Name of Policy:  
Phototherapy for the Treatment of Skin Disorders

Policy #: 301  
Category: Medical/DME

Background:  
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
Description of Procedure or Service:
Phototherapy is defined as the exposure to nonionizing radiation for therapeutic benefit. It may involve exposure to ultraviolet A (UVA), ultraviolet B (UVB) or various combinations of UVA and UVB radiation. In contrast, photochemotherapy or psoralens in conjunction with ultraviolet A (PUVA), is the therapeutic use of radiation in combination with a photosensitizing chemical. Treatment with these modalities may involve partial or whole-body exposure.

Photochemotherapy has been used for a large number of skin diseases, but confirmed data of its usefulness is available in only a relatively few.

Light therapy for vitiligo includes both targeted phototherapy and photochemotherapy with psoralen plus ultraviolet A (PUVA). Targeted phototherapy describes the use of ultraviolet light that can be focused on specific body areas or lesions. PUVA uses a psoralen derivative in conjunction with long wavelength ultraviolet A (UVA) light (sunlight or artificial) for photochemotherapy of skin conditions.

Vitiligo is an idiopathic skin disorder that causes depigmentation of sections of skin, most commonly on the extremities. Depigmentation occurs because melanocytes are no longer able to function properly. The cause of vitiligo is unknown; it is sometimes considered to be an autoimmune disease. The most common form of the disorder is nonsegmental vitiligo (NSV) in which depigmentation is generalized, bilateral, symmetrical, and increases in size over time. In contrast, segmental vitiligo (SV), also called asymmetric or focal vitiligo, covers a limited area of skin. The typical natural history of vitiligo involves stepwise progression with long periods in which the disease is static and relatively inactive, and relatively shorter periods in which areas of pigment loss increase.

There are numerous medical and surgical treatments aimed at decreasing disease progression and/or attaining repigmentation. Topical corticosteroids, alone or in combination with topical vitamin D3 analogs, is a common first-line treatment for vitiligo. Alternative first-line therapies include topical calcineurin inhibitors, systemic steroids, and topical antioxidants.

Treatment options for vitiligo recalcitrant to first-line therapy include, among others, PUVA and targeted light therapy. PUVA uses a psoralen derivative in conjunction with long wavelength ultraviolet A light (sunlight or artificial) for photochemotherapy of skin conditions. Psoralens are tricyclic furoucoumarin that occur in certain plants and can also be synthesized. They are available in oral and topical forms. Oral PUVA is generally given 1.5 hours before exposure to UVA radiation. Topical PUVA therapy refers to directly applying the psoralen to the skin with subsequent exposure to UVA light. With topical PUVA, UVA exposure is generally administered within 30 minutes of psoralen application.

Targeted light therapy is also being investigated. Potential advantages of targeted phototherapy include the ability to use higher treatment doses and to limit exposure to surrounding tissue. Original NB-UVB devices consisted of a Phillips TL-01 fluorescent bulb with a maximum wavelength (lambda max) at 311 nm. Subsequently, xenon chloride (XeCl) lasers and lamps were developed as targeted UVB treatment devices; they generate monochromatic or very NB radiation with a lambda max of 308 nm. Targeted phototherapy devices are directed at specific
lesions or affected areas, thus limiting exposure to the surrounding normal tissues. They may therefore allow higher dosages compared with a light box, which could result in fewer treatments.

Refer to policy# 009, Light Therapy for Psoriasis for phototherapy treatment of psoriasis.

Policy:
Effective for dates of service on or after May 21, 2016:
Ultraviolet A or B therapy meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage in the treatment of the following conditions:
- Atopic dermatitis
- Chronic urticaria
- Eczema
- Lichen planus
- Mycosis fungoides (cutaneous T-cell lymphoma)
- Pityriasis lichenoides
- Pityriasis rosea
- Pruritus of renal failure
- Vitiligo
- Localized scleroderma

Ultraviolet B with the addition of topical coal tar (also known as Goeckerman treatment) or petrolatum meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for severe psoriasis (defined as psoriasis that affects more than 10% of the body surface area).

