Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Home Phototherapy for Dermatologic Conditions

Policy Number: PG0383
Last Review: 08/01/2023

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

X Professional
_ Facility

DESCRIPTION:

Phototherapy is an established treatment for skin disorders that uses ultraviolet light, alone or in combination with topical preparations or oral medications, to treat various skin conditions.

Office-based phototherapy includes actinotherapy, type A ultraviolet (UVA) radiation; type B ultraviolet (UVB) radiation; and combination UVA/UVB radiation. Photochemotherapy includes psoralens (P) and type A ultraviolet (UVA) radiation, known as PUVA photochemotherapy and combinations of P/UVA/UVB. Most patients undergoing UV treatment can be treated in the office. However, some patients require frequent treatments, or live in remote locations such that office visits are not feasible.

Home ultraviolet B phototherapy is an alternative and involves using home phototherapy light devices prescribed by a physician to treat various dermatologic (skin) conditions. The devices usually contain multiple fluorescent lights that emit high intensity, long-wave ultraviolet light on specific wavelengths. Previous concerns regarding over-exposure to unsafe levels of UV radiation in the home setting have been addressed with the evolution of integrated security features such as keys, pass codes, etc. Nonetheless, routine clinical evaluation should be conducted to ensure that exposure is kept to the minimum level compatible with adequate control of disease, and the prevention of complications.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

- **Ultraviolet Light HCPCS Codes E0691 - E0694 require a prior authorization.**
- **Paramount covers the purchase of one system per member per lifetime, when the coverage criteria below is met.**

Related Medical Policies:

Refer to PG0208 Phototherapy for Seasonal Affective Disorder for coverage determination for code E0203.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Home UVB phototherapy treatment devices are generally covered subject to the indications listed below and per your plan benefits. Home UVB phototherapy treatment devices are covered as medically necessary when ALL the below criteria are met:

1. When prescribed by a licensed Dermatologist or practitioner in a dermatology clinic; and
2. The treatment is for one of the following conditions:
   a) Atopic dermatitis/eczema when first line therapies alone has failed; or
   b) Chronic urticaria; or
   c) Lichen planus; or
   d) Localized scleroderma; or
   e) Mycosis fungoides; or
   f) Parapsoriasis
   g) Pityriasis lichenoides; or
   h) Pruritus of hepatic disease; or
   i) Pruritus of renal failure; or
   j) Psoriasis, when topical treatment alone has failed and a history of frequent psoriasis flares (continuous, long term > 1 year in duration) that require home therapy for suppression; or
   k) Cutaneous T-cell lymphoma including mycosis fungoides and Sézary syndrome, or
   l) Vitiligo when it affects:
      i. The skin of the head and/or neck area, or
      ii. Other body areas in excess of 30% of skin surface
      and
3. When there has been a failure, intolerance, or contraindication to treatment with topical or systemic drug therapy as documented by the treating physician; and
4. The member is motivated, dependable, adherent to instructions, able to administer the treatment correctly, willing, and able to keep records of treatments and attend regular follow-up visits with prescribing physician; and
5. Treatment is expected to be:
   a) Ongoing or long-term (i.e., necessary for greater than 4 months); or
   b) UVB treatment is expected at least three (3) times per week; or
   c) As an alternative to biological, therapies and JAK inhibitors considered to treat psoriasis.
   and
6. The device must be approved for home use by the Food and Drug Administration; and
7. UVB phototherapy device size is the smallest size appropriate for the treatment area (i.e., handheld wands, tabletop units, portable boxes, single panels).

Ultraviolet light therapy in the home is considered NOT MEDICALLY NECESSARY, may not be an all-inclusive listing**:**

1. A home UVB Phototherapy device is non-covered for any other indication, including, but not limited to:
   a) First-line treatment of mild psoriasis
   b) Treatment of generalized or psoriatic arthritis
   c) Acne vulgaris
   d) Acquired perforating dermatosis
   e) Alopecia areata
   f) Chemical or contact dermatitis
   g) Cholestasis of pregnancy
   h) Dermatographic urticaria (dermographism and dermatographism)
   i) Graft-vs-Host Disease
   j) Granuloma annulare
   k) Hidradenitis suppurativa
   l) Infectious keratitis
   m) Lymphomatid papulosis
   n) Lichten Simplex Chronicus
   o) Morphea

p) Papular urticarial
q) Photodermatoses
r) Progressive macular hypomelanosis,
s) Pruritis
t) Skin-hypopigmentation from scarring
u) Rosacea
v) Warts

