

Medical Policy:

Phototherapy, Photochemotherapy and Photodynamic Therapy for Dermatologic Conditions

| POLICY NUMBER | LAST REVIEW |
|----------------|-------------------|
| MG.MM.ME. 271C | December 10, 2021 |

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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.

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Definitions

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| Phototherapy | The application of ultraviolet light, or actinotherapy — consists of exposure to nonionizing radiation. The treatment may involve exposure to any: <ul style="list-style-type: none"> - 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

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| 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

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| 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 $\geq 10\%$ 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

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| 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

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| 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 |

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| 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 |

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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 |