

Medical Policy

Photochemotherapy or Phototherapy for Dermatological Conditions in the Outpatient Setting

Policy Number: OCA 3.39

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Product Applicability

All Plan⁺ Products

Well Sense Health Plan

- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan

- MassHealth
- Qualified Health Plans/ConnectorCare/Employer Choice Direct
- Senior Care Options \diamond

Notes:

⁺ Disclaimer and audit information is located at the end of this document.

\diamond 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 Plan medical criteria are met. An additional Plan prior authorization is not required for phototherapy or photochemotherapy provided to a member in an inpatient setting if the inpatient admission is medically necessary and has already been authorized by the Plan. Prior authorization is required for phototherapy or photochemotherapy provided in an outpatient setting (including office or clinic-based treatments) when used for ANY dermatological condition EXCEPT for phototherapy used for the treatment neonatal jaundice (i.e., neonate is a newborn infant under 28 days of age according to the World Health Organization).

Photochemotherapy or Phototherapy for Dermatological Conditions in the Outpatient Setting

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When medically necessary phototherapy is provided in an outpatient setting for the treatment of **neonatal jaundice**, the provider must bill with a Plan-specified, waived primary diagnosis code and corresponding procedure code for phototherapy (as documented in the Applicable Coding section of this policy) for the prior authorization requirement to be waived. Documentation of medically necessary services and appropriate member diagnosis must be included in the member's medical record even when prior authorization is not required.

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 therapies. **ALL 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

Medically necessary photochemotherapy and/or phototherapy treatment must be ordered by a treating provider knowledgeable about these modalities, and the treating provider has adequately informed the Plan member of the risks of treatment; associated staff must be sufficiently qualified and trained to administer the treatments, and the equipment must be FDA approved, safe, purpose-built, adequately maintained, and sufficiently monitored. The Plan considers phototherapy or photochemotherapy to be medically necessary when the following criteria are met and prior authorization is obtained for services provided in outpatient setting (including office or clinic-based treatments), 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

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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 are considered medically necessary when ALL of the following criteria are met, as specified below in items a through d:

- a. Member is 10 years of age or older on the date of service; AND
- b. Conventional therapy clinically appropriate for the member's condition (as determined by the treating provider) has been tried for at least four (4) weeks and the conventional therapy has failed, no acceptable first-line therapy is available for the member's condition, and/or the member cannot tolerate the side effects of the conventional therapy (with conventional therapy including but not limited to topical corticosteroids, topical calcineurin inhibitors, systemic steroids, antihistamines, and/or immunomodulatory drugs such as methotrexate); AND
- c. Office or clinic-based psoralens and ultraviolet A light (PUVA) treatments will be provided up to two (2) times per week for up to three (3) consecutive, calendar months for a member with either a new onset of symptoms or exacerbation of symptoms from the member's baseline condition;‡ AND

‡ Note: Plan Medical Director review is required for treatment beyond these established guidelines for frequency and/or duration of treatment for the same episode of care (as stated in the Limitations section of this policy).

- d. 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

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- (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

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2. Phototherapy UVA and/or UVB:

Office or clinic-based phototherapy treatments with UVA and/or UVB are considered medically necessary when ALL of the following criteria are met, as specified below in items a through d:

- a. Member is 10 years of age or older on the date of service (unless phototherapy is used for the treatment of neonatal jaundice); AND
- b. Conventional therapy clinically appropriate for the member's condition (as determined by the treating provider) has been tried for at least eight (8) consecutive, calendar weeks and the conventional therapy has failed, no acceptable first-line therapy is available for the member's condition, and/or the member cannot tolerate the side effects of the conventional therapy (with conventional therapy including but not limited to topical corticosteroids, systemic steroids, antihistamines, and/or immunomodulatory drugs such as methotrexate);
- c. Office or clinic-based phototherapy treatments with UVA and/or UVB will be provided up to three (3) times per week for up to three (3) consecutive, calendar months for a member with either a new onset of symptoms or exacerbation of symptoms from the member's baseline condition;€ AND

€ Note: Plan Medical Director review is required for treatment beyond these established guidelines for frequency and/or duration of treatment for the same episode of care (as stated in the Limitations section of this policy).

