Subject: Phototherapy, Photochemotherapy and Laser Therapy for Dermatological Conditions	Original Effective Date: 11/20/08
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DISCLAIMER

This Molina Clinical Review (MCR) is intended to facilitate the Utilization Management process. 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 (i.e., 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 Molina Clinical Review (MCR) document and provide the directive for all Medicare members.[1]

DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL

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.

INITIAL CRITERIA [4-8 55]

1. Office-based phototherapy and photochemotherapy may be considered medically necessary when all of the following criteria are met: [ALL]
   - ❑ Diagnosis of any of the following conditions: [ONE]
     - o atopic dermatitis (i.e., atopic eczema)
     - o connective tissue diseases involving the skin (e.g., cutaneous graft vs. host disease [GVHD], localized scleroderma, lupus erythematosus)
     - o cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides)
     - o lichen planus
     - o photodermatoses (e.g., polymorphic light eruption, actinic prurigo, chronic actinic dermatitis)
     - o psoriasis

     AND

   - ❑ Clinical documentation of inadequate symptom control, intolerance or contraindication to conventional medical management that may include any of the following as applicable:
     - o Biological agents
     - o Diet restrictions
     - o Oral immunosuppressant's
     - o Stress management
     - o Topical and oral steroids
     - o Topical ointments or creams

2. Topical targeted phototherapy (excimer laser) may be considered medically necessary when all of the following criteria are met: [ALL]
   - ❑ Diagnosis of localized, plaque psoriasis

     AND

- ❑ Clinical documentation of inadequate symptom control, intolerance or contraindication to conventional medical management that includes any of the following: [ONE]
  - topical agents; or
  - phototherapy

FREQUENCY AND NUMBER OF TREATMENTS [4-8]

1. *Phototherapy (UVA or UVB)* with or without topical preparations may be authorized when the above criteria is met for phototherapy as follows:
   - ❑ 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 is met for PUVA as follows:
   - ❑ 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 as follows:
   - ❑ 2 to 3 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 is met for phototherapy and: [ALL]
   - ❑ 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 [4-8 55]

- ❑ 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 breast feeding 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.

SUMMARY OF MEDICAL EVIDENCE [9-54]

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, 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.

CODING INFORMATION: THE CODES LISTED IN THIS POLICY ARE FOR REFERENCE PURPOSES ONLY. LISTING OF A SERVICE OR DEVICE CODE IN THIS POLICY DOES NOT IMPLY THAT THE SERVICE DESCRIBED BY THIS CODE IS A COVERED OR NON-COVERED. COVERAGE IS DETERMINED BY THE BENEFIT DOCUMENT. THIS LIST OF CODES MAY NOT BE ALL INCLUSIVE.

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	Description (Home Therapy Devices)
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

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Revision/Review History

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