MEDICAL MUTUAL®

Medical Policy

Policy:	**200515**	**Effective Date:**	**12/10/2024**
SUBJECT:	**Infrared Coagulation and Laser Hemorrhoidectomy**	**Annual Review Date:**	**11/29/2024**
		Last Revised Date:	**11/29/2024**

Definition: Infrared coagulation (IRC) refers to cauterization of hemorrhoidal tissue using thermal energy generated by infrared radiation. An infrared coagulator is positioned at the base of the hemorrhoid, where it generates heat and coagulates the tissue in and around the hemorrhoid. This process cuts off the blood supply and encourages the formation of scar tissue, which provides support to the surrounding veins. Another approach involves coagulation of hemorrhoidal tissue using a carbon dioxide or neo dymiumyttrum aluminum garnet (Nd: YAG) laser for treatment of internal hemorrhoids. These procedures are used as alternatives to other office-based procedures (e.g., rubber band ligation) or surgery for reducing pain associated with hemorrhoids when more conservative measures have failed.

Medical Necessity: The Company considers IRC **(CPT Code 46930)** and laser hemorrhoidectomy **(CPT Code 46930) medically necessary** and eligible for reimbursement providing that the following medical criterion is met:

- Symptomatic (pain and bleeding) external hemorrhoids or combined internal hemorrhoids *and* external hemorrhoids, refractory to conservative management.

AND

At least one of the following clinical conditions is present:

- First-degree hemorrhoids
- Second-degree hemorrhoids
- Third-degree hemorrhoids
- Other hemorrhoids
- Unspecified hemorrhoids

Frequency limitations: The frequency of IRC is limited to three treatments within a 365-day period.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also

reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.

Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.

Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.

Sources of Information:

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Applicable Code(s):	
CPT:	**46930**
HCPCS:	**N/A**
ICD10 Procedure Codes:	**N/A**