Overview

This Coverage Policy addresses office-based phototherapy, photochemotherapy, and excimer laser therapy for dermatologic conditions. Phototherapy includes exposure to type A ultraviolet (UVA) radiation or type B ultraviolet (UVB) radiation or a combination of UVA and UVB. Photochemotherapy is exposure to UVA radiation following administration of a psoralen (e.g., methoxsalen, trioxsalen). Excimer laser therapy releases a spectrum of UVB wavelengths and is used to treat small, focused areas of the body. Home phototherapy may be indicated for a select subset of dermatologic conditions.

Coverage Policy

Coverage for home phototherapy devices varies across plans. Please refer to the customer’s benefit plan document for coverage details.

Coverage for the treatment of vitiligo varies across plans, may be subject to the provisions of a cosmetic exclusion and/or reconstructive surgery benefit, and may be governed by state mandates. Please refer to the customer’s benefit plan document for coverage details.

Office-Based Phototherapy and Photochemotherapy
Office-based phototherapy and photochemotherapy* are considered medically necessary when there is failure, intolerance or contraindication to conventional medical management (e.g., diet restrictions, topical ointments or creams, immunosuppressants) for ANY of the following dermatologic conditions:

- atopic dermatitis (i.e., atopic eczema)
- connective tissue diseases involving the skin (e.g., cutaneous graft vs. host disease [GVHD], localized scleroderma, lupus erythematosus)
- cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides)
- lichen planus
- photodermatoses (e.g., polymorphic light eruption, actinic prurigo, chronic actinic dermatitis)
- psoriasis

*Office-based phototherapy includes actinotherapy, type A ultraviolet (UVA) radiation; type B ultraviolet (UVB) radiation; and combination UVA/UVB radiation. Photochemotherapy includes psoralens (P) and type A ultraviolet (UVA) radiation, known as PUVA photochemotherapy and combinations of P/UVA/UVB.

Phototherapy or photochemotherapy is considered cosmetic and not medically necessary for the treatment of EITHER of the following in any setting. Please refer to the customer’s benefit plan document for coverage details on cosmetic services.

- alopecia areata
- localized or generalized vitiligo

Phototherapy or photochemotherapy is considered experimental, investigational, or unproven in any setting for EACH of the following dermatologic conditions:

- cicatricial alopecias
- cutaneous herpes virus
- chronic ordinary urticaria
- chronic palmoplantar pustulosis
- chronic vesicular dyshidrotic eczema
- diabetic foot ulcer
- dyshidrotic eczema
- erythropoietic porphyria
- granuloma annulare
- herpesviridae
- onychomycosis
- palmoplantar eczema, acute
- psoriatic nail disease
- pityriasis rosea
- prurigo nodularis
- uremic pruritis
- urticaria pigmentosa (cutaneous mastocytosis)

**Excimer Laser Therapy**

Office-based targeted excimer laser therapy (i.e., 308 nanometers [nm]) is considered medically necessary for the treatment of localized, plaque psoriasis refractory to conservative treatment with topical agents and/or phototherapy.

Excimer laser therapy is considered cosmetic and not medically necessary for the treatment of EITHER of the following in any setting. Services that are cosmetic are not covered under most benefit plans.

- alopecia areata
Targeted excimer laser therapy (i.e., 308 nanometers [nm]) is considered experimental, investigational or unproven in any setting for EACH of the following dermatologic conditions:

- localized or generalized vitiligo
- atopic dermatitis (i.e., atopic eczema)
- cicatricial alopecias
- cutaneous herpes virus
- chronic ordinary urticaria
- chronic palmoplantar pustulosis
- diabetic foot ulcer
- dyshidrotic eczema
- erythropoietic porphyria
- granuloma annulare
- lichen planus
- onychomychosis
- palmoplantar eczema, acute
- pityriasis rosea
- prurigo nodularis
- psoriatic nail disease
- urticaria pigmentosa (cutaneous mastocytosis)

Home Phototherapy Devices
If coverage for home phototherapy devices is available, the following conditions of coverage apply:

An appropriately sized (e.g. hand wand for hand, two-foot panel for lower leg**) ultraviolet B (UVB) home phototherapy device is considered medically necessary when the above criteria for office-based phototherapy and photochemotherapy are met with ALL of the following:

- outpatient UVB phototherapy has been utilized, demonstrated to be beneficial and is expected to be long-term
- the device is not available without a prescription and the device and treatment regimen are prescribed by a physician
- individual is motivated and compliant to prescribed usage

**Ultraviolet cabinets are generally not covered

Ultraviolet A (UVA) phototherapy in the home setting is considered not medically necessary.

The use of a tanning bed/unit for any reason in any setting is not considered medical in nature and as such does not meet the standard plan definition of Durable Medical Equipment. In addition, many benefit plans do not cover the use of a tanning bed/unit in any setting, including the home, for the treatment of dermatologic conditions because it is considered not medically necessary.

General Background

Phototherapy (e.g., actinotherapy) is defined as exposure to non-ionizing, ultraviolet (UV) radiation for therapeutic benefit by inducing DNA damage. The therapy involves exposure to type A ultraviolet (UVA) radiation or type B ultraviolet (UVB) radiation or various combinations of UV, and UVA and UVB. The differences in these ultraviolet light forms are the length of the waves. UVA wavelength is 320–400 nanometers [nm], broadband (bb) UVB is 280–320 nm and narrowband (nb) UVB is 311–312 nm. UVA is further broken down into UVA1 (340–400 nm) and UVA2 (320–340 nm). The longer wavelengths emit a lower energy level. UVA bulbs, for example, are used in tanning beds for cosmetic effects because they promote tanning using lower energy with less erythema than UVB. Photochemotherapy is exposure to UVA radiation following administration of a psoralen (e.g.,
methoxsalen, trioxsalen) given orally, topically, or in a bath. Combination therapy includes phototherapy or photochemotherapy with topical agents, such as tar, anthralin and corticosteroids, or with systemic agents, such as retinoids and methotrexate. The duration and number of treatments depends on the dermatologic condition; type, number, and location of the lesions; skin type; type of therapy (e.g., UVA, UVB, PUVA); and the dosage. Treatments may be given 2–5 times per week for several weeks and may involve up to 40 treatments depending on the response of the condition to the therapy.