- d. 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

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- (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 considered medically necessary when ALL of the following criteria are met, as specified below in items a through d:

- a. Member is 10 years of age or older on the date of service; AND
- b. Conventional therapy clinically appropriate for the member's condition (as determined by the treating provider) has been tried for at least eight (8) consecutive, calendar weeks and has failed, no acceptable first-line treatment is available for the member's condition, and/or the member cannot tolerate the side effects of first-line conventional therapy; AND
- c. Office or clinic-based UVB excimer laser treatments will be provided to a member with either a new onset of symptoms or exacerbation of symptoms from the member's baseline condition;
- d. 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

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

£ Note: Plan Medical Director review is required for treatment beyond these established guidelines for frequency and/or duration of treatment for the same episode of care for psoriasis (as stated in the Limitations section of this policy).

- (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 consecutive, calendar weeks with a review required for up to 12 additional treatments (and all applicable criteria must be met for both the initial 12 consecutive, calendar weeks of treatment and 12 additional treatments beyond the initial authorization).±

± Note: Plan Medical Director review is required for treatment beyond these established guidelines for frequency and/or duration of treatment for the same episode of care for vitiligo (as stated in the Limitations section of this policy).

B. Services That Do Not Require Prior Authorization:

Medically necessary phototherapy used for the treatment of neonatal jaundice does NOT require Plan prior authorization when provided in an outpatient setting and Plan guidelines are met. The provider must bill with a Plan-specified, waived primary diagnosis code and corresponding procedure code for phototherapy (as documented in the Applicable Coding section of this policy) for the prior authorization requirement to be waived. Documentation of medically necessary services and appropriate member diagnosis must be included in the member's medical record even when prior authorization is not required. (An additional Plan prior authorization is not required for phototherapy used for the treatment of neonatal jaundice in an inpatient setting if the inpatient admission has already been authorized by the Plan.)

Limitations

1. Plan Medical Director review is required for office or clinic-based psoralens and ultraviolet A light (PUVA) treatments requested for a Plan member when treatment will be provided more frequently than two (2) times per week and/or extending beyond three (3) consecutive, calendar months of treatment for the same episode of care (i.e., a new onset of symptoms or

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exacerbation of symptoms from the member's baseline condition). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date, verification of the clinical effectiveness of PUVA treatment (including photographic documentation, if requested), and an individualized treatment plan (including expected duration of PUVA treatment for this episode of care).

2. Plan Medical Director review is required for office or clinic-based phototherapy with UVA and/or UVB for a Plan member when treatment will be provided more frequently than three (3) times per week and/or extending beyond three (3) consecutive, calendar months of treatment for the same episode of care (i.e., a new onset of symptoms or exacerbation of symptoms from the member's baseline condition). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date, verification of the clinical effectiveness of phototherapy with UVA and/or UVB (including photographic documentation, if requested), and an individualized treatment plan (including expected duration of phototherapy with UVA and/or UVB treatment for this episode of care).
3. Plan Medical Director review is required for office or clinic-based UVB excimer laser treatments for a Plan member with psoriasis when treatment will be provided beyond 15 treatments and/or treatments extending beyond a 6 consecutive, calendar month period for the same episode of care (i.e., a new onset of symptoms or exacerbation of symptoms from the member's baseline condition). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date for psoriasis, verification of the clinical effectiveness of UVB excimer laser treatments (including photographic documentation, if requested), and an individualized treatment plan (including expected duration of UVB excimer laser treatments for this episode of care).
4. Plan Medical Director review is required for office or clinic-based UVB excimer laser treatments for a Plan member with vitiligo when treatment when Plan criteria are not met (for the initial authorization up to 12 consecutive, calendar weeks or the additional 12 treatments) or for treatments of vitiligo beyond the initial treatment up to 12 consecutive, calendar weeks and 12 additional treatments for the same episode of care (i.e., a new onset of symptoms or exacerbation of symptoms from the member's baseline condition). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date for vitiligo, verification of the clinical effectiveness of UVB excimer laser treatments (including photographic documentation, if requested), and an individualized treatment plan (including expected duration of UVB excimer laser treatments for this episode of care).

