

## CHAPTER 3 SECTION 1.3

### LASER SURGERY

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#### I. DESCRIPTION

Laser (light amplification by stimulated emission of radiation) is a device which converts incident electromagnetic radiation of mixed frequencies to one or more discrete frequencies of highly amplified and coherent visible radiation. Laser surgery has gained acceptance in several clinical fields, but is still considered unproven in others. It frequently shortens or eliminates hospital stays and reduces the trauma of conventional surgery.

#### II. POLICY

A. TRICARE recognizes the use of laser surgery when the surgery is medically necessary and an accepted standard of practice for treatment of the condition, and the laser device has been approved by the Food and Drug Administration.

##### B. Reimbursement.

1. Surgery which has a laser-specific Current Procedural Terminology (CPT) (e.g., CPT 67145) will be reimbursed at the CHAMPUS Maximum Allowable Charge (CMAC) for that procedure. Surgery using laser but without a laser-specific CPT code will be reimbursed at the CMAC for the conventional surgical procedure.

2. When the description of the CPT code indicates multiple visits for serial laser treatments, reimbursement for the subsequent sessions is included in the global fee for the initial surgery.

C. Covered Laser Surgery. Following is a list of some of the more commonly performed procedures with the laser that can be cost-shared by TRICARE. It is not all inclusive.

1. Photocoagulation of the eye ([67208-67228](#)) for the treatment of such conditions as exudative form of senile macular degeneration, ocular histoplasmosis syndrome, proliferative diabetic retinopathy, diabetic macular edema, and retinoblastomas. See also [Chapter 3, Section 16.1](#), Retinal Coagulation.

##### 2. Gynecological Indications.

a. Effective December 1, 1987, surgery in the treatment of infertility.

b. Refractory bleeding, generally referred to as laser ablation. The hysterectomy procedure code is not to be used for reimbursing the laser ablation; reimbursement should be based on the profiles for the diagnostic or surgical procedures actually performed.

c. Use of the laser (YAG or CO<sub>2</sub>) for vaporization of endometrial implants is covered (49200-49201).

3. Endoscopic laser photocoagulation to control upper gastrointestinal bleeding, such as from peptic ulcers that does not stop spontaneously after an appropriate interval, rebleeding despite appropriate medical therapy and bleeding in the presence of a visible vessel or sentinel clot (a clot extending from a tear in an artery in the ulcer base).

4. Argon Laser Trabeculoplasty for Primary Open-Angle Glaucoma, Pigmentary Glaucoma and cases associated with Pseudoexfoliation is covered only when the intraocular pressure remains uncontrolled despite maximal tolerated medical therapy.

5. Stapedotomy.

6. Neodymium YAG (Nd:YAG) Laser Surgery. YAG laser surgery is considered acceptable medical practice for the following:

a. Posterior Capsulotomies.

b. Control of bleeding gastrointestinal lesions and angiodysplasia.

c. Iridotomy.

d. Alleviate obstructions of the trachea or the main stem bronchi.

e. Removal of esophageal neoplasms.

f. Vaporization of endometrial implants.

g. Transurethral ultrasound-guided, laser-induced prostatectomy (TULIP) for treatment of benign prostatic hypertrophy (BPH), effective March 11, 1996.

7. CO<sub>2</sub> Laser Surgery. CO<sub>2</sub> laser surgery is acceptable medical practice for:

a. Gynecological lesions of the vulva, vagina, and cervix.

b. Lesions of the rectal mucosa.

c. Oral leukoplakia when the neoplastic stage is reached or dysplasia is found.

d. Head and neck surgery including lesions of the nose, oral cavity, larynx, pharynx, and tracheobronchial tree.

e. Vaporization of endometrial implants.

8. Argon Laser or Candela Pulsed Dye Laser Treatment for Port-wine Stains. The argon laser and the Candela pulsed tunable dye laser are covered for treatment of congenital vascular tumors such as a hemangioma.

9. Excimer Laser Phototherapeutic keratectomy (PTK) for corneal dystrophies. See Chapter 3, Section 16.9.

10. Transpupillary thermotherapy (laser hyperthermia), with chemotherapy, is covered for the treatment of retinoblastoma, effective November, 1, 1996.

### III. EXCLUSIONS

A. Any type of laser used for pain relief (often called acupuncture-like pain relief), biostimulation or non-surgical face-lifts.

B. Use of any laser for a noncovered service, such as removal of tattoos.

C. CO<sub>2</sub> laser surgery for applications of the eye.

D. Use of laser for arthritis or low back pain.

E. Corneal sculpting.

F. Use of laser bullectomy volume reduction surgery for emphysema.

G. Use of Transmyocardial laser revascularization for ischemic heart disease.

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