Medical Policy

Photochemotherapy or Phototherapy for Dermatological Conditions in the Outpatient Setting

Policy Number: OCA 3.39
Version Number: 15
Version Effective Date: 03/01/16

Product Applicability

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
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<tbody>
<tr>
<td>✖️ New Hampshire Medicaid</td>
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<td>✖️ Senior Care Options ◊</td>
</tr>
</tbody>
</table>

Notes:

* Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.bmchp.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers photochemotherapy or phototherapy for specific dermatological disorders to be medically necessary when medical criteria are met and services are provided in an outpatient setting. Prior authorization is required for phototherapy or photochemotherapy for all dermatological conditions except for phototherapy when used to treat neonatal jaundice in the outpatient setting.

It will be determined during the Plan’s prior authorization process if the service is considered medically necessary for the requested indication. See the Plan’s policy, *Medically Necessary*, policy number OCA 3.14, for the product-specific definitions of medically necessary treatment.
Providers may contact Northwood at www.northwoodinc.com or by phone at 1-866-802-6471 to obtain information about policies and administrative guidelines related to durable medical equipment (e.g., light boxes) for these services. Requests for home phototherapy must be submitted to Northwood for review.

**Description of Item or Service**

**Laser Therapy:** Provides intense, targeted ultraviolet B (UVB) light to a limited area of psoriasis or vitiligo. Laser therapy provides the potential benefit of more rapid clinical response from the more targeted therapy, while avoiding the side effects of ultraviolet light exposure to unaffected skin. This laser therapy is usually provided by either an excimer laser or a pulsed dye laser.

**Photochemotherapy (PUVA):** Therapeutic use of ultraviolet A (UVA) radiation in combination with oral or topical administration of psoralen, a photosensitizing chemical. PUVA is generally used as a treatment for certain dermatologic conditions such as psoriasis and eczema. Treatment with these modalities may involve partial or whole-body exposure.

**Phototherapy:** Utilizes the exposure to UVB, UVA, or various combinations of UVB and UVA radiation. There are three (3) types of UVB radiation: narrowband and broadband in a light box and narrowband emitted or delivered by a laser. Phototherapy is generally used as a treatment for certain dermatological conditions such as eczema.

**Medical Policy Statement**

The Plan considers phototherapy or photochemotherapy to be medically necessary when the following criteria are met and prior authorization is obtained, as specified below in item A (for services that require Plan prior authorization) and item B (for services that do not require Plan prior authorization). When the service requires Plan authorization, **continued treatment requires prior authorization every three (3) months (unless otherwise specified); authorization for continued treatment requires documentation of improvement from the treatment in the member’s medical record.**

A. **Services Requiring Prior Authorization:**

ALL of the following applicable criteria must be met for a service that requires prior authorization, including PUVA (as specified below in item 1), phototherapy UVA and/or UVB (as specified below in item 2), or laser therapy/targeted UVB (as listed below in item 3):

1. **Photochemotherapy (PUVA):**

Office or clinic-based psoralens and ultraviolet A light (PUVA) treatments two (2) times per week for up to three (3) months are medically necessary when:
a. Conventional therapy has been tried for at least four (4) weeks and has failed, no acceptable first-line treatment is available, or the member cannot tolerate the side effects of first-line conventional therapy; AND

b. The member has at least ONE (1) of the following conditions, as specified below in items (1) through (17):

   (1) Chronic palmoplantar pustulosis; OR

   (2) Mycosis fungoides (cutaneous T-cell lymphoma); OR

   (3) Cutaneous manifestations of graft versus host disease; OR

   (4) Eosinophilic folliculitis and other pruritic eruptions of HIV infection; OR

   (5) Graft vs. host disease; OR

   (6) Granuloma annulare; OR

   (7) Morphea and localized skin lesions associated with scleroderma; OR

   (8) Necrobiosis lipoidica; OR

   (9) Photodermatoses; OR

   (10) Pityriasis lichenoides; OR

   (11) Severe lichen planus; OR

   (12) Severe parapsoriasis; OR

   (13) Severe refractory atopic dermatitis/eczema; OR

   (14) Severe refractory pruritis of polycythemia vera; OR

   (15) Severe urticaria pigmentosa (cutaneous mastocytosis); OR

   (16) Severely disabling psoriasis when at least ONE (1) of the following criteria is met, as specified below in item (a) or item (b):