5. Contraindications for Phototherapy or Laser Therapy/Targeted Phototherapy

a. **Absolute Contraindications for Phototherapy or Laser Therapy/Targeted Phototherapy:**

Absolute contraindications include a member with ONE (1) or more of the following known conditions/contraindications, as specified below in items (1) through (7):

- (1) Age 9 years of age or less on the date of service (unless the phototherapy is used for the treatment of neonatal jaundice in the outpatient setting; phototherapy does NOT require Plan prior authorization when provided in an outpatient setting to treat neonatal jaundice); OR
- (2) Basal cell nevus syndrome; OR
- (3) Lupus erythematosus; OR
- (4) Personal history or presence of melanoma or presence of nonmelanoma skin cancer (including basal cell cancer and squamous cell cancer); OR
- (5) Porphyria; OR
- (6) Pregnancy; OR
- (7) Xeroderma pigmentosum.

b. **Relative Contraindications for Phototherapy or Laser Therapy/Targeted Phototherapy:**

Plan Medical Director review is required for a member with a relative contraindication to phototherapy or laser therapy/targeted phototherapy. Applicable clinical information must be submitted to the Plan Medical Director by the treating provider and include the member's medical history, duration of symptoms, results of physical examination, treatment to date (including documentation that other therapeutic options for the member's condition have been utilized with negative or ineffective outcomes), and the member's individualized treatment plan. Relative contraindications include a member with ONE (1) or more of the following conditions/contraindications, as specified below in items (1) through (12):

- (1) Age 10 to 17 years old on the date of service;∞ OR

∞ Note: See absolute contraindications for a member age 9 or younger on the date of service.

- (2) Albinism; OR

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- (3) Aphakia; OR
- (4) Cataracts; OR
- (5) Family history of melanoma; OR
- (6) Personal history of arsenic intake (e.g., Fowler solution); OR
- (7) Personal history of immunological therapy, contact with photosensitive substances, and/or a treatment with photosensitizing medications; OR
- (8) Personal history of ionizing radiation therapy; OR
- (9) Personal history of nonmelanoma skin cancer (including basal cell cancer and/or squamous cell cancer) and all other therapeutic options have been exhausted); OR
- (10) Photosensitivity disorder; OR
- (11) Phototherapy treatment of the genital area; OR
- (12) Skin type I or type II who tend to burn easily.

6. Contraindications for PUVA Photochemotherapy

a. **Absolute contraindications for Photochemotherapy (PUVA):**

Absolute contraindications include a member with ONE (1) or more of the following known conditions/contraindications, as specified below in items (1) through (10):

- (1) Age 9 years of age or younger on the date of service; OR
- (2) Albinism; OR
- (3) Basal cell nevus syndrome; OR
- (4) Lupus erythematosus; OR
- (5) Personal history or presence of melanoma; OR
- (6) Photosensitivity disorder; OR
- (7) Porphyria; OR

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- (8) Pregnancy or breastfeeding (since psoralen is a pregnancy class C medication); OR
- (9) Presence of nonmelanoma skin cancer (including basal cell cancer and squamous cell cancer); OR
- (10) Xeroderma pigmentosum.

b. Relative Contraindications for Photochemotherapy (PUVA):

Plan Medical Director review is required for a member with a relative contraindication to photochemotherapy (PUVA). Applicable clinical information must be submitted to the Plan Medical Director by the treating provider and include the member's medical history, duration of symptoms, results of physical examination, treatment to date (including documentation that other therapeutic options for the member's condition have been utilized with negative or ineffective outcomes), and the member's individualized treatment plan. Relative contraindications include a member with ONE (1) or more of the following conditions/contraindications, as specified below in items (1) through (7):

- (1) Albinism; OR
- (2) Aphakia; OR
- (3) Cataracts; OR
- (4) Past negative experience and/or response to light therapy; OR
- (5) Personal history of arsenic intake (e.g., Fowler solution); OR
- (6) Personal history of nonmelanoma skin cancer(s); OR
- (7) Personal history of treatment with cyclosporine or methotrexate; OR
- (8) Skin prone to burning easily and a first-degree relative with a history of melanoma; OR
- (9) Skin types I and II (who tend to burn easily); OR
- (10) Severe liver disease (that could lead to toxic levels of psoralens); OR
- (11) Severe myocardial disease or other condition likely to make treatment (or standing if required in the treatment unit for a prolonged period) hazardous or difficult.

