

Phototherapy Lights for Home Use

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines certificates of coverage for possible exclusions of benefit.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification as applicable.

Phototherapy lights require precertification and physician face-to-face.

National Coverage Determination Policy	National Coverage Determination for Durable Medical Equipment Reference List (280.1)
Local Coverage Determination Policy	None
Effective Date	For service performed on or after 10/31/13
Review/Revisions Effective Date	01/19, 10/18, 06/05/018, 07/01/16
The Health Plan	National Coverage Determination for Durable Medical Equipment Reference Lists (280.1) unless otherwise indicated in section of this policy or contractual agreements

DESCRIPTION

Phototherapy is defined as exposure to non-ionizing, ultraviolet (UV) radiation for therapeutic benefit. It involves exposure to type A (PUVA) radiation or type B (UVB) radiation or combinations thereof. The differences in these ultraviolet light forms are the length in waves. UVA wavelength is 320-400 nanometers [nm]. Broadband (bb) UVB is 290-320 [nm], and narrowband (nb) UVB is 311-312 nm. The longer wavelengths emit a lower energy level. UVA bulbs are used in tanning beds for cosmetic effects, because they promote tanning using lower energy with less erythema than UVB.

COVERAGE GUIDELINES

This policy refers specifically to Phototherapy for home use. Phototherapy for home use (UVB) is a covered treatment for individuals with severe psoriasis with a history of frequent flares. Home

ultraviolet booths, lamps, and replacement bulbs sold by prescription only, are considered medically appropriate for patients eligible for home UVB phototherapy when all the criteria below are met.

- a. Documentation submitted showing UVB required over all other treatment.
- b. Device must have Pricing, Data Analysis, & Coding (PDAC) approval.
- c. Member must show improvement with in office UVB treatment.
- d. Member is able to understand risks, able to operate device as ordered, and is compliant with treatment plan, including office visits for monitoring.
- e. It is a hardship to attend in office UVB/PUVA treatments.

The Health Plan considers UVB with the addition of topical coal tar, i.e, Goeckerman regimen, or petrolatum medically necessary for persons with severe psoriasis (defined as psoriasis that affects more than 10 percent of body surface area). The Health Plan considers UVB with the addition of topical coal tar or petrolatum experimental and investigational for all other indications.

The physician/provider must indicate body surface area affected with precertification.

NONCOVERAGE STATEMENT

An in-home UVB delivery device is considered **investigational and not medically necessary** for all other conditions not mentioned above, including but not limited to vitiligo, effective mood disorder and when the coverage guidelines above are not met.

Home ultraviolet light therapy using ultraviolet A (UVA) light devices is considered **investigational and not medically necessary** for all indications.

Tanning beds for home UVB are not covered, because they are not designed solely for medical treatment of skin diseases, and they emit a different wavelength of ultraviolet light.

Phototherapy, E0691-E0694 is not covered for any indication for any West Virginia Medicaid member's.

Code E0203 (therapeutic light box, minimum 10,000 lux, tabletop model) is NOT covered, as it does not meet the requirements of this policy. It is located on Medicare's non-covered list.

Based on Medicare reimbursement, there will be no payment for the programming module.

Routine regulation/maintenance are not covered for this device; therefore, no separate payment will be made for the calibration of light meter.

REPAIR, REPLACEMENT AND REASONABLE USEFUL LIFETIME

Replacements and repairs require precertification. See **Replacement and Repair** policy.

Repairs are not separately payable during rental period.

Replacements are not covered due to neglect or misuse.

Under typical home phototherapy usage, experience has shown that Philips UVB-Narrowband bulbs usually last five to ten years. Other bulbs may not have the same strength and may require longer treatment times. The Health Plan will not replace bulbs more often than once every 5 years, unless there is medical documentation that longer treatment times are medically contraindicated.

Most units have a 4-year warranty.

CODING INFORMATION

CPT/HCPCS codes: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS

EY	NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE
GA	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYOR POLICY, INDIVIDUAL CAS
GZ	ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT REASONABLE AND NECESSARY
KX	REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET

HCPCS CODES

A4633	REPLACEMENT BULB/LAMP FOR ULTRAVIOLET LIGHT THERAPY SYSTEM, EACH
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQ FEET OR LESS
E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; 4 FT PANEL
E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; 6 FT PANEL
E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION

COVERED DIAGNOSIS CODES

L40.0-L40.9	OTHER PSORIASIS [SEVERE/ WITH FREQUENT FLARES/ NEEDING TO INITIATE THERAPY IMMEDIATELY/ UNABLE TO ATTEND ON-SITE THERAPY]
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Diagnosis and ICD-10 that supports medical necessity indicated above.

DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records,

hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
 - a. Member's name
 - b. Date
 - c. Description of item. The medical record must contain the information that supports the request for each item, and must be submitted with the precertification, if the item requires precertification, or with the claim, if no precertification was required
 - d. Order must include diagnosis code
 - e. Physician signature with date. Date stamps are not appropriate
 - f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used

The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request usually with precertification per The Health Plan policy.
3. Proof of delivery to be kept on file by the provider of the item.

Note: If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

Note: Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

Precertification is required when supplies used are greater than the usual maximum quantity listed in above. There must be adequate, clear documentation in the medical record corroborating the medical necessity of this amount. This documentation is to be submitted with precertification.

COVERAGE OF PHOTOTHERAPY WHILE IN A PART A COVERED FACILITY

Reimbursement for phototherapy provided to a member while the member is covered in a Part A facility (hospital or inpatient acute rehabilitation or long term acute care facility) will be included in the facility reimbursement if the device is intended for use while the member is in the facility for inpatient treatment or rehabilitation. In order for it to be billed separately, it must be given two days or less

before discharge from the Part A covered stay and it must meet the above guidelines and be medically necessary for home use.

Reimbursement for phototherapy unit provided while a member is in a SNF receiving Part A services, will be reimbursed according to individual facility contracts.

EQUIPMENT RETAINED FROM A PRIOR PAYOR:

The Health Plan will not pay in excess of the contracted purchase price for any item in this policy. If the provider is seeking payment from The Health Plan, the item must be precerted and The Health Plan will pay the remaining rental months up to purchase price- if member meets guidelines above.

KX, GA, and GZ MODIFIERS

Suppliers may submit a claim with a KX modifier only if all the criteria for that item are met.

If the coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

ADVANCED BENEFICIARY NOTICE

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

NOTE: Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare's PDAC contractor for review of authorizations. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. dmepdac.com/

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INTERNET LINKS AND SOURCES

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Medicare National Coverage Determination Manual. Durable Medical Equipment website. Durable Medical Equipment Reference List. 60-9. Last accessed 10/31/18. Retrieved from [cms.gov/manuals/downloads/Pub06 PART 60.pdf](https://www.cms.gov/manuals/downloads/Pub06_PART_60.pdf)

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The Pricing, Data Analysis, and Coding Contractor. Noridian. Internet website. Last accessed 10/31/18. Retrieved from <https://www.dmepdac.com/dmecsapp/>

The Health Plan Provider Procedural Manual. Payment Voucher, Section 14, Page 11

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