Excimer laser, also called exciplex laser, is a form of ultraviolet laser proposed for the treatment of various dermatologic conditions including, atopic dermatitis, psoriasis and vitiligo. An excimer laser releases a spectrum of 308-nm UVB wavelengths and is used to treat small, focused areas of the body (e.g., 2 X 2 centimeters). Laser therapy is proposed to increase the precision and delivery of UVB energy to targeted tissue. The increased precision results in a faster therapeutic effect and decreases the total number of treatments needed, limits the amount of UV radiation exposure, and decreases the risk of skin cancer. The hand-held lasers are good for hard to treat areas such as elbows, knees, palms, soles of feet and scalp. This precision makes total-body treatment with laser therapy difficult. Some propose that laser therapy is effective, safe and well tolerated when limited to less than 20% of the body surface. Treatments are typically given two to three times a week on nonconsecutive days, last for 15-30 minutes and are given for 4–36 weeks resulting in improvement of the condition. The number of treatments required depends on multiple factors including the condition being treated, the severity of the condition and the skin type. A minimum or 48 hours between treatments is advised. Excimer laser therapy is an established treatment option for localized, plaque psoriasis (Menter, et al., 2010; Nicolaidou, et al., 2009). Although the therapy has been proposed for other conditions, the evidence does not support its use nor is it an established standard treatment for other conditions.

U.S. Food and Drug Administration (FDA)
Phototherapy and photochemotherapy light sources are approved by the FDA 510(k) process as Class II phototherapy units. Examples of phototherapy light sources include: VersaClear™ Skin Therapy System (TheraLight, Inc., Carlsbad, CA) and the Houva Phototherapy System with PhotoSense II™ (National Biological Corporation, Inc., Beachwood, OH). They are approved for the treatment of various skin disorders.

Excimer lasers are approved by the FDA 510(k) process. Not all excimer lasers are approved for the treatment of the same dermatological conditions. Excimer lasers include the following:

- **FENCER Excimer Laser System** (Kera Harvest/Laser Max Medical Technologies Corporation, Visalia, CA) is approved for the treatment of psoriasis, vitiligo, leukoderma, and atopic dermatitis.
- **XTRAC XL Excimer Laser System** (PhotoMedex, Inc. Carlsbad, CA) is approved for the treatment of psoriasis, vitiligo, leukoderma, and atopic dermatitis.
- **308 Dermatological Excimer Lamp Phototherapy system** (Quantel Medical, Hasbrouck Heights, NJ), distributed by National Biological Corporation, is approved for the treatment of psoriasis and vitiligo.
- **Excilite™ and Excilite-µ** (Cynosure, Inc., Chelmsford, MA) monochromatic excimer light systems are approved for the treatment of "leukoderma, psoriasis, vitiligo, eczema, and seborrheic dermatitis, for skin types I to VI".
- **Levia Phototherapy System** (Lerner Medical devices, Inc., Los Angeles, CA) is “intended for use in UVB phototherapy in all skin types for the treatment of psoriasis including scalp psoriasis, vitiligo, atopic dermatitis (eczema) seborrheic dermatitis and leucoderma”. The Levia has a fiber-optic brush used for areas of the skin covered with hair (FDA, 2008; FDA, 2007; FDA, 2005; FDA, 2004).

**Indications for Phototherapy, Photochemotherapy and Excimer Laser Therapy**
Evidence in the published peer-reviewed scientific literature, including randomized controlled trials and case series, as well as professional societies and organizations support the safety and effectiveness of phototherapy and photochemotherapy for the treatment of atopic dermatitis, connected tissue diseases involving the skin, cutaneous T-cell lymphoma, lichen planus, photodermatoses, and psoriasis for patients who do not tolerate or are unresponsive to conventional medical management (e.g., diet restrictions, stress control, oral immunosuppressive agents, biologic agents, topical and oral steroids). Excimer laser therapy is supported by the evidence in the literature and is an established treatment option for patients with psoriasis that is unresponsive to topical agents or phototherapy.
The treatment of vitiligo is aimed at repigmentation and improved cosmesis and not medically indicated. Likewise, because the treatment for alopecia areata is to restore hair loss and improve cosmesis, it is not medically indicated. Phototherapy, photochemotherapy and excimer laser therapy are proposed for the treatment of numerous other dermatologic conditions. However, there is insufficient evidence in the peer-reviewed literature to support the efficacy of these therapies for the treatment of other conditions.

**Atopic Dermatitis (Atopic Eczema)**
Atopic dermatitis, or atopic eczema, is a chronic skin condition characterized by a dry, itchy rash on the face, elbows, hands, knees, and/or feet. In addition to skin care and avoidance of substances that might irritate the skin, topical ointments and creams, and oral corticosteroid are standard treatment options. For severe cases in adults, immunosuppressants may be prescribed. If unresponsive to medication, phototherapy and photochemotherapy (i.e., UVB, UVA and PUVA) are established treatment alternatives (Brown and Reynolds, 2006; Wise, 2006). Evidence to support excimer laser therapy for the treatment of atopic dermatitis is lacking.

**Literature Review:** The evidence in the published peer-reviewed scientific literature in the form of systematic reviews and randomized controlled trials supports UVB, nbUVB, and UVA phototherapy, PUVA, and combination treatments as safe, effective, and well-tolerated therapies for atopic dermatitis. Studies reported appreciative improvement in symptoms and in some cases long-term remission (Tzaneva, et al., 2010; Meduri, et al., 2007).

