MEDICAL POLICY

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MEDICAL POLICY DETAILS	
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POLICY STATEMENT

I. Based upon our criteria and assessment of the peer-reviewed literature, the following treatments have been medically proven to be effective and, therefore, are considered **medically appropriate:**

A. Ultraviolet B (UVB) light, alone or in combination with other treatment modalities (e.g., topical coal tar [Goeckerman treatment]), when the following criteria are met:

1. In the absence of **ALL** contraindications including the following:
   a. xeroderma pigmentosum;
   b. disorders with significant light sensitivity (e.g., albinism);
   c. lupus erythematosus;

   AND
2. Treatment is for **ANY** of the following indications:
   a. moderate to severe psoriasis that is not responsive to topical or systemic (e.g., methotrexate) drug therapies alone;
   b. eczema/atopic dermatitis that is not responsive to topical or systemic drug therapies alone or that interferes with an individual's normal functional capacity;
   c. cutaneous T-cell lymphoma (e.g., mycosis fungoides);
   d. vitiligo of sun-exposed regions (such as the face, neck, and dorsum of the hands) because the depigmented skin is sun-sensitive, is subject to severe sunburn, and may pose a risk for skin cancer;
   e. lichen planus;

B. Psoralen Ultraviolet A (PUVA) when the following criteria are met:

1. In the absence of **ALL** the following contraindications:
   a. xeroderma pigmentosum;
   b. disorders with significant light sensitivity (e.g., albinism);
   c. lupus erythematosus;
   d. pregnancy;
   e. breast-feeding;

f. uremia and hepatic failure;

AND

2. Treatment is for **ANY** of the following indications:
   a. severe, disabling psoriasis that is not responsive to conservative therapy or UVB therapy; ~~or~~
   b. severe, disabling eczema/atopic dermatitis that is not responsive to conservative therapy or UVA/UVB therapy;
   c. cutaneous T-cell lymphoma (e.g., mycosis fungoides);
   d. vitiligo of sun-exposed regions (such as the face, neck, and dorsum of the hands) because the depigmented skin is sun-sensitive, is subject to severe sunburn, and may pose a risk for skin cancer;
   e. severe lichen planus;

C. Ultraviolet A (UVA) light, alone or in combination with other treatment modalities, when the following criteria are met:
   1. In the absence of **ALL** contraindications including the following:
      a. xeroderma pigmentosum
      b. disorders with significant light sensitivity (e.g., albinism);
      c. lupus erythematosus;

      AND
   2. Treatment is for **ANY** of the following indications:
      a. eczema/atopic dermatitis that is not responsive to topical or systemic drug therapies alone or that interferes with an individual's normal functional capacity
      b. lichen planus;

D. Targeted phototherapy using an excimer lamp or laser device that has received Section 510(k) approval from the U.S. Food and Drug Administration (FDA) (e.g., Fencer 308 Excimer Laser, XTRAC XL excimer laser and VTRAC excimer lamp system, BClear lamp, and European-manufactured Excilite and Excilite µ XeCL lamps) when the following criteria are met:
   1. In the absence of **ALL** contraindications including the following:
      a. xeroderma pigmentosum;
      b. disorders with significant light sensitivity (e.g., albinism);
      c. lupus erythematosus;

      AND
   2. Treatment is for **ANY** of the following indications:
      a. moderate-to-severe localized psoriasis comprising less than 20% of the body area for which narrowband UVB or PUVA is indicated; or
      b. mild-to-moderate psoriasis that is unresponsive to conservative treatment;

E. Home phototherapy utilizing UVB radiation for the treatment of moderate-to-severe psoriasis, comprising at least 3% of the body area, **OR** eczema/atopic dermatitis, that is not responsive to conservative therapies, when **ALL** the following criteria are met:
   1. In the absence of **ALL** contraindications including the following:
      a. Xeroderma pigmentosum;
      b. Disorders with significant light sensitivity (e.g., albinism);
      c. Lupus erythematosus;
   2. The patient's dermatologist has submitted a letter of medical necessity stating the reason that the home-based, rather than office-based, therapy is needed; and
   3. The patient has had ineffective courses of treatment using topical or systemic drug therapy; and
   4. The patient is motivated and reliable, ensuring that treatment is pursued correctly and consistently and that exposures are accurately recorded;

