Laser Treatment for Psoriasis and Other Selected Skin Conditions

Number: 0577

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Policy
Aetna considers excimer and pulsed dye laser treatment medically necessary for persons with mild-to-moderate localized plaque psoriasis affecting 10% or less of their body area who have failed to adequately respond to 3 or more months of topical treatments, including at least 3 of the following:

1. Anthralin;
2. Corticosteroids (e.g., betamethasone dipropionate ointment and fluocinonide cream);
3. Keratolytic agents (e.g., lactic acid, salicylic acid, and urea);
4. Retinoids (e.g., tazarotene);
5. Tar preparations; and/or
6. Vitamin D derivatives (e.g., calcipotriene).

No more than 13 laser treatments per course and 3 courses per year are generally considered medically necessary. If the person fails to respond to an initial course of laser therapy, as documented by a reduction in Psoriasis Area and Severity Index

Policy History

Last Review 06/23/2016
Effective: 11/13/2001
Next Review: 06/22/2017

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes
(PASI) score or other objective response measurement, additional courses are not considered medically necessary.

Aetna considers combinational use of pulsed dye laser and ultra-violet B (UVB) experimental and investigational for the treatment of persons with localized plaque psoriasis because of insufficient evidence in the peer-reviewed literature.

Aetna considers the excimer laser or pulsed dye laser experimental and investigational in the treatment of forms of psoriasis other than plaque psoriasis because of insufficient evidence in the peer-reviewed literature.

Aetna considers laser treatment experimental and investigational for the following indications because of insufficient evidence in the peer-reviewed literature (not an all-inclusive list):

- Atopic dermatitis
- Eczematous lesions
- Granuloma annulare
- Granuloma faciale
- Herpes simplex labialis
- Hidradenitis suppurativa
- Jessner lymphocytic infiltration of the skin
- Lichen sclerosus
- Lupus erythematoses
- Melasma
- Morphea (scleroderma of the skin)
- Mycosis fungoides
- Onychia
- Onychomycosis
- Pilonidal sinus disease
- Prurigo nodularis
- Reticular erythematous mucinosis
- Sarcoidosis
- Spongiotic dermatitis
- Vulval intraepithelial neoplasia.
Aetna considers laser treatment of acne scarring as cosmetic.

See also CPB 0205 - Phototherapy and Photochemotherapy (PUVA) for Skin Conditions (/200_299/0205.html), and CPB 0658 - Psoriasis and Psoriatic Arthritis: Biological Therapies (/600_699/0658.html).

Background

**Plaque Psoriasis:**

Psoriasis is a chronic skin disease that generally appears as patches of raised red skin covered by a flaky white buildup. Although the exact cause is unknown, psoriasis is thought to be due to an immunologic dysfunction, which accelerates the growth cycle of skin cells, causing them to accumulate faster than they can be shed.

Approximately 80% of persons with psoriasis have "plaque psoriasis". Plaque psoriasis can appear on any skin surface, although the knees, elbows, scalp, trunk and nails are the most common locations. There are several other types of psoriasis, and between 10% and 30% of people with psoriasis also develop psoriatic arthritis.

Treatments for psoriasis can be divided into 3 basic categories: (i) sunlight and topical agents (corticosteroids, calcipotriene, anthralins, tazarotene, coal tar, salicylic acid, moisturizers); (ii) phototherapy (broad-band ultraviolet-B [UVB], PUVA); and (iii) systemic medications (methotrexate, oral retinoids, cyclosporine).

Excimer lasers [XTRAC Excimer Laser Treatment System, (PhotoMedex, Carlsbad, CA) and EX-308 Excimer Laser System (Ra Medical Systems, Carlsbad, CA)] have been cleared by the Food and Drug Administration based on 510(k) applications for treatment of mild-to-moderate localized psoriasis. Both the XTRAC and the EX-308 are hand-held laser devices that use xenon chloride sources and provide intense, targeted UVB light. The potential benefits over standard UVB treatments are
in terms of more rapid clinical response and more targeted therapy, avoiding the side effects of UV light exposure to unaffected skin. This procedure is usually repeated at least twice-weekly for 2 to 4 weeks.

There is evidence from controlled clinical trials of the effectiveness of excimer laser treatment of mild-to-moderate psoriasis. However, the comparative effectiveness of topical and laser treatment of psoriasis is unknown because these treatments have not been directly compared in a prospective clinical study. In addition, there is no adequate evidence of the effectiveness of laser therapy in combination with topical therapy. There is also limited evidence of the durability of the response to laser treatment of psoriasis. There is some evidence that a significant proportion of patients with psoriasis that is refractory to topical therapies may respond to laser treatment.

Asawanonda et al (2000a) reported on a dose-response study involving 13 patients with psoriasis plaques. Varying numbers of excimer pulses were delivered at fixed doses with a range of fluences from sub-erythemogenic to supra-erythemogenic. Lesions remained in remission with as few as a single high fluence (up to 16 times the minimal erythemogenic dose (MED)) treatment, whereas recurrences occurred in lesions treated with multiple doses of lower fluences shortly after cessation of treatment. The duration of remissions seen with the high fluences was 6.5 months. Based on these findings, the authors stated that "[w]e speculate that the ideal approach for localized, limited plaques may well be single or at most a few 'high-dose' treatments, whereas for widespread psoriasis several 'medium-dose' treatments may make more sense".

Feldman et al (2002) reported on a multi-center study of the excimer laser involving 124 patients with stable mild-to-moderate plaque-type psoriasis; 32 of whom dropped out of the study before completing the course of treatment. Patients were scheduled twice-weekly for a total of 10 treatments. Seventy-two percent of patients who completed the treatment
course achieved at least 75% clearing in an average of 6.2 treatments. Eighty-four percent of patients reached improvement of 75% or better after 10 or fewer treatments. Side effects included erythema in half of the 124 patients, blisters in 56%, hyper-pigmentation in 47%, and erosion in 31%. Other side effects included pain, sunburn sensation, scaling, itching, tenderness, flaking, peeling, vesicles, disease flare, scab, and weeping lesions. The authors concluded that the excimer laser appears to be safe and effective for psoriasis, and has an advantage over conventional photo-chemotherapy in that it requires fewer visits and targets only the affective areas of skin, sparing the surrounding uninvolved skin.

