



CLINICAL MEDICAL POLICY	
Policy Name:	Ultraviolet B Light Therapies in the Home
Policy Number:	MP-159-MD-PA
Responsible Department(s):	Medical Management
Provider Notice/Issue Date:	09/28/2026
Effective Date:	12/01/2026
Next Annual Review:	12/2027
Revision Date:	05/20/2026
Products:	Highmark Wholecare SM Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 6

Policy History

Date	Action
12/01/2026	Provider Effective Date
08/27/2026	PARP Approval
05/20/2026	QI/UM Committee review
05/20/2026	Policy initially developed HHO-DE-MP-1229-003 Ultraviolet Light Therapies hho-de-mp-1099-corneal-surgery , based on DHS Memo

Disclaimer

Highmark WholecareSM 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 WholecareSM may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary ultraviolet B light therapy in the home.

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.

(Current applicable Pennsylvania HealthChoices Agreement Section V. Program Requirements, B. Prior Authorization of Services, 1. General Prior Authorization Requirements.)

Definitions

Prior Authorization Review Panel (PARP) – A panel of representatives from within the PA Department of Human Services who have been assigned organizational responsibility for the review, approval and denial of all PH-MCO Prior Authorization policies and procedures.

Ultraviolet B (UVB) light therapy – UVB is present in natural sunlight and is an effective treatment for psoriasis. UVB penetrates the skin and slows the growth of affected skin cells. Treatment using UVB can include UVB phototherapy, excimer laser, or in-office or home UVB phototherapy. UVB phototherapy treatment involves exposing the skin to an artificial UVB light source for a set length of time on a regular schedule. This treatment is administered in a health care provider's office or clinic or at home with a phototherapy unit. There are two types of UVB treatment: Broad band and Narrow band.

Ultraviolet A (UVA) light therapy - combines the use of an oral or topical medication to maximize the effect of light therapy for conditions like psoriasis and vitiligo. UVA-1 is an innovative light therapy for many skin conditions, including scleroderma, morphea and cutaneous graft-versus-host disease (GVHD), which is not commonly available. UVA therapy reaches the dermis layer (inner layer) of the skin.

Procedures

1. UVB in-home therapy requires a Program Exception. The ordering physician must provide a supporting statement indicating why the requested therapy or device is medically necessary, and the alternative options have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction.

In-home Ultraviolet B (UVB) light therapy may be medically effective under specific but very narrow clinical circumstances for a small number of individuals. Medical evidence is limited but promising or not available in large clinical trials. Highmark WholecareSM will require the submission of a Program Exception request.

2. In-home Ultraviolet B (UVB) light therapy may be considered medically necessary when the individual requires UVB treatment at least three (3) times per week, and for ANY ONE of the following diagnoses:

- A. Severe Psoriasis; OR
- B. Atopic Dermatitis/Severe Eczema; OR
- C. Pruritus of renal disease; OR
- D. Lichen Planus; OR
- E. Mycosis Fungoides; OR
- F. Pityriasis Lichenoides; OR
- G. Pruritis of hepatic disease.

3. Eligibility for a home therapy device is contingent upon compliance with ALL of the following criteria:
- A. The individual's condition must comply with one (1) of the eligible diagnoses listed above; AND
 - B. There must be a documented positive response to ultraviolet light; AND
 - C. The condition must be chronic in nature requiring long term maintenance exceeding four (4) months; AND
 - D. The device must be ordered by a physician; AND
 - E. The device must be approved by the Food and Drug Administration (FDA); AND
 - F. The device must be appropriate for the body surface/area being treated.

Note: In addition to meeting the eligibility criteria listed above, usage should be limited to the most appropriate device which adequately meets the needs of the individual. All requests for ultraviolet light cabinets and hand-held units will be reviewed by a Medical Director on a case-by-case basis.

4. Ultraviolet B light home therapy not meeting the criteria as outlined in this policy is considered not medically necessary. Home ultraviolet light therapy using ultraviolet A (UVA) light devices are considered not medically necessary for all indications.
5. Post-payment Audit Statement
The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark WholecareSM at any time pursuant to the terms of your provider agreement.
6. Place of Service
The proper place of service for in-home UVB therapy is outpatient.

Governing Bodies Approval

CMS

The Centers for Medicare & Medicaid Services (CMS) has published the following guidance:

- . National Coverage Determination (NCD) Treatment of Psoriasis (250.1)

The Pennsylvania Department of Human Services Technology Assessment Group (TAG) workgroup meets quarterly to discuss issues revolving around new technologies and technologies or services that were previously considered to be a program exception. During this meeting, decisions are made as to whether or not certain technologies will be covered and how they will be covered. TAG's decisions are as follow:

- Option #1: Approved - Will be added to the Fee Schedule
- Option #2: Approved as Medically Effective - Will require Program Exception
- Option #3: Approved with (or denied due to) Limited/Minimal Evidence of Effectiveness - Will require Program Exception
- Option #4: Denied - Experimental/Investigational

As of March 2026, the TAG workgroup assigned in-home ultraviolet B therapy an Option # 3, specifically for procedure codes E0691, E0693 and E0694.

Program Exception

UVB in-home therapy requires a Program Exception. The ordering physician must provide a supporting statement indicating why the requested therapy or device is medically necessary, and the alternative options have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction.

Procedure Codes

CPT/HCPCS Code	Description
0691	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft or less
0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 ft pane
0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 ft panel
0694	Ultraviolet multidirectional light therapy system in 6 ft cabinet, includes bulbs/lamps, timer, and eye protection

These procedure codes require a Program Exception and will not be reimbursed without Medical Director approval.

Diagnosis Codes

ICD-10 Code	Description
C84.00	Mycosis fungoides, unspecified site
C84.01	Mycosis fungoides, lymph nodes of head, face, and neck
C84.02	Mycosis fungoides, intrathoracic lymph nodes
C84.03	Mycosis fungoides, intra-abdominal lymph nodes
C84.04	Mycosis fungoides, lymph nodes of axilla and upper limb
C84.05	Mycosis fungoides, lymph
C84.07	Mycosis fungoides, spleen
C84.08	Mycosis fungoides, lymph nodes of multiple sites
C84.09	Mycosis fungoides, extranodal and solid organ sites
L20.0	Besnier's prurigo
L20.9	Atopic dermatitis, unspecified
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis
L40.2	Acrodermatitis continua
L40.3	Pustulosis palmaris et plantaris
L40.4	Guttate psoriasis
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified
L41.0	Pityriasis lichenoides et varioliformis acuta
L41.1	Pityriasis lichenoides chronica
L43.0	Hypertrophic lichen planus
L43.1	Bullous lichen planus

Reimbursement

Participating facilities will be reimbursed per their Highmark WholecareSM contract.

Reference Sources

Pennsylvania Department of Human Services. Technology Assessment Group Coverage Decisions. Managed Care Operations Memorandum: MCOPS #03/2026-006. March 10, 2026. Accessed on April 29, 2026.

National Psoriasis Foundation. Phototherapy for Psoriasis. January 23, 2025. Accessed on April 29, 2026.

Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) Treatment of Psoriasis (250.1). Accessed on April 29, 2026.

Cancer Research UK. Ultraviolet light treatment (phototherapy). September 8, 2025. Accessed on April 29, 2026.