There are a limited number of studies evaluating excimer laser therapy for the treatment of atopic dermatitis. Studies are primarily in the form of case series or retrospective reviews with small patient populations and short-term follow-ups. Brenninkmeijer et al. (2010) conducted a within patient, randomized controlled trial (n=10) to compare the safety and efficacy of 0.05% topical clobetasol propionate (CP) ointment to excimer laser (EL) therapy for the treatment of prurigo atopic dermatitis. The patients had more than four symmetrical prurigo nodules on the lower and upper extremities that had persisted for six months or longer. Treatment was randomized to either the right or left side of the patient’s body. Laser therapy was administered for ten weeks. Compared to baseline scores, both sides showed a significant improvement of mean Physician Assessment of Individual Signs (PAIS) (p<0.001) during follow up weeks 14–34. At week 34, the EL-treated nodules had a significantly better PAIS score compared to the CP-treated nodules (p<0.05). More patients reported marked improvement following EL (n=7) compared to CP (n=4). Less relapse of disease was seen following EL treatment. There was no significant difference in the pruritus scores between the two treatments. Author-noted limitations of the study included the small patient population, selection of more severely affected patients, loss of blinding due to sustained hyperpigmentation in the EL group and the use of various radiant exposures.

**Professional Societies/Organizations:** The American Academy of Dermatology (AAD) (2014) recommended phototherapy for the treatment of atopic dermatitis following failure of first-line therapy, including emollients, topical steroids, and topical calcineurin inhibitors. Phototherapy can also be used for treatment in chronic disease as a maintenance therapy. The light modality, dosing and scheduling is based on various factors, such as phototherapy technique, skin type, skin cancer history, and use of photosensitizing medication. Although AAD stated that home phototherapy may be considered for a subset of patients who are unable to go to an office setting, they noted that there are no studies that document the safety and efficacy of home phototherapy for AD. Due to the lack of evidence, laser therapy is not recommended treatment modality for atopic dermatitis.

**Connective Tissue Disease, Including Cutaneous Graft Versus Host Disease (GVHD)**
Connective tissue disease, also referred to as sclerosing skin diseases, includes numerous conditions that affect the connective tissue in various parts of the body. Sclerosing skin diseases include: necrobiosis lipoidica, systemic sclerosis, localized scleroderma, also known as morphea; sclerodermoderm GVHD; extragenital lichen sclerosus et atrophicus; lupus erythematosus; and sclerodermoderm rarities (e.g., eosinophilic fasciitis, pansclerotic morphea); and polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome. Symptoms and treatment options vary according to each condition. In some diseases, topical steroids are indicated and in others, phototherapy and photochemotherapy are considered a treatment option. The choice of the best therapeutic option is contingent upon the disease entity and the clinical manifestations (Kerr, et al., 2012; Zandi, et al., 2012; Brenner, et al., 2005).
Literature Review: Systematic reviews, randomized controlled trials, and case series support the efficacy of UVA and PUVA for the treatment of sclerosing skin diseases (Buense, et al., 2012; Kroft, et al., 2008; Kreuter, et al., 2006; El-Mofty, et al., 2004; Polderman, et al., 2004; Wetzig, et al., 2005; Wolff, et al., 2004).

Cutaneous T-Cell Lymphoma, Including Mycosis Fungoides
Cutaneous T-cell lymphoma (CTCL) is a slowly evolving form of non-Hodgkin lymphoma of the T-cell. Early stages of the disease may present as distinctive lymphoid dermatoses, such as parapsoriasis, poikiloderma atrophicans, follicular mucinosis (alopecia mucinosa), and pityriasis lichenoides. Two-thirds of CTCL cases are mycosis fungoides (MF), a form of CTCL that evolves from scaly skin patches and plaques. Sezary syndrome is an aggressive form of mycosis fungoides. CTCL may initially be treated with topical chemotherapy agents. PUVA is a widely used treatment for early cutaneous T-cell lymphoma, mycosis fungoides and Sezary syndrome. UVB for MF and Sezary is typically administered 2–3 times a week with ≥24 hours between treatments. A response may be seen within one month of initiation of treatment. PUVA is also typically given 2–3 times a week with 48 hours between treatments. Long-term maintenance is proposed after the initial clearing. Frequency of treatments will depend on the extent of the disease and recurrence rate (Olsen, et al., 2016; Zandi, et al., 2010; National Cancer Institute, 2016; Olsen, et al., 2007; Gokdemir, et al., 2006; El-Mofty, et al., 2005).

Literature Review: Randomized controlled trials and case series support the safety and efficacy of phototherapy and photochemotherapy for the treatment of CTCL. The results from the clinical trials reported significant improvement to complete remission of T-cell lymphoma and mycosis fungoides (Farnaghi, et al., 2011; Ponte, et al., 2010; Gokdemir, et al., 2006; El-Mofty, et al., 2005; Scheinfeld, et al., 2003; Whitaker, et al., 2003).


In their guidelines for the treatment of primary cutaneous lymphomas, the National Comprehensive Cancer Network® (NCCN®) (2019) lists phototherapy as treatment options for mycosis fungoides and Sezary syndrome recommending UVB and nbUVB for patch/thin plaques and PUVA for the treatment of thicker plaques. Treatment varies based on the disease stage.

Lichen Planus
Lichen planus is an inflammatory disease that usually affects the skin and/or the mouth and is characterized by recurrent, itchy, inflammatory rash and/or lesions. Since there is no cure for lichen planus, treatment is aimed at relieving symptoms. Milder cases may be treated with corticosteroid creams and ointments, anti-inflammatory drugs, and antihistamines. More severe cases may require oral or injectable corticosteroids, phototherapy and photochemotherapy.

Literature Review: Although the evidence supporting the efficacy of phototherapy and photochemotherapy for lichen planus is primarily in the form of case series and retrospective reviews, these modalities are established treatment options for this condition when conventional therapies are not effective, not tolerated or are contraindicated. Partial and complete response have been reported in patients following therapy (Pavlotsky, et al., 2008; Wackernagel, et al., 2007; Saricaoglu, et al., 2003; Reichrath, et al., 2002).