Trehan and Taylor (2002) reported on a self-controlled study involving 16 patients with multiple stable psoriasis plaques who were treated with the excimer laser. Two plaques were selected on each patient, and half of each plaque was treated with a single excimer laser dose, whereas the other half (control) was left untreated. Eleven patients showed significant improvement with reduction of the plaque to a flat red macule within treated sites within one month. There was no change in the control halves of the psoriatic plaques. At baseline, the mean Psoriasis Area and Severity Index (PASI) score was 6.31, but 4 weeks after a single treatment the mean modified PASI score was 3.56 (p < 0.01).

Gerber et al (2003) reported on the effectiveness of the excimer laser in an uncontrolled study involving 120 patients with chronic plaque psoriasis; 102 of whom completed the study. Patients were treated twice a week for the first 3 weeks, then once-weekly until clearance was achieved. Of these patients, 2/3 had a 90% or greater improvement in PASI score after a maximum of 10 treatments, and 85% had 90% or greater improvement in PASI score after a maximum of 13 sessions. Blistering occurred at least once in 40% of the patients, and 26% in this group had erosions and pain. Duration of remission was not reported.

Taneja et al (2003) reported on a before-and-after study of
excimer laser therapy in 18 subjects with recalcitrant plaque psoriasis that had not responded to other treatments, 4 of whom dropped out before the end of the study. Patients were treated twice-weekly. A total of 44 plaques were treated with the excimer laser, and 1 lesion in each subject was left untreated as a control. Plaques received a mean of 10 treatments (range of 4 to 14). The mean PASI scores of the treated plaques decreased from 6.2 before treatment to 1.2 after 10 treatments, whereas the mean PASI scores of the untreated plaques increased from 6.4 before treatment to 6.9 after 10 treatments. At follow-up, the mean modified PASI scores of all treated lesions gradually regressed from 1.0 at the time of the last treatment; to 2.0 by the end of the 3rd month; to 3.1 at the 6-month follow-up. The relapse was mild in all cases and mostly focal in 20 of 44 cases.

Thus, the excimer laser may be considered as a treatment option for those patients in whom topical therapy has failed. According to published clinical studies, responses increase with up to 13 treatments, and the typical duration of response is 4 to 6 months. Additionally, clinical trials of the laser therapy selected patients with less than 10 % of body surface area affected because, in the clinical setting, it is not practical to treat more than 10 % of body surface area with the laser, because of the extended treatment time required due to the relatively small treatment spot size.

There is also adequate evidence that pulsed dye laser (PDL) is effective in the treatment of psoriasis (Ros et al, 1996; Zelickson et al, 1996; Lanigan et al, 1997; Taibjee et al, 2005; Erceg et al, 2006; Ilknur et al, 2006; de Leeuw et al, 2006; Bovenschen et al, 2007). It should be noted that the National Psoriasis Foundation (2007) states that PDL can be used to treat chronic localized plaque lesions.

Ros et al (1996) used the flash-lamp-pumped PDL, which selectively damages dermal vessels, to treat psoriatic plaques and evaluated the role of the vasculature in the therapeutic response. A total of 10 patients with psoriasis were treated
with the PDL on single, stable psoriasis plaques. Treatments varied between 1 and 3 times, and the lesional response was graded using a scale for erythema, scaling, and infiltration. Six of 10 patients experienced a beneficial clinical effect after therapy. The psoriasis severity scale in these patients was reduced to 2.2 +/- 1.3 compared with a 7.2 +/- 1.7 grade for control areas. The plaques readily developed crusting with therapy, with 1 leg lesion healing with atrophy. Histopathology in 3 patients immediately after therapy showed no epidermal damage. One week after laser therapy, the necrotic former epidermis was apparent in superficial crusting. Epidermal thinning and regeneration was seen without any signs of psoriasis. The authors concluded that PDL therapy may improve plaque psoriasis; and this improvement may be related to the role the microvasculature plays in psoriasis.

Zelickson and co-workers (1996) examined the clinical and histological events of psoriasis treated with the PDL. Psoriatic plaques were treated with a short (450 microseconds) and long (1,500 microseconds) pulse-width PDL. Photographs of the plaques were used for clinical assessment. Biopsy specimens were examined microscopically. Significant clinical improvement was seen, and no significant difference between the short and long pulse-width PDL was observed. Patients responding to treatment with the PDL remained in remission for up to 13 months. Histological normalization occurred after treatment. Two pre-treatment vascular patterns were seen: (i) vertically oriented vessels with few horizontal vessels, and (ii) numerous tortuous vessels. Tortuous vessels were associated with poor clinical results. The authors concluded that the PDL can induce prolonged remission in chronic plaque psoriasis; and the vascular pattern may help to distinguish those patients likely to respond to this treatment.

Taibjee and colleagues (2005) noted that the excimer laser delivers high energy monochromatic ultraviolet (UV) B at 308 nm. Advantages over conventional UV sources include targeting of lesional skin, reducing cumulative dose and inducing faster clearance. Studies of the PDL in psoriasis
reported between 57% and 82% response rates; remission may extend to 15 months. These investigators examined excimer laser and PDL in the treatment of psoriasis. They conducted a within-patient controlled prospective trial of treatment of localized plaque psoriasis. A total of 22 adult patients, mean PASI (mPASI) 7.1, were recruited. Fifteen patients completed the full treatment, of which 13 were followed-up to 1 year. Two selected plaques were treated with excimer twice-weekly and V Beam PDL, pre-treated with salicylic acid (SA), every 4 weeks, respectively. Two additional plaques, treated with SA alone or untreated, served as controls. The primary outcome measures were: (i) changes in plaque-modified Psoriasis Activity and Severity Index (PSI) scores from baseline to end of treatment; (ii) clinical response to treatment (CR(T)), assessed by serial photographs; (iii) percentage of plaques clear at the end of treatment; and (iv) percentage of plaques clear at 1-year follow-up. The secondary outcome measures were: (i) number of laser treatments to clearance; (ii) time to relapse; (iii) frequency of side-effects; and (iv) qualitative observations with SIAscope. The mean improvement in PSI was 4.7 (SD 2.1) with excimer and 2.7 (SD 2.4) with PDL. PSI improvement was significantly greater in excimer than PDL (p = 0.003) or both control plaques (p < 0.001). CR(T) indicated 13 patients responded best with excimer, 2 patients best with PDL, and in 7 patients there was no difference between the two lasers. CR(T) was significantly greater for excimer than PDL (p = 0.003) or both controls (p < 0.001). CR(T) was also significantly greater for PDL than SA alone (p = 0.004) or untreated control (p = 0.002). Nine (41%) patients cleared with excimer, after mean 8.7, median 10 weeks treatment. Seven of these 9 patients were followed-up to 1 year; 4 remained clear, 2 relapsed at 1 month, and 1 at 6 months. Six (27%) patients cleared with PDL, after mean 3.3, median 4 treatments. All 6 patients were followed-up to 1 year; 4 remained clear, 1 relapsed at 4 months and 1 at 9 months. Despite common side-effects including blistering and hyper-pigmentation, patient satisfaction was high. Serial images obtained with the SIAscope during treatment indicated different mechanisms of action of the two lasers. The authors
concluded that excimer and V Beam PDL are useful treatments for plaque psoriasis. Although the excimer appears to be on average more effective, a subset of patients may respond better to PDL; and long-term remission is achievable with both lasers.

