MEDICAL POLICY

POLICY TITLE	LIGHT THERAPIES
POLICY NUMBER	MP-2.046

Effective Date:	5/1/2023

I. POLICY

Ultraviolet Light B [UVB] phototherapy may be considered **medically necessary** for members who have one of the following diagnoses that are resistant or have not responded to conservative treatment (i.e., topical corticosteroids, coal/tar preparations, topical retinoids, etc.):

- Aquagenic pruritus (AP) associated with polycythemia vera (PV)
- Atopic Dermatitis/Severe Eczema
- Dermographism (Dermatographic Urticaria)
- Dyshidrotic Eczema
- Lichen Planus
- Morphea/Scleroderma
- Mycosis Fungoides (T-Cell Lymphoma)
- Parapsoriasis
- Photodermatoses
- Pityriasis Lichenoides
- Pityriasis Rosea
- Polymorphic Light Eruptions
- Prurigo nodularis
- Pruritus
- Psoriasis
- Sezary's Disease
- Vitiligo

Psoralen and Ultraviolet light A (PUVA) therapy may be considered **medically necessary** for members who have one of the following diagnoses that are resistant or has not adequately responded to conservative treatment (i.e. topical corticosteroids, coal/tar preparations, topical retinoids, etc.):

- Alopecia Areata
- Atopic Dermatitis/Severe Eczema
- Chronic Palmoplantar Pustulosis
- Cutaneous graft-versus-host-disease occurring as a result of allogeneic bone marrow transplant
- Dyshidrotic Eczema
- Eosinophilic Folliculitis
- Granuloma Annulare
- Lichen Planus

- Morphea and Localized Skin Lesions Associated with Scleroderma
- Mycosis fungoides (T-Cell Lymphoma)
- Necrobiosis Lipoidica
- Other Pruritic Eruptions of HIV Infection
- Parapsoriasis
- Pityriasis Lichenoides
- Polymorphic Light Eruptions
- Pruritus of Renal Disease
- Pruritus of Malignancy
- Psoriasis
- Severe Refractory Pruritus of Polycythemia Vera
- Severe urticaria pigmentosa (cutaneous mastocytosis)
- Sezary's Disease
- Vitiligo

PUVA is considered **not medically necessary** for all other conditions.

308nm Excimer Laser and/or Lamp

308nm Excimer Laser and/or Lamp may be considered **medically necessary** for the treatment of localized vitiligo (i.e., comprising less than 20% body area).

308nm Excimer Laser and/or Lamp may be considered **medically necessary** for the treatment of localized psoriasis (i.e., comprising less than 20% body area) who have failed to adequately respond to 3 or more months of topical treatments, including at least 3 of the following:

- Anthralin;
- Corticosteroids (e.g., betamethasone dipropionate ointment and fluocinonide cream);
- Keratolytic agents (e.g., lactic acid, salicylic acid, and urea);
- Retinoids (e.g., tazarotene);
- Tar preparations; and/or
- Vitamin D derivatives (e.g., calcipotriene).

No more than 13 laser treatments per course and 3 courses per year may be considered **medically necessary**. If the person fails to respond to an initial course of laser therapy, as documented by a reduction in Psoriasis Area and Severity Index (PASI) score or other objective response measurement, additional courses are considered not medically necessary.

Laser treatment for acne scarring is considered **cosmetic** and **not medically necessary**.

Goeckerman therapy

Goeckerman therapy may be considered **medically necessary** in the treatment of:

- Atopic dermatitis/severe eczema
- Dyshidrotic eczema
- Lichen Planus
- Mycosis Fungoides (Cutaneous T-cell Lymphoma)
- Psoriasis (moderate to severe)

Targeted Phototherapy

Targeted phototherapy may be considered **medically necessary** for the treatment of the following:

- Moderate to severe localized psoriasis (i.e., comprising less than 20% body area) for which NB-UVB or PUVA are indicated.
- Mild to moderate localized psoriasis that is unresponsive to conservative treatment.

Targeted phototherapy is considered **not medically necessary** for all other conditions as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure for these indications.

Home Phototherapy

Broad Band (BB) or Narrow Band (NB) UVB home phototherapy may be considered **medically necessary** when all of the following criteria are met:

- The member has a documented positive response to UVB light; and
- The member's condition must be chronic in nature requiring long term maintenance exceeding (4) months; and
- The member's condition must comply with one of the eligible diagnoses listed below:
    - Psoriasis;
    - Vitiligo;
    - Cutaneous T-cell lymphoma/mycosis fungoides;
    - Polymorphous light eruption;
    - Atopic dermatitis;
    - Pruritus; and
- The device must be ordered by the physician; and
- The device must be approved by the Food and Drug Administration; and
- The device must be appropriate for the body surface/area being treated.