      (a) Involves 5% or more of the member’s body surface area (BSA) and/or involves the member’s hands, feet, scalp, face, and/or neck; OR
(b) Psoriasis area and severity index (PASI) score is greater than 10; OR

(17) Vitiligo when at least ONE (1) of the following criteria is met, as specified below in item (a) or item (b):

(a) Involves 10% or more of the member’s body surface area (BSA); OR

(b) Involves the scalp, face, and/or neck; OR

2. **Phototherapy UVA and/or UVB:**

Office or clinic-based phototherapy with UVA and/or UVB up to three (3) times per week for up to three (3) months are medically necessary when:

a. Conventional therapy has been tried for at least four (4) weeks and has failed, no acceptable first-line treatment is available, or the member cannot tolerate the side effects of first-line conventional therapy; AND

b. The member has at least ONE (1) of the following conditions, as specified below in items (1) through (10):

(1) Atopic dermatitis/eczema; OR

(2) Eosinophilic folliculitis and other pruritic eruptions of HIV infection; OR

(3) Lichen planus; OR

(4) Parapsoriasis; OR

(5) Photodermatoses; OR

(6) Pityriasis lichenoides; OR

(7) Pityriasis rosea; OR

(8) Prurigo nodularis; OR

(9) Psoriasis when at least ONE (1) of the following criteria is met, as specified below in item (a) or item (b):

(a) Involves 5% or more of the member’s body surface area (BSA) and/or involves the member’s hands, feet, scalp, face, and/or neck; OR
(b) Psoriasis area and severity index (PASI) score is greater than 10; OR

(10) Vitiligo when at least ONE (1) of the following criteria is met, as specified below in item (a) or item (b):

(a) Involves 10% or more of the member’s body surface area (BSA); OR

(b) Involves the scalp, face, and/or neck; OR

3. Laser Therapy/Targeted UVB:

Office or clinic-based UVB excimer laser treatments are medically necessary when ALL of the following criteria are met, as specified below in items a and b:

a. Conventional therapy has been tried for at least four (4) weeks and has failed, no acceptable first-line treatment is available, or the member cannot tolerate the side effects of first-line conventional therapy; AND

b. The member has at least ONE (1) of the following conditions, as specified below in item (1) or item (2):

(1) Psoriasis when BOTH of the following criteria are met, as specified below in item (a) and item (b):

(a) Involves less than 5% of body surface area (BSA); AND

(b) Treatment for psoriasis is limited to no more than 15 treatments within a 6 month period; OR

(2) Vitiligo when BOTH of the following criteria are met, as specified below in item (a) and item (b):

(a) Involves less than 5% of body surface area (BSA); AND

(b) Treatment of vitiligo with laser therapy is limited to no more than 12 weeks with a review required for up to 12 additional treatments

B. Services That Do Not Require Prior Authorization:

Phototherapy for the treatment of neonatal jaundice does NOT require Plan prior authorization when the treatment is provided in an outpatient setting.
Limitations

1. Contraindications for Phototherapy or Laser Therapy/Targeted Phototherapy

   a. Absolute contraindications include a member with ONE (1) or more of the following known conditions, as specified below in items (1) through (3):

   (1) Lupus erythematosus; OR
   (2) Porphyria; OR
   (3) Xeroderma pigmentosum

   b. Relative contraindications include a member with ONE (1) or more of the following conditions, as specified below in items (1) through (4):

   (1) History of arsenic intake (e.g., Fowler solution); OR
   (2) History of melanoma or multiple nonmelanoma skin cancers (including basal cell cancer and squamous cell cancer); OR
   (3) Photosensitivity disorder; OR
   (4) Skin types I and II who tend to burn easily

2. Contraindications for PUVA Photochemotherapy

   a. Absolute contraindications include a member with ONE (1) or more of the following known conditions, as specified below in items (1) through (3):

   (1) Lupus erythematosus; OR
   (2) Porphyria; OR
   (3) Xeroderma pigmentosum

   b. Relative contraindications include a member with ONE (1) or more of the following, as specified below in items (1) through (9):

   (1) History of arsenic intake (e.g., Fowler solution); OR
   (2) History of melanoma or multiple nonmelanoma skin cancers; OR

