDT possess the potential to improve inflammatory acne on a short-term basis with the most consistent outcomes for PDT. We recommend that patients are informed of the existing evidence, which denotes that optical treatments for acne today are not included among first-line treatments" There is no separate conclusion focusing on laser therapy. The systematic reviews identified a number of side effects from optical treatments, and these include pain, erythema, edema, crusting, hyperpigmentation, and pustular eruptions.

Key individual RCTs with at least 40 participants are described as follows:

Seaton et al., 2003: This trial was a double-blind RCT of 41 adults with mild to moderate facial inflammatory acne (i.e., Leeds acne severity score of between 2 and 7). Patients were randomized to receive a single low fluence pulsed dye laser treatment or sham treatment. At 12 weeks, Leeds acne scores fell from 3.8 to 1.9 in the treatment group and from 3.6 to 3.5 in the control group. Total lesion counts fell by 53% and 9% and inflammatory lesion counts fell by 49% and 10% in the laser treatment group and control group, respectively. While the authors reported statistically significant improvements, they concluded that "laser treatment should be further explored as an adjuvant or alternative to daily conventional pharmacological treatments."

Orringer et al., 2004: The article reported on a single-blind, split-face RCT of 40 patients (aged 13 years or older with a Leeds acne score of two or greater) who were randomized to receive either one or two sessions of pulsed dye laser treatment (3 J/cm2 fluence) to half of the face with the opposite, non-treated side serving as the control. At 12 weeks, changes in lesion counts (including pustules, comedones, macules, cysts, and papules) and mean Leeds acne scores were not significantly different for the treated versus untreated sides of the face. The authors concluded that "…additional well designed studies are needed before the use of pulse dye laser becomes a part of acne therapy."

Orringer et al., 2007: This RCT assessed the efficacy of a 1320-nm laser (CoolTouch II) in 46 patients in a split-face design. Laser treatment was given once every three weeks, with blinded evaluation by a panel of three dermatologists (from photographs taken at 7 and 14 weeks). Thirty patients completed the 14-week assessment (35% dropout); data were carried forward to adjust for subjects who may have dropped out of the study due to lack of effect. The authors report that the

treated side remained unchanged at 0.22 cysts (10 total cysts in 46 subjects) while the untreated side increased from 0.27 to 0.70 cysts. Subjective patient reports (of 37 who completed at least the 7-week assessment; not blinded to treatment) favored the treated side over the control side for a decrease in acne (59%) and oily skin (54%). No differences were found between the treated and un-treated sides in the number of papules, pustules, open comedones, or closed comedones at 14 weeks.

Laheta, 2009: This study included 45 patients with mild to moderate acne who were randomly assigned to one of three groups (15 patients per group). Group A received pulsed dye laser therapy (3 J/cm2 fluence) every two weeks for six sessions; Group B applied topical treatment with 0.1% tretinoin cream every evening and 5% benzoyl peroxide gel every morning; and Group C underwent chemical peeling using trichloroacetic acid 25%. An assessor blinded to treatment group evaluated outcomes; 41 patients were included in the analysis. There was no significant difference between groups in the acne severity score (0=no acne to 10=severe acne) at the end of the 3-month treatment period. Mean scores were 0.56 ± 0.57 for Group A, 0.65 ± 0.47 for Group B, and 0.68 ± 0.50 for Group C (p=0.38). The analysis of disease severity did not adjust for baseline scores, and standard deviations were large due to the small number of participants in each group. The degree of clinical response (marked or moderate) and side effects (trace, mild, or moderate) also did not differ significantly between the three groups. The proportion of patients with moderate side effects was 23% in Group A, 15% in Group B, and 13% in Group C (overall p-value=0.95).

Summary

Due to the small sample sizes of the published trials, lack of long-term follow-up, small number of studies on any particular type of laser, and paucity of studies comparing light therapy to standard acne treatments, the evidence is insufficient to draw conclusions about the impact of laser treatments on health outcomes in patients with active acne. Therefore, the technology is considered investigational.

Rosacea

Rosacea is a chronic, inflammatory skin condition without a known cure; the goal of treatment is symptom management. Nonpharmacologic treatments, including laser and light therapy as well as dermabrasion, which are the focus of this evidence review, are proposed for patients who do not want to use or are unresponsive to pharmacologic therapy.

