Clinical Policy: Phototherapy and Photochemotherapy for Dermatological Conditions

Reference Number: HNCA.CP.MP. 441
Effective Date: November 2008
Last Review Date: January 2019

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Targeted phototherapy is the localized delivery of ultraviolet light (UV) in the form of type A (UVA) or type B (UVB) therapy, to affected areas of skin using laser or non-laser devices. Photochemotherapy includes psoralens (P) and UVA radiation, known as PUVA photochemotherapy and combinations of P/UVA/UVB are used for severe skin diseases.

Policy/Criteria

I. It is the policy of Health Net of California that phototherapy with UVA or UVB therapy, Psoralens or photochemotherapy (PUVA) is medically necessary when there has been a failure to treatment using conventional therapy for any of the following conditions (may not be an all- inclusive list) :

A. Severe atopic dermatitis or atopic eczema
B. Severe lichen planus
C. Severe photodermatoses
D. Cutaneous C lymphoma (i.e., early stages of mycosis fungoides)
E. Severe large plaque parapsoriasis
F. Sclerotic skin disease
G. Severe disabling psoriasis generally defined as psoriasis affecting more than 10% of the body surface area (BSA)
H. Palmar/plantar psoriasis that affects less than 10 percent of the body surface area (BSA) but is deemed severe due to its physically debilitating effect on the quality of life related to painful exacerbations that impair the use of the hands and/or feet
I. Narrow-band UVB phototherapy for mild to moderate psoriasis unresponsive to conservative treatment [Anthralin, coal tar products, topical corticosteroids, topical tazarotene, topical calcipotriene (Davonex)]
J. Cutaneous graft vs host disease when unresponsive to conventional therapy (systemic glucocorticoid therapy)

II. It is the policy of Health Net of California that home phototherapy (UVB) treatment may be considered for individuals with severe psoriasis with a history of frequent flares when all of the following are met:

A. Documentation of medical necessity of UVB over other treatment by a dermatologist.
B. The prescribed device must be FDA approved.
C. Demonstrated improvement with in-office UVB light treatments.

D. The patient has the capacity to understand the risks, appropriate dosing, and the benefits of home UVB light treatments and is reliable and expected to be compliant with the treatment plan, including periodic office visits for monitoring.
E. It is a hardship for the patient to attend in-office PUVA/UVB treatments, OR a home unit is more cost-effective.

Note: On average, up to 25 PUVA treatments may be necessary to achieve clearance.

III. It is the policy of Health Net of California that the following are not medically necessary for treatment of psoriasis because there is inadequate scientific evidence in the medical literature validating their effectiveness:
A. Targeted phototherapy for the **first-line** treatment of mild psoriasis
B. Tanning beds for home UVB phototherapy. (Home UVB devices are designed solely for the medical treatment of skin diseases and emit a different wavelength of ultraviolet light than tanning beds).

Background
Phototherapy is defined as exposure to nonionizing radiation for therapeutic benefit. This treatment modality may be useful in some patients with various dermatological conditions involving a limited area of the body, <10 percent of the body surface area, or difficult-to-treat anatomical areas. It can encompass the use of visible light, photodynamic therapy, photothermolysis, and laser therapy. More specifically, visible light phototherapy utilizes ultraviolet-free light within the visible spectrum, such as blue and red visible light, with wavelengths spanning 415 to 660 nm. [2, 3]

Psoralen plus ultraviolet A (PUVA) photochemotherapy combines the administration of psoralens, a class of phototoxic plant-derived compounds, with an exposure to ultraviolet A radiation (UVA). The patient is exposed first to psoralens, drugs containing chemicals that react with ultraviolet light, and then to UVA light. [4, 7]

Cowen (Uptodate 2018) reports that acute and chronic graft-versus-host disease (GVHD) are multisystem disorders that are complications of hematopoietic cell transplant (HCT). Skin involvement is common, and mucosal, hair, or nail abnormalities may also occur. Phototherapy may be an additional treatment option for acute cutaneous GVHD. In retrospective studies, psoralen plus UVA (PUVA) and narrow band UVB phototherapy have been associated with improvement in acute cutaneous GVHD that was refractory to systemic glucocorticoid therapy or that flared upon glucocorticoid tapering. Prior to a recommendation for the routine use of phototherapy, further study is necessary to determine the long-term safety and efficacy of phototherapy in this population[12.]