F. Photodynamic Therapy (PDT) with 5-aminolevulinic acid (5-ALA) topical preparations, when the following criteria are met:
   1. In the absence of **ALL** contraindications including the following:
      a. Xeroderma pigmentosum;
      b. Disorders with significant light sensitivity (e.g., albinism);

c. Lupus erythematosus;
AND

2. Treatment is for **ANY** of the following:
   a. actinic keratoses
   b. superficial basal cell skin cancer, only when surgery and/or radiation is contraindicated; ~~or~~
   c. Bowen's disease (squamous cell carcinoma in situ), only when surgery and/or radiation is contraindicated;

G. Pulsed Dye Laser for the treatment of Port wine birthmarks.

II. Based upon our criteria and assessment of peer-reviewed literature, the following treatments have not been medically proven to be effective and, therefore, are considered **investigational**:
   A. Targeted phototherapy (e.g., the XTRAC XL and VTRAC lamp, the BClear lamp, and the European-manufactured Excilite and Excilite µ XeCL lamps) for the following indications:
      1. first-line treatment of mild psoriasis;
      2. treatment of generalized psoriasis or psoriatic arthritis;
      3. vitiligo.
   B. PDT with topical preparations for the treatment of other dermatologic conditions, including, but not limited to, acne vulgaris, regional squamous cell carcinoma, and non-superficial basal cell carcinoma.
   C. Treatment of acne with light or laser therapy, including pulsed dye or smooth beam laser.

Refer to Corporate Medical Policy #1.01.24 Phototherapy for the Treatment of Seasonal Affective Disorder

Refer to Corporate Medical Policy #7.01.11 Cosmetic and Reconstructive Procedures

Refer to Corporate Medical Policy #8.01.01 Extracorporeal Photochemotherapy/Photopheresis

Refer to Corporate Medical Policy #8.01.06 Photodynamic Therapy (PDT) for Malignant Disease

Refer to Corporate Medical Policy #11.01.03 Experimental or Investigational Services

Refer to Administrative Policy #37 Laser Treatment of Psoriasis

POLICY GUIDELINES

I. The number of treatments required for clearance and remission for both UVB and PUVA therapy is based upon the severity of the disease and the individual response to treatment. The number of psoriatic flare-ups that a person experiences in a lifetime also varies by severity of the disease.

II. UVB therapy usually begins with three to five sessions per week until clearing is achieved, followed by maintenance therapy with a gradual reduction in sessions until sessions are no longer required. PUVA therapy begins with two to three sessions per week for initial clearing, then one to two times a month for maintenance. If no improvement in the psoriatic lesions is seen after four weeks of either UVB or PUVA therapy, treatment should be discontinued.

III. Medical necessity documentation, such as a treatment plan and/or photographs, is generally not required until after a threshold of 30 visits.

IV. The number of treatments required for clearance and remission for atopic dermatitis/eczema and for re-pigmentation in vitiligo for both UVB a PUVA therapy is based upon the severity of the disease and the individual response to treatment.;

V. In general, a phototherapy home unit should be purchased only when there is anticipation of long-term use.

VI. Because of its potential long-term side effects, PUVA is rarely indicated for children or young adults.

VII. Treatment should be used with *caution* in the following circumstances:

   A. History or family history of melanoma;
   B. History of non-melanoma skin cancer, extensive solar damage, and previous treatment with ionizing arsenic;
   C. Pemphigus or pemphigoid;

D. Immunosuppression;
E. Cataracts and aphakia;
F. Photosensitivity; and
G. Uremia and hepatic failure.

DESCRIPTION

Ultraviolet light therapy is exposure to the skin with non-ionizing radiation for therapeutic benefit. It may involve exposure to UVB, UVA, or various combinations of UVB and UVA radiation.

Goeckerman therapy is a psoriasis treatment that was developed in 1921 and involves the use of coal tar in combination with UVB phototherapy. It is a safe and effective option for patients with severe or recalcitrant psoriasis. Coal tar and UVB are thought to work in concert to inhibit angiogenesis and keratinocyte proliferation, as well as to decrease T-lymphocyte numbers in the skin and alter inflammatory cytokine expression.

