



Geisinger Health Plan Policies and Procedure Manual

Policy: MP194

Section: Medical Benefit Policy

Subject: Rhinophototherapy

Applicable line of business:

| | | | |
|-------------------|----------|-----------------|----------|
| Commercial | x | Medicaid | x |
| Medicare | x | ACA | x |
| CHIP | x | | |

I. Policy: Rhinophototherapy

II. Purpose/Objective:

To provide a policy of coverage regarding Rhinophototherapy

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.

Commercial

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

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

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- 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

DESCRIPTION:

Rhinophototherapy involves the use of a special instrument to deliver visible and non-visible light to the nasal cavities to suppress the immune effects of allergic rhinitis. Because the therapeutic benefits of ultraviolet light on atopic dermatitis have been established, and clinical similarity between atopic dermatitis and allergic rhinitis exists, it is thought that the procedure would be effective for the treatment of allergic rhinitis.

EXCLUSIONS:

The Plan does **NOT** provide coverage for Rhinophototherapy for any indication because it is considered **unproven**. Although the device is FDA approved, 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

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

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: Rhinophototherapy

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 or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

30999 Unlisted procedure, nose

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

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 Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

Neuman, I., and Y. Finkelstein. Narrow-band red light phototherapy in perennial allergic rhinitis and nasal polyps. *Annals of Allergy Asthma and Immunology* (1997 April) 78(4): 399-406.

Koreck, A.I., Csoma, Z., et al. Rhinophototherapy: a new therapeutic tool for the management of allergic rhinitis. *Journal of Allergy and Clinical Immunology* (2005 March) 115(3): 541-7.

Mitchell, D., Paniker, L., et al. Molecular response of nasal mucosa to therapeutic exposure to broad-band ultraviolet radiation [J Cell Mol Med.](#) 2010 Jan;14(1-2):313-22

Garaczi, E., et al. Intranasal Phototherapy Is More Effective Than Fexofenadine Hydrochloride in the Treatment of Seasonal Allergic Rhinitis: Results of a Pilot Study *Photochemistry and Photobiology*, March/April 2011 8(2) 474-477

Alyasin S, Hesamedin S, et al. Short Time Efficiency of Rhinophototherapy in Management of Patients with Allergic Rhinitis Resistant to Medical Therapy. *Iran J Allergy Asthma Immunol.* August 2016; 15(4):317-327.

Bella Z, Kiricsi A, et al. Rhinophototherapy in persistent allergic rhinitis. *Eur Arch Otorhinolaryngol.* 2017 Mar;274(3):1543-1550.

Karali E, Gunes A, Ural A, et al. Effect of Rhinophototherapy on nasal congestion in patients with seasonal allergic rhinitis. *Acta Otorhinolaryngol Ital.* 2021; 41(2): 151-158.

Costa TMR, Carneiro FM, Oliveira KAS de, et al. Rhinophototherapy, an alternative treatment of allergic rhinitis: Systematic review and meta-analysis. *Braz J Otorhinolaryngol.* 2021; 87(6):742-752.

Kiricsi Á, Kiricsi M, Szabó Z, et al. Open, prospective, multicenter study on postoperative intranasal phototherapy in nasal polyposis. *Ir J Med Sci.* 2022; 191(1):375-383

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

Devised: 12/07

Revised: 10/24 (revise exclusion language)

Reviewed: 12/08: 12/09; 11/10, 11/11, 11/12, 11/13, 11/14, 11/15, 11/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23

CMS UM Oversight Committee Approval: 12/23, 12/24

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited

without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.