Molina Clinical Policy
Phototherapy, Photochemotherapy and Laser Therapy for Dermatological Conditions: Policy No. 292

Last Approval: 6/14/2023
Next Review Due By: June 2024

DISCLAIMER

This Molina Clinical Review (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. 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 (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Phototherapy/Actinotherapy is used to treat various dermatological skin conditions such as eczema, vitiligo, and psoriasis (Berger 2023; Feldman 2022; Howe 2023; Richard 2022; Spergel 2022). Phototherapy has been defined by the American Academy of Dermatology as "controlled exposure to certain types of electromagnetic radiation (Elmets et al. 2019)." Treatment includes actinotherapy, type A ultraviolet (UVA) radiation, type B ultraviolet (UVB) radiation, and combination UVA/UVB radiation (Feldman 2022).

Photochemotherapy (PUVA) is the therapeutic use of radiation in combination with a photosensitizing chemical for various skin conditions. It currently involves the use of psoralens (typically oral or topical) prior to exposure to UVA radiation. Treatment with these modalities may involve partial or whole-body exposure and includes psoralens (P) and type A ultraviolet (UVA) radiation, known as PUVA photochemotherapy and combinations of P/UVA/UVB (Richard 2022).

Excimer Laser uses a highly concentrated beam of ultraviolet light that provides targeted delivery of UV exposure to specific vitiligo patches or spots. The targeted delivery prevents exposure of adjacent skin to UV light (Feldman 2022).

COVERAGE POLICY

Initial Criteria

1. Office-based phototherapy and photochemotherapy **may be considered medically necessary** when **ALL** of the following criteria are met:
   a. Diagnosis of **ANY** of the following conditions:
      - Atopic dermatitis (i.e., atopic eczema); **OR**
      - Connective tissue diseases involving the skin (e.g., cutaneous graft vs. host disease [GVHD], localized scleroderma); **OR**
      - Cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides); **OR**
      - Lichen planus; **OR**
      - Photodermatoses (e.g., polymorphic light eruption, actinic prurigo, chronic actinic dermatitis); **OR**
      - Psoriasis; **OR**
      - Vitiligo

   AND

   b. Clinical documentation of inadequate symptom control, intolerance or contraindication to conventional medical management that may include **ANY** of the following, as applicable:
      - Biological agents; **OR**
      - Diet restrictions; **OR**

- Oral immunosuppressants; **OR**
- Stress management; **OR**
- Topical and oral steroids; **OR**
- Topical ointments or creams.

2. Topical targeted phototherapy (excimer laser) **may be considered medically necessary** when **ALL** of the following criteria are met:
   a. Diagnosis of localized, plaque psoriasis; **AND**
   b. Clinical documentation of inadequate symptom control, intolerance or contraindication to conventional medical management that includes **ANY** of the following:
      - Topical agents; **OR**
      - Phototherapy.

Frequency and Number of Treatments

1. Phototherapy (UVA or UVB) with or without topical preparations **may be authorized** when the above criteria is met for phototherapy:
   - Three times per week for up to 12 weeks have shown to be effective. Documentation is required after the initial 12 weeks to determine if any improvement has occurred. Approval of additional treatments after the initial 12 weeks trial requires documentation of significant improvement for ongoing authorization.

2. Psoralen with Ultraviolet A (PUVA) **may be authorized** when the above criteria are met for PUVA:
   - Three times per week for up to 15 treatments have shown to be effective. Documentation is required after 15 treatments to determine if any improvement has occurred. Treatments beyond the initial 15 require documentation for necessity.

3. Topical targeted phototherapy (excimer laser) **may be authorized** when the above criteria is met for laser:
   - Two to three times a week for up to 12 treatments. Documentation is required after 12 treatments to determine medical necessity for continued treatment.

4. Home UVB phototherapy (Ultraviolet light only) **may be considered medically necessary** under the direction of a physician for the treatment of when the above criteria are met for phototherapy:
   - In patients who are unable to receive phototherapy in an office setting; **OR**
   - For those patients that have difficulty in maintaining frequent office visits due to their medical condition or considerable distance in travel from home to office (e.g., >45 minutes one way)

Limitations and Exclusions

- Phototherapy, photochemotherapy or excimer laser therapy are considered not medically necessary for any other condition.
- PUVA or oral phototherapy treatment is contraindicated in children under age 12 and pregnant or breastfeeding women.
- Home UV phototherapy is considered NOT medically necessary for patients who need maintenance courses of outpatient UV phototherapy every 6 months, with 3-6 months of clearance in between.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

The peer-reviewed published medical literature, including randomized controlled trials, systematic reviews, clinical

trials and case series, as well as professional societies and organizations support the safety and effectiveness of phototherapy and photochemotherapy for the treatment of atopic dermatitis, connected tissue diseases involving the skin, cutaneous T-cell lymphoma, lichen planus, photodermatoses, vitiligo, and psoriasis for patients who have inadequate symptom control, do not tolerate or are unresponsive to conventional medical management.