American Academy of Dermatology

For patients with severe atopic dermatitis who have been unable to control their symptoms using first-line therapies, phototherapy with UV light may be prescribed or used as a maintenance therapy. UVB, UVA, or a combination of UVB and UVA may be used during therapy. Patients are encouraged to talk with their dermatologist about the risks of UV exposure, including the possible risk of skin cancer. [1]

American Academy of Dermatology
Ultraviolet light (UVL)–based therapy, specifically, ultraviolet B light (UVB) phototherapy and psoralen plus ultraviolet A light (PUVA) photochemotherapy, has been a mainstay of treatment of mycosis fungoides for the past 50 years. [5]

United States Cutaneous Lymphoma Consortium
They are developing standardized guidelines for phototherapy, including photochemotherapy for patients with cutaneous lymphoma, mycosis fungoides and its leukemic counterpart, Sézary syndrome, to facilitate the analysis of treatment results and ultimately improve patient outcomes.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
96910	Photochemotherapy; tar and ultraviolet B (Goekerman treatment) or petrolatum or ultraviolet B
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)
96913	Photochemotherapy; Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)

HCPCS Codes	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

HCPCS Codes	Description
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

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
C84.0X	Mycosis fungoides
C84.01-C84.09	Mycosis fungoides, different sites
L20.X	Atopic dermatitis
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L40.0	Psoriasis vulgaris
L43.0-L43.8	Lichen planus
L41.4	Large plaque parapsoriasis
L56.2	Photocontact dermatitis
L56.8	Other specified acute skin changes due to ultraviolet radiation
L90.0	Lichen sclerosus et atrophicus
L92.1	Necrobiosis lipoidica, not elsewhere classified
M34.2	Systemic sclerosis induced by drug and chemical
M35.4	Diffuse (eosinophilic) fasciitis

Reviews, Revisions, and Approvals	Date	Approval Date
Policy Adopted from Health Net NMP#441, Phototherapy and Photochemotherapy for Dermatological Conditions	1/17	
Added psoriasis information from Phototherapy for Psoriasis policy to combine into one policy	10/17	
References updated	1/18	1/18
Added graft vs host disease, references and codes updated	1/19	1/19

References

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2. Antiniou C. UVB phototherapy. European Handbook of Dermatological Treatments pp 683-684. 2003.
3. Feldman SR. Targeted Phototherapy. UpToDate. October 13, 2015.

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5. Olsen EA, Hodak E, Anderson T, et al. Guidelines for phototherapy of mycosis fungoides and Sézary syndrome: A consensus statement of the United States Cutaneous Lymphoma Consortium. Journal of American Academy of Dermatology. January 2016, Volume 74, Issue 1, Pages 27–58.
6. Olsen EA, Whittaker, S., Kim, Y.H. et al. Clinical end points and response criteria in mycosis fungoides and Sézary syndrome: a consensus statement of the International Society for Cutaneous Lymphomas, the United States Cutaneous Lymphoma Consortium, and the Cutaneous Lymphoma Task Force of the European Organisation for Research and Treatment of Cancer. J Clin Oncol. 2011; 29: 2598–2607.
7. Richard EG, Morison W. Psoralen Plus Ultraviolet A (PUVA) Photochemotherapy. UpToDate. July 25, 2015.
8. Menter A, Korman NJ, Elmets CA, Feldman SR, Gelfand JM, Gordon KB, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 5. Guidelines of care for the treatment of psoriasis with phototherapy and photochemotherapy. J Am Acad Dermatol. 2010 Jan;62(1):114-35.
9. Furlong T, Leisenring W, Storb R, et al. Psoralen and ultraviolet A irradiation (PUVA) as therapy for steroid-resistant cutaneous acute graft-versus-host disease. Biol Blood Marrow Transplant 2002; 8:206.
10. Feldstein JV, Bolaños-Meade J, Anders VL, Abuav R. Narrowband ultraviolet B phototherapy for the treatment of steroid-refractory and steroid-dependent acute graft-versus-host disease of the skin. J Am Acad Dermatol 2011; 65:733
12. Edward W Cowen, MD, MHSc Cutaneous manifestations of graft-versus-host disease (GVHD) UptoDate Mar 2018
13. Richard, EG, MD Psoralen plus ultraviolet A (PUVA) photochemotherapy. UpToDate May 2017

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs,

and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.