For individuals who have rosacea who receive nonpharmacologic treatment (eg, laser therapy, light therapy, dermabrasion), the evidence includes several small randomized, split-face design trials. The relevant outcomes are symptoms, change in disease status, and treatment-related morbidity. The randomized controlled trials evaluated laser and light therapy. No trials assessing other nonpharmacologic treatments were identified. None of the randomized controlled trials included a comparison group of patients receiving a placebo or pharmacologic treatment; therefore, these trials do not offer evidence on the efficacy of laser or light treatment compared with alternative treatments. There is a need for randomized controlled trials that compare nonpharmacologic treatments with placebo controls and with pharmacologic treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information

Practice Guidelines and Position Statements

American Acne and Rosacea Society

The American Acne and Rosacea Society (2014) issued consensus recommendations on the management of rosacea. The Society stated that lasers and intense pulsed light (IPL) devices could improve certain clinical manifestations of rosacea that have not responded to medical therapy. The recommendations indicated that these therapies would have to be repeated intermittently to sustain improvement.

The American Acne and Rosacea Society (2019) issued updated consensus recommendations on the management of rosacea. The update focused on how medical and device therapies are used--whether concurrently or in a staggered fashion--noting that there is a lack of evidence to justify either use. The Society's consensus recommendation on rosacea management correlated with clinical manifestations observed at the time of presentation are summarized in Table 1:

Table 1. Recommendations on Use of Lasers and Intensely Pulse Light Devices for the Management of Rosacea

Condition	Recommendation	Grade[a]
Persistent central facial erythema without PP lesions	IPL, KTP crystal laser, or pulsed-dye laser	B

Diffuse central facial erythema with PP lesions	"While the data on the use of IPL, KTP or pulsed-dye laser are limited for PP lesions, these options are useful to treat erythema"	NR
Granulomatous rosacea	· Intense pulsed-dye laser · "No current standard of treatment; limited data based on case reports"	C
Phymatous Rosacea	· "Surgical therapy for fully developed phymatous changed (carbon dioxide laser, erbium-doped [YAG] laser, electrosurgery, dermabrasion)" · "Treatment selection dependent on stage of development (early or fibrotic) and extent of inflammation (active or burnt out)"	C

IPL: intense pulsed light, KTP: Potassium titanyl phosphate; PP: papulopustular; YAG: yttrium aluminum garnet; NR: not reported.
[a] Grade A: Criteria not described in recommendation; Grade B: Systematic review/meta-analysis of lower-quality clinical trials or studies with limitations and inconsistent findings; lower-quality clinical trial; Grade C:Consensus guidelines; usual practice, expert opinion, case series—limited trial data

American Academy of Dermatology
The AAD (2017) released online guidance for the treatment and management of rosacea. The AAD encouraged patients to identify their triggers to minimize symptoms, including protection from exposure to the sun, heat, stress, alcohol, and spicy foods. The AAD indicated that laser or light therapy may be used to reduce redness and that laser resurfacing may be used to remove thickening skin. The AAD also stated that "researchers continue to study how lasers and light treatments can treat rosacea. As we learn more, these devices may play a bigger role in treating rosacea."

Rosacea Consensus Panel
The Rosacea Consensus panel (2017), comprised of international experts including representatives from the U. S., published recommendations for rosacea treatment. The panel agreed that treatments

should be based on phenotype. IPL and pulsed dye laser were recommended for persistent erythema, but not for transient erythema. IPL and lasers were also recommended for telangiectasia rosacea.

The panel updated their recommendations on rosacea treatment in 2019, agreeing that lasers were recommended for persistent centrofacial erythema. They also noted that "use of IPL and vascular lasers in darker skin phototypes requires consideration by a healthcare provider with experience…, as it can result in dyspigmentation." The panel also acknowledged that combining treatments could benefit patients with more severe rosacea and multiple rosacea features; however "there remains an ongoing need for more studies to support combination treatment use in rosacea."

National Institutes for Health and Care Excellence
The National Institutes for Health and Care Excellence (2017) published online pathways addressing skin damage and skin conditions. Pathways provide guidance on the use of topical agents to manage rosacea. There are no pathways, guidance, or recommendations on nonpharmacologic treatments for rosacea.

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage

Rosacea
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Acne
No national coverage determination.

Ongoing and Unpublished Clinical Trials
Some currently ongoing and unpublished trials that might influence this review are listed in Table 2.

Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT03211585[a]	Evaluation Of The Effect Of The Perfecta V-Beam Laser On Rosacea (Facial Redness, Telangiectasias And Photodamage)	20	Dec 2018 (ongoing)
NCT02075671[a]	Photodynamic Therapy for Papulopustular Rosacea	30	Feb 2019 (ongoing)
Unpublished			
NCT03194698	Efficacy of Intense Pulsed Light Treatment of Dry Eye and Ocular Rosacea	20	Dec 2018 (Completed)

NCT: national clinical trial.
[a] Denotes industry-sponsored or cosponsored trial.

References

1. Blue Cross-and Blue Shield Association, Medical Policy Reference Manual, "Laser Treatment of Acne", 2.01.69, 12:2009- Archived policy.
2. Blue Cross-and Blue Shield Association, Medical Policy Reference Manual, "Non-Pharmacologic Treatment of Rosacea", 2.01.71, 01:2020.
3. Van Zuuren EJ, Kramer S, Carter B et al. Interventions for rosacea. Cochrane Database Syst Rev 2011; (3):CD003262.
4. Wat H, Wu DC, Rao J, et al. Application of intense pulsed light in the treatment of dermatologic disease: a systematic review. Dermatol Surg. Apr 2014;40(4):359-377. PMID 24495252

5. Erceg A, de Jong EM, van de Kerkhof PC, et al. The efficacy of pulsed dye laser treatment for inflammatory skin diseases: a systematic review. J Am Acad Dermatol. Oct 2013;69(4):609-615 e608. PMID 23711766
6. Alam M, Voravutinon N, Warycha M, et al. Comparative effectiveness of nonpurpuragenic 595-nm pulsed dye laser and microsecond 1064-nm neodymium:yttrium-aluminum-garnet laser for treatment of diffuse facial erythema: A double-blind randomized controlled trial. J Am Acad Dermatol. Sep 2013;69(3):438-443. PMID 23688651
7. Maxwell E, Ellis DA, Manis H. Acne rosacea: effectiveness of 532 nm laser on the cosmetic appearance of the skin. J Otolaryngol Head Neck Surg 2010; 39(3):292-6.
8. Neuhaus IM, Zane LT, Tope WD. Comparative efficacy of nonpurpuragenic pulsed dye laser and intense pulsed light for erythematotelangiectatic rosacea. Dermatol Surg 2009; 35(6):920-8.
9. Salem SA, Abdel Fattah NS, Tantawy SM, et al. Neodymium-yttrium aluminum garnet laser versus pulsed dye laser in erythemato-telangiectatic rosacea: comparison of clinical efficacy and effect on cutaneous substance (P) expression. J Cosmet Dermatol. Sep 2013;12(3):187-194. PMID 23992160
10. Karsai S, Roos S, Raulin C. Treatment of facial telangiectasia using a dual-wavelength laser system (595 and 1,064 nm): a randomized controlled trial with blinded response evaluation. Dermatol Surg. May 2008;34(5):702-708
11. National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). 2009. Available online at: http://www.niams.nih.gov/Health_Info/Rosacea/default.asp
12. Hamilton FL, Car J, Lyons C et al. Laser and other light therapies for the treatment of acne vulgaris: systematic review. Br J Dermatol 2009; 160: 1273-1285.
13. Haedersdal M, Togsverd-Bo K, Wiegell SR et al. Long-pulsed dye laser versus long-pulsed dye laser-assisted photodynamic therapy for acne vulgaris: a randomized controlled trial. J Am Acad Dermatol 2008; 58(3):387-94.
14. Seaton ED, Charakida A, Mouser PE et al. Pulsed-dye laser treatment for inflammatory acne vulgaris: randomized controlled trial. Lancet 2003; 362(9393):1347-52.
15. Orringer JS, Kang S, Hamilton T et al. Treatment of acne vulgaris with a pulsed dye laser: a randomized controlled trial. JAMA 2004; 291(23):2834-9.
16. Orringer JS, Kang S, Maier L et al. A randomized, controlled, split-face clinical trial of 1320-nm Nd:YAG laser therapy in the treatment of acne vulgaris. J Am Acad Dermatol 2007; 56(3):432-8.
17. Laheta TM. Role of the 585-nm pulsed dye laser in the treatment of acne in comparison with other topical therapeutic modalities. J Cesmetic Laser Ther 2009; 11: 118-124.