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7. 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.

Albinism: A group of genetic disorders in which there is partial or total lack of the pigment melanin in the eyes, skin, and hair with significant light sensitivity.

Aphakia: Absence of the lens of an eye, occurring congenitally or as a result of trauma or surgery. An eye that has undergone cataract surgery without implantation of an intraocular lens is aphakic; without a natural or artificial lens, images are defocused and the eye is functionally blind at all distances.

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.

Jaundice: A symptom of a number of different diseases and disorders of the liver, gallbladder, and hemolytic blood disorders; symptoms include yellowness of skin, sclerae (whites of the eyes), mucous membranes, and excretions due to hyperbilirubinemia and deposition of bile pigments. Neonatal jaundice (or hyperbilirubinemia) is an elevated level of bilirubin in the blood, a by-product of the breakdown of red blood cells. Most cases of newborn jaundice resolve without medical intervention within two to three weeks but should be monitored by a health care provider. If bilirubin levels are extremely high, the infant may be treated for several days with phototherapy in the hospital or home setting. The bilirubin in the baby's skin absorbs the light and is changed to a

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substance that can be excreted in the urine. The baby's eyes are shielded to prevent optic nerves from absorbing too much light.

Kernicterus: A type of brain damage due to excessive bilirubin in the blood.

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. Mild disease can be defined as body surface area (BSA) ≤ 10 and psoriasis area and severity index (PASI) ≤ 10 and dermatology life quality index (DLQI) ≤ 10 and moderate to severe psoriasis as (BSA > 10 or PASI > 10) and DLQI > 10 . Special clinical situations may change mild psoriasis to moderate to severe including involvement of visible areas or severe nail involvement.

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 States by the National Center for Health Statistics (NCHS) of the Centers for

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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.

CPT Codes	Description: Codes covered when medically necessary for phototherapy, photochemotherapy, or laser treatment, as specified below.
96900	Actinotherapy (ultraviolet light) Plan note: Code used for phototherapy
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 4-8 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

CPT Codes	Description: Code covered for medically necessary phototherapy used to treat neonatal jaundice, as specified below.
96900	Actinotherapy (ultraviolet light) Plan note: Code used for phototherapy. This procedure code must be billed with one (1) of the primary diagnosis codes listed below for the prior authorization requirement to be waived for phototherapy used to treat neonatal jaundice.

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ICD-10 Codes	Description: No prior authorization is required for any of the following waived, primary diagnosis codes for medically necessary phototherapy used to treat neonatal jaundice, as specified below. (The waived, primary diagnosis code must be documented on the claim form with the covered procedure code for phototherapy).
P58.0	Neonatal jaundice due to bruising
P58.1	Neonatal jaundice due to bleeding
P58.2	Neonatal jaundice due to infection
P58.3	Neonatal jaundice due to polycythemia
P58.41	Neonatal jaundice due to drugs or toxins transmitted from mother
P58.42	Neonatal jaundice due to drugs or toxins given to newborn
P58.5	Neonatal jaundice due to swallowed maternal blood
P58.8	Neonatal jaundice due to other specified excessive hemolysis
P58.9	Neonatal jaundice due to excessive hemolysis, unspecified
P59.0	Neonatal jaundice associated with pre term delivery
P59.1	Inspissated bile syndrome
P59.20	Neonatal jaundice from unspecified hepatocellular damage
P58.29	Neonatal jaundice from other hepatocellular damage
P59.3	Neonatal jaundice from breast milk inhibitor
P59.8	Neonatal jaundice from other specified causes
P59.9	Neonatal jaundice, Unspecified