2. Treatment of cosmetic skin conditions is not medically necessary. Cosmetic is defined as any condition which if left untreated will result in on adverse medical outcome.
3. It is being prescribed solely for the member's convenience.
4. The use of a tanning bed(s)/unit(s) or sun lamps is non-covered in any setting, including the home, for the treatment of dermatologic conditions, because it is not considered medically necessary. Unlike tanning beds, home UVB devices are designed solely for the medical treatment of skin diseases and emit a different wavelength of ultraviolet light than tanning beds. In addition, Paramount does not cover the use of a tanning bed/unit for any reason in any setting because it is not considered medical in nature and as such does not meet the standard plan definition of Durable Medical Equipment.
5. Sunscreen lotions or lip balms are non-covered.
6. Electrical outlet adapters are non-covered.
7. Ultraviolet A (UVA) phototherapy in the home setting is non-covered because it is considered investigational and not medically necessary for all indications.

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

HCPCS CODES	
E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection; treatment area 2sq ft or less
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection; four-foot panel
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer, and eye protection; six-foot panel
E0694	Ultraviolet multidirectional light therapy system in six-foot cabinet, includes bulbs/lamps, timer, and eye protection

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 02/01/2009

Date	Explanation & Changes
06/26/2012	• No changes
06/20/2014	• Changed name of policy from Seasonal Affective Disorder Lights and Light Therapy Systems to Phototherapy for Seasonal Affective Disorder and Dermatologic Conditions • Criteria added from Paramount's BENEFIT DESCRIPTION AND LIMITATIONS OF COVERAGE for Seasonal Affective Disorder Phototherapy (SAD Lamps) 2013 • Policy reviewed and updated to reflect most current clinical evidence per TAWG
07/18/2014	• TAWG committee determined that seasonal affective disorder (SAD) will no longer require prior authorization for any product line • Medical Policy Steering Committee will do future reviews for seasonal affective disorder (SAD) • Policy reviewed and updated to reflect most current clinical evidence per TAWG
02/14/2017	• Changed name of policy from PG0208 Phototherapy for Seasonal Affective Disorder and Dermatologic Conditions to PG0208 Phototherapy for Seasonal Affective Disorder • Codes E0691, E0692, E0693, & E0694 removed and added to new policy PG0383 Home Phototherapy for Dermatologic Conditions • Codes E0691-E0693 now requires prior authorization • Code E0694 is now non-covered • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee

08/15/2019	• Updated coverage determination • Procedure E0694, ultraviolet multidirectional light therapy system is six-foot cabinet, includes bulbs/lamps, timer, and eye protection, is covered per the criteria indicated in the medical policy, for all product lines • Covered diagnosis codes added
12/20/2020	• Medical policy placed on the new Paramount Medical Policy Format
03/01/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
08/01/2023	• Policy reviewed and updated to reflect most current clinical evidence. • Added the covered treatment conditions. • Removed vitiligo and scleroderma from the noncovered listing and moved to the covered listing. • Removed the listing of covered diagnosis codes, this is not needed as the procedures require a prior authorization.
04/09/2024	• Medical Policy placed on the new Paramount Medical Policy format

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review

Medical Policy History – Prior to 04/01/2024

Paramount Commercial Insurance Plans, Medicare Advantage Plans, and Paramount Advantage Medicaid

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   v) Psoriasis, when topical treatment alone has failed and a history of frequent psoriasis flares (continuous, long term > 1 year in duration) that require home therapy for suppression; or
   w) Cutaneous T-cell lymphoma including mycosis fungoides and Sézary syndrome, or
   x) Vitiligo when it affects:
      iii. The skin of the head and/or neck area, or
      iv. Other body areas in excess of 30% of skin surface
      and
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    d) Ongoing or long-term (i.e., necessary for greater than 4 months); or
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