Erceg and colleagues (2006) compared the effectiveness of the PDL in the treatment of localized, recalcitrant plaque psoriasis with a potent topical therapy, using calcipotriol/betamethasone dipropionate (Dovobet) as an active comparator. A total of 8 patients with psoriasis were treated with both PDL (585 nm) and calcipotriol/betamethasone dipropionate in an open, intra-patient, left right comparison. A plaque severity score (sum score) and photographs were used to document the course of therapy. Patients reported pain on a visual analogue scale. Both treatments were well- tolerated, although 1 patient left the study due to post-PDL treatment pain. A significant difference in the sum score 12 weeks after treatment was seen in favor of the PDL (62 % versus 19 % reduction; p < 0.05). Scores for erythema declined significantly at week 12 in both the PDL and the calcipotriol/betamethasone dipropionate group (p < 0.001). Induration and desquamation scores were significantly reduced at week 12 in the PDL group, without a statistically significant reduction in calcipotriol/betamethasone-treated lesions. The pain scores declined with progressive PDL treatments, although not statistically significantly. The authors concluded that PDL treatment might be considered for the treatment of localized, recalcitrant plaque psoriasis, when other topical therapies have failed.

Ilknur et al (2006) compared the effectiveness of the PDL treatment with that of clobetasol propionate treatment. A total of 21 patients with chronic, stable psoriatic plaques that involved less than 20 % of their body were included in the study. Three similar-appearing psoriasis plaques in these patients were selected. Whereas the 1st plaque received only PDL, the 2nd plaque received PDL after salicylic acid, and the 3rd plaque received clobetasol propionate ointment and salicylic acid. Evaluation of the study plaques was carried out by the mPASI score and by measuring the area of the plaques.
Of the 21 patients, 19 completed the study. Although the decrease in mPASI scores was determined to be maximum for clobetasol propionate + salicylic acid-treated plaques and minimum for only PDL-treated plaques, the decrease was statistically significant in all groups when compared with baseline (p < 0.003). At the 3- and 6-week evaluations, there was a statistically significant difference between clobetasol propionate + salicylic acid-treated plaques and the two PDL-treated plaques (p < 0.003); however, the difference observed at the 9-, 12-, and 15-week evaluations was statistically significant only between clobetasol propionate + salicylic acid-treated plaques and PDL-treated plaques (p < 0.003). When the baseline and 15-week evaluations were compared, there was no statistically significant increase in the mean lesion areas of clobetasol propionate + salicylic acid-treated psoriatic plaques (p > 0.003), but there was a statistically significant increase in the mean lesion areas of two PDL-treated psoriatic plaques (p < 0.003). The authors concluded that the results of this study showed that the effect of PDL could be increased when salicylic acid was added to treatment, although there was no statistically significant difference between both treatment protocols. However, clobetasol propionate + salicylic acid treatment is more effective than both PDL and PDL + salicylic acid treatment.

de Leeuw et al (2006) prospectively assessed the safety and effectiveness of PDL treatment of psoriasis of the hands and feet. A total of 41 patients with therapy-resistant psoriasis of the hands and feet were treated once every 4 to 6 weeks with PDL at 585-nm wavelength, 450-microsecond pulse duration, 7-mm spot diameter, and 5- to 6.5-J/cm2 fluence. Calcipotriol ointment and salicylic acid 5% to 10% ointment were used as keratolytic agents. Treatment effectiveness was evaluated by blinded comparison of photographs of the lesions taken before and after PDL treatment in each patient. A good to very good improvement in the lesions was observed in 76% of the patients after treatment. An average duration of remission was 11 months. Side effects were transient purpura, moderate discomfort during the treatment, transient hyper-pigmentation
or hypo-pigmentation, and incidental transient crustae. The authors concluded that concomitant treatment with PDL and topical calcipotriol, salicylic acid, or both was a satisfactory modality for treating psoriasis of the hands and feet. There was a subjective improvement in the symptoms and quality of life in all patients.

Bovenschen and colleagues (2007) reported that after 8 weeks of follow-up, PDL treatment for localized and recalcitrant plaque psoriasis resulted in persistent reductions of activated and memory effector T-helper cells in the dermis, cytotoxic T cells in the epidermis, and normalization of epidermal proliferation and keratinization, in contrast to treatment with calcipotriol/betamethasone dipropionate ointment.

In summary, direct comparative studies have shown the excimer laser to be more effective than the pulsed dye laser for psoriasis (Taibjee et al, 2005). However, the pulsed dye laser requires fewer treatments and has fewer side effects. The pulsed dye laser target a different part of the psoriasis pathway than the excimer laser, with the pulsed dye laser targeting the abnormal microvasculature of psoriatic plaques. Because of its different target, it has been suggested that the pulsed dye laser may be useful in excimer-laser–resistant cases (Hruza, 2005), as some patients who do not respond to the excimer laser have been shown to respond to the pulsed dye laser.

