Neighborhood Health Plan OF RHODE ISLAND™

Clinical Medical Policy

Phototherapy and Photochemotherapy for Dermatologic Conditions- # 066

Last reviewed: 06/07/2023

Benefit Coverage

Covered Benefit for lines of business including:
Covered Benefit for lines of business including: Health Benefits Exchange (HBE), Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Medicare-Medicaid Plan (MMP) Integrity
Excluded from Coverage:
Extended Family Planning (EFP)

This clinical medical policy addresses coverage of Phototherapy and Photo-chemotherapy for Skin Conditions.

Description

Psoralen plus ultraviolet A (PUVA) chemotherapy combines the administration of psoralens, a class of phototoxic plant-derived compounds, with an exposure to ultraviolet A radiation (UVA). PUVA is used for the treatment of a variety of skin diseases.

Ultraviolet B (UVB) is present in sunlight and can be divided into two types, broadband and narrow band. Broadband UVB radiation with or without topical tar has been used for the treatment of moderate to severe psoriasis. More recently narrowband UVB has been more frequently used.

Coverage Determination

Neighborhood Health Plan of Rhode Island (Neighborhood) covers Phototherapy and Photochemotherapy as a clinical option when recommended by the member's primary care physician or dermatologist and when determined medically necessary by the Medical Management Department. Retroactive requests for procedures already performed may not be covered.

Criteria

PUVA Photochemotherapy criteria

PUVA is considered medically necessary for new lesions up to three (3) times per week for up to three (3) months when **ONE** of the following conditions is being treated:

- ☐ Cutaneous T cell Lymphoma (mycosis fungiodes) – limited patch/plaque disease **OR**
- ☐ Any of the following diagnoses that have failed narrow band UVB therapy
  - ☐ Moderate to severe psoriasis
  - ☐ Pityriasis lichenoides chronica
  - ☐ Pityriasis lichenoides et varioliformis acutea (PLEVA)
  - ☐ Severe atopic dermatitis
  - ☐ Severe lichen planus

- ☐ **AND at least ONE** of the following criteria is met.
  - ☐ Clinical documentation of moderate to severe disease involving 10% or greater body surface area **OR**
  - ☐ Specific involvement of the hands, feet or scalp **OR**
  - ☐ Trial and failure of at least four to six weeks conventional medical treatment involving topical or oral medications of at least two of the following; corticosteroids (oral or topical), topical calcipotriene, calcineurin inhibitors, oral antihistamines, oral methotrexate or tazarotene.

(Please note some of these medications may be subject to Neighborhood's pharmacy and therapeutics committee requirements).

Maintenance treatments may be covered for Cutaneous T cell Lymphoma and psoriasis only, if the clinical documentation shows that the skin condition has been treated successfully and requires continued treatment. These additional treatments will require prior authorization. Up to 24 additional treatments per 12 month period may be authorized. Clinical documentation must be submitted.

Vitiligo is NOT a covered condition for PUVA photochemotherapy.

UVB Photochemotherapy criteria

UVB Therapy is considered necessary for new lesions up to three (3) times per week for up to three (3) months when **ONE** of the following conditions is being treated:

- ☐ Cutaneous T cell Lymphoma (mycosis fungiodes) – limited patch/plaque disease **OR**
- ☐ Treatment of any one of the following:
  - ☐ Moderate to severe psoriasis
  - ☐ Pityriasis lichenoides chronica
  - ☐ Pityriasis lichenoides et varioliformis acutea (PLEVA)
  - ☐ Severe atopic dermatitis
  - ☐ Severe lichen planus
  - ☐ Vitiligo

AND at least one of the following criteria is met.

- ☐ Clinical documentation of moderate to severe disease involving 10% or greater body surface area or
- ☐ Specific involvement of the hands, feet or scalp or
- ☐ Trial and failure of at least four to six weeks conventional medical treatment involving topical or oral medications of at least two of the following; corticosteroids (oral or topical), topical calcipotriene, calcineurin inhibitors, oral antihistamines, oral methotrexate or tazarotene. (Please note some of these medications may be subject to Neighborhood's pharmacy and therapeutics committee requirements).

Maintenance treatments may be covered for Cutaneous T cell Lymphoma and psoriasis if the clinical documentation shows that the skin condition has been treated successfully and requires continued treatment. These will require prior authorization. Up to 24 additional treatments per 12 month period may be authorized. Clinical documentation must be submitted.

UVB Excimer Laser Therapy

UVB Excimer Laser Therapy is considered medically necessary for psoriasis **only** when all the following criteria are met:

- ☐ Less than or equal to 5% of the total body surface area is affected, **AND**
- ☐ Failure of at least three months of three (3) of the following therapies:
  - ☐ Topical or oral corticosteroids
  - ☐ Topical tazarotene or other retinoid
  - ☐ Topical calcipotriene or other vitamin D analogs
  - ☐ Topical calcineurin inhibitors
  - ☐ Tar preparations
  - ☐ Anthralin

(Please note some of these medications may be subject to Neighborhood's pharmacy and therapeutics committee requirements)

Up to 13 treatments can be authorized initially. If there is significant improvement, a request for another 13 treatments per 12 month period can be submitted for prior authorization.

Exclusions
There is no coverage for conditions not listed or listed conditions that do not meet the criteria above.

Authorization Forms

Please access Prior Authorization forms by visiting Neighborhood's website at www.nhpri.org
1. Go to the section for Providers
2. Click on "Resources & FAQ's"
3. Click on "Medical Management Request Forms"- forms are listed alphabetically by program.

Prior Authorization Forms

For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060.
Fax authorization forms to 401-459-6023.
Covered Codes: For information on Coding please reference the Authorization Quick Reference Guide

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Neighborhood reviews clinical medical policies on an annual base.

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.

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