There is insufficient evidence in the published peer-reviewed literature to support the efficacy of excimer laser therapy for the treatment of lichen planus. Studies are primarily in the form of case studies with small patient populations. One randomized controlled trial (Dillenburg, et al., 2014) compared the application of topical clobetasol propionate gel (0.05%) three times a day (n=21) to laser irradiation (InGaAlP; MM Optics, São Carlos, São Paulo, Brazil)) three times a week (n=21) for the treatment of atrophic and erosive oral lichen planus. Both groups showed initial improvement. At the 60-day follow-up the laser group had one recurrence and the clobetasol group had 10 recurrences. At the 90-day follow-up the laser group showed a significant improvement in the resolution of lesions (p<0.001) and exhibited more hyperkeratotic lesions and fewer atrophic/erosive lesions than the clobetasol group (p<0.001). The difference in recurrence between the groups at day 90 was not significant (p=0.276). There were no reported side effects in the laser group. According to the authors, this is the
Photodermatoses (e.g., Polymorphic Light Eruption, Actinic Prurigo, Chronic Actinic Dermatitis):
Photodermatoses refers to skin conditions that are aggravated by sunlight. The primary photodermatoses include polymorphic light eruption, actinic prurigo, and chronic actinic dermatitis, also known as photosensitivity dermatitis. Solar urticaria is a rare photodermatoses characterized by pruritis, erythema, pain and wheal formation. Treatment options include avoiding sun exposure, using sunscreens, and topical and/or oral steroids. Phototherapy is viewed as a mainstay of treatment for severe cases.

Literature Review: A limited number of studies in the form of randomized controlled trials and case series have reported that photodermatoses can be successfully treated with UVA, UVB, UVA/UVB, nbUVB phototherapy, and PUVA. Phototherapy and photochemotherapy are recognized treatment options for these conditions (Gambichler, et al., 2006; Ibbotson, et al., 2004).

Psoriasis
Psoriasis is a skin disease involving thickened, red areas covered with silvery scales and characterized by chronic, recurrent exacerbations and remissions. The forms of psoriasis include plaque, pustular (e.g., palmoplantar), inverse, erythrodermic and guttate. Medical management of psoriasis may include bath solutions, moisturizers, topical corticosteroid ointments and creams, vitamin D ointment, retinoid gel and coal tar (i.e., Goeckerman treatment). Phototherapy, photochemotherapy and excimer laser therapy are established treatment options for patients with psoriasis who do not respond to medical treatment.

Literature Review: Systematic reviews, randomized controlled trials, and case series support the safety and efficacy of phototherapy, photochemotherapy and excimer laser for the treatment of psoriasis. Studies have reported favorable response to treatment using bbUVB, nbUVB, PUVA, and followed by phototherapy (e.g., balneophototherapy). Phototherapy is considered an essential treatment option for psoriasis (Mudigonda, et al., 2012; Paul, et al., 2012; Khandpur and Sharma, 2012; Dayal, et al., 2010; Jain, et al., 2010; Mahajan, et al., 2010; Nisticò, et al., 2009; Sivanesan, et al., 2009; Trott, et al., 2008; Brockow, et al., 2007; Erkin, et al., 2007; He, et al., 2007; Lapidoth, et al., 2007; Kirke, et al., 2007; Schiener, et al., 2007; Sezer, et al., 2007; Amornpinyokeit and Asawanonda, 2006; Boztepe, et al., 2006; Goldinger, et al., 2006; Nisticò, et al., 2006; Yones, et al., 2006; Vongthongsri, et al., 2006; Asawanonda, et al., 2005; Kollner, et al., 2005; Lebwohl, et al., 2005; Berneburg, et al., 2005; Pahlajani, et al., 2005; Taibjee, et al., 2005; Zanoli, 2004; Tahir, et al., 2004; Taneja, et al., 2003; Trehan and Taylor, 2002; Rodewald, et al., 2002; Feldman, et al., 2002).

Professional Societies/Organizations: In their guidelines on the treatment of psoriasis, the American Academy of Dermatology’s (AAD) (Menter, et al., 2010) recommendations included UVB phototherapy, PUVA and excimer laser therapy. According to AAD, UVB phototherapy is safe and effective, and nbUVB phototherapy is generally preferable and has improved efficacy compared to bbUVB phototherapy. UVB phototherapy can be given in the office or at home. PUVA is also effective and may result in long remissions, but may increase the risk for squamous cell carcinoma and malignant melanoma. The duration of treatment using phototherapy or photochemotherapy varies depending on the type of psoriasis, skin type, ultraviolet dosing, and whether nbUVB (e.g., 15–20 treatments), bbUVB (e.g., 20–25 treatments), or topical or systemic PUVA is used. Improvement may be seen within 2–4 weeks and 8–40 treatments. AAD recommended excimer laser for the treatment of mild, moderate or severe psoriasis with less than 10% body surface area involvement. Initial dosage depends on the skin type and plaque characteristics and thickness. Treatment is typically administered two to three times a week until the condition clears (average of 10–12 weeks). Mean remission time is reported to be 3.5–6 months.

In an evidence-based clinical consensus document, the National Psoriasis Foundation Medical Board identified two tiers for categorizing severity of disease. Localized therapy, which includes topical treatments and excimer laser treatments, is recommended for patients with psoriasis that affects less than 5% body surface area (BSA). Systemic therapy and/or phototherapy (broad and narrowband phototherapy, photochemotherapy (PUVA), systemic agents, and biologics) is/are recommended for patients with psoriasis affecting greater than 5% BSA; for those with less than 5% BSA affected in vulnerable areas, such as the face, genitals, hands or feet; and for other forms of psoriasis, including but not limited to erythrodermic, pustular and guttate. In addition, patients with limited affected areas and inadequate response to localized therapy or impairment in physical or mental
functioning should also be considered candidates for systemic and/or phototherapy treatment (Pariser, et al., 2007).