Ultraviolet B with the addition of topical coal tar (also known as Goeckerman treatment) or petrolatum does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage and is considered investigational for all other indications.

Ultraviolet B light therapy administered in the home meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage of the following conditions and when conducted under a physician’s supervision with regularly scheduled exams:
- Atopic dermatitis-mild to moderate forms when standard treatment has failed,
- Lichen planus,
- Mycosis fungoides,
- Pityriasis lichenoides,
- Pruritus of hepatitis disease,
- Pruritus of renal failure,
- Severe atopic dermatitis.

Ultraviolet B light therapy administered in the home does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for conditions not listed above.
**PUVA therapy meets** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage of the following conditions:
- Acute/chronic pityriasis lichenoides;
- Atopic dermatitis;
- Eczema;
- Lichen planus;
- Mycosis fungoides (cutaneous T-cell lymphoma);
- Vitiligo.

**Excimer laser treatment of vitiligo of the face, neck, abdomen, back and/or proximal limbs meets** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage **up to three sessions per week for 12 weeks.**

**Excimer laser treatment of vitiligo of the distal limbs and bony prominences (i.e. fingers, wrists, elbows, knees) does not meet** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage.

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**Effective for dates of service prior to May 21, 2016:**

**Ultraviolet A or B therapy meets** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage in the treatment of the following conditions:
- Atopic dermatitis
- Chronic urticaria
- Eczema
- Lichen planus
- Mycosis fungoides (cutaneous T-cell lymphoma)
- Pityriasis lichenoides
- Pityriasis rosea
- Pruritus of renal failure
- Vitiligo
- Localized scleroderma

**Ultraviolet B light therapy administered in the home meets** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage of the following conditions and when conducted under a physician’s supervision with regularly scheduled exams:
- Atopic dermatitis-mild to moderate forms when standard treatment has failed
- Lichen planus
- Mycosis fungoides
- Pityriasis lichenoides
- Pruritus of hepatitis disease
- Pruritus of renal failure
- Severe atopic dermatitis
Ultraviolet B light therapy administered in the home does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for conditions not listed above.

PUVA therapy meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage of the following conditions:
- Acute/chronic pityriasis lichenoides
- Atopic dermatitis
- Eczema
- Lichen planus
- Mycosis fungoides (cutaneous T-cell lymphoma)
- Vitiligo

Excimer laser treatment of vitiligo of the face, neck, trunk, abdomen, back and/or proximal limbs meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage up to three sessions per week for 12 weeks.

Excimer laser treatment of vitiligo of the distal limbs and bony prominences (i.e. fingers, wrists, elbows, knees) does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage.

Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administer benefits based on the member’s contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:
Ultraviolet treatments are given with different wavelengths, depending on the condition and response to treatment. Broad band UVB (290-320nm), narrow band 311-nm UVB, PUVA (psoralen with UVA 320-400nm) and UVA1 (340 to 400nm) are available. Ultraviolet wavelengths cause erythema, desquamation, and pigmentation and may cause a temporary suppression of basal cell mitosis followed by a rebound increase in cell turnover. Both forms of UVB and PUVA are used for psoriasis and vitiligo, but other conditions such as nummular and atopic dermatitis, pruritus due to uremia, and cutaneous T-cell lymphoma are treated with this therapy. High-dose UVA-1 is used to treat atopic dermatitis, localized scleroderma, and mastocytosis. Common minor toxicities associated with PUVA include erythema, pruritus, irregular pigmentation and gastrointestinal tract symptoms; these generally can be managed by altering the dose of psoralen or UV light. Potential long-term effects include photoaging and skin cancer, particularly squamous cell carcinoma (SCC) and possibly malignant melanoma. The risk of skin cancer has been found to be related to the lifetime cumulative exposure to oral PUVA and may be higher in people with lighter skin types. For example, one study found that patients treated with at least 337 PUVA treatments had at least a 100-fold increase in risk of SCC.
compared to general population incidence rates. In addition, the risk of malignancy was nearly three times higher in individuals with Fitzpatrick skin Types I and II, compared to those with Types III and IV. Thus, an attempt is made to reduce the total exposure, especially in lighter skin types, such as limiting the number of treatments and/or avoiding maintenance treatment. There is also a concern from animal studies about a potential risk of cataract development and eye protection is recommended.

