Sentara® Health Plans

Commercial

Infrared Light Therapy and Low-Level Laser Therapy

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Effective Date	12/2007
Next Review Date	9/15/2024
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

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:

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: *

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.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

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