

**Policy: MP259**

**Section: Medical Benefit Policy**

**Subject: Phototherapy for the Treatment of Dermatological Conditions**

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**I. Policy:** Phototherapy for the Treatment of Dermatological Conditions

**II. Purpose/Objective:**

To provide a policy of coverage regarding Phototherapy for the Treatment of Dermatological Conditions

**III. Responsibility:**

- A. Medical Directors
- B. Medical Management

**IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

**V. Additional Definitions**

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

**Medicaid Business Segment**

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**ALL Durable Medical Equipment** provided for home use requires advanced determination of coverage. Devices furnished at inpatient or outpatient centers are **NOT SEPARATELY REIMBURSABLE**.

**DESCRIPTION:**

Phototherapy is defined as the exposure to Ultraviolet radiation for the therapeutic use of skin conditions. The various therapies include Psoralen with Ultraviolet A (PUVA), Ultraviolet A or B, laser UVB, an UVB plus coal tar (Goeckerman regimen). UV therapies reduce inflammation, slow the production of skin cells, and confer an immune-modifying response.

**INDICATIONS:**

The following treatments are considered medically necessary when prescribed by a Dermatologist and any of the following criteria are met:

1. PUVA for the following conditions that are resistant to or not responsive to conventional therapies:

- severe, disabling psoriasis (affecting 10% or more of the body)
- severe dermatitis/ eczema
- Stage IA- IIA Cutaneous T-cell lymphoma (mycosis fungoides)
- Severe Lichen planus

2. Laser UVB (Excimer or pulsed dye) is considered medically necessary for mild to moderate psoriasis affecting 10% or less of the body surface area in insured individuals who have had suboptimal response to conservative treatment including topical agents and UV phototherapy, or a contraindication to such treatments.

3. UVA / UVB treatment is medically necessary for the following diseases that is not responsive to conservative therapies:

- psoriasis
- cutaneous T-cell lymphoma (e.g., mycosis fungoides)
- connective tissue diseases involving the skin (e.g., localized scleroderma)
- atopic dermatitis / Eczema
- Lichen planus
- Severe pruritus
- Vitiligo when it affects:
  - a. the skin of the head and/or neck area, or,
  - b. other body areas in excess of 30% of skin surface

4. UVB with the addition of topical coal tar (Goeckerman regimen) is considered medically necessary for severe psoriasis that affects 10% or more of the body.

5. Photodynamic therapy utilizing Levulan Kerastick and blue light, or Metvixia and red light is considered medically necessary for treatment of actinic keratoses after failure of topical therapy or cryotherapy with liquid nitrogen.

6. Excimer laser phototherapy is considered medically necessary for the treatment of vitiligo which is not responsive to other forms of conservative therapy (e.g., topical corticosteroids, coal/tar preparations, and ultraviolet light).

**Home Light Therapy Units: Requires Prior Authorization by a Plan Medical Director or Designee**

Home light therapy will be covered if all of the following criteria are met:

1. The panel is requested by a dermatologist; and
2. The individual is under the requesting provider's supervision with regularly scheduled exams (patient is seen at least once a year); and
3. Treatment is expected to be ongoing or long term (e.g., greater than 4 months) ; and
4. The individual has a diagnosis of one of the following:
  - psoriasis characterized by  $\geq 5\%$  of body surface area involved or disease involving crucial body areas such as the hands, feet, face, or genitals, and a therapeutic failure on, intolerance to, or contraindication to topical therapy
  - atopic dermatitis / Eczema
  - Lichen planus;

- Localized scleroderma
  - Chronic urticaria
  - Severe pruritus
  - Cutaneous T-cell lymphoma (e.g., mycosis fungoides)
  - Vitiligo when it affects:
    - a. the skin of the head and/or neck area, or,
    - b. other body areas in excess of 30% of skin surface
5. The panel size requested is appropriate for the affected area(s).

**EXCLUSIONS:**

Phototherapy as a first line of therapy for any dermatological condition is considered **not medically necessary**

Home tanning beds for any use is **NOT COVERED**

Phototherapy is considered COSMETIC when used to alter one's appearance, including but not limited to Vitiligo, Alopecia Areata, and therefore is **NOT COVERED**

The Plan does **NOT** routinely provide coverage for Phototherapy as a treatment for other conditions not listed, including but is not limited to Granuloma Annulare and Photodermatoses, because it is considered **experimental, investigational or unproven**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies. Coverage of phototherapy in these circumstances will be considered only in exceptional cases. Determination of coverage will be considered on a case by case basis when there is no FDA-approved or standard of care, after thorough communication between the treating physician and the Plan.

**Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.**

**CODING ASSOCIATED WITH:** Phototherapy for the Treatment of Dermatological Conditions

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.*

**96567** Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosal (Eg. lip) by activation of photosensitive drug(s), each phototherapy session.

**96900** actinotherapy (ultraviolet light)

**96910** Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B

**96912** Photochemotherapy; psoralens and ultraviolet A (PUVA)

**96913** Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings) (when specified as PUVA)

**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. cm

**96922** Laser treatment for inflammatory skin disease (psoriasis); over 500 sq. cm

**A4633** Replacement bulb/lamp for ultraviolet light therapy system, each

**E0691** Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection; treatment area two square feet or less

**E0692** Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection, four foot panel

**E0693** Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection, six foot panel

**E0694** Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer, and eye protection

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**LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For PA Medicaid Business segment, this policy applies as written.**

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This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 11/21/2011

**Revised:** 3/12, 3/13 (added indication), 3/15 (added indication); 6/15 (add criteria for home light units); 4/17 (revise home UVB criteria) 7/17 (expand home criteria); 4/18 (expand criteria)

**Reviewed:** 3/14; 5/16, 4/19, 4/20