In some cases, UVB phototherapy may be transitioned to home use if the individual has extensive, widespread disease (e.g., psoriasis) that is going to require long-term use, and the phototherapy has been proven to be effective. Home devices emitting predominantly UVB phototherapy are used primarily for the treatment of psoriasis and require that the patient be motivated, reliable, and adherent to instructions, able to administer the treatment correctly, keep records of exposure, and attend regular follow-up visits.

The effectiveness of excimer laser therapy is attributed to the induction and secretion of cytokines, T-cell mediated apoptosis or immunomodulatory mechanisms. It is also hypothesized that inactive melanocytes in the outer root sheath of the hair follicles are stimulated to proliferate and migrate by the irradiation and thus reproduce repigmentation. This theory helps explain the ineffectiveness of excimer laser treatments on bony prominences as there are fewer hair follicles on these areas. The use of high cumulative energy doses needed to treat these areas increases the risk of UV-induced carcinogenesis.

**Vitiligo**

The most appropriate comparison for targeted phototherapy and oral psoralens with ultraviolet A (PUVA) is narrowband ultraviolet B (NB-UVB), which is considered a standard treatment for active and/or widespread vitiligo based on efficacy and safety.

In 2015, Whitton et al published an updated Cochrane review of randomized controlled trials (RCTs) on treatments for vitiligo. The investigators searched the literature through October 2013 and identified twelve trials on laser light therapy. Six trials evaluated the combination of laser light devices and a topical therapy and two evaluated the combination of laser devices and surgical therapy. Three trials compared regimens of laser monotherapy. The remaining trial compared a helium neon laser and a 290 to 320 nm broadband ultraviolet B (UVB) fluorescent lamp. Due to heterogeneity across studies, the Cochrane investigators did not pool findings of the studies on laser therapy for vitiligo. In most trials, all groups received laser light treatment, alone or as part of combination therapy, and thus the effect of targeted phototherapy could not isolated.

In 2015, Sun et al published a systematic review of RCTs that focused on treatment of vitiligo with the 308 nm excimer laser. Review authors identified seven RCTs with a total of 390 patients. None of the studies were conducted in the United States; five were from Asia. Three of the trials compared the excimer laser with an excimer lamp, and four studies compared the excimer laser with narrowband (NB)-UVB. The four studies with the comparison with NB-UVB are of greatest interest to this review. However, two of these were not published in English, and one had a sample size of only 14 patients. The fourth study, published by Yang et al in 2010, did not report efficacy outcomes such as clinical response rate or repigmentation rate. Instead, the investigators reported on the proportion of patients with various types of repigmentation.
perifollicular, marginal, diffuse, or combined. Repigmentation rates did not differ significantly between groups treated with the excimer laser versus NB-UVB. The authors of the systematic review conducted a meta-analysis of the two studies that were not published in English; thus, results cannot be verified. They reported that the likelihood of a minimum 50% repigmentation rate was significantly higher with the excimer laser compared with NB-UVB (risk ratio, 1.39, 95% confidence interval [CI], 1.05 to 1.85). Review authors also stated that, in qualitative analysis, neither of these studies showed significant benefit of the excimer laser for achieving a minimum 75% repigmentation rate.