Photochemotherapy is the therapeutic use of radiation in combination with a photosensitizing chemical, currently PUVA. Psoralens makes the skin more sensitive and responsive to this wavelength of light. It can be taken orally, applied topically, or added to a bath via a solution for soaking into the skin.

Excimer laser, a xenon chloride (XeCl) laser (e.g., XTRAC, Ex-308 laser), emits a narrow beam of UVB light from a handheld unit which results in a much higher concentration of UVB exposure than in the standard phototherapy unit. The use of excimer laser may shorten the number of exposures necessary, and only specific areas of the body are treated with the laser, limiting the number of exposures and the area being treated, potentially reducing the harmful effects of UV radiation.

PhotoMedex (XTRAC laser) and Surgilight (EX-308 laser) have received FDA Section 510(k) market approval for the use of excimer lasers in the treatment of psoriasis. Section 510(k) clearance has subsequently been issued for a number of targeted UVB lamps and lasers, including the XTRAC XL laser and VTRAC lamp (PhotoMedex), the BClear lamp (Lumenis), and the European-manufactured Excilite and Excilite µ XeCL lamps. The indicated use of these devices is targeted UVB phototherapy for treatment of skin conditions, including psoriasis, vitiligo, atopic dermatitis, and leukoderma.

PDT using 5-ALA has been investigated as a treatment of actinic keratoses (AK), skin cancers, and superficial dermatologic lesions such as Bowen's disease. Levulan Kerastick is one example of a topical preparation of 5-ALA. The Levulan Photodynamic system is a two-step treatment, involving application of Levulan Kerastick, then exposure of the area to blue light via the BLU-U Blue Light Photodynamic Therapy Illuminator.

Topical application of methyl aminolevulinate (Metvix, MAL), followed by exposure with the CureLight Broadband (Model CureLight 01), a proprietary red-light source, or the PhotoCure Aktilite CL128 lamp, an LED-based narrow band (630 nm) red light technology device, is another variant of photodynamic therapy for skin lesions. Although MAL is an approved photosensitizer for PDT, it is no longer produced in the United States (NCCN, 2020).

In 2016, Ameluz gel (aminolevulinic acid hydrochloride gel, 10%) was approved by the FDA for use in combination with PDT using BF-RhodoLED lamp, a narrowband, red light illumination source, for lesion-directed and field-directed treatment of mild-to-moderate AKs on the face and scalp.

Pulsed Dye Lasers (PDL) which use yellow light wavelengths (585-600 nm) that selectively target both oxyhemoglobin and deoxyhemoglobin. PDLs penetrate up to 2 mm in the skin. Newborns and young children, who have thinner skin, tend to respond well to this type of laser; the response in thicker and darker lesions may be lower. Several laser systems have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process for a variety of dermatologic indications, including treatment of port wine stains. Approved lasers for this indication include the Candela® PDL system (Candela Corp., Wayland, MA), the Cynosure Photogenica PDL (Cynosure Inc., Westford, MA).

RATIONALE

Psoriasis

The published data has demonstrated that psoriasis has an excellent response rate when treated with either UVB or PUVA. The overall risk of complications from phototherapy and photochemotherapy are low, when compared to the thousands of patients treated with these therapies. Phototherapy and photochemotherapy have been standard treatment alternatives used by dermatologists for severe psoriasis and for vitiligo.

The National Institute for Health and Care Excellence (NICE) updated its Clinical Guideline for Psoriasis: Assessment and Management in 2017. The guidelines suggest offering narrowband ultraviolet B (UVB) phototherapy to people with plague or guttate-pattern psoriasis that cannot be controlled with topical treatments alone, to consider psoralen (oral or topical) with local ultraviolet A (PUVA) irradiation to treat palmoplantar pustulosis, and, when considering PUVA for psoriasis (plaque type or localized palmoplantar pustulosis), to discuss other treatment options and associated risk of increased skin cancer.

The National Psoriasis Foundation defines the classifications of psoriasis as: Mild < 3%; Moderate 3-10%, and Severe >10%. However, the severity of psoriasis is also measured by how psoriasis affects a person's quality of life. For example, psoriasis can have a serious impact on one's daily activities even if it involves a small area such as the palms of the hands or soles of the feet.