Other Indications

Alopecia Areata: Alopecia areata is an autoimmune disorder affecting hair follicles and sometimes the nails. The hair stops growing and suddenly starts falling out in patches from the roots. The patches of hair loss enlarge and then grow back. The patient can experience total scalp hair loss (alopecia totalis), loss of all hair on the body (alopecia universalis) or diffuse thinning of the hair (alopecia areata incognita). Pitting and drainage of the nails may be seen in 10% of cases. Alopecia sometimes starts after a stressful event. There is no reliable cure for the disease. Spontaneous remission occurs in up to 80% of patients. Scalp creams, corticosteroids (topical and injectable) and contact immunotherapy have been used, but have not been shown to alter the course of the disease. Phototherapy, PUVA and excimer laser therapy have been proposed as treatment options but there is insufficient evidence in the published peer-reviewed scientific evidence to support these therapies for the treatment of alopecia areata. There is little documented evidence that UVB is effective and the limited success and long-term safety, side effects and a high relapse rate have curtailed the use of PUVA. There are few studies investigating excimer laser for the treatment of alopecia areata. Overall, studies investigating the effectiveness of UVB, PUVA and excimer laser are primarily in the form of case series and retrospective reviews with small patient populations (n=3–18) and short-term follow-ups (e.g., five weeks to six months). Outcomes varied depending on the type of alopecia and some patients had no response to therapy (New Zealand Dermatologic Society, 2015; Alkhalifah, et al., 2010; British Association of Dermatology, 2012).

Cicatricial Alopecia
Cicatricial (scarring) alopecia (hair loss), also called scarring alopecia or scarring hair loss, refers to a diverse group of rare disorders that destroy the hair follicles, replaces them with scar tissue, and causes permanent hair loss. Cicatricial alopecias are classified as primary or secondary. Primary cicatricial alopecias are inflammatory disorders of the scalp in which the hair follicle is the target of destruction. Primary disorders are classified as lymphocytic or neutrophilic. Lymphocytic cicatricial alopecias include lichen planopilaris, frontal fibrosing alopecia (FA), central centrifugal cicatricial alopecia (CCCA) and discoid lupus erythematosus. Neutrophilic cicatricial alopecias include folliculitis decalvans and dissecting cellulitis. Secondary cicatricial alopecia is destruction of the hair follicle from disorders that cause diffuse scarring of the dermis, including burns, radiation, severe skin infections, localized scleroderma, and scalp tumors (National Organization for Rare Disorders. [NORD], 2016; Shapiro, 2018; Sperling, 2018; New Zealand Dermatology Society, 2014).

Symptoms of itching, burning, pain, or tenderness usually signal ongoing activity. Signs of scalp inflammation include redness, scaling, and pustules. In some cases there are very few signs and symptoms. A punch biopsy of the scalp is indicated to identify the type of inflammation, degree of activity and other changes in the scalp (NORD, 2018; Shapiro, 2018; Sperling, 2018).

Treatment depends on the type of cicatricial alopecia and includes anti-inflammatory agents (e.g., topical or intralesional steroids), calcineurin inhibitors, tetracyclines, hydroxychloroquine, and cyclosporin. Discontinuation of traumatic hair care practices is an essential aspect of treatment of CCCA. Hair restoration surgery or scalp reduction are surgical treatment performed for cosmetic benefits and are only considered in individuals with a one to two year period of inactive disease (NORD, 2018; Shapiro, 2018; Sperling, 2018; New Zealand Dermatology Society, 2014). Phototherapy, photochemotherapy and excimer laser are not proposed treatment options for cicatricial alopecias. Studies have primarily been in the form of retrospective reviews and case series with small patient populations and short-term follow-ups (Fertig and Tosti, 2016; Navarini, 2011).

Onychomycosis: Onychomycosis is infection of the nail bed and nail plate caused by any type of fungus (e.g., yeasts, onychomycosis. The three main types of dermatophytic onychomycosis (also called tinea unguium) are distal subungual, proximal subungual and white superficial. Dermatophyte fungi (e.g., Trichophyton sp.) are more likely to be pathogenic than nondermatophyte fungi, also referred to as molds (e.g., Fusarium sp.). Other types of onychomycosis include endonyx and totally dystrophic. One of several fingernails and/or toenails may be involved, but onychomycosis is more common on toenails. Onychomycosis can cause nail discoloration, thickening, irritation, pain and detachment of the nail plate. The presence of diabetes or other immunocompromised conditions may increase the risk of cellulites or other types of bacterial infection (Durme, 2012; Gupta, et al., 2011; Hoy, et al., 2012).
Treatment depends on the underlying cause and the patient’s comorbidities. Oral medications (e.g., terbinafin and itraconazole) may be used in immunocompromised patients. A topical antifungal nail lacquer with or without an oral agent may be indicated. Surgery may be used to treat an isolated nail infection involving only one digit or for the treatment of a dermatophytoma (i.e., collection of dermatophytes in solid form under the nail). Candida onychomycosis responds to oral agents, but it is prone to relapse if the underlying reason for the infection is not resolved. Long-term recurrence rates of 20%–50% have been reported. Because of the varied response and side effects of oral agents and the high relapse rates, additional nonsystemic treatment modalities are being investigated. Phototherapy and laser therapy have been proposed for the treatment of onychomycosis but there is insufficient evidence in published clinical trials to support the safety and efficacy of these modalities (Durme, 2012; Gupta, et al., 2011; Hoy, et al., 2012).

Bristow (2014) conducted a systematic review of the literature to evaluate the effectiveness of laser therapy for the treatment of onychomycosis. Two randomized controlled trials, four comparative studies with no control groups and four case series met inclusion criteria. Although some studies reported improvement in onychomycosis, the outcomes were conflicting and the study methodology was heterogeneous and of poor quality. Some studies reported recurrence suggesting that laser therapy only had a temporary effect. Additional limitations of the studies included small patient populations (n=8–131) with predominantly short-term follow-ups of < 24 weeks. Several of the studies excluded patients with severe or dystrophic disease. The authors noted that there is no consensus on laser effectiveness.