A 2016 systematic review identified 3 studies that compared targeted phototherapy with a 308 nm excimer lamp to NB-UVB and 3 studies that compared the excimer laser to the excimer lamp. No differences between the excimer lamp and NB-UVB were identified for the outcome of 50% or greater repigmentation (RR=1.14; 95% CI, 0.88 to 1.48). For repigmentation of 75% or greater, only 2 small studies were identified and the relative risk was 1.81 (95% CI, 0.11 to 29.52), showing a lack of precision in the estimate. For the 3 studies that compared the excimer lamp to the excimer laser, there were no significant differences between the treatments for either 50% or greater repigmentation (RR=0.97; 95% CI, 0.84 to 1.11) or 75% or greater repigmentation (RR=0.96; 95% CI, 0.71 to 1.30). All of the treatments were most effective in lesions located on the face, with the worst response being lesions on the extremities. There was some evidence of an increase in adverse events such as blistering with targeted phototherapy.

One of the few trials comparing laser therapy to an alternative treatment was published in 2012 by Nistico et al. This was a nonblinded RCT that included 53 patients with localized and generalized vitiligo. Patients were randomly assigned to one of three treatments for 12 weeks: (1) Excimer laser plus vitamin E (n=20); (2) excimer laser plus topical 0.1% tacrolimus ointment and vitamin E (n=20); and (3) vitamin E only (control group, n=13). All patients in the two excimer laser groups completed treatment; one patient in the control group dropped out. Before and after treatment, two independent clinicians rated clinical response; 51% to 75% repigmentation was considered a “good” response and greater than 75% repigmentation was considered an ‘excellent’ response. The proportion of patients with a good or excellent response was 11 (55%) of 20 in the laser plus vitamin E group, 14 (70%) of 20 in the laser E plus tacrolimus plus vitamin E group, and 0 in the control group. The rate of good or excellent response did not differ significantly between the groups that received excimer laser therapy with and without topical treatment (p=0.36). The response rate was significantly better in both groups receiving laser treatment compared with the control group (p<0.001).

A number of RCTs have evaluated targeted phototherapy for treating vitiligo. Studies tended to have small sample sizes, and few were designed to isolate the effect of laser therapy. Moreover, studies were heterogeneous e.g., different interventions or combinations of interventions and different comparison interventions. These characteristics make it difficult to pool study findings or to draw conclusions about the efficacy of targeted phototherapy for vitiligo. In addition, studies have suggested a potential for blistering with targeted phototherapy; larger studies are needed to evaluate this adverse outcome.
Psoralens with Ultraviolet A
The 2015 Cochrane review of trials on treatments for vitiligo, previously discussed in the section on targeted phototherapy, identified 12 RCTs evaluating oral PUVA. Four trials assessed oral PUVA alone, and eight assessed PUVA in combination with other treatments e.g., calcipotriol, azathioprine, polypodium leucotomos, khellin, or surgical treatment. Seven of the eight studies used nine methoxypsoralen. Six trials were identified on oral PUVA plus sunlight; two of these used placebo as the comparison. Due to differences among studies, findings of trials on oral PUVA and on oral PUVA plus sunlight were not pooled.

An earlier meta-analysis of treatments for vitiligo was published in 1998 by Njoo et al. A pooled analysis of two RCTs on oral unsubstituted psoralen plus sun for generalized vitiligo (total n=97) found a statistically significant treatment benefit of active treatment compared with placebo (pooled odds ratio [OR], 19.9, 95% confidence interval [CI], 2.4 to 166.3). A pooled analysis of three RCTs, two on oral methoxsalen plus sun and one on oral trioxsalen plus sun (total n=181) also found a significant benefit of active treatment versus placebo on generalized vitiligo (OR=3.8, 95% CI, 1.3 to 11.3). All studies were published before 1985, had relatively small sample sizes (confidence intervals were wide), and used sun exposure rather than artificial UVA.