De Leeuw et al (2009) compared the results of PDL with UVB and looked for synergism of both therapies in patients with plaque type psoriasis. In each eligible individual, 4 similar target plaques were selected, and halves of these plaques were treated using PDL, UVB, or a combination of PDL and UVB or were not treated. Results were recorded single-blind using the Physician’s Global Assessment score at study enrolment and week 13. Non-parametric, paired statistical tests were used to test for differences within and between therapies. The results were also analyzed after dichotomization of the changes in the Physician’s Global Assessment score into responsive and non-responsive to treatment. A significant improvement of the
psoriasis lesions was noted at week 13 \((p < 0.001)\) with each therapy. No significant differences were noted between the therapies. Synergism of PDL and UVB was not observed. The authors concluded that PDL is safe for treating plaque type psoriasis, but its effectiveness is limited to a subgroup of patients. They noted that combining PDL with UVB has no additional benefit.

Gattu and colleagues (2009) stated that the 308-nm excimer laser is a recent development in the treatment of psoriasis vulgaris, palmoplantar psoriasis, and psoriasis of the scalp. These researchers reviewed recent updates on the effectiveness of excimer laser and its most recent trials in psoriasis. A review of the medical literature in PubMed database was performed using the terms "psoriasis" and "308 nm excimer laser". All trials to date that studied the 308-nm excimer including those that compared the excimer with other modalities were included. A total of 18 trials showed positive results surrounding the effectiveness of the excimer laser. Selectivity of the 308-nm excimer laser, when compared with non-selective narrow-band UVB (NB-UVB) phototherapy allows one to adjust the fluency to the lesion. The excimer laser may also stand superior to NB-UVB in its efficacy of mechanism. The authors concluded that excimer laser is a useful and effective treatment for psoriasis that may be used as a compliment to topical medications as well as NB-UVB. However, they stated that large randomized trials with long-term follow-up are needed to further support this.

**Hidradenitis Suppurativa:**

Krakowski et al (2014) stated that hidradenitis suppurativa (HS) is a chronic, relapsing, inflammatory skin condition that can have a significant psychosocial impact, both with the active disease and with residual scarring. Although a wide variety of treatment options exist for HS, there are no reported modalities aimed specifically at treating HS scarring. These researchers described the case of an adolescent female who received medical management of intra-mammary HS followed by
successful treatment with fractionated 10,600-nm carbon dioxide (CO2) laser for her residual cribriform scarring. The authors believed there is great potential for the use of fractionated CO2 laser to improve short- and long-term psychosocial outcomes of HS, promote physical scar remodeling, and possibly alter the disease process itself.

**Lichen Sclerosis:**

The Royal College of Obstetricians and Gynaecologists' clinical practice guideline on "The management of vulval skin disorders" (RCOG, 2001) stated that "surgery and CO2 laser vaporisation are not recommended for the treatment of symptoms of lichen sclerosus".

**Melasma:**

In a randomized, controlled, observer-blinded, split-face clinical study, Wind et al (2010) evaluated the safety and effectiveness of non-ablative 1,550 nm fractional laser therapy (FLT) as compared to the gold standard, triple topical therapy (TTT) for the treatment of melasma. A total of 29 patients were included in the study. Each side of the face was randomly allocated to either 4 to 5 non-ablative FLT sessions (15 mJ/microbeam, 14 to 20 % coverage) or TTT (hydroquinone 5 %, tretinoin 0.05 %, and triamcinolone acetonide 0.1 % cream). Triple topical therapy was applied once-daily for 15 weeks until the last FLT session. After this last treatment, patients were asked to apply TTT twice-weekly on both sides of the face during follow-up. Improvement of melasma was assessed by patient's global assessment (PGA), patient's satisfaction, physician's global assessment (PhGA), melanin index, and lightness (L-value) at 3 weeks, and at 3 and 6 months after the last treatment. Mean PGA and satisfaction were significantly lower at the FLT side (p < 0.001). Melanin index, PhGA and L-value showed a significant worsening of hyperpigmentation at the FLT side. At the TTT side, no significant change was observed. At 6 months follow-up, most patients preferred TTT. Side effects of FLT were erythema, burning sensation, edema, and pain. Nine patients
(31 %) developed post-inflammatory hyperpigmentation after 2 or more laser sessions. Side effects of TTT were erythema, burning sensation, and scaling. The authors concluded that given the high rate of post-inflammatory hyperpigmentation, non-ablative 1,550 nm fractional laser at 15 mJ/microbeam is not recommendable in the treatment of melasma; TTT remains the gold standard treatment.

**Mycosis Fungoides:**

UpToDate reviews on "Treatment of early stage (IA to IIA) mycosis fungoides" (Hoppe and Kim, 2012a) and "Treatment of advanced stage (IIB to IV) mycosis fungoides and Sezary syndrome" (Hoppe and Kim, 2012b) do not mention the use of laser.

**Onychomycosis:**

Landsman et al (2010) stated that the Noveon is a unique dual-wavelength near-infrared diode laser used to treat onychomycosis. The device operates at physiologic temperatures that are thermally safe for human tissue. It uses only 870- and 930-nm near-infrared light, wavelengths that have unique photo-lethal effects on fungal pathogens. These wavelengths lack the teratogenic danger presented by UV light and the photo-ablation toxic plume associated with pulsed Nd:YAG lasers. In this randomized, controlled study, treatments followed a pre-defined protocol and laser parameters and occurred on days 1, 14, 42, and 120. Toes were cultured and evaluated, and measurements were taken from standardized photographs obtained periodically during the 180 day follow-up period. These researchers treated mycologically confirmed onychomycosis in 26 eligible toes (10 mild, 7 moderate, and 9 severe). All of the patients were followed-up for 180 days. An independent expert panel, blinded regarding treatment versus control, found that at 180 days, 85 % of the eligible treated toenails were improved by clear nail linear extent (p = 0.0015); 65 % showed at least 3 mm and 26 % showed at least 4 mm of clear nail growth. Of the 16 toes with moderate-to-severe
involvement, 10 (63%) improved, as shown by clear nail growth of at least 3 mm (p = 0.0112). Simultaneous negative culture and periodic acid-Schiff was noted in 30% at 180 days. The authors concluded that these results indicated a role for this laser in the treatment of onychomycosis, regardless of degree of severity. Ease of delivery and the lack of a need to monitor blood chemistry are attractive attributes. Drawbacks of this study were its' small sample size and short-term follow-up.