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; dermatologists or radiation oncologists prescribe the form of therapy as well as the dose, frequency, and duration of treatment. 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. Patients should be informed of the benefits and risks of phototherapy versus the increased risks of skin cancer

At the time of the Plan's most recent policy review, no clinical guidelines were found from the Centers for Medicare & Medicaid Services (CMS) specifically for phototherapy or photochemotherapy for the treatment of a dermatological condition. According to national coverage determination (NCD) 250.1, CMS covers the following conventional treatment for psoriasis for Medicare beneficiaries: Topical application of steroids or other drugs, ultraviolet light (actinotherapy), and/or coal tar alone or in combination with ultraviolet B light (Goeckerman treatment). In addition CMS covers PUVA therapy when used for the treatment of intractable, disabling psoriasis, but only after the psoriasis has not

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responded to more conventional treatment; reimbursement for PUVA therapy is limited to amounts paid for other types of photochemotherapy (ordinarily, payment is not be allowed for more than 30 days of treatment, unless improvement is documented). Verify applicable CMS criteria are in effect for the specified service and the indication for treatment in an NCD or local coverage determination (LCD) on the date of the prior authorization request for a Senior Care Options member.

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Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Approved by
Regulatory Approval: N/A Internal Approval: 06/25/03	06/25/03 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)	Quality and Clinical Management Committee (Q&CMC)

*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

*Effective Date for the Senior Care Options Product(s): 01/01/16

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
12/06/05	Updated clinical coverage criteria.	Version 2	12/06/05: Q&CMC
02/06/07	Updated references and template.	Version 3	02/06/07: Q&CMC
02/19/08	Revised clinical criteria effective July 1, 2008.	07/01/08 Version 4	02/19/08: MPCTAC 02/26/08: Utilization Management Committee (UMC) 03/12/08: QIC
12/01/08	No changes.	Version 5	01/27/09: MPCTAC 01/27/09: UMC 02/25/09: QIC

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Policy Revisions History			
12/01/09	No changes.	Version 6	12/23/09: MPCTAC 02/24/10: QIC
12/01/10	Updated clinical criteria and added limitations for phototherapy and photochemotherapy, updated coding and references.	Version 7	12/28/10: MPCTAC 01/26/11: QIC
12/01/11	Updated references, added definition for atopic dermatitis.	Version 8	12/12/11: MPCTAC 12/20/11: QIC
07/01/12	Off cycle review for Well Sense Health Plan, reformatted Clinical Guideline Statement, updated coding, added reference to Northwood Policies for related DME.	Version 9	08/03/12: MPCTAC 09/13/12: QIC
01/01/13	Revised title and Summary section, referenced <i>Medically Necessary</i> 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.	Version 10	01/16/13: MPCTAC 02/21/13: QIC
08/14/13 and 08/15/13	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.	Version 11	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
02/01/14	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.	06/01/14 Version 12	02/19/14: MPCTAC 02/26/14: QIC
01/01/15	Review for effective date 03/01/15. Updated code definitions in the Applicable Coding section. Revised References section.	03/01/15 Version 13	01/21/15: MPCTAC 02/11/15: QIC

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Policy Revisions History			
11/25/15	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.	01/01/16 Version 14	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
11/25/15	Review for effective date 03/01/16. Revised criteria in the Medical Policy Statement and Limitations sections. Updated references.	03/01/16 Version 15	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
11/01/16	Review for effective date 03/01/17. Revised criteria in the Medical Policy Statement and Limitations sections. Added ICD-10 primary diagnosis codes for neonatal jaundice with a waived prior authorization requirement for phototherapy. Added Plan notes to the Applicable Coding section. Administrative changes made to the Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	03/01/17 Version 16	11/16/16: MPCTAC 12/14/16: QIC

Last Review Date

11/01/16

Next Review Date

11/01/17

Authorizing Entity

QIC

Other Applicable Policies

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

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Reference to Applicable Laws and Regulations

78 FR 48164-69. Centers for Medicare & Medicaid Services (CMS). Medicare Program. Revised Process for Making National Coverage Determinations. August 7, 2013. Accessed at:

<https://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf>

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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