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(3) Past negative experience and/or response to light therapy; OR

(4) Photosensitivity disorder; OR

(5) Skin prone to burning easily and a first-degree relative with a history of melanoma; OR

(6) Skin types I and II (who tend to burn easily); OR

(7) Pregnancy or nursing; OR

(8) History of treatment with cyclosporine or methotrexate; OR

(9) Severe liver disease (that could lead to toxic levels of psoralens)

3. The Plan considers photochemotherapy, phototherapy, or laser therapy for specific dermatological disorders to NOT be medically necessary for an indication unless specified in the medical criteria of the Medical Policy Statement section of this policy.

Definitions

**Actinic Dermatitis:** Dermatitis due to exposure to actinic radiation, such as that from the sun, ultraviolet waves, or x- or gamma radiation.

**Atopic Dermatitis (AD):** A common chronic skin disease characterized by itchiness, pruritus, and inflammation of the skin. Eczematous lesions are a hallmark of the disease, which have periods of exacerbations (flares) and/or remissions. In children, these lesions involve the face, neck, and extensor skin surface. In older children and adults, the lesions often involve lichenification, and are localized to the folds of the extremities. The disease may be exacerbated by a number of factors, including temperature, humidity, infections, food, allergens, microbial agents, and psychological stress. AD may have a significant impact on morbidity and quality of life including a decline in school attendance of affected children, as well as their caregivers and families.

**Body Surface Area (BSA):** The estimation of body surface area involvement for a dermatological condition. Hand or palm surface area (including fingers) is commonly used for the estimate, with an assumption that the size of a hand surface area represents 1% of the total body surface area. The use of hand surface area equating to 1% total body surface area is a standard method of assessment. The accuracy of determining the amount of dermatological involvement using BSA may vary by the patient’s gender, age (under-estimating women and children), and body mass index.

**Granuloma Annulare:** A chronic skin disease consisting of a rash with reddish bumps arranged in a circle or ring.
**Mycosis Fungoides (MF or Cutaneous T-Cell Lymphoma):** A type of non-Hodgkin lymphoma cancer of T cell origin that primarily develops in the skin, but can ultimately involve the lymph nodes, blood, and visceral organs. Patients with staged IA, IB, and IIA disease are considered to have early-stage disease, and those with stages IIB (tumor), III (erythroderma), and IV (pathologic nodes with or without viscera) have advanced-stage disease. Early stage (IA to IIA) disease consists of papules, patches, or plaques, with limited, if any, lymph node involvement and no visceral involvement.

**Prurigo Nodularis:** A chronic inflammatory skin disease with nodular itching lesions.

**Pruritus:** An unpleasant sensation of the skin that provokes the urge to scratch (i.e., itch). It is a characteristic feature of many skin diseases and an unusual sign of some systemic diseases. Pruritus may be localized or generalized and can occur as an acute or chronic condition. Itching lasting more than six (6) weeks is termed chronic pruritus.

**Psoriasis:** A chronic skin disease that is classically characterized by thickened, red areas of skin covered with silvery scales. The extent of skin involvement can range from discrete, localized areas to generalized body involvement. The joints, nails, and mucous membranes may also be affected with the disease.

**Psoriasis Area and Severity Index (PASI):** Categorizes severity of psoriasis based on the physician’s global assessment of the individual’s condition and an evaluation of the lesions by the characteristics of erythema, induration and scaling, and surface area affected. This score is most useful in patients with moderate to severe psoriasis.

**Vitiligo:** A disfiguring medical disease of unknown origin that causes destruction of melanocytes in the skin, mucous membranes, eyes, inner ear, and occasionally in hair bulbs. The loss of melanocytes alters both structure and function of these organs and results in the absence of pigment.