In 2007, Yones et al published a RCT using a psoralen formulation available in the U.S. The study used data on 56 patients in the U.K. who had nonsegmental vitiligo. Outcome assessment was blinded. Patients were randomly assigned to receive twice-weekly treatments with 8-MOP psoralen plus UVA (n=28) or NBUVB therapy (n=28). In the PUVA group, the starting dose of irradiation was 0.5 J/cm², followed by 0.25 J/cm² incremental increases if tolerated. Patients were evaluated after every 16 sessions and followed for up to one year. Treatment was discontinued if there was complete or near complete resolution of vitiligo, no or minimal improvement after 32 treatments, completion of 200 lifetime treatments, or upon patient request. All patients were included in the analysis. The median number of treatments received was 49 in the PUVA group and 97 in the NBUVB group. At the end of treatment, the median improvement body surface area with vitiligo (BSA-V) was 23% in the PUVA group and 61% in the NBUVB group. In addition, five of 25 (20%) of patients in the PUVA group and eight of 25 (32%) in the NBUVB group had at least 75% improvement in BSA-V at the end of follow-up. The authors did not provide p-values in their outcome table. They stated though, that the difference in improvement in BSA-V did not differ significantly between groups. A total of 24 (96%) patients in the PUVA group and 17 (68%) in the NBUVB group developed erythema at some point during treatment; this difference was statistically significant, p=0.02.

There is some evidence from randomized studies, mainly those published prior to 1985, that PUVA is more effective than placebo for treating vitiligo. The limited number of studies comparing PUVA with NB-UVB have had mixed findings.

Summary of Evidence
For individuals who have vitiligo who receive targeted phototherapy, the evidence includes randomized controlled trials (RCTs). Relevant outcomes are change in disease status, quality of life, and treatment-related morbidity. The studies tend to have small sample sizes, and few were designed to isolate the effect of laser therapy. There is a lack of clinical trial evidence that
compares this technique with more conservative treatments or no treatment/placebo. The evidence is insufficient to determine the effects of the technology on health outcomes. For individuals who have vitiligo who receive PUVA, the evidence includes RCTs. Relevant outcomes are change in disease status, quality of life, and treatment-related morbidity. There is some evidence from randomized studies, mainly those published before 1985, that PUVA is more effective than placebo for treating vitiligo. PUVA for vitiligo is recommended in British guidelines for adults who do not respond to more conservative treatments. Based on the available evidence and clinical guidelines, PUVA may be considered in patients with vitiligo who have not responded adequately to conservative therapy. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Practice Guidelines and Position Statements**

**British Association of Dermatologists et al**

In 2008, a guideline on the diagnosis and management of vitiligo was published by several organizations in the U.K. including the British Association of Dermatologists, the Royal College of Physicians of London and the Cochrane Skin Group. The guideline included the following statements:

1. PUVA therapy should be considered for treatment of vitiligo only in adults who cannot be adequately managed with more conservative treatments. PUVA is not recommended in children. *Grade of recommendation D, Level of evidence 4*

2. If phototherapy is to be used for treating nonsegmental vitiligo, NB-UVB should usually be used in preference to oral PUVA. *Grade of recommendation A, Level of evidence 1+

3. A trial of PUVA therapy should be considered only for adults with widespread vitiligo, or localized vitiligo associated with a significant impact on patient's quality of life. Ideally, this treatment should be reserved for patients with darker skin types. *Grade of recommendation D, Level of evidence 3*

4. Before starting PUVA treatment, patients should be made aware that there is no evidence that this treatment alters the natural history of vitiligo. They should also be made aware that not all patients respond, and that somebody sites, such as the hands and feet, respond poorly in all patients. They should also be informed of the limit to the number of treatments due to possible side-effects. *Grade of recommendation D, Level of evidence 3*

**European Dermatology Forum**

In 2013, consensus guidelines on management of vitiligo were published by the European Dermatology Forum. The guidelines state that oral PUVA is commonly used in adults with generalized vitiligo as second-line treatment. The guideline also state that targeted phototherapy is indicated for localized vitiligo, particularly small lesions of recent onset and childhood vitiligo, to avoid adverse effects due to total body irradiation and when total body irradiation is contraindicated. The guidelines were based on expert opinion and not on a systematic review of the literature.