All other uses of the lasers and lights not listed above as medically necessary are considered **not medically necessary** as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the procedure.

Policy Guidelines

Disease severity is minimally defined by body surface area (mild psoriasis affects less than 5% of body surface area, moderate psoriasis affects 5%-10%, and severe disease affects greater than 10% body surface area). However, lesion characteristics (e.g., location and severity of erythema, scaling, induration, pruritus) and impact on quality of life are also taken into account. For example, while a handprint is equal to approximately 1% body surface area, lesions on the hands, feet, or genitalia that cause disability may be classified as moderate-to-severe. The Psoriasis Area and Severity Index may be used as an outcome measure in clinical research. Clinical assessment of disease severity is typically qualitative.

Established treatments for psoriasis include the use of topical ointments and ultraviolet light ("light lamp") treatments. Lasers and targeted ultraviolet B lamps are considered equivalent devices; targeted ultraviolet devices are comparable with ultraviolet light panels for treatment purposes. First-line treatment of ultraviolet-sensitive lesions may involve around 6 to 10 office visits; treatment of recalcitrant lesions may involve around 24 to 30 office visits. Maintenance therapy or repeat courses of treatment may be required.

During psoralen plus ultraviolet A therapy, the patient with vitiligo or psoriasis needs to be assessed on a regular basis to determine the effectiveness of the therapy and the development of adverse effects. These evaluations are essential to ensure that the exposure dose of radiation is kept to the minimum compatible with adequate control of disease. Therefore, psoralen plus ultraviolet A is generally not recommended for home therapy.

Cross-reference:

MP 4.018 Dermatologic Applications of Photodynamic Therapy
MP 4.019 Oncologic Applications of Photodynamic Therapy Including Barrett's Esophagus

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO: Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

III. DESCRIPTION/BACKGROUND

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Ultraviolet Light B

Broadband ultraviolet B (UVB) radiation (280 to 320 nm), with or without topical tar, has been used for the treatment of moderate to severe psoriasis for decades. In the early 1980s, the observation that wavelengths around 311 nm were more effective than broad-spectrum UVB in clearing psoriasis led to a major advancement in phototherapy with the development of fluorescent lamps emitting selective UVB spectra in the range of 311 to 313 nm (narrowband UVB). Narrowband UVB has since become the type of phototherapy most frequently used for the treatment of psoriasis and a wide range of skin diseases, including atopic dermatitis, vitiligo, early stages of mycosis fungoides, and pruritic disorders.

Treatment of Psoriasis

Topical therapy (e.g., corticosteroids, vitamin D analogues) is generally considered first-line treatments of psoriasis, especially for mild disease. Phototherapy and systemic therapy are treatment options for patients with more extensive and/or severe disease and those who fail conservative treatment with topical agents. Phototherapy is available in various forms including exposure to natural sunlight, use of broadband ultraviolet B devices, narrowband ultraviolet B

(NB-UVB) devices, targeted phototherapy, and psoralen plus ultraviolet A (PUVA). NB-UVB is an established treatment for psoriasis, based on efficacy and safety.

Targeted Phototherapy

Potential advantages of targeted phototherapy include the ability to use higher treatment doses and to limit exposure to surrounding tissue. Broadband ultraviolet B devices, which emit wavelengths from 290 to 320 nm, have been largely replaced by NB-UVB devices. NB-UVB devices eliminate wavelengths below 296 nm, which are considered erythemogenic and carcinogenic, but not therapeutic. NB-UVB is more effective than broadband ultraviolet B and approaches PUVA in efficacy. Original NB-UVB devices consisted of a Phillips TL-01 fluorescent bulb with a maximum wavelength (lambda max) at 311 nm. Subsequently, an excimer (excited dimer) laser using xenon chloride (XeCl) and lamps were developed as targeted NB-UVB treatment devices; they generate monochromatic or very narrow band radiation with a lambda max of 308 nm. Targeted phototherapy devices, either excimer laser/lamps or other non-laser 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 to produce clearing. The original indication of the excimer laser was for patients with mild-to-moderate psoriasis, defined as involvement of less than 10% of the skin. Newer XeCl laser devices are faster and more powerful than the original models, which may allow treatment of patients with more extensive skin involvement (10%-20% body surface area).