Hochman et al (2011) evaluated the treatment of onychomycosis using a novel 0.65-millisecond (ms) pulsed 1,064-nm laser. A total of 8 subjects were treated over 2 to 3 sessions spaced at least 3 weeks apart. Of the 8 subjects evaluated, 7 had negative post-treatment cultures after the 2nd or 3rd session. Treatments were well-tolerated by all subjects. These data suggested that treatment of onychomycosis with a 0.65-ms pulsed Nd:YAG 1,064-nm laser should be studied further to determine the long-term clinical and microbiologic effect. The optimal number of treatment sessions for each patient needs to be determined.

A report by the National Horizon Scanning Centre (2011) on laser treatment of onychomycosis concluded: "Randomised controlled trials of infrared treatment are needed to determine the safety and effectiveness of this type of therapy for onychomycosis. Long-term studies are also necessary to investigate recurrence. Comparative studies of these three devices with alternative therapies, and with each other, would help determine the most effective type of treatment for this condition".

Ortiz et al (2014) performed a literature search on laser and light-based treatments for onychomycosis. Early data are promising, however, many of these studies are small or poorly designed. The authors concluded that further evaluation and larger studies are needed to determine the optimal light source, pulse duration, and treatment schedule for long-term success.
Nenoff et al (2014) noted that since 2010 the Food and Drug Administration (FDA) has approved laser systems as capable of producing a “temporary increase in clear nails” in patients with onychomycosis. Fungal eradication is probably mediated by heat in infrared laser systems; their efficacy has been confirmed thermographically, histologically and in electron microscopy.

Another approach to decontaminate the nail organ is to disrupt fungi and spores by q-switched pulse applications. Recently specific combinations of wavelengths have been tested for their ability to disrupt the mitochondrial transmembrane potential at physiological temperatures by generating ATP and ROS. While clinically extremely high clearance rates of approximately 87.5 to 95.8 % have been reported, in-vitro investigations have failed to confirm the clearance. The variety of systems and advised parameters hampers a systematic evaluation.

Recommendations for safe and practical treatment protocols, informed consent items, and combination with conventional treatment options are all areas of active work. The authors concluded that currently there is a lack of data concerning the long-term effectiveness of laser therapy of onychomycosis; certified treatment protocols are needed.

**Pilonidal Sinus Disease:**

Lukish et al (2009) the use of laser epilation (LE) of the inter-gluteal hair in adolescents with pilonidal disease (PD) as a method of permanent hair removal. A retrospective review of all patients with PD who underwent LE from 2003 to 2006 at the National Naval Medical Center (Bethesda, MD) and Walter Reed Army Medical Center, (Washington, DC) was performed. Laser epilation of the inter-gluteal hair was performed with a 1064 nm Nd:YAG laser (Coolglide Vantage, Altus/Cutera, Brisbane, CA) at a standard fluence (joule/square centimeter), pulse duration, and repetition rate based on skin phototype. Patients were observed for hair regrowth and recurrence. A total of 28 teenagers (17 males, 11 females; mean age of 17.2 +/- 1.4 years) underwent LE. Eight patients presented with abscess and were managed by incision and drainage followed by excision and open wound management, 17 patients
presented with a cyst or sinus and underwent excision and primary closure, and 3 patients with asymptomatic sinus were managed non-operatively. Laser epilation was performed after complete wound healing or immediately in those patients with asymptomatic sinus disease. Laser epilation was well-tolerated and without complication in all patients. Inter-gluteal hair was completely removed in all patients. Patients required an average of 5 +/- 2 LE therapy sessions for hair removal. All patients underwent at least 3 LE sessions (range of 3 to 7 sessions) at 4-week intervals. One female developed a recurrence. The mean follow-up for the group was 24.2 +/- 9.9 months. The authors concluded that laser epilation is a safe method to remove inter-gluteal hair in teenagers with PD. This technique is an effective adjunctive therapy for the treatment of PD that may reduce recurrence. The drawbacks of this study included a small sample size and lack of a control group.

Petersen et al (2009) examined the potential benefits of post-operative epilation after pilonidal sinus surgery, and the long-term effect of hair removal on pilonidal recurrence. The authors stated that razor hair removal increases the rate of long-term recurrence after surgery for pilonidal sinus disease and therefore should not be recommended. However, the rationale for hair removal in pilonidal sinus disease is compelling. Other epilation techniques such as laser hair removal should be investigated in appropriate studies.

Oram and colleagues (2010) evaluated the role of alexandrite laser hair removal after surgery in the treatment of patients with pilonidal sinus disease. A total of 60 patients who underwent surgical treatment of pilonidal sinus disease and were treated with a 755-nm alexandrite laser after surgery between 1999 and 2007 were examined retrospectively. The charts were reviewed, and the patients were interviewed on the telephone about their post-laser period and recurrence. The laser parameters, patient history, and surgical details were recorded. The overall recurrence rate was 13.3 %, after a mean follow-up period +/- standard error of the mean of 4.8 +/- 0.3 years. The mean number of laser treatment was 2.7 +/- 0.1.
Seventy-five percent of the recurrences were detected after a follow-up period of 5 to 9 years. Fifty percent of the recurrent cases had drainage and secondary intention before the laser epilation. The authors concluded that these findings suggested that laser hair removal after surgical interventions in pilonidal sinus disease decreases the risk of recurrence over the long-term. This study had no control group, which limits the validity of the study’s conclusion.

There is insufficient evidence to conclude that laser hair removal is effective for treating pilonidal sinus disease. Most of the studies regarding this treatment were small and uncontrolled. Well-designed studies are needed to determine the effectiveness of laser hair removal for this condition.

Prurigo Nodularis:

Saraceno et al (2008) stated that 308 nm excimer light has been reported to be safe and effective in the treatment of chronic skin diseases, but the range of potential applications has not been fully explored. These researchers evaluated the effectiveness of monochromatic excimer light (MEL) in the treatment of prurigo nodularis. A total of 11 patients were enrolled in this pilot study. Patients were treated weekly and an average of 8 sessions of MEL was given. Follow-up was 4 months. Partial or complete clinical and histological remission was observed in all patients who completed the study (81%).