Peer-reviewed literature is limited; however, the published evidence supports the use of targeted phototherapy for the treatment of moderate-to-severe psoriasis comprising less than 20% of the body area for which NB-UVB or PUVA is indicated, and for the treatment of mild-to-moderate psoriasis that is unresponsive to conservative treatment. There is insufficient evidence to support the use of targeted phototherapy for the first-line treatment of mild psoriasis or for the treatment of generalized psoriasis or psoriatic arthritis.

A 2016 systematic review identified three studies that compared targeted phototherapy with a 308 nm excimer lamp to NB-UVB and three studies that compared the excimer lamp to the excimer laser. No differences between the excimer lamp and NB-UVB were identified for the outcome of 50% or greater re-pigmentation (RR=1.14; 95% CI, 0.88 to 1.48). For re-pigmentation of 75% or greater, only two 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 three studies that compared the excimer lamp to the excimer laser, there were no significant differences between treatments for either 50% or greater re-pigmentation (RR=0.97; 95% CI, 0.84 to 1.11) or 75% or greater re-pigmentation (RR=0.96; 95% CI, 0.71 to 1.30). All 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.

The American Academy of Dermatology and National Psoriasis Foundation guidelines (2019) for the management and treatment of psoriasis with phototherapy state the Goeckerman regimen is an old treatment, there are no RCTs or systematic reviews evaluating its effectiveness and long-term risks. Photo carcinogenesis is a theoretical risk but has not been demonstrated despite long-term follow-up. The most common reported adverse effects have been local burning as a result of tar sensitivity (‘‘tar smarts’’). The necessary time investment on the part of the patient is a disadvantage of Goeckerman therapy, and outpatient treatment requires close proximity to a capable medical facility. The relatively rapid and robust clinical response seen with the Goeckerman regimen, the long duration of remission, and the low adverse effect profile render Goeckerman therapy an attractive option for the treatment of psoriasis, particularly for those with resistant disease. Because of the messy and cumbersome nature of tar application and the wide availability of highly effective NB-UVB, the Goeckerman regimen is no longer commonly used. Despite this, there is ample evidence to recommend this treatment for psoriasis.

Eczema/Atopic Dermatitis

Published data have demonstrated that phototherapy in the form of UVA, UVB and PUVA have been proven to be safe and effective treatments, with a low overall risk of complications, for eczema/atopic dermatitis. The American Academy of Dermatology Association (2023) published Guidelines of Care for Atopic Dermatitis recommend phototherapy as a second-line treatment, after failure of first-line treatment (emollients, topical steroids, and topical calcineurin inhibitors). Phototherapy can be used as maintenance therapy in patients with chronic disease. The light modality chosen should be guided by factors such as availability, cost, patient skin type, skin cancer history, and patient use of photosensitizing medications. Home phototherapy under the direction of a physician may be considered for patients who are unable to

receive phototherapy in an office setting. Most current literature reports on the efficacy and safety of narrow band UVB. Wherever possible, use a light source that minimizes the potential for harm under the supervision of a qualified clinician.

Mycosis Fungoides

The peer-reviewed literature consists of small case series that indicate good outcomes when phototherapy in the form of PUVA and UVB is used for the treatment of mycosis fungoides, a very rare lymphoma of the skin.

