Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

UVB Home Units for Skin Disease

Effective: September 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☐ No ☒
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Psoriasis is a chronic skin condition, which involves both thickening of the skin, redness, and silvery scales or plaques. Psoriasis is thought to be a disorder of the immune system, which causes overproduction of T cells in the skin. Treatment is directed towards slowing the overproduction of skin cells. Phototherapy is one of several treatments which may be tried to treat the disorder. The choice of treatment is dependent upon the severity of the disease and the patient's response to treatment. Ultraviolet light from the sun stimulates production of vitamin D by the skin, which slows the excessive development of skin cells. Artificial light treatment rather than natural sunlight provides a more controlled treatment method and is often used in psoriasis (UVB Phototherapy). For more severe cases in which the plaques cover a greater expanse of body surface, Ultraviolet A in combination with the drug Psoralen (also called PUVA) may be used.

UVB Phototherapy: Uses artificial light, type B (UVB). The treatment may be provided in a hospital, outpatient facility, physician's office, and in the home. A patient initiating home UVB therapy should be reliable and able to comply with the treatment protocol prescribed by the physician.

PUVA Phototherapy: Uses ultraviolet light, type A, combined with a psoralen medication (a medication which increases the skin's sensitivity to UVA). There is a greater risk of adverse effects with PUVA treatment when compared to UVB phototherapy; PUVA is more complicated to administer and has potential for harm if it is used incorrectly.

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Clinical Guideline Coverage Criteria

The Plan may authorize coverage for the purchase of a **home** UVB phototherapy unit when **ALL** the following criteria are met:

1. Member has a diagnosis of moderate-to-severe psoriasis and a history of frequent psoriasis flares that require home therapy for suppression **or** Diagnosis of severe atopic dermatitis/eczema for members who have failed first line therapies and **BOTH**:

a. A positive response or a history of a positive response to the UVB treatment of psoriasis as demonstrated by at least 50% improvement based on any of the following objective measurement tool scores: Psoriasis Area and Severity Index (PASI), Physician Static/Dynamic Global Assessment (PGA) or Body Surface Area (BSA); **and**
b. Communication from the member's physician, which includes the following:
    i. A description of the severity of psoriasis or atopic dermatitis/eczema; **and**

    Note: If the psoriasis or atopic dermatitis/eczema involves the palms, soles, or intertriginous areas, this description should include the percent of the affected area involved, and the associated disability.
    ii. A prescription from the physician describing the UVB exposure protocol; **and**
    iii. A plan describing planned follow-up with the physician (i.e., the physician will need to see the patient periodically to determine effectiveness of therapy and the need for continuing treatment); **and**
c. Patient has been trained in the use of UVB Phototherapy and understands the need to communicate with the physician regarding any unexpected side effects; **and**
d. The patient is competent to use the treatment regimen appropriately; **and**
e. The patient has failed treatment with multiple topical agents or developed side effects from such agents as documented by the treating physician; **and**

2. Home UVB may be considered in cases of chronic idiopathic hand and foot dermatitis refractory to other treatments and causing disability

Limitations

The Plan considers UVB home units as not medically necessary for all other indications including the following:

1. Home UVB therapy for vitiligo is not covered and is considered investigational
2. Home UVB therapy for cosmetic purposes, such as tanning, is not covered

Codes

The following code(s) are associated with this service

Table 1: CPT/HCPCS Codes

Code	Description
E0691	Ultraviolet light therapy system panel, 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

References:

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11. Robinson A, Kardos M, Kimball AB. Physician Global Assessment (PGA) and Psoriasis Area and Severity Index (PASI): why do both? A systematic analysis of randomized controlled trials of biologic agents for moderate to severe plaque. Am Acad Dermatol. 2012 Mar; 66(3):369-75.
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Approval And Revision History

October 21, 2020: Reviewed by the Medical Policy Approval Committee (MPAC) renewed without changes

Subsequent endorsement date(s) and changes made:

- November 24, 2020: Fax number for Unify updated
- December 16, 2020: Under limitations, changed UVB therapy for vitiligo is not covered to UVB therapy for vitiligo is not covered and is “considered investigational”
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- February 1, 2022: Template Updated
- July 20, 2022: Reviewed by MPAC for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan, renewed without changes for an effective date of 11/1/2022
- December 1, 2022: Reviewed by MPAC, renewed without changes
- June 21, 2023: Reviewed by MPAC, E0691, E0692, E0693, and E0694 will no longer require prior authorization, effective August 1, 2023
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Unify name changed to One Care effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, renewed without changes, effective December 1, 2024
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- September 17, 2025: Reviewed by the UM Committee, renewed without changes effective October 1, 2025
- July 15, 2026: Reviewed by MPAC for annual review, renewed without changes and administrative update to template, effective September 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.