**Applicable Coding**

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.
Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

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<thead>
<tr>
<th>CPT Codes</th>
<th>Description: Codes Covered When Medically Necessary</th>
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<tr>
<td>96900</td>
<td>Actinotherapy (ultraviolet light)</td>
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<tr>
<td></td>
<td>(Plan note: Phototherapy)</td>
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<tr>
<td>96910</td>
<td>Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B</td>
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<tr>
<td>96912</td>
<td>Photochemotherapy; psoralens and ultraviolet A (PUVA)</td>
</tr>
<tr>
<td>96913</td>
<td>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)</td>
</tr>
<tr>
<td>96920</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm</td>
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<tr>
<td>96921</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm</td>
</tr>
<tr>
<td>96922</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm</td>
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**Clinical Background Information**

Ultraviolet (UV) light therapy, including phototherapy or photochemotherapy, is used for the treatment of certain dermatological conditions. It involves exposing an individual’s skin to ultraviolet A (UVA) or ultraviolet B (UVB) radiation using a specialized light source. Targeted laser therapy may also be used in very specific conditions, such as psoriasis that has not responded to standard therapies. Phototherapy and photochemotherapy are generally performed in a physician’s office or other outpatient setting. The use of phototherapy or photochemotherapy in children and pregnant women should be limited due to concerns over their long-term carcinogenic potential; these therapies can be useful treatment options for selected dermatological conditions with these populations, provided they are used under carefully controlled conditions.

**References**


Photochemotherapy or Phototherapy for Dermatological Conditions in the Outpatient Setting

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<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>Regulatory Approval: N/A Internal Approval: 06/25/03</td>
<td>06/25/03 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>Quality and Clinical Management Committee (Q&amp;CMC)</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13

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<th>Policy Revisions History</th>
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<tr>
<td>Review Date</td>
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<tr>
<td>12/06/05</td>
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<tr>
<td>02/06/07</td>
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<tr>
<td>02/19/08</td>
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### Policy Revisions History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Version</th>
<th>Date</th>
<th>Committee</th>
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<tr>
<td>07/01/12</td>
<td>Off cycle review for Well Sense Health Plan, reformatted Clinical Guideline Statement, updated coding, added reference to Northwood Policies for related DME.</td>
<td>Version 9</td>
<td>08/03/12:</td>
<td>MPCTAC</td>
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<td>09/13/12:</td>
<td>QIC</td>
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<tr>
<td>01/01/13</td>
<td>Revised title and Summary section, referenced <em>Medically Necessary</em> policy, reformatted Description of Item or Service section, updated references. Deleted HCPCS codes E0691, E0692, E0693, and E0694 from applicable code list. Updated language in Applicable Coding introductory paragraph and referenced Northwood, Inc., added Limitations section. Changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”</td>
<td>Version 10</td>
<td>01/16/13:</td>
<td>MPCTAC</td>
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<td>02/21/13:</td>
<td>QIC</td>
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<tr>
<td>08/14/13 and 08/15/13</td>
<td>Off cycle review for Well Sense Health Plan and merged policy format. Incorporate policy revisions dated 01/01/13 (as specified above) for the Well Sense Health Plan product; these policy revisions were approved by MPCTAC on 01/16/13 and QIC on 02/21/13 for applicable Plan products.</td>
<td>Version 11</td>
<td>08/14/13:</td>
<td>MPCTAC</td>
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<td>(electronic vote)</td>
<td>08/15/13: QIC</td>
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<tr>
<td>02/01/14</td>
<td>Review for effective date 06/01/14. Revised criteria in the Medical Policy Statement section and Limitations section. Updated Description of Item or Service, Definitions, Clinical Background Information, and References sections.</td>
<td>06/01/14</td>
<td>02/19/14:</td>
<td>MPCTAC</td>
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<td>02/26/14:</td>
<td>QIC</td>
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<td>01/01/15</td>
<td>Review for effective date 03/01/15. Updated code definitions in the Applicable Coding section. Revised References section.</td>
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<td>01/21/15:</td>
<td>MPCTAC</td>
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<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and corresponding notes. Revised the language in the Applicable Coding section.</td>
<td>01/01/16</td>
<td>11/18/15:</td>
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<td>Version 14</td>
<td>11/25/15:</td>
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<td>12/09/15:</td>
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<tr>
<td>11/25/15</td>
<td>Review for effective date 03/01/16. Revised criteria in the Medical Policy Statement and Limitations sections.</td>
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Policy Revisions History

| Updated references. |

Last Review Date

11/25/15

Next Review Date

11/01/16

Authorizing Entity

QIC

Other Applicable Policies

Medical Policy - *Medically Necessary*, policy number OCA 3.14

Disclaimer Information:

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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