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MEDICAL POLICY – 2.01.542

Ultraviolet B Light Therapy in the Home to Treat Skin Conditions

Ref. Policy: MP-041

Effective Date:	Apr. 1, 2025	RELATED MEDICAL POLICIES:
Last Revised:	Mar. 24, 2025	None
Replaces:	N/A	

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POLICY CRITERIA | CODING | RELATED INFORMATION
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Introduction

Ultraviolet B (UVB) light therapy, also called phototherapy, is a treatment for severe and chronic skin conditions. The goal of UVB therapy is to reduce itching, help the skin make more vitamin D, and increase bacteria-fighting systems in the skin. With UVB therapy, affected areas of the skin are exposed to artificial UV light through a light box. This policy describes when using ultraviolet B light therapy in the home to treat skin conditions may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Service	Medical Necessity

Light therapy in the home, ultraviolet B (UVB), to treat skin conditions	**Ultraviolet B light therapy in the home to treat skin conditions may be considered medically necessary for the following indications:**
	• Coverage of home light box therapy requires all of the following:
	  ○ The individual must be diagnosed with one of the following diseases specified for home therapy use:
	  ▪ Psoriasis
	  ▪ Atopic dermatitis/severe eczema
	  ▪ Pruritis secondary to an underlying disease
	  ▪ Cutaneous T-cell lymphoma (CTCL)
	  ▫ Sezary's Disease
	  ▪ Mycosis fungoides (MF)
	  ▪ Lichen planus
	  ▪ Polymorphic light eruption
	  ○ The individual's skin disorder must be all of the following:
	  ▪ Severe
	  ▪ Extensive (large body area or extensive involvement of the hands and feet)
	  ▪ Refractory for a long-period of time (greater than 4 months)
	  ▪ Require treatments at least three times per week
	  ▪ Condition must be chronic in nature and require long-term maintenance therapy
	  ○ The device must be/have all of the following:
	  ▪ Prescribed by a dermatologist
	  ▪ Approved by the US Food and Drug Administration (FDA)
	  ▪ Appropriate for the extent of body surface involvement
	  ▪ Light source of the device must provide UVB light only
	  ○ The individual must have all of the following:
	  ▪ Capable of operating the light box and following specific treatment instructions determined by the prescribing dermatologist
	  ▪ Unable to travel for office-based therapy **OR** it has been determined that home therapy will be more cost-effective than office-based treatment

Service	Medical Necessity
	○ The dermatologist must maintain accurate treatment records available upon request **Note:** See Related Information below for **Limitations**

Coding

Code	Description
HCPCS Codes Covered if Selection Criteria are Met (If Appropriate)	
A4633	Replacement bulb/lamp for ultraviolet light therapy system, each
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 6 foot cabinet, includes bulbs/lamps, timer and eye protection
ICD-10 Codes Covered if Selection Criteria are Met	
C84.0-C84.09	Mycosis fungoides
C84.1-C84.19	Sezary disease
C84.4-C84.49	Peripheral T cell lymphoma
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L29.0-L29.9	Pruritis
L40.0-L40.96	Psoriasis
L41.0-L41.9	Parapsoriasis
L43.0-L43.9	Lichen Planus
L56.2	Photocontact dermatis

Code	Description
L56.4	Polymorphous light eruption

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Limitations

1. UV box therapy in the home is NOT covered when:
    - Used for treatment of Seasonal Affective Disorders (SAD)
    - The individual does not meet all of the qualifying clinical indications
    - It is being requested solely for the individual's convenience
    - It is for cosmetic purposes such as tanning
2. Psoralen and Ultraviolet A Light Therapy (PUVA) are not covered for home use.

NOTE: Medicare Variation (NCD 250.1 – Treatment of Psoriasis) - PUVA therapy is covered for treatment of intractable, disabling psoriasis, but only after the psoriasis has not responded to more conventional treatment. The Medicare Administrative Contractor should document this before paying for PUVA therapy. In addition, reimbursement for PUVA therapy should be limited to amounts paid for other types of photochemotherapy; ordinarily, payment should not be allowed for more than 30 days of treatment, unless improvement is documented.

Evidence Review

N/A

References

1. Myers, E., Kheradmand, S., & Miller, R. (2021). An Update on Narrowband Ultraviolet B Therapy for the Treatment of Skin Diseases. Cureus. **https://doi.org/10.7759/cureus.19182**. Accessed March 5, 2025.

2. Branisteanu, D., Dirzu, D., Toader, M., Branisteanu, D., Nicolescu, A., Brihan, I., Bogdanici, C., Branisteanu, G., Dimitriu, A., Anton, N., & Porumb, E. (2022). Phototherapy in dermatological maladies (Review). Experimental and Therapeutic Medicine, 23(4). **https://doi.org/10.3892/etm.2022.11184**. Accessed March 5, 2025.

History

Date	Comments
09/16/19	New policy, approved August 13, 2019, effective January 1, 2020. Ultraviolet B light therapy in the home to treat skin conditions may be considered medically necessary to treat the following conditions when criteria are met: psoriasis, atopic dermatitis/severe eczema, pruritis secondary to an underlying disease, cutaneous T-cell lymphoma (CTCL), mycosis fungoides (MF), lichen planus, polymorphic light eruption, and Sezary's Disease.
08/01/20	Annual Review, approved July 2, 2020. No changes to policy statement.
08/01/21	Annual Review, approved July 9, 2021. No changes to policy statement.
05/01/22	Annual Review, approved April 11, 2022. No changes to policy statement.
04/01/23	Annual Review, approved March 20, 2023. No changes to policy statement, references updated. Changed the wording from "patient" to "individual" throughout the policy for standardization.
04/01/24	Annual Review, approved March 25, 2024. No changes to policy statement, references updated.
04/01/25	Annual Review, approved March 24, 2025. Minor update to policy statement wording. References updated.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member

benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy only applies to Individual Plans.