Zhu et al. (2022) completed a systematic review and network meta-analysis to compare the effectiveness of narrowband UVB (NBUVB) to combination regimens with NBUVB and another treatment in enhancing skin repigmentation. The review and meta-analysis included 28 studies with 1194 participants. Inclusion criteria included patients presenting with vitiligo of any type and location and NBUVB combined with another active treatment. Active treatments included carboxytherapy, topical 5% 5-flurouracil, topical vitamin D, topical Prunus mume tincture, topical tacrolimus, topical latanoprost, needling/microneedling, oral Chinese medicinal compound, betamethasone intramuscular injection, Er: YAG laser, and fractional carbon dioxide laser. The mean treatment course was 16 weeks with a range of 8-32 weeks. All but 2 studies reported using treatment 2-3 times per week. The age range of participants was between 7 years and 74 years. Pooled results showed all combination therapies were superior to NBUVB alone at improving skin repigmentation. NBUVB and Er: YAG laser and NBUVB and topical 5% 5-fluroracil were superior to all combination treatments.

Musters et al. (2021) completed a systematic review of 32 studies with a total of 1219 participants. The participants included adults and children and the mean age of participants was 28 years. Therapies with enough information to assess outcomes included NBUVB, UVA1, and PUVA. Comparators to each therapy included a placebo, no treatment, another phototherapy, or alternate doses of the same therapy. Outcomes for each therapy were reported using physician-assessed signs using the Eczema Area and Severity Index (EASI), the severity Scoring of Atopic Dermatitis (SCORAD), the Six Area Six Sign Atopic Dermatitis Severity (SASSAD), and Costa's Simple Scoring System. Mean treatment duration for all studies as 13 weeks. All comparisons had a low certainty of evidence due to the risk of bias. NBUVB compared to a placebo showed a larger reduction in physician-assessed signs after 12 weeks of therapy. There was minor difference with 4-6 weeks of NBUVB therapy compared to no treatment. However, there were improved signs at 9 weeks of NBUVB therapy compared to no treatment. NBUVB compared to UVA1 showed no difference in physician-assessed signs at 6 weeks of treatment. One split-body trial did report lower scores at 7-8 weeks of treatment with NBUVB compared to UVA1. PUVA had lower physician-assessed signs at 3 weeks of treatment when compared to UVA1.

The **American Academy of Dermatology** and the **National Psoriasis Foundation** released joint guidelines for the management and treatment of psoriasis using phototherapy. The guidelines recommend the following (Elmets et al. 2019):

- Treatment with NBUVB 2-3 times per week with stronger evidence supporting treatment 3 times per week.
- Treatment with targeted UVB (such as excimer laser) 2-3 times per week with the standard low-dose regimen. There is no evidence supporting using more higher doses when starting therapy.
- Topical PUVA is recommended for palmoplantar disease and localized psoriasis. Bath PUVA is as effective as topical PUVA.
- Oral PUVA 1-3 times per week is recommended as maintenance therapy. A combination therapy of oral PUVA and an oral retinoid is more effective than individual treatment with either therapy alone.
- PUVA is contraindicated in children < 10 years of age, those that are pregnant, nursing mothers, and those with a history of melanoma, lupus erythematosus, or xerodermas pigmentosum.
- Oral PUVA should be used cautiously in those 10-18 years of age with a history of dysplastic nevi, nonmelanoma skin cancer, photosensitivity, exposure to carcinogenic agents, or immunosuppressive medications.
- Photodynamic therapy is not recommended for the treatment of psoriasis.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology) Codes

CPT	Description
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)
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

HCPCS (Healthcare Common Procedure Coding System) Codes

HCPCS	Description
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

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

06/14/2023	Policy reviewed, no changes to criteria. Grammatical edits to Disclaimer section and Documentation Requirements disclaimer. Overview, Summary of Medical Evidence, and References updated. Supplemental Information section removed. Code description for E0691 updated. IRO Peer Review on June 3, 2023, by a practicing, board-certified physician with a specialty in Dermatology.
06/08/2022	Coverage policy updated to include treatment of vitiligo with phototherapy or photochemotherapy.
04/05/2021	Policy reviewed, no changes to criteria, references updated.
04/23/2020	Policy reviewed, no changes to criteria, references updated.
06/19/2019	Policy reviewed, no changes to criteria, references updated.
03/08/2018	Policy reviewed, no changes to criteria, references updated.
01/25/2017	MCR is no longer scheduled for revisions.
06/15/2016	Policy reviewed, no changes.
12/16/2015	Policy reviewed, no changes.
06/12/2014	MCR is no longer scheduled for revisions.
10/26/2011	Policy reviewed, no changes.
11/20/2008	New policy.

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