Spongiotic Dermatitis:

Spongiotic dermatitis is another way of referring to a condition known as acute eczema that is usually found affecting the abdomen, chest and even the bottom while the scalp is generally free from this condition. An UpToDate review on “Treatment of atopic dermatitis (eczema)” (Weston and Howe, 2014) does not mention the use of laser as a therapeutic option. In fact, a study by Levine and Geronemus (1995) reported spongiotic dermatitis as a side effect following PDL therapy. These investigators assessed the incidence of adverse
effects associated with the use of the PDL in the treatment of vascular lesions. They studied 500 patients undergoing PDL treatments for port-wine stains, telangiectases, and hemangiomas. All patients were examined during the course of their treatment to assess the incidence of adverse effects associated with the use of the PDL. There were no cases of hypertrophic scarring. The incidence of atrophic scarring was less than 0.1%. Moreover, spongiotic dermatitis was seen in 11 of 297 patients (4%) after multiple treatments of port-wine stains. Hyper-pigmentation was seen in 5 of 500 patients (1%), whereas transient hypo-pigmentation was seen in 13 (2.6%).

**Vulval Intraepithelial Neoplasia:**

Vulval intraepithelial neoplasia (VIN) is a pre-malignant condition of the vulval skin. This uncommon chronic skin condition of the vulva is associated with a high-risk of recurrence and the potential to progress to vulval cancer. The condition is complicated by its multi-centric and multi-focal nature. There is a lack of consensus on the optimal surgical treatment method. However, the rationale for surgical treatment of VIN has been to treat symptoms and exclude underlying malignancy with the continued aim of preservation of vulval anatomy and function. Repeated treatments affect local cosmesis and cause psychosexual morbidity, thus impacting on the patients' quality of life (Kaushik et al, 2011).

In a Cochrane review, Kaushik and colleagues (2011) evaluated the effectiveness and safety of surgical interventions for high-grade VIN. These investigators searched the Cochrane Central Register of Controlled Trials (CENTRAL), Issue 3, 2010, Cochrane Gynaecological Cancer Group Trials Register, MEDLINE and EMBASE up to September 2010. They also searched registers of clinical trials, abstracts of scientific meetings, reference lists of included studies and contacted experts in the field. Randomized controlled trials (RCTs) that compared surgical interventions, in adult women diagnosed with high-grade VIN. Two review authors independently abstracted data and assessed risk of bias. They found only 1
RCT, which included 30 women that met inclusion criteria and this trial reported data on carbon dioxide laser (CO(2) laser) versus ultrasonic surgical aspiration (USA). There was no statistically significant difference in the risk of disease recurrence after 1 year follow-up, pain, presence of scarring, dysuria or burning, adhesions, infection, abnormal discharge and eschar between women who received CO(2) laser and those who received USA. The trial lacked statistical power due to the small number of women in each group and the low number of observed events, but was at low-risk of bias. The authors concluded that the included trial lacked statistical power due to the small number of women in each group and the low number of observed events. Thus, in the absence of reliable evidence regarding the effectiveness and safety of the 2 surgical techniques for the management of VIN precludes any definitive guidance or recommendations for clinical practice.

**Acne Scars:**

In a Cochrane review, Abdel et al (2016) evaluated the effects of interventions for treating acne scars. These investigators searched the following databases up to November 2015: the Cochrane Skin Group Specialised Register, the Cochrane Central Register of Controlled Trials (CENTRAL) in the Cochrane Library (2015, Issue 10), MEDLINE (from 1946), EMBASE (from 1974), and LILACS (from 1982). They also searched 5 trials registers, and checked the reference lists of included studies and relevant reviews for further references to RCTs. These researchers included RCTs that allocated participants (whether split-face or parallel arms) to any active intervention (or a combination) for treating acne scars. They excluded studies dealing only or mostly with keloid scars. Three review authors independently extracted data from each of the studies included in this review and evaluated the risks of bias. They resolved disagreements by discussion and arbitration supported by a method expert as required. The primary outcomes were participant-reported scar improvement and any adverse effects serious enough to cause participants to withdraw from the study. The authors included 24 trials with 789 adult participants aged 18 years or
older; 20 trials enrolled men and women, 3 trials enrolled only women and 1 trial enrolled only men. These investigators judged 8 studies to be at low risk of bias for both sequence generation and allocation concealment. With regard to blinding the authors judged 17 studies to be at high risk of performance bias, because the participants and dermatologists were not blinded to the treatments administered or received; however, the authors judged all 24 trials to be at a low risk of detection bias for outcome assessment. They evaluated 14 comparisons of 7 interventions and 4 combinations of interventions; 9 studies provided no usable data on the outcomes and did not contribute further to this review’s results. For the outcome “Participant-reported scar improvement” in 1 study, fractional laser was more effective in producing scar improvement than non-fractional non-ablative laser at week 24 (risk ratio (RR) 4.00, 95% confidence interval (CI): 1.25 to 12.84; n = 64; very low-quality evidence); fractional laser showed comparable scar improvement to fractional radiofrequency in 1 study at week 8 (RR 0.78, 95% CI: 0.36 to 1.68; n = 40; very low-quality evidence) and was comparable to combined chemical peeling with skin needling in a different study at week 48 (RR 1.00, 95% CI: 0.60 to 1.67; n = 26; very low-quality evidence). In a further study chemical peeling showed comparable scar improvement to combined chemical peeling with skin needling at week 32 (RR 1.24, 95% CI: 0.87 to 1.75; n = 20; very low-quality evidence). Chemical peeling in 1 study showed comparable scar improvement to skin needling at week 4 (RR 1.13, 95% CI: 0.69 to 1.83; n = 27; very low-quality evidence). In another study, injectable fillers provided better scar improvement compared to placebo at week 24 (RR 1.84, 95% CI: 1.31 to 2.59; n = 147 moderate-quality evidence). For the outcome “Serious adverse effects” in 1 study, chemical peeling was not tolerable in 7/43 (16%) participants (RR 5.45, 95% CI: 0.33 to 90.14; n = 58; very low-quality evidence). For the secondary outcome “Participant-reported short-term adverse events”, all participants reported pain in the following studies: in 1 study comparing fractional laser to non-fractional non-ablative laser (RR 1.00, 95% CI: 0.94 to 1.06; n = 64; very low-quality evidence); in another study comparing fractional laser to
combined peeling plus needling (RR 1.00, 95 % CI: 0.86 to 1.16; n = 25; very low-quality evidence); in a study comparing chemical peeling plus needling to chemical peeling (RR 1.00, 95 % CI: 0.83 to 1.20; n = 20; very low-quality evidence); in a study comparing chemical peeling to skin needling (RR 1.00, 95 % CI: 0.87 to 1.15; n = 27; very low-quality evidence); and also in a study comparing injectable filler and placebo (RR 1.03, 95 % CI: 0.10 to 11.10; n = 147; low-quality evidence). For the outcome “Investigator-assessed short-term adverse events”, fractional laser (6/32) was associated with a reduced risk of hyper-pigmentation than non-fractional non-ablative laser (10/32) in 1 study (RR 0.60, 95 % CI: 0.25 to 1.45; n = 64; very low-quality evidence); chemical peeling was associated with increased risk of hyper-pigmentation (6/12) compared to skin needling (0/15) in 1 study (RR 16.00, 95 % CI: 0.99 to 258.36; n = 27; low-quality evidence). There was no difference in the reported adverse events with injectable filler (17/97) compared to placebo (13/50) (RR 0.67, 95 % CI: 0.36 to 1.27; n = 147; low-quality evidence). The authors concluded that there is a lack of high-quality evidence about the effects of different interventions for treating acne scars because of poor methodology, under-powered studies, lack of standardized improvement assessments, and different baseline variables.

