n05632

Home Phototherapy Units for the Treatment of Skin Conditions

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS) Utilization Management (UM) department, applies review guidelines for determinations involving medical necessity for when it is medically appropriate to utilize home phototherapy units for the treatment of skin conditions.

Policy Detail:

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, or Individual and Family Plan to determine eligibility and coverage because Employer Group/Plan Sponsor and government contracts may vary. NHIC follows Medicare's National/Local (Wisconsin area) Coverage Determinations for its Medicare Advantage membership.

Procedure Detail:

I. Description
   - A. Phototherapy is the administration of artificial UV light for the treatment of skin conditions. This policy defines the medical necessity indications Network Health will allow for home phototherapy units for the treatment of skin conditions.

II. Medical Indications/Criteria
   - A. Network Health follows MCG guideline Phototherapy, Skin ACG: A-0255 (AC) for in office phototherapy requests received.
   - B. Network Health covers the use of an ultraviolet B (UVB) home phototherapy device as medically necessary for individuals who meet the above MCG criteria for office-based phototherapy and photochemotherapy.

III. Coverage
   - A. NHP/NHIC/NHAS may extend coverage for home phototherapy units as medically necessary for the indications as noted in this policy.
   - B. In the absence of a CMS National or Local Coverage Determination, NHP/NHIC/NHAS follows the criteria within the policy for application to its Medicare Advantage membership.

IV. Limitations/Exclusions
   - A. Network Health does not cover the use of an ultraviolet A (UVA) phototherapy device in the home setting as this use is considered not medically necessary.

B. Network Health considers home phototherapy units as not medically necessary for any other indication not meeting the criteria outlined above.

V. References

A. Anderson, K.L, Feldman, S.R. A guide to prescribing home phototherapy for patients with psoriasis: the appropriate patient, the type of unit, the treatment regimen, and the potential obstacles. *Journal AM AC Dermatol.* 2015; 868-882.

B. Koek, M.B, Buskens, E, VanWeelden, H, Steegmans, P, Bruijnzell-Koomen, C, Sigurdsson, V. Home versus outpatient ultraviolet B phototherapy for mild to severe psoriasis: pragmatic multicenter randomized controlled non -inferiority trial (PLUTO study). BMJ 2009;338: b1542

C. MCG, Ambulatory Care 29th edition, Phototherapy, Skin ACG: A-0255 (AC)

CPT Codes

E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 2 square feet or less
E0692	Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 4-foot panel
E0693	Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 6-foot panel
E0694	Ultraviolet multidirectional light therapy system in 6-foot cabinet, includes bulbs/lamps, timer, and eye protection
	*CPT codes are subject to change as codes are retired or new ones developed, the CPT code list may not be all inclusive.

Regulatory Citations:

UM 2

Related Documents:

Disclaimer:

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e. Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only.

Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

Origination Date:	Approval Date:	Next Review Date:
06/19/2018	04/17/2025	04/17/2026
Regulatory Body: NCQA	**Approving Committee:** Utilization Management Committee	
Department of Ownership: Utilization Management		**Revision Number:** 8

Revision Reason:

7/19/18- new policy developed
05/16/2019- annual review
4/16/2020 annual review
4/15/2021-annual review, minor grammatical & formatting updates, CPT codes added, removed criteria to demonstrate OP is beneficial & expected to be long term.
04/21/2022 - annual review, minor grammatical and formatting updates. (Approved 04/21/22 by Medical Policy Committee) Approved by Medical Policy Committee on 04/21/2022
06/15/2023 – annual review-consent agenda, ETF document name changed to reflect current naming convention
4/18/2024- annual review, minor grammar updates, references reviewed and updated, CPT/HCPCS codes reviewed.
04/17/2025- Annual review was completed. Minor grammatical changes were made. References were reviewed and updated. A CPT/HCPCS code review was conducted without changes made. Approved at UM Committee 4/17/2025.