

Ultraviolet Light Therapies

Policy ID:	HHO-DE-MP-1229
Approved By:	Highmark Health Options – Market Leadership
Provider Notice Date:	12/15/2021; 03/01/2023
Original Effective Date:	01/15/2022; 04/01/2023
Annual Approval Date:	12/28/2022
Last Revision Date:	12/21/2021; 12/28/2022
Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 8

Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary ultraviolet light therapies.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children (DHCP) and Diamond State Health Plan Plus members.

Phototherapy – Treatment for certain skin diseases that exposes the affected skin to ultraviolet light. Ultraviolet light (UVL) is light which is beyond the violet range in the spectrum. It consists of various subdivisions including long wavelength ultraviolet light A (UVA) and shorter wavelength ultraviolet light B (UVB).

PROCEDURES

A prior authorization is not required.

ACTINOTHERAPY (ULTRAVIOLET LIGHT)

Ultraviolet Light B (UVB) may be considered medically necessary for patients who have not responded to conservative treatment and any ONE of the following:

- Mycosis Fungoides (T-Cell Lymphoma); or
- Sezary's Disease; or
- Psoriasis; or
- Atopic Dermatitis/Severe Eczema; or
- Pruritus of Renal Disease; or
- Pruritus of Malignancy; or
- Parapsoriasis; or
- Dyshidrotic Eczema; or
- Vitiligo; or
- Polymorphic Light Eruptions; or
- Lichen Planus; or
- Pityriasis Lichenoides; or
- Pityriasis Rosea; or
- Pruritic Eruptions of HIV.

Ultraviolet light therapy provided for patients with vitiligo is limited to those patients whose condition affects any ONE of the following:

- The skin of the face and/or neck area, or
- Other body areas in excess of 30% of skin surface.

Ultraviolet Light A (UVA) without topical preparations may be considered medically necessary for any ONE of the following conditions:

- Acne; or
- Eczema; or
- Eosinophilic Folliculitis; or
- Other Pruritic Eruptions of HIV; or
- Lichen Planus; or
- Morphea; or
- Parapsoriasis; or
- Photodermatoses; or
- Pityriasis Lichenoides; or
- Pityriasis Rosea; or
- Prurigo Nodularis; or
- Psoriasis; or
- Atopic Dermatitis; or
- Chronic Urticaria; or
- Mycosis Fungoides; or
- Pruritus of Renal Failure; or
- Vitiligo.

Actinotherapy (Ultraviolet Light) is considered not medically necessary for all other conditions.

LASER UVB

Excimer and pulsed dye laser may be considered medically necessary for any ONE of the following conditions:

- Mild to moderate localized plaque psoriasis affecting 10% or less of body area for persons who have failed to adequately respond to three or more months of topical treatments, including at least three of the following with or without standard non-laser ultraviolet actinotherapy:
 - Anthralin; or
 - Corticosteroids (e.g., betamethasone dipropionate ointment and fluocinonide cream);
 - Keratolytic agents (e.g., lactic acid, salicylic acid, and urea); or
 - Retinoids (e.g., tazarotene); or
 - Tar preparations; or
 - Vitamin D derivatives (e.g., calcipotriene)
- Vitiligo of the face and hands.

No more than thirteen treatments per course and three courses per year are considered medically necessary. If the member fails to respond to an initial course of laser therapy, additional courses are not considered medically necessary.

Combination use of pulsed dye laser and ultraviolet B is considered experimental and investigational for the treatment of persons with localized plaque psoriasis, and therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

Targeted phototherapy may also be considered medically necessary for any ONE of the following:

- Treatment of moderate to severe psoriasis comprising less than 20% body area for which NB-UVB or PUVA are indicated; or
- Treatment of mild to moderate localized psoriasis that is unresponsive to conservative treatment.

Targeted phototherapy is considered not medically necessary for all other conditions.