There is moderate-quality evidence that injectable filler might be effective for treating atrophic acne scars; however, no studies have assessed long-term effects, the longest follow-up being 48 weeks in 1 study only. Other studies included active comparators, but in the absence of studies that establish efficacy compared to placebo or sham interventions, it is possible that finding no evidence of difference between 2 active treatments could mean that neither approach works. The authors stated that the findings of this review did not provide support for the 1st-line use of any intervention in the treatment of acne scars. They noted that although their aim was to identify important gaps for further primary research, it might be that placebo and or sham trials are needed to establish whether any of the active treatments produce meaningful patient benefits over the long-term.
Herpes Simplex Labialis:

Chi and associates (2015) noted that herpes simplex labialis (HSL), also known as cold sores, is a common disease of the lips caused by the herpes simplex virus (HSV), which is found throughout the world. In a Cochrane review, these researchers evaluated the effects of interventions for the prevention of HSL in people of all ages. They searched the following databases up to May 19, 2015: the Cochrane Skin Group Specialised Register, the Oral Health Group Specialised Register, CENTRAL in the Cochrane Library (Issue 4, 2015), Medline (from 1946), Embase (from 1974), LILACS (from 1982), the China National Knowledge Infrastructure (CNKI) database, Airiti Library, and 5 trial registers. To identify further references to relevant RCTs, these investigators scanned the bibliographies of included studies and published reviews, and they also contacted the original researchers of the included studies. Randomized controlled trials of interventions for preventing HSL in immunocompetent people were selected for analysis. Two authors independently selected trials, extracted data, and assessed the risk of bias; a 3rd author was available for resolving differences of opinion.

This review included 32 RCTs, with a total of 2,640 immunocompetent participants, covering 19 treatments. The quality of the body of evidence was low-to-moderate for most outcomes, but was very low for a few outcomes. The primary outcomes were “Incidence of HSL” and “Adverse effects during use of the preventative intervention”. The evidence for short-term (less than or equal to 1 month) use of oral aciclovir in preventing recurrent HSL was inconsistent across the doses used in the studies: 2 RCTs showed low quality evidence for a reduced recurrence of HSL with aciclovir 400-mg twice-daily (RR 0.26, 95 % CI: 0.13 to 0.51; n = 177), while 1 RCT testing aciclovir 800-mg twice-daily and 2 RCTs testing 200-mg 5 times daily found no similar preventive effects (RR 1.08, 95 % CI: 0.62 to 1.87; n = 237; moderate quality evidence and RR 0.46, 95 % CI: 0.20 to 1.07; n = 66; low quality evidence, respectively). The direction of intervention effect was unrelated to the risk of bias. The evidence from 1 RCT for the effect of short-term use of valaciclovir in reducing recurrence of HSL by clinical evaluation
was uncertain (RR 0.55, 95% CI: 0.23 to 1.28; n = 125; moderate quality evidence), as was the evidence from 1 RCT testing short-term use of famciclovir. Long-term (greater than 1 month) use of oral antiviral agents reduced the recurrence of HSL. There was low quality evidence from 1 RCT that long-term use of oral aciclovir reduced clinical recurrences (1.80 versus 0.85 episodes per participant per a 4-month period, p = 0.009) and virological recurrence (1.40 versus 0.40 episodes per participant per a 4-month period, p = 0.003). One RCT found long-term use of valaciclovir effective in reducing the incidence of HSL (with a decrease of 0.09 episodes per participant per month; n = 95). One RCT found that a long-term suppressive regimen of valaciclovir had a lower incidence of HSL than an episodic regimen of valaciclovir (difference in means (MD) -0.10 episodes per participant per month, 95% CI: -0.16 to -0.05; n = 120). These trials found no increase in adverse events associated with the use of oral anti-viral agents (moderate quality evidence). There was no evidence to show that short-term use of topical antiviral agents prevented recurrent HSL. There was moderate quality evidence from 2 RCTs that topical aciclovir 5% cream probably has little effect on preventing recurrence of HSL (pooled RR 0.91, 95% CI: 0.48 to 1.72; n = 271). There was moderate quality evidence from a single RCT that topical foscarnet 3% cream has little effect in preventing HSL (RR 1.08, 95% CI: 0.82 to 1.40; n = 295). The effectiveness of long-term use of topical aciclovir cream was uncertain. One RCT found significantly fewer research-diagnosed recurrences of HSL when on aciclovir cream treatment than on placebo (p < 0.05), but found no significant differences in the mean number of participant-reported recurrences between the 2 groups (p ≥ 0.05). One RCT found no preventive effect of topical application of 1,5-pentanediol gel for 26 weeks (p > 0.05). Another RCT found that the group who used 2-hydroxypropyl-β-cyclo dextrin 20% gel for 6 months had significantly more recurrences than the placebo group (p = 0.003). These studies found no increase in adverse events related to the use of topical anti-viral agents. Two RCTs found that the application of sunscreen significantly prevented recurrent HSL induced by experimental UV light (pooled RR
0.07, 95 % CI: 0.01 to 0.33; n = 111), but another RCT found that sunscreen did not prevent HSL induced by sunlight (RR 1.13, 95 % CI: 0.25 to 5.06; n = 51). These RCTs did not report adverse events. There were very few data suggesting that thymopentin, low-level laser therapy, and hypnotherapy are effective in preventing recurrent HSL, with 1 to 2 RCTs for each intervention. These researchers failed to find any evidence of effectiveness for lysine, LongoVital supplementation, gamma globulin, HSV type I subunit vaccine, and yellow fever vaccine in preventing HSL. There were no consistent data supporting the effectiveness of levamisole and interferon, which were also associated with an increased risk of adverse effects such as fever. The authors concluded that the current evidence demonstrated that long-term use of oral anti-viral agents can prevent HSL, but the clinical benefit is small. These investigators did not find evidence of an increased risk of adverse events. On the other hand, the evidence on topical anti-viral agents and other interventions either showed no effectiveness or could not confirm their effectiveness in preventing HSL.