Vitiligo

Bae, J.M. et al. (2017) performed a systematic review and meta-analysis of patient response to narrowband UV-B (NBUVB) phototherapy and psoralen-UV-A (PUVA) phototherapy in the treatment of vitiligo. Inclusion criteria consisted of: (1) prospective studies; (2) participants with a diagnosis of generalized or symmetrical vitiligo; (3) at least one phototherapy group; (4) at least 10 participants in each treatment arm; (5) treatment duration of at least 12 weeks or 24 treatment sessions; (6) outcomes measured based on all vitiligo lesions on the participants whole or half body; and (7) degree of re-pigmentation based on a quartile scale. In the final analysis, 35 studies were included, with 29 studies of 1201 patients undergoing NBUVB phototherapy and nine studies of 227 patients undergoing PUVA phototherapy. A mild response (≥25%) to NBUVB phototherapy occurred in 62.1% of 130 patients in three studies at three months, 74.2% of 232 patients in 11 studies at six months, and 75.0% of 512 patients in eight studies at 12 months. A marked response, defined as ≥75%, was achieved in 13.0% of 106 patients in two studies at three months, 19.2% of 266 patients in 13 studies at six months, and 35.7% of 540 patients in nine studies at 12 months. For PUVA phototherapy, at least a mild response occurred in 51.4% of 103 patients in four studies at six months and 61.6% of 72 patients in three studies at 12 months. After at least six months of NBUVB phototherapy, at least a mild response occurred on the face and neck in 82.0% of 153 patients, and a marked response in 44.2%, while hands and feet received a mild response in 11.0% of 172 patients, and no marked responses of the same group. The authors could not determine the appropriate treatment duration of phototherapy but did verify treatment duration of at least one year to achieve maximal response and suggested at least six months of treatment to determine responsiveness to NBUVB phototherapy. Overall, treatment response to NBUVB phototherapy was better than PUVA therapy. The most responsive body sites were the face and neck, with hands and feet being the least responsive.

A 2015 systematic review was conducted of randomized, controlled trials (RCTs) that focused on treatment of vitiligo with the 308 nm excimer laser. Authors identified seven RCTs with a total of 390 patients. None of the studies was conducted in the United States. Three of the trials compared the excimer laser with an excimer lamp. Four studies compared the excimer laser with narrowband (NB)-UVB; however, two of these were not published in English, and one had a sample size of only 14 patients. The fourth study, published in 2010, did not report efficacy outcomes such as clinical response rate or re-pigmentation rate; but reported on the proportion of patients with various types of re-pigmentation: perifollicular, marginal, diffuse, or combined. Re-pigmentation rates did not differ significantly between groups treated with the excimer laser versus NB-UVB. The authors conducted a meta-analysis of the two studies that were not published in English, so results cannot be verified, but they reported that the likelihood of a minimum 50% re-pigmentation 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) and that, in qualitative analysis, neither of these studies showed significant benefit of the excimer laser for achieving a minimum 75% re-pigmentation rate. (Sun et al., 2015).

Studies addressing targeted phototherapy for treating vitiligo tended to have small sample sizes, few were designed to isolate the effect of laser therapy, and were heterogeneous (e.g., different interventions or combinations of interventions, and different comparison interventions), making it difficult to pool study findings or to draw conclusions about the efficacy of targeted phototherapy for vitiligo.

Actinic Keratosis

In 2018, the FDA-approved indications for Levulan Kerastick were expanded to include non-hyperkeratotic AKs of the upper extremities, in addition to the face and scalp. Studies demonstrate that photodynamic therapy with 5-ALA is an effective nonsurgical technique for treating non-hyperkeratotic AKs of the face and scalp, with an acceptable rate of recurrence of 19% over 12 months. In two placebo controlled RCTs, significantly more patients had complete clearance of

AKs of the upper extremities with ALA and blue light, compared to placebo at 12 weeks (Schmieder et al., 2012; Jiang et al., 2019).

In 2007, the International Society for Photodynamic Therapy in Dermatology published consensus-based guidelines on the use of PDT for nonmelanoma skin cancer. Based on efficacy and cosmetic outcome, the authors recommended PDT as a first-line therapy for actinic keratosis. The guideline recommended photodynamic therapy for superficial basal cell carcinoma as "a viable alternative when surgery would be inappropriate, or the patient or physician wishes to maintain normal skin appearance" and concludes that photodynamic therapy is at least as effective as cryotherapy or 5-FU for Bowen's disease. The authors found insufficient evidence to support the routine use of topical photodynamic therapy for squamous cell carcinoma. (Braathen L.R. et al.)

In a 2021 Executive Summary, the American Academy of Dermatology published guidelines for the care and management of AK, which included conditional recommendations for the use of ALA red-light PDT or ALA blue-light PDT treatment for AKs and considered the associated risks of skin irritation, pain and cosmesis to represent a minimal potential for harm. They highlighted the conditional recommendation is based on limited quality of evidence, however, noted that there is evidence suggesting complete clearance of AK with repeated treatment of ALA-PDT.