Psoralen Plus Ultraviolet A

PUVA uses a psoralen derivative in conjunction with long wavelength ultraviolet A (UVA) light (sunlight or artificial) for photochemotherapy of skin conditions. Psoralens are tricyclic furocoumarins 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 the direct application of the psoralen to the skin with subsequent exposure to UVA light. Bath PUVA is used in some European countries for generalized psoriasis, but the agent used (trimethylpsoralen) is not approved by the Food and Drug Administration (FDA). Paint PUVA and soak PUVA are other forms of topical application of psoralen and are often used for psoriasis localized to the palms and soles. In paint PUVA, 8-methoxypsoralen in ointment or lotion form is put directly on the lesions. With soak PUVA, the affected areas of the body are placed in a basin of water containing psoralen. With topical PUVA, UVA exposure is generally administered within 30 minutes of psoralen application.

PUVA has most commonly been used to treat severe psoriasis, for which there is no generally accepted first-line treatment. Each treatment option (e.g., systemic therapies such as methotrexate, phototherapy, biologic therapies) has associated benefits and risks. Common minor toxicities associated with PUVA include erythema, pruritus, irregular pigmentation, and gastrointestinal tract symptoms; they generally can be managed by altering the dose of psoralen or ultraviolet light. Potential long-term effects include photoaging and skin cancer, particularly squamous cell carcinoma and possibly malignant melanoma. PUVA is generally considered more effective than targeted phototherapy for the treatment of psoriasis. However, the requirement of systemic exposure and the higher risk of adverse reactions (including a higher carcinogenic risk) have generally limited PUVA therapy to patients with more severe disease.

Vitiligo

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 an autoimmune disease. The most common form of the disorder is nonsegmental vitiligo in which depigmentation is generalized, bilateral, symmetrical, and increases in size over time. In contrast, segmental vitiligo, 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.

Treatment

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 D_3 analogues, are common first-line treatments 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, light box therapy with narrow-band ultraviolet B (NB-UVB) and psoralen plus ultraviolet A (PUVA).

Targeted phototherapy with handheld lamps or lasers is also being evaluated. Potential advantages of targeted phototherapy include the ability to use higher treatment doses and to limit exposure to surrounding tissue. Original UVB devices consisted of a Phillips TL-01 fluorescent bulb with a maximum wavelength (lambda max) of 311 nm. Subsequently, xenon chloride lasers and lamps were developed as targeted UVB treatment devices; they generate monochromatic or very narrowband 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.

PUVA uses a psoralen derivative in conjunction with long wavelength ultraviolet A (UVA) light (sunlight or artificial) for photochemotherapy of skin conditions. Psoralens are tricyclic furocoumarins 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 the direct application of psoralen to the skin with subsequent exposure to UVA light. With topical PUVA, UVA exposure is generally administered within 30 minutes of psoralen application.

Regulatory Status

In 2001, XTRAC™ (PhotoMedex), a xenon chloride (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 UVB 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), MultiClear Multiwavelength Targeted Phototherapy System, Psoria-Light™, 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. FDA product code: GEX.

In 2010, the Levia Personal Targeted Phototherapy® UVB device (Daavlin; previously manufactured by Lerner Medical Devices) was cleared for marketing by the FDA through the 510(k) process for home treatment of psoriasis.

The oral psoralen product, Oxsoralen-Ultra (methoxsalen soft gelatin capsules), has been approved by the FDA and is made by Bausch Health; a generic product is also available from various manufacturers. Topical psoralen products (Oxsoralen; Valeant Pharmaceuticals) and methoxsalen hard gelatin capsules have been discontinued.

IV. RATIONALE

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Summary of Evidence Psoriasis

For individuals who have mild localized psoriasis who receive targeted phototherapy, there is little evidence. Relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. Evidence is lacking on the use of targeted phototherapy as first-line treatment of mild psoriasis. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have mild psoriasis that is resistant to topical medications who receive targeted phototherapy, the evidence includes small within-subject studies. Relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. The available pre-post studies have shown that targeted phototherapy can improve mild localized psoriasis (<10% body surface area) that has not responded to topical treatment. Targeted phototherapy is presumed to be safer or at least no riskier than whole body phototherapy, due to risks of exposing the entire skin to the carcinogenic effects of UVB light. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have moderate-to-severe localized psoriasis who receive targeted phototherapy, the evidence includes RCTs and systematic reviews of RCTs. Relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. Systematic reviews of small RCTs and non-RCTs in patients with moderate-to-severe psoriasis have found that targeted phototherapy has efficacy similar to whole body phototherapy and supports the use of targeted phototherapy for the treatment of moderate-to-severe psoriasis comprising less than 20% of body surface area for which narrowband UVB or phototherapy with PUVA are indicated. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have generalized psoriasis who receive PUVA, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. RCTs and systematic reviews of RCTs have found that PUVA is more effective than narrowband UVB, topical steroids, or UVA without psoralens in patients with generalized psoriasis. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Summary of Evidence Vitiligo