Other Indications:

Erceg and colleagues (2013) systematically reviewed all available literature concerning PDL treatment for inflammatory skin diseases and proposed a recommendation. These investigators searched for publications dated between January 1992 and August 2011 in the database PubMed. All studies reporting on PDL treatment for an inflammatory skin disease were obtained and a level of evidence was determined. Literature search revealed 52 articles that could be included in this study. The inflammatory skin diseases treated with PDL consisted of: psoriasis, acne vulgaris, lupus erythematoses, granuloma faciale, sarcoidosis, eczematous lesions, papulopustular rosacea, lichen sclerosis, granuloma annulare, Jessner lymphocytic infiltration of the skin, and reticular erythematous mucinosis. The effectiveness of PDL laser treatment for these inflammatory skin diseases was described and evaluated. However, most conclusions formulated were
not based on RCTs. The authors concluded that PDL treatment can be recommended as an effective and safe treatment for localized plaque psoriasis and acne vulgaris (recommendation grade B). However, for all other described inflammatory skin diseases, PDL appeared to be promising, although the level of recommendation did not exceed level C.

<table>
<thead>
<tr>
<th>CPT Codes / HCPCS Codes / ICD-10 Codes</th>
<th>Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by &quot;+&quot;:</th>
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<tr>
<td><strong>ICD-10 codes will become effective as of October 1, 2015:</strong></td>
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<tr>
<td><strong>CPT codes covered if selection criteria are met:</strong></td>
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<tr>
<td>96920</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm</td>
</tr>
<tr>
<td>96921</td>
<td>250 sq cm to 500 sq cm</td>
</tr>
<tr>
<td>96922</td>
<td>over 500 sq cm</td>
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<td><strong>CPT codes not covered for indications listed in the CPB:</strong></td>
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<tr>
<td>17110 - 17111</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions [not covered for laser treatment]</td>
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<tr>
<td><strong>Other CPT codes related to the CPB:</strong></td>
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<tr>
<td>96900</td>
<td>Actinotherapy (ultraviolet light)</td>
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<tr>
<td>96910</td>
<td>Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B</td>
</tr>
<tr>
<td>96913</td>
<td>Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4 to 8 hrs of care under direct supervision of the physician (includes applications of medication and dressings)</td>
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<td><strong>ICD-10 codes covered if selection criteria are met:</strong></td>
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Psoriasis

ICD-10 codes not covered for indications listed in the CPB (not all-inclusive):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>B35.1</td>
<td>Tinea unguium</td>
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<tr>
<td>C84.00</td>
<td>Mycosis fungoides</td>
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<td></td>
<td>C84.09</td>
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<tr>
<td>D07.1</td>
<td>Carcinoma in situ of vulva</td>
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<tr>
<td>D86.0</td>
<td>Sarcoidosis</td>
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<td>D86.0</td>
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<tr>
<td>L03.01</td>
<td>Cellulitis of finger</td>
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<td>L03.01</td>
<td>L03.019</td>
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<tr>
<td>L03.03</td>
<td>Cellulitis of toe</td>
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<td>L03.03</td>
<td>L03.039</td>
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<tr>
<td>L05.01</td>
<td>Pilonidal cyst and sinus</td>
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<td>L05.01</td>
<td>L05.92</td>
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<tr>
<td>L20.0</td>
<td>Atopic dermatitis</td>
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<tr>
<td>L20.0</td>
<td>L20.9</td>
</tr>
<tr>
<td>L23.0</td>
<td>Contact dermatitis and other eczema</td>
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<td>L23.0</td>
<td>L27.9</td>
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<td>L28.1</td>
<td>Prurigo nodularis</td>
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<td>L73.2</td>
<td>Hidradenitis suppurativa</td>
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<td>L81.0</td>
<td>Other disorders of pigmentation [melasma]</td>
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<td>L81.0</td>
<td>L81.9</td>
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<tr>
<td>L90.0</td>
<td>Lichen sclerosus et atrophicus</td>
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<td>L92.0</td>
<td>Granuloma annulare</td>
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<td>L92.2</td>
<td>Granuloma faciale</td>
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<td>L93.0</td>
<td>Lupus erythematosus</td>
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<td>L93.0</td>
<td>L93.2</td>
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<td>L94.0</td>
<td>Localized scleroderma [morphea]</td>
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<td>L98.5</td>
<td>Mucinosis of the skin</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>L98.8</td>
<td>Other specified disorders of the skin and subcutaneous tissue [jessner lymphocytic infiltration of the skin]</td>
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<td>N90.0</td>
<td>Mild vulvar dysplasia</td>
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<tr>
<td>N90.1</td>
<td>Moderate vulvar dysplasia</td>
</tr>
</tbody>
</table>

**The above policy is based on the following references:**


40. Gattu S, Rashid RM, Wu JJ. 308-nm excimer laser in
51. Royal College of Obstetricians and Gynaecologists
52. Hoppe RT, Kim YH. Treatment of early stage (IA to IIA) mycosis fungoides. UpToDate [online serial]. Waltham, MA: UpToDate; last reviewed April 2012a.
53. Hoppe RT, Kim YH. Treatment of advanced stage (IIB to IV) mycosis fungoides and Sézary syndrome. UpToDate [online serial]. Waltham, MA: UpToDate; last reviewed April 2012b.
AETNA BETTER HEALTH® OF PENNSYLVANIA

Amendment to
Aetna Clinical Policy Bulletin Number: 0577
Laser Treatment for Psoriasis and Other Selected Skin Conditions

There are no amendments for Medicaid.