Gupta and Simpson, 2013 conducted a systematic review to determine the efficacy of laser therapy for the treatment of onychomycosis. A review of the literature identified three basic science articles, five peer-reviewed articles, and four pending clinical trials. The authors concluded that studies with large patient populations, mycologic examination before and after treatment, long-term follow-ups and standardized outcome measures are needed to determine if laser therapy is effective for the treatment of onychomycosis or comparable to traditional pharachoterapeutics.

Ledon et al. (2012) conducted a systematic review of published peer-reviewed studies for laser and light therapy for the treatment of onychomycosis. Ten clinical trials, primarily case series, met inclusion criteria. No studies included UV light or excimer laser therapy for the treatment of this condition.

Psoriatric Nail Disease
Psoriatric nail disease, psoriatric nail dystropy or nail psoriasis occurs in up to 55% of individuals with skin psoriasis, but nail psoriasis can occur without the presence of skin psoriasis. Nail psoriasis may involve pitting, discoloration (white or yellow-red), onycholysis (separation of the nail plate from the nail bed), scaling under the nail (subungual hyperkeratosis), crumbling, thickening and horizontal lines in the nail. Psoriasis can affect fingernails and toenails. Nail psoriasis can lead to pain, tenderness, functional disability and secondary bacterial or fungal infections. Scrapings and/or biopsy may be necessary to confirm the diagnosis (New Zealand Dermatology Society, 2018; Manhart and Rich, 2015; Crowley, et al., 2014; Schons et al., 2014).

Topical therapies such as corticosteroids, calcipotriol, tazarotene, and tacrolimus creams and ointments may be helpful in mild or early nail psoriasis. For individuals who also have severe skin psoriasis and/or psoriatic arthritis, a systemic or biologic treatment can reduce symptoms overall. Nail improvement may lag behind clearing of psoriasis plaques on the body by several months. It can take six months to a year for an affected nail to grow out and be replaced by a new nail (New Zealand Dermatology Society, 2016; Manhart and Rich, 2015; Crowley, et al., 2014; Schons et al., 2014).

Studies investigating the effectiveness of phototherapy, PUVA and excimer laser therapy for the treatment of nail psoriasis are primarily in the form of retrospective reviews (Crowley et al., 2015; Sanchez-Regana, et al., 2015; Manhart and Rich, 2015). A 2014 systematic review (Armstrong, et al., 2014) found one retrospective review investigating PUVA and UVB for the treatment of nail psoriasis.

Based on a systematic review, a 2015 consensus statement for the treatment of nail psoriasis from the Medical Board of the National Psoriasis Foundation does not recommend phototherapy, PUVA or excimer laser therapy for the treatment of nail psoriasis (Crowley, et al., 2015).
**Vitiligo:** Vitiligo is an autoimmune disease resulting in a loss of pigment cells (i.e., melanocytes), producing white patches. Treatments that repigment the affected areas such as phototherapy, photochemotherapy and laser therapy are aimed at improving the untoward cosmetic sequelae associated with the condition and do not treat the underlying autoimmune condition. Self-management of vitiligo includes avoiding sun exposure, and using sunscreens and self-tanning dyes. In some cases, the use of interventions that repigment is only temporizing and may not result in long-term or permanent results. Follow-up data on the long-term effectiveness of phototherapy maintaining pigmentation are limited, but relapse has been reported in up to 25–44% of patients within 12–18 months following cessation of nbUVB therapy. Some patients have reportedly relapsed within three months (Nicolaidou, et al., 2009). Treatment of vitiligo is typically cosmetic in nature to help blend the color to match surrounding skin.

**Other conditions:** Phototherapy, photochemotherapy and/or excimer laser therapy have been proposed for numerous other dermatologic conditions including chronic ordinary urticaria, chronic palmoplantar pustulosis, diabetic foot ulcers, dyshidrotic eczema or acute palmoplantar eczema (vesicular eczema, pompholyx, cheiropompholyx or pedopompholyx), erythropoietic porphyria, granuloma annulare, cutaneous herpes virus (e.g., herpes simplex type 1 and 2, varicella-zoster virus, human herpesvirus 7, Kaposi sarcoma), pityriasis rosea, prurigo nodularis or nodular prurigo, uremic pruritis and/or urticaria pigmentosa (cutaneous mastocytosis) (Simonsen, et al., 2017; Wang, et al., 2017; Su, et al., 2016; Lim, et al., 2009, Nistico, et al. 2009; Engin, et al., 2008; Chuh, et. al., 2007; Gambichler, et al., 2005; Petering, et al., 2004).

There is insufficient evidence in the published peer-reviewed literature to support phototherapy, photochemotherapy and excimer laser therapy for these other conditions, nor are these therapies an established treatment option. Studies are primarily in the form of retrospective reviews, case series with small patient populations (n=8–22) and short-term follow-ups (e.g., five weeks to eight months) or case reports. Outcomes were conflicting and/or reported no improvement. Some studies combined phototherapy with topical steroids and have not investigated phototherapy as a monotherapy for a specific condition (Tan, et al., 2010; Lim, et al., 2009, Nistico, et al. 2009; Engin, et al., 2008; Chuh, et. al., 2007; Gambichler, et al., 2005; Petering, et al., 2004).

A Cochran systematic review (Wang, et al., 2017) of randomized controlled trials evaluated phototherapy for the treatment of open foot ulcers in adult diabetics. Included studies compared 1) phototherapy with sham phototherapy, no phototherapy, or other physical therapy modalities; 2) different forms of phototherapy; or 3) phototherapy of different output power, wavelength, power density, or dose range. Eight studies (n=316) met inclusion criteria. No studies reported valid data for time to complete wound healing. Meta-analysis of four studies (n=116) indicated that more wounds treated with phototherapy experienced more healing compared with no phototherapy or placebo. Results from individual trials (n=16–84) generally suggested that after two to four weeks of treatment phototherapy may have resulted in a greater reduction in ulcer size. Analyses for quality of life (n=28) and amputations (n=23) showed no clear differences between phototherapy and no phototherapy or placebo. No significant adverse events were reported. The level of evidence was considered low due to the small patient populations, methodological flaws and unclear or high risk of bias. Large, well-designed randomized controlled trials are needed to confirm whether phototherapy is an effective treatment option for diabetic foot ulcers.