PSORALEN AND ULTRAVIOLET LIGHT A (PUVA)

PUVA may be considered medically necessary for any ONE of the following conditions after conservative therapies have failed:

- Mycosis fungoides (T-Cell Lymphoma); or
- Sezary's Disease; or
- Psoriasis; or
- Atopic Dermatitis/Severe Eczema; or
- Pruritus of Renal Disease; or
- Pruritus of Malignancy; or
- Parapsoriasis; or
- Dyshidrotic Eczema; or
- Vitiligo; or
- Polymorphic Light Eruptions; or
- Lichen Planus; or
- Alopecia Areata; or
- Chronic Palmoplantar Pustulosis; or
- Eosinophilic Folliculitis; or
- Other Pruritic Eruptions of HIV Infection; or
- Granuloma Annulare; or
- Morphea and Localized Skin Lesions Associated with Scleroderma; or
- Necrobiosis Lipoidica; or
- Pityriasis Lichenoides; or
- Severe Refractory Pruritis of Polycythemia Vera; or

- Cutaneous graft-versus-host-disease occurring as a result of allogeneic bone marrow transplant; or
- Severe urticaria pigmentosa (cutaneous mastocytosis).

PUVA is considered not medically necessary for all other conditions.

UVB WITH TOPICAL TAR OR PETROLATUM

Photochemotherapy (e.g. Goeckerman regimen or petrolatum) may be considered medically necessary in the treatment of any **ONE** of the following:

- Psoriasis; or
- Atopic Dermatitis/Severe Eczema; or
- Dyshidrotic Eczema; or
- Lichen Planus; or
- Mycosis fungoides (cutaneous T-cell lymphoma).

PUVA is considered not medically necessary for all other conditions.

HOME THERAPY

Home therapy should be limited to UVB and are eligible in the home only when the individual requires UVB treatment at least three times per week. PUVA is not an appropriate choice for home therapy. Oxsoresalen is a potent photosensitizing agent that should only be used under controlled conditions and under the supervision of a physician.

Home phototherapy may be considered medically necessary for any **ONE** of the following diagnoses:

- Severe Psoriasis; **or**
- Atopic Dermatitis/Severe Eczema; **or**
- Pruritus of Renal Disease; **or**
- Lichen Planus; **or**
- Mycosis Fungoides; **or**
- Pityriasis Lichenoides; **or**
- Pruritis of Hepatic Disease.

Eligibility for a home therapy device may be contingent upon compliance with **ALL** of the following criteria:

- The patient's condition must comply with one of the eligible diagnoses listed above, must have a documented positive response to ultraviolet light and must be chronic in nature requiring long term maintenance exceeding four (4) months; and
- The device must be ordered by the physician; and
- The device must be approved by the Food and Drug Administration; and
- The device must be appropriate for the body surface/area being treated.

In addition to meeting the eligibility criteria listed above, payment should be limited to the most appropriate device which adequately meets the needs of the patient. All requests for ultraviolet light cabinets and handheld units will be reviewed on an individual basis.

Ultraviolet light therapy and home therapy provided for other conditions will be denied as not medically necessary. Although evaluation and management services are periodically necessary to evaluate the patient's progress and response to therapy, they should not be routinely billed with ultraviolet light therapy. Evaluation and management services reported on the same date of service as ultraviolet light therapy are appropriate in any **ONE** of the following circumstances:

- When therapy is provided during the initial evaluation of the patient's condition; or
- During periodic assessment of the patient's response to therapy; or
- If the patient's condition worsens; or
- If a complication occurs, e.g., burns; or
- If the patient has a new complaint.

POST-PAYMENT AUDIT STATEMENT

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

PLACE OF SERVICE: OUTPATIENT

Experimental/investigational (E/I) services are not covered regardless of place of service.