For individuals who have vitiligo who receive targeted phototherapy, the evidence includes systematic reviews of randomized controlled trials. 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. Two meta-analyses were attempted; however, results from a meta-analysis could not be verified because the selected studies were not available in English, and one estimate was imprecise due to the small number of studies and participants. 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 have not responded to conservative therapy who receive PUVA (photochemotherapy), the evidence includes systematic reviews and randomized control trials. 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. When compared with narrowband ultraviolet B in meta-analyses, results have shown that patients receiving narrowband ultraviolet B experienced higher rates of repigmentation than patients receiving PUVA, though the differences were not statistically significant. 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.

V. DEFINITIONS TOP

510 (K) A premarketing submission made to FDA to demonstrate that the device to be marketed is as safe and effective, that is, substantially equivalent (SE), to a legally marketed device that is not subject to premarket approval (PMA). Applicants must compare their 510(k) device to one or more similar devices currently on the U.S. market and make and support their substantial equivalency claims.

DERMATITIS is an inflammatory rash marked by itching and redness.

ECZEMA is an itchy red rash that initially oozes serum and may become crusted, thickened, or scaly. Eczematous rash may result from various causes, including allergies, irritating chemicals, drugs, or sun exposure. It may be acute or chronic.

GOECKERMAN THERAPY a regimen that consists of exposure to ultraviolet B (UVB) light and application of crude coal tar (CCT)

LASER ULTRAVIOLET LIGHT BLUE (UVB) a special type of laser (i.e., narrow band) used to deliver UVB light in the specific range between 310-312 nm.

LIGHT THERAPY FOR PSORIASIS includes both targeted phototherapy and photochemotherapy with psoralin plus ultraviolet A (PUVA)**.**

PHOTOTHERAPY refers to the treatment of disorders by the use of light, especially ultraviolet light.

PITYRIASIS ROSEA refers to a mild exanthematous inflammation of unknown etiology. It is characterized by the presence of salmon-colored maculopapular lesions. The eruptions are usually generalized, affecting chiefly the trunk, and the course is often self-limiting.

PRURITUS is a tingling or faintly burning skin sensation that prompts a person to rub or scratch.

PSORALEN refers to a group of substances derived from plants, which are capable of causing a phototoxic dermatitis when applied to the skin and exposed to sunlight or artificial ultraviolet wavelengths.

PSORIASIS is a common, chronic disease of the skin that consists of reddened papules that develop to form plaques with distinct borders. As the disease progresses and if it is untreated, a silvery, yellow-white scale develops. New lesions tend to appear at sites of trauma, but frequently are located on the scalp, knees, elbows, and genitalia.

PUVA uses a psoralen derivative in conjunction with long wavelength ultraviolet A (UVA) light (sunlight or artificial) for photochemotherapy of skin conditions.

TARGETED PHOTOTHERAPY describes the use of ultraviolet light that can be focused on specific body areas or lesions. It involves application of light energy directly focused on, the lesion through special delivery mechanisms such as fiber-optic cables. It includes different technologies such as excimer laser, intense pulse light systems, and UV light sources with hand-held delivery systems.

ULTRAVIOLET B (UVB) is one of the three types of invisible light rays (together with ultraviolet A and ultraviolet C) given off by the sun.

VITILIGO is a idiopathic skin disorder characterized by a patchy loss of skin pigment. The depigmented areas, which appear most commonly on the hands, face, and genital regions, are flat and pale and surrounded by normal pigmentation.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice, and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's

plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes								
E0691	E0692	E0693	E0694	S9098	96900	96910	96912	96913
96920	96921	96922						

