Medical Policy:

Phototherapy, Photochemotherapy and Photodynamic Therapy for Dermatologic Conditions

POLICY NUMBER	LAST REVIEW
MG.MM.ME. 27lC	December 10, 2021

The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as "EmblemHealth"), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definitions

Phototherapy	The application of ultraviolet light, or actinotherapy — consists of exposure to nonionizing radiation. The treatment may involve exposure to any: – Ultraviolet B (UVB) – Ultraviolet A (UVA) – Combined UVB and UVA delivered using a broad or narrow-beamed laser
Photochemotherapy Psoralen and ultraviolet A (PUVA)	PUVA utilizes UVA radiation in combination with a photosensitizing chemical that increases the skin's sensitivity to the UVA.
Photodynamic Therapy (PDT)	PDT is a multi-step (typically 2-day) process that consists of the application of a topical photosensitizer cream followed by a laser light source (e.g., methyl aminolevulinate hydrochloride [MAL] that is accompanied by a red light; 5-aminolevulinic acid [5-ALA] or by a blue).

Guideline

Phototherapy, PUVA and PDT are considered medically necessary for certain dermatologic conditions refractory to topical or systemic drug therapies when any of the applicable criteria sets in Tables 1–4 are met.

(Note: For case-by-case consideration of vitiligo treatment; see Table 4)

Table 1 — Phototherapy

1. Allergic contact dermatitis
2. Atopic dermatitis (moderate–severe)
3. Chronic urticaria
4. Dermatologic manifestations of graft vs host disease
5. Eczema
6. Granuloma annulare
7. Lichen planus
8. Mycosis fungoides (cutaneous T-cell lymphoma)
9. Nummular dermatitis
10. Photodermatosis
11. Pityriasis lichenoides
12. Pityriasis rosea
13. Pruritic eruptions of HIV infection
14. Pruritus
15. Parapsoriasis
16. Psoriasis
Home Phototherapy (UVB) Units (DME benefit required) Coverage for members with moderate to severe persistent psoriasis covering at least 20% of the body surface may be provided for the purchase of a home UVB Phototherapy unit. All of the following criteria must be met: 1. Documentation of effective psoriasis suppression as a result of at least 6 months of UVB treatment, whereby the continuation of home-UVB would be construed as a reasonable means to deter exacerbations. 2. Physician documentation of medical necessity, which includes: ▪ Severity description, e.g., if there is involvement of the palms, soles, or intertriginous areas, the percent of the affected area involved, and the associated disability should be part of the record. ▪ A prescription describing the UVB exposure protocol. ▪ A follow-up plan to determine treatment effectiveness, i.e., office visit frequency. 3. Demonstration of patient proficiency in the use of UVB with the understanding of the necessity of physician communication with the occurrence of any unexpected side effects. 4. History of ineffective (or intolerance to) treatments with multiple topical agents or systemic therapy.

Table 2 — PUVA

1. Acute/chronic pityriasis lichenoides
2. Atopic dermatitis (moderate — severe)
3. Chronic urticaria
4. Dermatologic manifestations of graft-versus-host disease
5. Eczema (severe)
6. Granuloma annulare
7. Lichen planus
8. Morphea and localized skin lesions associated with scleroderma
9. Mycosis fungoides (cutaneous T-cell lymphoma)
10. Parapsoriasis (severe)
11. Psoriasis (severe)
12. scleromyxedema

Table 3 — PDT

Presence of either of the following lesions that have failed to adequately respond to ≥ 3 weeks of topical 5-fluorouracil, imiquimod, Diclofenac or cryosurgery:

1. Non-hyperkeratotic actinic keratoses lesions on the face or scalp.
2. Actinic cheilitis, also known as solar cheilitis, sailor's lip or farmer's lip.

Note: A 2nd treatment post 8 weeks of the initial therapy may be necessary for any lesions that fail to respond to therapy.

Table 4 — Treatment of Vitiligo

On a case-by-case basis, coverage consideration will be given for excimer laser, PUVA, UVB light (alone or in combination with other treatment modalities) for treatment of the face, neck, hands or ≥ 10% body surface area. Prior to Medical Director consideration, substantiating documentation must first be submitted for review; these include:

1. Progress notes indicative of the following:
    a. Baseline skin color.
    b. Treatment history; documented failure of adherent 3-month trial of both:
        i. high-potency (Class II steroids)
        ii. Protopic.
    c. Extent and distribution of vitiligo to the face, neck and or hands.
2. Photographic evidence.

Limitations/Exclusions

1. Phototherapy, PUVA or PDT is not considered medically necessary for any indications other than those listed above.
2. More than 2 courses of PDT treatments per year are not considered medically necessary, as effectiveness beyond this timeframe has not been established.
3. Requests for coverage of more than 30 units of Phototherapy, PUVA or PDT per course of treatment must be accompanied by documentation that substantiates medical necessity.
4. Grenz ray therapy is not considered medically necessary for any indications, as it is considered investigational.