Basal Cell Skin Cancer

The 2023 National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines for basal cell skin cancer indicate, that while cure rates are approximately 10% lower than for surgical treatment modalities, topical therapies including topical imiquimod, topical 5-fluroruracil (5-FU), photodynamic therapy (e.g., aminolevulinic acid [ALA], porifimer sodium) or cryotherapy may be considered as well as recommended when surgery is contraindicated or impractical. The guidelines report that most studies have focused on the superficial and nodular histologic subtypes, and several have found higher cure rates for superficial versus nodular subtypes in both low- and high-risk locations. Compared to other superficial therapies, PDT has similar efficacy as cryotherapy but with much better cosmetic outcomes. The literature has demonstrated varied results in comparison of PDT and imiquimod.

Lichen Planus

In 2020, the European Academy of Dermatology and Venereology released guidelines on the management of lichen planus which state squamous cell carcinoma may arise from mucosal lesions (mouth, vulva, penile) and hypertrophic LP lesions (distal extremities). Case reports of SCC emerging from hypertrophic cutaneous LP lesions or chronic anogenital or esophageal lesions have been described. Persistent ulcers/lesions should undergo biopsy, particularly when resistant to therapy. Infections, osteoporosis, adrenal insufficiency, bone marrow suppression, renal damage and hyperlipidemia may occur due to medication. Lichen planus is a chronic disease, and the primary focus of treatment is to control symptoms and minimize damage. The treatment should be associated with the severity of the disease and the less possible side-effects and should improve the patients' quality of life. First line treatment for cutaneous LP includes topical medications. When LP persists second-line treatments recommended are broadband or narrowband UVB, and combination of UV and acitretin. Third line treatment includes photodynamic therapy and Nd-YAG laser, low-dose 308 nm excimer laser.

Dawood M, et al. (2022) conducted a retrospective, single-center, cohort study which showed more than half of the 192 studied patients were disease-free for at least 4.8 years after a single course of Narrowband UVB (NB UVB). Younger aged and male patients achieved better outcomes while female patients and patients with lighter skin phototypes appeared to have higher major response rates.

Weber B, et al. (2022) compared NB UVB with psoralen plus UVA photochemotherapy in a retrospective analysis. They reported the therapeutic outcome and the number of treatments required for achieving a complete or good response were comparable for NB-UVB and PUVA. Both were very effective and demonstrated their beneficial use in patients with generalized cutaneous LP. Based on the lower rate of side effects and its greater ease of use, the authors recommended NB-UVB be considered as the first-line phototherapeutic modality for this indication. In non-responding patients or in case of unavailability of NB-UVB, oral or bath PUVA may serve as a valid alternative therapeutic measure.

Port Wine Birthmarks

Sturge-Weber syndrome (SWS) is a neurocutaneous disorder that classically presents with a triad of vascular anomalies affecting the skin, eyes, and brain. Previously, the trigeminal nerve distribution of a PWB of the face was used to identify risk of SWS. However, recent evidence has demonstrated that PWBs are vascular, not neurologic, in embryologic origin, and facial PWBs at highest risk for the brain involvement of SWS involve the forehead location. Furthermore, a PWB involving the upper or lower eyelid carries a risk of glaucoma, which requires lifelong monitoring. The gold standard of treatment for PWB is the pulsed dye laser, which has many advantages when started as early as possible in infancy. Poliner, et al. (2022) states Based on strong evidence, PDL is safe to use in children and is the gold standard of treatment for PWBs. PDL is most effective at fading the PWB when initiated early in infancy, preferably within the first year of life. Initiating treatment at this age also optimizes psychosocial development, minimizes school absenteeism, and minimizes the need for general anesthesia during early treatments.

The American Academy of Pediatrics (Krowchuck et al.) 2019 clinical practice guidelines for the management of infantile hemangiomas (IH) state there is a window of opportunity to treat problematic IHs. Consult early (by 1 month of age) for lesions that are potentially high risk because of potential for disfigurement, life-threatening complications, functional impairment, ulceration and underlying abnormalities. Surgery and/or laser treatment are most useful for the treatment of residual skin changes after involution. They may be used earlier to treat selected His. PDL has been used for several decades to treat IHs. There is wide recognition that PDL is effective and safe in removing residual macular erythema and superficial telangiectasias in involuting or involuted IHs, but it often requires several treatments to achieve optimal results.