ICD-10-CM Diagnosis Codes	Description
C84.00	Mycosis fungoides, unspecified site
C84.01	Mycosis fungoides, lymph nodes of head, face, and neck
C84.02	Mycosis fungoides, intrathoracic lymph nodes
C84.03	Mycosis fungoides, intra-abdominal lymph nodes
C84.04	Mycosis fungoides, lymph nodes of axilla and upper limb
C84.05	Mycosis fungoides, lymph nodes of inguinal region and lower limb
C84.06	Mycosis fungoides, intrapelvic lymph nodes
C84.07	Mycosis fungoides, spleen
C84.08	Mycosis fungoides, lymph nodes of multiple sites
C84.09	Mycosis fungoides, extranodal and solid organ sites
C84.10	Sezary disease, unspecified site
C84.11	Sezary disease, lymph nodes of head, face, and neck
C84.12	Sezary disease, intrathoracic lymph nodes
C84.13	Sezary disease, intra-abdominal lymph nodes
C84.14	Sezary disease, lymph nodes of axilla and upper limb
C84.15	Sezary disease, lymph nodes of inguinal region and lower limb
C84.16	Sezary disease, intrapelvic lymph nodes
C84.17	Sezary disease, spleen
C84.18	Sezary disease, lymph nodes of multiple sites
C84.19	Sezary disease, extranodal and solid organ sites
C84.A0	Cutaneous T-cell lymphoma, unspecified, unspecified site
C84.A1	Cutaneous T-cell lymphoma, unspecified lymph nodes of head, face, and neck

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ICD-10-CM Diagnosis Codes	Description
C84.A2	Cutaneous T-cell lymphoma, unspecified, intrathoracic lymph nodes
C84.A3	Cutaneous T-cell lymphoma, unspecified, intraabdominal lymph nodes
C84.A4	Cutaneous T-cell lymphoma, unspecified, lymph nodes of axilla and upper limbs
C84.A5	Cutaneous T-cell lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C84.A6	Cutaneous T-cell lymphoma, unspecified, intrapelvic lymph nodes
C84.A7	Cutaneous T-cell lymphoma, unspecified, spleen
C84.A8	Cutaneous T-cell lymphoma, unspecified, lymph nodes of multiple sites
C84.A9	Cutaneous T-cell lymphoma, unspecified, extranodal and solid organ sites
D45	Polycythemia vera
D47.01	Cutaneous mastocytosis (urticaria pigmentosa)
D89.810	Acute graft-versus-host disease
D89.811	Chronic graft-versus-host disease
D89.812	Acute on chronic graft-versus-host disease
D89.813	Graft-versus-host disease, unspecified
L20.0	Besnier's prurigo
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L28.1	Prurigo nodularis
L28.2	Other prurigo
L29.8	Other pruritus
L30.1	Dyshidrosis [pompholyx]
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis
L40.2	Acrodermatitis continua
L40.3	Pustulosis palmaris et plantaris
L40.4	Guttate psoriasis
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified
L41.0	Pityriasis lichenoides et varioliformis acuta
L41.1	Pityriasis lichenoides chronica
L41.3	Small plaque parapsoriasis
L41.4	Large plaque parapsoriasis

ICD-10-CM Diagnosis Codes	Description
L41.5	Retiform parapsoriasis
L41.8	Other parapsoriasis
L41.9	Parapsoriasis, unspecified
L42	Pityriasis rosea
L43.0	Hypertrophic lichen planus
L43.1	Bullous lichen planus
L43.2	Lichenoid drug reaction
L43.3	Subacute (active) lichen planus
L43.8	Other lichen planus
L43.9	Lichen planus, unspecified
L50.3	Dermatographic urticaria
L56.3	Solar urticaria
L56.4	Polymorphous light eruption
L56.8	Other specified acute skin changes due to ultraviolet radiation
L57.1	Actinic reticuloid
L63.8	Other alopecia areata
L63.9	Alopecia areata, unspecified
L66.1	Lichen planopilaris
L73.8	Other specified follicular disorders
L80	Vitiligo
L90.0	Lichen sclerosus et atrophicus
L92.0	Granuloma annulare
L92.1	Necrobiosis lipoidica, not elsewhere classified
L94.0	Localized scleroderma [morphea]

IX. REFERENCES

TOP

Psoriasis

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X. POLICY HISTORY

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MP 2.046	**1/24/19 Consensus review**. No change to policy statements. Background and references updated. Rationale condensed.
	02/25/2020 Minor review. Separated treatments with criteria and title changed. Formerly titled Ultraviolet Light Therapies. Added diagnosis codes. Updated background rationale and literature. Effective 7/1/2020.
	07/28/2021 Minor review. Criteria updated for Home Phototherapy. Reference added.
	9/8/2021 Administrative update. New codes L24.A0 and L24.A9 added. Effective 10/1/2021
	3/31/2022 Minor review. Combined all the UVB sections into one. Changed INV statements concerning other therapies to NMN. Updated FEP, background, references, and ICD-10 codes.
	1/31/2023 Consensus review. Updated background and references. No changes to coding.

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POLICY TITLE	LIGHT THERAPIES
POLICY NUMBER	MP-2.046

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