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

Last Approval: 6/8/2022
Next Review Due By: June 2023

OHIO MEDICAID: No hard limits are applied. All requests will be reviewed for medical necessity. Medical necessity review will be done after initial course of treatment

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 and has been defined by the American Academy of Dermatology as "exposure to nonionizing radiation for therapeutic benefit." Treatment includes actinotherapy, type A ultraviolet (UVA) radiation; type B ultraviolet (UVB) radiation; and combination UVA/UVB radiation.

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.

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.

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.

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 excimer laser therapy for the treatment of psoriasis in patients who are unresponsive to topical agents or phototherapy. There are a limited number of studies evaluating laser therapy for the treatment of atopic dermatitis and other conditions. Studies are primarily in the form of case series or retrospective reviews with small patient populations and short-term follow-ups.

SUPPLEMENTAL INFORMATION

None.

CODING & BILLING INFORMATION

CPT 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 Codes

HCPCS	Description
E0691	Ultraviolet light therapy system panel, 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

6/8/2022	Coverage policy updated to include treatment of vitiligo with phototherapy or photochemotherapy.
4/5/2021	Policy reviewed, no changes to criteria, references updated.
4/23/2020	Policy reviewed, no changes to criteria, references updated.
6/19/2019	Policy reviewed, no changes to criteria, references updated.
3/8/2018	Policy reviewed, no changes to criteria, references updated.
1/25/2017	MCR is no longer scheduled for revisions.

6/15/2016	Policy reviewed, no changes.
12/16/2015	Policy reviewed, no changes.
6/12/2014	MCR is no longer scheduled for revisions.
10/26/2011	Policy reviewed, no changes.
11/20/2008	New policy.

REFERENCES

Government Agencies

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2. Food and Drug Administration (FDA) Center for Devices and Radiological Health (CDRH). Available from FDA.
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Evidence Based Reviews and Publications

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National and Specialty Organizations

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APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

OHIO MEDICAID: No hard limits are applied. All requests will be reviewed for medical necessity. Medical necessity review will be done after initial course of treatment