Procedure Codes

96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session
96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
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)
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm (The appropriate ICD-10 codes to use are: L40.0, L40.1, L40.2, L40.4, L40.8, L40.9, L41.3, L41.4, L41.5, L41.8 and L41.9)
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm (The appropriate ICD-10 codes to use are: L40.0, L40.1, L40.2, L40.4, L40.8, L40.9, L41.3, L41.4, L41.5, L41.8 and L41.9)
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm (The appropriate ICD-10 codes to use are: L40.0, L40.1, L40.2, L40.4, L40.8, L40.9, L41.3, L41.4, L41.5, L41.8 and L41.9)
96999	Unlisted special dermatological service or procedure
E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft or less
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection, 4 ft. panel
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection, 6 ft. panel
E0694	Ultraviolet multidirectional light therapy system in 6 ft. cabinet, includes bulbs/lamps, timer, and eye protection
A4633	Replacement bulb/lamp for ultraviolet light therapy system, each
J7308	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7309	Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 g
J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg

Diagnosis Codes

C84.00	Mycosis fungoides, unspecified site
C84.01	Mycosis fungoides, lymph nodes of head, face, and neck
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L23.1	Allergic contact dermatitis due to adhesives
L23.3	Allergic contact dermatitis due to drugs in contact with skin
L23.5	Allergic contact dermatitis due to other chemical products
L24.4	Irritant contact dermatitis due to drugs in contact with skin
L24.5	Irritant contact dermatitis due to other chemical products
L25.1	Unspecified contact dermatitis due to drugs in contact with skin
L25.3	Unspecified contact dermatitis due to other chemical products
L29.8	Other pruritus
L29.9	Pruritus, unspecified
L30.0	Nummular dermatitis
L30.4	Erythema intertrigo
L30.5	Pityriasis alba
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis
L40.2	Acrodermatitis continua
L40.4	Guttate psoriasis
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified
L41.0	Pityriasis lichenoides et varioliformis acuta
L41.1	Pityriasis lichenoides chronica
L41.3	Small plaque parapsoriasis
L41.4	Large plaque parapsoriasis
L41.5	Retiform parapsoriasis
L41.8	Other parapsoriasis
L41.9	Parapsoriasis, unspecified
L42	Pityriasis rosea

L43.0	Hypertrophic lichen planus
L43.1	Bullous lichen planus
L43.3	Subacute (active) lichen planus
L43.8	Other lichen planus
L43.9	Lichen planus, unspecified
L50.6	Contact urticaria
L50.8	Other urticaria
L56.2	Photocontact dermatitis [berloque dermatitis]
L56.3	Solar urticaria
L56.5	Disseminated superficial actinic porokeratosis (DSAP)
L56.8	Other specified acute skin changes due to ultraviolet radiation
L56.9	Acute skin change due to ultraviolet radiation, unspecified
L57.0	Actinic keratosis
L66.1	Lichen planopilaris
L80	Vitiligo
L90.0	Lichen sclerosus et atrophicus
L92.0	Granuloma annulare
L94.0	Localized scleroderma [morphea]
L98.5	Mucinosis of the skin

References

Cather J, Menter A. Novel therapies for psoriasis. Am J Clin Dermatol. 2002;3(3):159-173.

CMS. National Coverage Determination. Treatment of Actinic Keratosis. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=129&ncdver=1&DocID=250.4&bc=gAAAAAgAAAAAAA%3d%3d&. Accessed September 20, 2022.

CMS. National Coverage Determination. Treatment of Psoriasis. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=88&ncdver=1&DocID=250.1&bc=gAAAAAgAAAAAAA%3d%3d&. Accessed September 20, 2022.

Dutz J. Treatment options for localized scleroderma. Skin Therapy Lett. 2000;5(2):3-5.

Griffiths CE, Clark CM, Chalmers RJ, Li Wan Po A, Williams HC. A systematic review of treatments for severe psoriasis. Health Technol Assess. 2000;4(40):1-125.

Hawk A, English JC 3rd. Localized and systemic scleroderma. Semin Cutan Med Surg. March 2001;20:27-37.

Hayes, Inc. Laser Therapy for Psoriasis. Lansdale, Pa: Winifred S. Hayes, Inc.; July 2002. Search updated February 28, 2006.

Millard TP, Hawk JL. Photosensitivity disorders: cause, effect and management. Am J Clin Dermatol. 2002;3:239-246.
Sapadin AN, Fleischmajer R. Treatment of scleroderma. Arch Dermatol. January 2002;138:99-105.

Saricaoglu H, Karadogan SK, Baskan EB, Tunali S. Narrowband UVB therapy in the treatment of lichen planus. Photodermatol Photoimmunol Photomed. October 2003;19:265-267.

Specialty-matched clinical peer review.

Storbeck K, Holzle E, Schurer N, Lehmann P, Plewig G. Narrow-band UVB (311 nm) versus conventional broad-band UVB with and without dithranol in phototherapy for psoriasis. J Am Acad Dermatol. 1993;28(2 Pt 1):227-231.

Wolff K. Treatment of cutaneous mastocytosis. Int Arch Allergy Immunol. Feburary 2002;127:156-159.

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	Dec. 11, 2020	Added scleromyxedema to PUVA
ConnectiCare	Jan. 1, 2020	Removed under Exclusions/Limitations-#5 Prior authorization is required for all procedures listed in this policy
EmblemHealth ConnectiCare	Dec. 13, 2019	Added case-by-case language for vitiligo involving 10% body surface area
ConnectiCare	Oct. 2019	Reformatted and reorganized policy, transferred content to new template
EmblemHealth ConnectiCare	Oct. 12, 2018	Added allergic contact dermatitis and nummular dermatitis to phototherapy table
EmblemHealth ConnectiCare	Sept. 21, 2017	Clarified that medical documentation substantiating medical necessity must be submitted for coverage consideration of > 30 units per course of treatment for phototherapy/photochemotherapy
EmblemHealth ConnectiCare	Feb. 10, 2017	Added PUVA and UVB light to vitiligo table for case-by-case consideration