Ultraviolet Light Therapy is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a co-morbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

CODING REQUIREMENTS

CPT code	Description
96900	Actinotherapy (ultraviolet light).
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm.
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq sm.
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq sm.
96912	Photochemotherapy; psoralens and ultraviolet A (puva).
96913	Photochemotherapy (geockerman and/or puva) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings).
96910	Photochemotherapy; tar and ultraviolet B (goecherman treatment) or petrolatum and ultraviolet B.
E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 2 square feet or less.
E0692	Ultraviolet light therapy system panel, includes bulbs/lams, timer, and eye protection, 4-foot panel.
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection; 6-foot panel.
E0694	Ultraviolet multidirectional light therapy system in 6-foot cabinet, includes bulbs/lamps, timer and eye protection.

COVERED DIAGNOSIS CODES FOR PROCEDURE CODE 96900

Codes						
A67.2	C84.00	C84.01	C84.02	C84.03	C84.04	C84.05

C84.06	C84.07	C84.08	C84.09	C84.10	C84.11	C84.12
C84.13	C84.14	C84.15	C84.16	C84.17	C84.18	C84.19
L20.0	L20.9	L20.81	L20.82	L20.84	L20.89	L29.8
L30.1	L40.0	L40.1	L40.2	L40.3	L40.4	L40.8
L40.9	L41.0	L41.1	L41.3	L41.4	L41.5	L41.8
L41.9	L42	L43.0	L43.1	L43.2	L43.3	L43.8
L43.9	L56.0	L56.1	L56.2	L56.3	L66.1	L80
L94.0	L94.5					

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES 96912 AND 96913

Codes						
A67.2	B78.1	C84.00	C84.01	C84.02	C84.03	C84.04
C84.05	C84.06	C84.07	C84.08	C84.09	C84.10	C84.11
C84.12	C84.13	C84.14	C84.15	C84.16	C84.17	C84.18
C84.19	E83.2	L08.9	L08.82	L08.89	L20.0	L20.9
L20.81	L20.82	L20.84	L20.89	L26	L29.0	L29.8
L30.1	L30.4	L40.0	L40.1	L40.2	L40.3	L40.4
L40.8	L40.9	L41.0	L41.1	L41.3	L41.4	L41.5
L41.8	L41.9	L43.0	L43.1	L43.2	L43.3	L43.8
L43.9	L53.8	L54	L56.0	L56.1	L56.2	L56.3
L63.2	L63.8	L63.9	L66.1	L66.3	L73.1	L73.8
L80	L92.0	L94.5	L95.1	L98.1	L98.2	M34.0
M34.1	M34.2	M34.9	M34.81	M34.82	M34.83	M34.89
Q82.1	Q82.2	Q82.3	T86.00	T86.01	T86.02	T86.03
T86.09						

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES 96910 AND 96913

Codes						
A67.2	B78.1	C84.00	C84.01	C84.02	C84.03	C84.04
C84.05	C84.06	C84.07	C84.08	C84.09	C84.10	C84.11
C84.12	C84.13	C84.14	C84.15	C84.16	C84.17	C84.18
C84.19	E83.2	L08.9	L08.82	L08.89	L20.0	L20.9

L20.81	L20.82	L20.84	L20.89	L26	L29.0	L29.8
L43.8	L43.9	L66.1				

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES 96920, 96921, 96922

Codes						
L40.0	L40.1	L40.2	L40.3	L40.4	L40.8	L40.9
L80						

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES E0691, E0692, E0693 AND E0694

Codes						
C84.00	C84.01	C84.02	C84.03	C84.04	C84.05	C84.06
C84.07	C84.08	C84.09	L20.0	L20.9	L20.81	L20.82
L20.84	L20.89	L40.0	L40.1	L40.2	L40.3	L40.4
L40.8	L40.9	L41.0	L41.1	L41.3	L41.4	L41.5
L41.8	L41.9	L43.0	L43.1	L43.2	L43.3	L43.8
L43.9	L66.1	L94.5				

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Health Options contract.

Reference

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POLICY UPDATE HISTORY

12/21/2021	Approved in Medical Policy Committee
01/2022	Approved in QI/UM
12/28/2022	Annual review; approved in Medical Policy Committee
01/03/2023	Approved in QI/UM