Sentara Health Plans

Medicaid

Infrared Light Therapy and Low-Level Laser Therapy

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Effective Date	12/2007
Next Review Date	9/15/2024
Coverage Policy	Medical 109
Version	5

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses the medical necessity of Infrared Light Therapy and Low-Level Laser Therapy.

Description & Definitions:

Infrared light therapy is a noninvasive laser delivered through a device emitting single wavelength, nonvisible, low-level infrared light energy via flexible pads applied to the skin.

Infrared Gloves (Prolotex Therapy Glove) are used to promote circulation for Raynaud's syndrome and other diseases that promote poor circulation.

Low-level laser therapy, also known as cold laser therapy or photobiomodulation is a non-invasive therapy that uses a light to help reduce inflammation and promote healing.

Criteria:

Low-level laser therapy is medically necessary for prevention of oral mucositis for **ALL** of the following:

- Individual undergoing cancer treatment associated with increased risk of oral mucositis, including chemotherapy and/or radiotherapy.

Low-level laser therapy is considered **not medically necessary** for any use other than those indicated in clinical criteria.

Infrared Light Therapy is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Infrared gloves
- Infrared therapy and low-level laser treatment for musculoskeletal pain (ie low back, neck and arthritis)

Coding:

Medically necessary with criteria:

Coding	Description
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional

Considered Not Medically Necessary:

Coding	Description
97026	Application of a modality to 1 or more areas; infrared
E1399	Durable medical equipment, miscellaneous

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2022: September
- 2021: February
- 2020: January, November
- 2015: July
- 2014: July
- 2012: July
- 2008: July

Reviewed Dates:

- 2023: September
- 2021: November
- 2019: November
- 2018: August, October
- 2017: November
- 2016: July
- 2013: July
- 2011: July
- 2010: July
- 2009: July

Effective Date:

- December 2007

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. (2017, April 4). Retrieved Aug 22, 2023, from American College of Physicians: https://www.acpjournals.org/doi/10.7326/M16-2367?_ga=2.21889915.1168407371.1692715901-175756950.1692715901&_gac=1.149176706.1692715901.EAIaIQobChMI69X6i8LwgAMVCDnUAR0nXwVEEAAYASAAEgLTs_D_BwE

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

SHP Anodyne Therapy, SHP Infrared Glove, Prolotex Therapy Glove, circulation, Trigger Finger, Tendonitis, Plantar Fasciitis, Peripheral Neuropathy, Chilblains , Arthritis and Carpal Tunnel Syndrome, Raynaud's Disease, SHP Medical 109, monochromatic infrared energy, MIRE, red blood cells, heal, wounds, nitric oxide, Infra- Red Energy therapy, Low-level infrared therapy, Spectropad System, Infrared Therapy, Pain-X 2000, BioScan, Light Force Therapy, Infrared Glove, Prolotex Therapy Glove, circulation, Trigger Finger, Tendonitis, Plantar Fasciitis, Peripheral Neuropathy, Chilblains , Arthritis and Carpal Tunnel Syndrome, Raynaud's Disease