**U.S. Preventive Services Task Force Recommendation**

Not applicable.
Key Words:
Phototherapy, photochemotherapy, UVA, UVB, PUVA, ultraviolet A, ultraviolet B, excimer laser phototherapy, excimer laser, 308-nm excimer laser, 308-nm xenon chloride excimer laser, vitiligo, psoralen plus ultraviolet A

Approved by Governing Bodies:
In 2001, XTRAC™ (PhotoMedex), a XeCl excimer laser, was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process for the treatment of skin conditions such as vitiligo. The 510(k) clearance has subsequently been obtained for a number of targeted ultraviolet B lamps and lasers, including newer versions of the XTRAC system including the XTRAC Ultra™, the VTRAC™ lamp (PhotoMedex), the BClear™ lamp (Lumenis), the 308 excimer lamp phototherapy system (Quantel Medical) and the Excilite™ and Excilite µ™ XeCl lamps. The intended use of all of these devices includes vitiligo among other dermatologic indications. Some light-emitting devices are handheld.

The oral psoralen products Oxsoralen-Ultra® (methoxsalen soft gelatin capsules) and 8-MOP® (methoxsalen hard gelatin capsules) have been approved by FDA; both are made by Valeant Pharmaceuticals. Topical psoralen products have also received FDA approval, e.g., Oxsoralen® (Valeant).

Benefit Application:
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.
ITS: Home Policy provisions apply
FEP contracts: Special benefit consideration may apply. Refer to member’s benefit plan. FEP does not consider investigational if FDA approved and will be reviewed for medical necessity.

Coding:
CPT Codes: 96900 Actinotherapy (ultraviolet light)
96910 Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
96912 Photochemotherapy; psoralens and ultraviolet A
96913 Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings)

HCPCS: E0691 Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less
E0692 Ultraviolet light therapy system panel, includes bulbs/ lamps, timer and eye protection, 4 foot panel
E0693 Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel

E0694 Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection

References:


34. Sivanesan SP, Gattu S, Hong J et al. Randomized, double-blind, placebo-controlled evaluation of the efficacy of oral psoralen plus ultraviolet A for the treatment of plaque-type
psoriasis using the Psoriasis Area Severity Index score (improvement of 75% or greater) at 12 weeks. J Am Acad Dermatol 2009; 61(5):793-8.


Policy History:
Medical Policy Group, January 2007 (1)
Medical Policy Administration Committee, March 2007
Available for comment March 23-May 7, 2007
Medical Policy Group, June 2007 (2)
Medical Policy Administration Committee, June 2007
Available for comment June 30-August 13, 2007
Medical Policy Group, May 2009 (4)
Medical Policy Administration Committee, June 2009
Available for comment May 15-June 27, 2009
Medical Policy Group, July 2009 (2)
Medical Policy Administration Committee, August 2009
Available for comment August 10-September 23, 2009
Medical Policy Group, November 2011 (2): Updated Key Points & References
Medical Policy Group, December 2011 (3): 2012 Coding Update; Verbiage change to code E0691
Medical Policy Panel, March 2013
Medical Policy Group, April 2013 (3): Updated Key Points and References; no change in policy statement
Medical Policy Panel, April 2014
Medical Policy Group, April 2014 (3): Updated Description, Key Points & References; no change in policy statement
Medical Policy Panel, April 2015  
Medical Policy Group, June 2015 (3): Updated Key Points & References; no change in policy statement.  
Medical Policy Panel, December 2015  
Medical Policy Group, January 2016 (2): 2016 Updates to Key Points, Key Words, and Approved by Governing Bodies; no change in policy statement.  
Medical Policy Group, January 2016 (2): Moved criteria for phototherapy treatment of psoriasis with Ultraviolet A or B therapy, PUVA, and home use of Ultraviolet B light therapy to policy #009, removed codes 96920 – 96922 from policy.  
Medical Policy Group, April 2016 (2): Policy section updated to include criteria for Ultraviolet B therapy with topical coal for severe psoriasis with effective date of May 21, 2016.  
Medical Policy Administration Committee, April 2016  
Available for comment April 5 through May 20, 2016  
Medical Policy Panel, December 2016  
Medical Policy Group, December 2016 (7): Updated Key Points and References; no change in policy statement.

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member’s plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield’s administration of plan contracts.