Simonsen et al. (2017) conducted a systematic review of the literature to assess treatment options for uremic pruritus. A total of 44 randomized controlled trials evaluating 39 different treatments were included in the review. Regarding phototherapy, four studies (n=112) met inclusion criteria. Three studies compared UV-B to UV-A therapy and one study evaluated narrow-band UVB. Dosages varied based on the patient’s skin characteristics. The two studies using broadband UV-B indicated a significant benefit in favor of UV-B therapy over UV-A. However, the study comparing narrow-band UV-B to UV-A showed no statistically significant benefit of narrow-band UV-B therapy compared to UV-A therapy. Sunburn and tanning were noted side effects of the UV-B therapy. Additional studies are needed to support the effectiveness of phototherapy for the treatment of uremic pruritus.

A limited number of randomized controlled trials with small patient populations and short-term follow-ups have investigated phototherapy and photochemotherapy for dermatologic conditions. Ko et al. (2011) conducted a randomized controlled trial to evaluate the efficacy of nbUVB (n=11) compared to a control group (n=10) who
received no treatment for uremic pruritis in patients with stage III–V chronic kidney disease. At the 12-week follow-up, both groups showed significant improvement in the visual analogue scores (VAS) but there were no significant differences between the groups. Based on an interview questionnaire, the nbUVB groups reported improvement in the percentage of affected skin (p=0.004), in difficulty falling to sleep (p=0.02) and sleep disturbance (p=0.01). Phototherapy did not have a significant effect in reducing pruritis intensity compared to the control group. Petering et al. (2004) randomized high-dose UVA1 to PUVA for the treatment of chronic vesicular dyshidrotic eczema on the palms and backs of hands of 27 patients. Each hand was randomly treated with a different therapy. At the end of three weeks, the Dyshidrosis Area and Severity Index (DASI) scores improved to nearly half the pretreatment scores in both hands with no significant differences between the treatments.

Kelley and Rashid (2011) conducted a systematic review to evaluate published studies investigating phototherapy for the treatment of Herpesviridae (n=267). Eleven clinical trials and case reports included patients with herpes simplex, varicella-zoster, human herpesvirus, and Kaposi sarcoma. Studies included case reports or case series and randomized controlled trials with small patient populations, short-term follow-ups and various types of herpes. Long-term studies with large patient populations comparing phototherapy with conventional treatment modalities are needed. Phototherapy regimens for Herpesviridae have not been established.

**Home Phototherapy**

In some cases, UVB phototherapy may be transitioned to home use under the supervision of a physician if the individual has extensive, widespread disease (e.g., psoriasis) that is going to require long-term use, and office-based phototherapy has been proven to be effective. Home devices emitting predominantly narrowband UVB phototherapy are used primarily for the treatment of psoriasis and require that the patient be motivated, reliable, adherent to instructions, able to administer the treatment correctly, keep records of exposure and attend regular follow-up visits. Opponents to home therapy cite issues related to patient poor compliance, suboptimal efficacy and greater potential for phototoxicity, erythema, burns, carcinogenesis and photoaging. Some propose limiting home phototherapy to those with overwhelming difficulties in traveling to a facility (Lapolla, et al., 2011; Menter, et al., 2010; Rajpara, et al., 2010).

There are various types of home UVB phototherapy devices available (i.e., full-body, half-body, hand and/or foot, localized/spot treatment units).

Full-body UVB panels include six-foot stand-alone panels, such as the 6-Foot Panosol II® (National Biological Corporation, Inc., Beachwood, OH). Half-body units include two- to four-foot stand-alone panels that are indicated for localized treatment areas (i.e., the back). An example of the half-body unit is the 2-Foot Panosol II®.

Hand and foot UVB units may be in the form of a combined unit or may be individual units. A combined unit has the appearance of a desk and allows the patient to place their hands and feet into the unit, receiving treatment simultaneously (e.g., Hand/Foot II™, National Biological Corporation, Inc., Beachwood, Inc., OH). Individual hand and foot units may have the appearance of a tabletop device such as the SolRX™ 500 Series (Solarc Systems, Inc., Ontario, Canada).

Localized/spot treatment devices may be a portable tabletop UVB device, such as the SolRx 500 mentioned above or a handheld wand-type device, like the DermaLume 2X™ (National Biological Corporation, Inc., Beachwood, OH), for small areas.

Once the size of unit is determined, a decision will be made by the physician as to the type of UVB light source indicated for treatment. The physician may prescribe bbUVB or nbUVB. The number of bulbs needed will be determined based on the size of the unit.

UVA phototherapy is primarily used in combination with psoralen (i.e., PUVA) for the treatment of disease (e.g., psoriasis) and is administered in an outpatient setting. On its own, UVA is ineffective in treating conditions such as psoriasis and atopic dermatitis and is therefore not generally used in the home setting.
Tanning beds, or units, which typically emit UVA, are used for self-tanning solely for the purpose of improvement in appearance (i.e., cosmetic); they are not medical devices designed to be used to administer physician-prescribed treatment for a dermatologic condition.

**Literature Review:** A Hayes Technology Brief (2013; reviewed 2015) stated that although the overall body of evidence is low, the data suggested that home UVB for the treatment of moderate to severe psoriasis is effective and well tolerated. Patient adherence was generally high and there were no identified safety issues. The Brief included one multicenter randomized controlled study, one 2-phase prospective comparative study, and three prospective case series.