Sabeti, S et al. (2021) published a consensus statement of guidelines for treating SWS and PWB with input from 12 nationally peer-recognized experts in dermatology with experience treating patients with SWS. The committee stated Treatment of PWBs is indicated to minimize the psychosocial impact and diminish nodularity and potentially tissue hypertrophy. Better outcomes may be attained if treatments are started at an earlier age. In the US, pulsed dye laser is the standard for all PWBs regardless of the lesion size, location, or color. When performed by experienced physicians, laser treatment can be safe for patients of all ages. The choice of using general anesthesia in young patients is a complex decision that must be considered on a case-by-case basis. These recommendations are intended to help guide clinical practice and decision-making for patients with SWS and those with isolated PWBs and may improve patient outcomes.

Acne

Overall, the literature investigating the use of photodynamic therapy in the treatment of acne consists of very small studies in which the patient is also the control. These studies lack long-term data on effectiveness and safety. Due to the small sample sizes of the published trials, lack of long-term follow-up, small number of studies on any particular type of laser, and paucity of studies comparing light therapy to standard acne treatments, the evidence is insufficient to draw conclusions about the impact of laser treatments on health outcomes in patients with active acne.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm *(effective 01/01/00)*
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm *(effective 01/01/03)*

Code	Description
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm *(effective 01/01/00)*
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day
96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
96574	Debridement of premalignant hyperkeratotic lesion(s) (i.e., targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
96900	Actinotherapy (ultraviolet light)
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	250 sq cm to 500 sq cm
96922	over 500 sq cm

HCPCS Codes

Code	Description
E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 2 sq ft or less
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 ft panel
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 ft panel
E0694	Ultraviolet multidirectional light therapy system in 6 ft cabinet, includes bulbs/lamps, timer, and eye protection
J7308	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7309	Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 gram (product no longer available in the U.S.)
J7345	Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg

ICD10 Codes

Code	Description
C44.00-C44.99	Other and unspecified malignant neoplasm of skin (code range)

Code	Description
C80.0-C80.2	Malignant neoplasm without specification of site (code range)
C84.00-C84.09	Mycosis fungoides; code range
C84.10-C84.19	Sézary disease; code range
D04.0-D04.9	Carcinoma in situ of skin (code range)
L40.0-L40.9	Psoriasis (code range)
L43.0 -L43.9	Lichen planus (code range)
L57.0	Actinic keratosis
L70.0-L70.9 **(E/I)**	Acne (code range)
L73.0 **(E/I)**	Acne keloid
L80	Vitiligo
Q82.5	Congenital non-neoplastic nevus

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*Key Article

KEY WORDS

Aminolevulinic acid, BClear lamp, Excilite lamp, Levulan Kerastick, methyl aminolevulinate, Metvix, Narrow band ultraviolet B, Psoralens, PUVA, Ultraviolet light, UVA, UVB, xenon chloride laser, XeCL, XTRAC, VTRAC lamp.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for the Treatment of Psoriasis (250.1) Please refer to the following websites for Medicare Members: [https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=88&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Upstate&KeyWord=psoriasis&KeyWordLookUp=Title&KeyWordSearchType=And&ncd_id=250.1&ncd_version=1&basket=ncd%25253A250%25252E1%25253A1%25253ATreatment+of+Psoriasis&bc=gAAAABAAAAAA&] accessed 07/11/24.

There is currently a National Coverage Determination (NCD) for the Treatment of Actinic Keratosis (250.4). Please refer to the following websites for Medicare Members: [https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=129&ncdver=1&NCAId=1&ver=23&NcaName=Actinic+Keratoses&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Upstate&KeyWord=actinic+keratoses&KeyWordLookUp=Title&KeyWordLookUp=Title&KeyWordSearchType=And&KeyWordSearchType=And&ncd_id=250.1&ncd_version=1&basket=ncd%25253A250%25252E1%25253A1%25253ATreatment+of+Psoriasis&bc=gAAAABAAIAAA&] accessed 07/11/24.