POLICY AND PROCEDURE MANUAL

Policy Title: Phototherapy and Laser Therapy for Skin Conditions	**Policy Number: I.22**
Primary Department: Medical Management	**NCQA Standard: N/A** **URAC Standard: N/A**
Affiliated Department(s): Utilization Management	
Last Revision Date: 03/08/2019 **Revision Dates: 06/2018; 03/08/2019** **Effective Date: 06/2018**	**Next Review Date: 03/31/2020** **Review/Revision Dates: 06/27/2018; 03/20/2019**
Applicable Lines of Business: ☐MeridianCare ☒MeridianHealth ☐MeridianComplete ☒MeridianChoice	
Applicable States: ☐All ☒MI ☒IL ☐OH ☐_____ ☐_____	
Applicable Programs: ☒All ☐Other _____	
Policy is to be published: Internally Only ☐ Internally & Externally ☒	

Definitions:

Phototherapy	Includes type A ultraviolet (UVA) radiation; type B ultraviolet (UVB) phototherapy; and combination UVA/UVB phototherapy. Photochemotherapy includes psoralens (P) and type A ultraviolet (UVA) radiation, known as PUVA photochemotherapy and combinations of P/UVA/UVB. UV radiation may act via antiproliferative effects (slowing keratinization) and anti-inflammatory effects (inducing apoptosis of pathogenic T cells in psoriatic plaques). Treatment goals are to restore the function of melanocytes, which aid in protection of the skin from carcinomatous degeneration.
Excimer laser	Ultraviolet therapy for psoriasis involves use of a high energy 308 nm excimer laser. The laser allows treatment of only involved skin; thus, considerably higher doses of UVB can be administered to psoriatic plaques at each treatment session when compared with traditional phototherapy.
Psoriasis	Plaque type psoriasis usually present with symmetrically distributed cutaneous plaques. The scalp, extensor elbows, knees, and gluteal cleft are common sites for involvement. The extent of involvement can range from limited localized disease to involvement of the majority of the body surface area.
Vitiligo	Causes functional disturbance to the skin. Narrow band IVB is considered gold standard for vitiligo. Treatment goals are to restore the function of melanocytes, which aid in protection of the skin from carcinomatous degeneration.

Policy: Meridian considers phototherapy for skin conditions medically necessary in the situations outlined below.

Procedure:

1. **Treatment of Skin Conditions with Phototherapy:**
    a. Phototherapy and photochemotherapy is medically necessary when there has been a failure of conventional therapy :
        i. Atopic dermatitis (atopic eczema)
        ii. Chronic uticaria palmoplantar pustulosis
        iii. Chronic plaque psoriasis (see criteria below)
        iv. Connective tissue diseases involving the skin (e.g., cutaneous graft vs. host disease [GVHD], localized scleroderma, lupus erythematosus)
        v. Cutaneous T-cell lymphoma (CTCL), including mycosis fungoides (MF)
        vi. Lichen planus severe
        vii. Necrobiosis lipoidica
        viii. Photodermatoses (e.g., polymorphic light eruption, actinic prurigo, chronic actinic dermatitis)
        ix. Pityriasis-rosea and/or lichenoides
        x. Psoriasis (see criteria below)
        xi. Grover's disease (transient and persistent acantholytic dermatosis)
        xii. Pruritus of renal failure

Criteria for Coverage:
Specific Diagnoses
Psoriasis

Phototherapy (UVB) treatment for psoriasis is a covered benefit when **ALL** of the following criteria are met:

1.
    a. Severe disabling psoriasis (greater than or equal to 10% of total body surface area [TBSA] unresponsive to conventional treatment)
    b. Documentation of failed first line treatment, topical therapy
        i. Examples include: Corticosteroids, Calcipotriene, Retinoids, Coal Tar, Anthralin or tazarotene, Salicylic Acid, Topical Immodulators (TIMs), Bath Solutions, Moisturizers
    c. Clinical documentation showing dermatologist evaluation
    d. If this is a request for continued treatment, the documentation should support/show that there has been improvement from the start of therapy. If the documentation does not support improvement following 9 months of weekly treatment, further treatment is generally considered not medically necessary due to lack of efficacy.