In a single-blind randomized controlled trial, Koek et al. 2009 compared the outcomes of outpatient UVB therapy (n=98) to home UVB therapy (n=98) for patients treated for mild to severe psoriasis. After the completion of therapy, the first 105 consecutive patients were followed for one year. Outcomes were measured by the self-administered psoriasis area and severity index (SAPASI) and the psoriasis area and severity index (PASI). Treatment effect indicated by the mean decline in the PASI and SAPASI scores was significant (p<0.001) and similar across groups (p>0.3) indicating that home therapy was as good as and in some cases, superior (SAPASI 90) to outpatient therapy. Improvement in quality of life for home patients was rated as a 42% compared to 23% for outpatients. Total cumulative doses of ultraviolet B light and the occurrence of short term side effects were not significantly different between the groups.

**Centers for Medicare & Medicaid Services (CMS)**
- National Coverage Determinations (NCDs): Treatment of Psoriasis (250.1). This is a longstanding NCD; the effective date is not posted. The coverage policy is broader in scope.

**Use Outside of the US**
The British Association of Dermatologists (BAD) and UK Cutaneous Lymphoma Group (UKCLG) 2018 guidelines for the management of primary cutaneous lymphomas stated the following regarding phototherapy and the treatment of stage IA-IIA mycosis fungoides (MF):
- Phototherapy is the “standard of care” for the treatment of early stages of MF but the duration of response may be limited. The risk of skin cancer limits the number of treatments that can be given in a lifetime.
- Narrowband ultraviolet UVB (311–313 nm) and broadband UVB (290–320 nm) can produce high complete response rates. Response rates are more likely in patients with only patches.
- High-dose UVA1 phototherapy (340–400 nm), which penetrates more deeply than both UVB and UVA, has shown clinical efficacy in small case series.
- High complete response rates for PUVA in early stages have been reported.
- The precise therapeutic role of excimer laser has not been established.

Additional statements included:
- PUVA can often be used as salvage therapy for stage IVA-B MF and Sezary syndrome (SS).
- Overall complete response rates for treatment combining PUVA and interferon alpha appear to be similar to those with PUVA alone.
- Results achieved by combining PUVA with retinoids (acitretin) are similar to results with PUVA alone.
- Although there is a lack of data, combination regimens involving PUVA have been utilized as first-line treatment for patients with erythrodermic MF. Patients with SS tolerate PUVA poorly.
- Combination PUVA regimens are rarely indicated as first-line therapy for tumor or nodal disease, but may be used as an adjuvant or salvage therapy for patients with persistent cutaneous disease following debulking treatment for cutaneous tumors or nodal/visceral disease. However there is a lack of evidence supporting this use.

The British Association of Dermatologists' and British Photodermatology Group joint guidelines (2016) for the safe and effective use of PUVA included the following recommendations based on case controls or cohort studies:
• PUVA should usually be offered before oral systemic therapy for patients with chronic plaque psoriasis that has not responded adequately to other therapies, including narrowband UVB.
• Although PUVA may occasionally be appropriate as a first-line phototherapy treatment for especially thick and/or extensive plaque psoriasis it should usually only be considered in patients with chronic plaque psoriasis, if NB-UVB has not been adequately effective.
• PUVA is the first-line treatment for plaque-stage cutaneous T-cell lymphoma (CTCL).
• PUVA using topical or oral psoralen should be considered as a treatment for palmoplantar psoriasis.
• PUVA using oral psoralen should be considered as a treatment for palmoplantar pustulosis.

In 2007, the National Institute for Clinical Excellence (NICE) (United Kingdom) published a guidance document for the treatment of atopic eczema in children up to age 12 years. The clinical trials revealed limited evidence of the effectiveness of phototherapy in the treatment of children and possible serious adverse effects. The Guidance Development Group concluded that phototherapy should only be considered “for the treatment of severe atopic eczema in children when other management options have failed or are inappropriate and where there is a significant negative impact on quality of life.” Laser therapy was not discussed as a treatment option.

The National Institute for Health and Care Excellence (NICE) 2012 (updated 2017) included phototherapy (broad or narrow-band UVB and PUVA) as a treatment option for psoriasis in their guideline for management of this condition. NICE recommended phototherapy for the treatment of plaque or guttate-pattern psoriasis that cannot be controlled with topical therapy. PUVA can be considered for the treatment of palmoplantar pustulosis. NICE stated that phototherapy should not be routinely used as a maintenance therapy.

The European Organization for Research and Treatment for Cancer (EORTC) (Belgium) (Trautinger, et al., 2006; updated 2017) consensus recommendations for the treatment of stages IA, IB and IIA mycosis fungoides and Sezary syndrome included PUVA as a treatment option for these conditions. PUVA and UVB were listed as agents that can be used after remission has been achieved for MF and SS.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Office-Based Phototherapy and Photochemotherapy

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96900</td>
<td>Actinotherapy (ultraviolet light)</td>
</tr>
<tr>
<td>96910</td>
<td>Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B</td>
</tr>
<tr>
<td>96912</td>
<td>Photochemotherapy; psoralens and ultraviolet A (PUVA)</td>
</tr>
<tr>
<td>96913</td>
<td>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)</td>
</tr>
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Office-Based Excimer Laser Therapy

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<table>
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<tbody>
<tr>
<td>96920</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm</td>
</tr>
<tr>
<td>96921</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm</td>
</tr>
<tr>
<td>96922</td>
<td>Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm</td>
</tr>
</tbody>
</table>
Treatment of Vitiligo

Considered Not Medically Necessary/Cosmetic:

<table>
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<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E0691</td>
<td>Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less</td>
</tr>
<tr>
<td>E0692</td>
<td>Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel</td>
</tr>
<tr>
<td>E0693</td>
<td>Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel</td>
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</tbody>
</table>

Home Phototherapy Devices

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<td>Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less</td>
</tr>
<tr>
<td>E0692</td>
<td>Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel</td>
</tr>
<tr>
<td>E0693</td>
<td>Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel</td>
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Considered Specifically Excluded Under Some Benefit Plans:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>E0694</td>
<td>Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection</td>
</tr>
</tbody>
</table>


References


112. Sivanesan SP, Gattu S, Hong J, Chavez-Frazier A, Bandow GD, Malick F, Kricorian G, Koo J. Randomized, double-blind, placebo-controlled evaluation of the efficacy of oral psoralen plus ultraviolet


