Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Phototherapy (non-neonatal)

PRIOR AUTHORIZATION: Not required.

POLICY: PUVA, UVA and UVB

SWHP may consider psoralens with ultraviolet A light (PUVA), or UVA, or UVB treatments medically necessary for office-based treatment of the following conditions after conventional therapies have failed:

- Atopic dermatitis/eczema that is refractory
- Cutaneous T-cell lymphoma (mycosis fungoides)
- Eosinophilic folliculitis and other pruritic eruptions of HIV infection
- Lichen planus
- Morphea and localized skin lesions associated with scleroderma
- Parapsoriasis
- Photodermatoses,
- Pityriasis Lichenoides
- Pruritis secondary to systemic disease, e.g., HIV, or unknown etiology
- Psoriasis
- Urticaria pigmentosa (cutaneous mastocytosis)

SWHP may consider 2 to 3 PUVA treatments per week for up to 23 weeks for psoriasis.

SWHP may consider one treatment every 1 to 3 weeks with the majority of persons treated once every 3 weeks for an indefinite period. If the psoriasis fails to improve after two months of PUVA therapy, continued treatment is generally not considered medically necessary due to lack of efficacy.

Home UVA treatment is considered experimental and investigational because of insufficient evidence of its safety and effectiveness and thus not a covered benefit.

SWHP considers home phototherapy (UVB) treatment medically necessary DME for persons with severe psoriasis with a history of frequent flares who are unable to attend on-site therapy or those needing to initiate therapy immediately to suppress psoriasis flares. Home ultraviolet light booths or ultraviolet lamps, as well as replacement bulbs sold by prescription only, are considered medically necessary for persons eligible for home UVB phototherapy. The following conditions must be met:
• outpatient UVB phototherapy has been utilized, demonstrated to be beneficial and is expected to be long-term
• the device is not available without a prescription and the device and treatment regimen are prescribed by a physician
• the device, if a UV light booth, must require programming by the supplier using the physician script
• individual is motivated and compliant to prescribed usage

SWHP does NOT cover any form of phototherapy (including light boxes, panels, or visors) for the following conditions because light therapy has not been shown to be more effective than placebo for:
• Jet lag
• Disorders related to shift work or irregular work cycles
• Delayed or altered sleep phase syndromes
• Circadian rhythm disorders.

OVERVIEW: Ultraviolet light has a wavelength shorter than that of visible light, but longer than x-rays. This means electromagnetic waves with a wavelength between 400 nm and 10 nm, with energies from 3 eV to 124 eV. UV light is more energetic than visible light and has a shorter wavelength, letting it penetrate more readily through obstacles. The "ultraviolet" in ultraviolet light references that UV light is beyond violet on the electromagnetic spectrum.

There are two types of phototherapy – UVA and UVB. UVA phototherapy is usually given in conjunction with a light sensitizing tablet called psoralen (PUVA therapy). Sometimes a light sensitizing cream or lotion containing psoralen can be used in localized skin areas, e.g. feet (topical PUVA). UVA is part of the UV spectrum associated with pigmentation. UVB phototherapy utilizes the sun-burning part of the UV spectrum. “Narrowband” UVB uses light of one wavelength only.

MANDATES: None

CODES:
Important note: CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>96900</td>
<td>Actinotherapy (ultraviolet light)</td>
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<tr>
<td>96910</td>
<td>Photochemotherapy; tar and ultraviolet B</td>
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<tr>
<td>96912</td>
<td>Photochemotherapy; psoralens and ultraviolet A (PUVA)</td>
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<tr>
<td>96913</td>
<td>Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses</td>
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<table>
<thead>
<tr>
<th>ICD10 Codes</th>
<th>Description</th>
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<tr>
<td>C84.00 - C84.09</td>
<td>Mycosis fungoides</td>
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<tr>
<td>C84.10 - C84.19</td>
<td>Sezary's disease</td>
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<tr>
<td>D89.810 - D89.813</td>
<td>Graft-versus-host disease</td>
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<tr>
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<td>L20.81 - L20.82</td>
<td>Atopic neurodermatitis</td>
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<tr>
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<tr>
<td>L20.89</td>
<td>Other atopic dermatitis</td>
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<tr>
<td>L20.9</td>
<td>Atopic dermatitis, unspecified</td>
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</table>
MEDICAL COVERAGE POLICY

SERVICE: Phototherapy (non-neonatal)

Policy Number: 128
Effective Date: 08/01/2019
Last Review: 06/27/2019
Next Review Date: 06/27/2020

L40.0 - L40.9 Psoriasis vulgaris
L41.0 - L41.9 Pityriasis lichenoides
L43.0 - L43.9 Lichen planus
L56.0 - L56.9 Drug phototoxic response
L66.0 Pseudopelade
L66.1 Lichen planopilaris
L90.0 Lichen sclerosus et atrophicus
L94.0 - L94.3 Localized scleroderma [morphea]
L94.3 Sclerodactyly
L94.5 Poikiloderma vasculare atrophicans
M33.00 - M33.09 Juvenile dermatopolymyositis
M33.10 - M33.19 Other dermatopolymyositis
M33.90 - M33.99 Dermatopolymyositis, unspecified
M34.0 – M34.2 Progressive systemic sclerosis
M35.4 Diffuse (eosinophilic) fasciitis
M35.9 Systemic involvement of connective tissue, unspecified
M36.0 Dermato(poly)myositis in neoplastic disease
M36.8 Systemic disorders of connective tissue in other diseases classified elsewhere
M72.8 Other fibroblastic disorders
T86.00 - T86.09 Complication of bone marrow transplant

ICD10 Not Covered
L63.2 Ophiasis
L63.8 Other alopecia areata
L63.9 Alopecia areata, unspecified
L80 Vitiligo

CMS: See CMS.gov

POLICY HISTORY:

<table>
<thead>
<tr>
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<th>Action</th>
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<tr>
<td>New</td>
<td>7/1/2010</td>
<td>New policy</td>
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<tr>
<td>Reviewed</td>
<td>8/30/2012</td>
<td>Added policy statement regarding home phototherapy.</td>
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<td>Reviewed</td>
<td>5/23/2013</td>
<td>ICD10 codes added.</td>
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<td>4/24/2014</td>
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<td>Reviewed</td>
<td>4/30/2015</td>
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<tr>
<td>Reviewed</td>
<td>06/27/2019</td>
<td>Updated covered conditions and codes</td>
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REFERENCES:
The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy.
Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

MEDICAL COVERAGE POLICY

SERVICE: Phototherapy (non-neonatal)

Policy Number: 128
Effective Date: 08/01/2019
Last Review: 06/27/2019
Next Review Date: 06/27/2020