2. Excimer laser treatment for Plaque Psoriasis may be covered if the following criteria are met:
    a. Diagnosis of **plaque psoriasis**
        i. Excimer laser is considered experimental and investigational for all other types of psoriasis
    b. Psoriasis involving 10 % or more of the total body surface area (TBSA), or severe psoriasis involving the hands, feet, or scalp
    c. Patients with chronic, stable, localized, mild to moderate plaque psoriasis.
    d. Plaque psoriasis that have proven refractory to at least a three-month trial of conservative treatment of topical agents and/or non-laser phototherapy.
    e. Conventional treatment with at least two of the following treatments for psoriasis have failed:
        i. Topical treatments

1. Examples include, but are not limited to: Corticosteroids, Calcipotriene, Retinoids, Coal Tar, Anthralin or tazarotene, Salicylic Acid, Topical Immodulators (TIMs), Bath Solutions, Moisturizers

ii. Light therapy (PUVA or UVB)
iii. Systemic treatment
iv. Combination treatment
v. Intralesional injections of steroids

f. Patients in the following categories would be excluded from consideration for laser treatment:
   i. Pregnant/lactating females (unless maternal fetal/OB documentation of approval for treatment)
   ii. Anyone with a history of photosensitivity
   iii. Anyone with a history of keloid formation
   iv. Psoriasis that responds to standard therapies
   v. Persons < 18 years of age*(MD to review current literature regarding age restrictions)

g. If this is a request for continued treatment, the documentation should support/show that there has been improvement from the start of therapy. Medical Director to review for medical necessity

3. Vitiligo

A. Phototherapy is a covered benefit for vitiligo when **ALL** of the following criteria are met:
   i. Clinical documentation of total body surface area (TBSA) affected and locations showing vitiligo involves at least 10% of the TBSA.
   ii. Documentation of failed first line treatment topical therapy
      1. Examples include: topical steroids, Topical calcineurin inhibitors, etc.
   iii. Clinical documentation showing dermatologist evaluation
   iv. If this is a request for continued treatment, the documentation should support/show that there has been improvement from the start of therapy. If the documentation does not support improvement following 9 months of weekly treatment, further treatment is generally considered not medically necessary due to lack of efficacy.

General Information Required:

Absolute Contraindications:
A medical director will review these cases for laser skin therapy for medical necessity if cosmetic reason is suspected, as this is not a covered benefit.

1. These following conditions are considered cosmetic (not all-inclusive list):
   a. Acne
   b. Hair loss (Alopecia Areata)
   c. Hair removal (may be medically necessary for tissue transfers)
   d. Melasma
   e. Pruritis
   f. Rhinophyma
   g. Warts, including facial warts (verrucae)
   h. Vascular malformation that does not affect bodily function[6,7]
2. Requests for **inpatient** Modified Goeckerman protocol.
   a. This is viewed as not medically necessary as this care does not need to be provided in the inpatient setting as nursing education, topical medications, and UV therapy it can be provided safely and effectively in the outpatient setting.
3. Excimer laser or pulsed dye laser experimental and investigational in the treatment of forms of psoriasis other than plaque psoriasis.

Line of Business Applicability:
This policy applies to Michigan Medicaid, Illinois Medicaid, and Individual plans.

For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

For **Individual** members, consult the individual insurance policy. If there is a discrepancy between this policy and the individual insurance policy document, the guidelines in the individual insurance policy will govern.

State specific special instructions:

None: ☐

MI: Medicaid: Home phototherapy devices or home visits from provider for skin conditions is not a covered benefit

IL: Medicaid: Home phototherapy devices or home visits from provider for skin conditions is not a covered benefit

OH:

References:

1. UVB therapy (broadband and narrowband). In: UpToDate. Edited by Honigsmann, H, UpToDate, Waltham, MA. 2018
2. UVA1 phototherapy. In: UpToDate. Edited by Krutmann, J, Morita, A, UpToDate, Waltham, MA. 2018.
3. Treatment of psoriasis in adults. In: UpToDate. Edited by Feldman, SR, UpToDate, Waltham, MA. 2018.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 5. Guidelines of care for the treatment of psoriasis with phototherapy and photochemotherapy. J Am Acad Dermatol 2010; 62:114.
5. American Academy of Dermatology Work Group, Menter A, Korman NJ, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. J Am Acad Dermatol 2011; 65:137.
6. (2016). Laser treatment of vascular lesions. The Indian Journal of Medical Research, 144(2), 304.
7. Brightman, L. A., Geronemus, R. G., & Reddy, K. K. (2015). Laser treatment of port-wine stains. Clinical, cosmetic and investigational dermatology, 8, 27-33. doi:10.2147/CCID.S53118

Medicare Managed Care Manual:	**NCD 250.1**	**NCD 140.5 Laser Procedures**	
Medicaid CFR:			
State Administrative Codes:			
Contract Requirements:			
Related Policies:			

Related Desk Level Procedures/ Job Aids/Template Letters:			
Related Algorithms/Flowcharts/ Attachments			