18. http://www.skincarephysicians.com/acnenet/PhysicalProcedures.html .
19. Tanghetti E, Del Rosso JQ, Thiboutot D, et al. Consensus recommendations from the American Acne & Rosacea Society on the management of rosacea, part 4: a status report on physical modalities and devices. Cutis. Feb 2014;93(2):71-76. PMID 24605343
20. American Academy of Dermatology. Lasers and lights: How well do they treat rosacea? 2017; https://www.aad.org/public/diseases/acne-and-rosacea/rosacea/lasers-and-lights-how-well-do-they-treat-rosacea.
21. Tanghetti E, Del Rosso JQ, Thiboutot D, et al. Consensus recommendations from the American Acne & Rosacea Society on the management of rosacea, part 4: a status report on physical modalities and devices. Cutis. Feb 2014;93(2):71-76. PMID 24605343
22. Del Rosso JQ, Tanghetti E, Webster G, et al. Update on the Management of Rosacea from the American Acne & Rosacea Society (AARS). J Clin Aesthet Dermatol. 2019;12(6):17-24. PMID: 31360284
23. Schaller M, Almeida LMC, Bewley A, et al. Recommendations for rosacea diagnosis, classification and management: update from the global ROSacea COnsensus 2019 panel. Br J Dermatol. 2019 Aug 7. PMID: 31392722
24. National Institutes for Health and Care Excellence (NICE). Skin conditions overview. 2017; https://pathways.nice.org.uk/pathways/skin-conditions.

Policy History

Original Effective Date: 03/07/2005
Current Effective Date: 10/12/2020

12/07/2004	Medical Director review
12/14/2005	Medical Policy Committee review
03/07/2005	Managed Care Advisory Council approval
09/07/2005	Medical Director review
09/20/2005	Medical Policy Committee review. Laser treatment for scar revision removed from policy.
09/22/2005	Quality Care Advisory Council approval
07/07/2006	Medical Policy Committee approval. Format revision, including addition of FDA and/or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
07/10/2007	Medical Director review

Laser Treatment of Acne and Rosacea

Policy # 00162
Original Effective Date: 03/07/2005
Current Effective Date: 10/12/2020

07/18/2007	Medical Policy Committee approval. No change to coverage eligibility.
07/02/2009	Medical Director review
07/22/2009	Medical Policy Committee approval. No change to coverage eligibility.
07/01/2010	Medical Policy Committee Director approval.
07/21/2010	Medical Policy Implementation Committee approval. No change to coverage.
07/07/2011	Medical Policy Committee Director approval.
07/20/2011	Medical Policy Implementation Committee approval. No change to coverage.
10/12/2011	Coding correction.
06/28/2012	Medical Policy Committee Director approval.
07/27/2012	Medical Policy Implementation Committee approval. No change to coverage.
06/27/2013	Medical Policy Committee Director approval.
07/17/2013	Medical Policy Implementation Committee approval. No change to coverage.
07/10/2014	Medical Policy Committee Director approval.
07/16/2014	Medical Policy Implementation Committee approval. No change to coverage.
08/03/2015	Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
09/03/2015	Medical Policy Committee Director approval.
09/23/2015	Medical Policy Implementation Committee approval. No change to coverage.
09/08/2016	Medical Policy Committee Director approval.
09/21/2016	Medical Policy Implementation Committee approval. No change to coverage.
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
09/07/2017	Medical Policy Committee Director approval.
09/20/2017	Medical Policy Implementation Committee approval. No change to coverage.
09/06/2018	Medical Policy Committee Director approval.
09/19/2018	Medical Policy Implementation Committee approval. No change to coverage.
09/05/2019	Medical Policy Committee Director approval.
09/11/2019	Medical Policy Implementation Committee approval. No change to coverage.
09/03/2020	Medical Policy Committee Director approval.
09/09/2020	Medical Policy Implementation Committee approval. No change to coverage.

Next Scheduled Review Date: 09/2021

Laser Treatment of Acne and Rosacea

Policy # 00162
Original Effective Date: 03/07/2005
Current Effective Date: 10/12/2020

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 2019 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	17110, 17111, 96920
HCPCS	No codes
ICD-10 Diagnosis	L70.0-L70.9, L71.0-L71.9, L73.0, L90.5

*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.

‡ Indicated trademarks are the registered trademarks of their respective owners.

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.