Name of Policy:
Phototherapy for the Treatment of Skin Disorders

Policy #: 301
Category: Medical/DME

Latest Review Date: April 2014
Policy Grade: B

Background:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
Description of Procedure or Service:
Phototherapy is defined as the exposure to nonionizing radiation for therapeutic benefit. It may involve exposure to ultraviolet A (UVA), ultraviolet B (UVB) or various combinations of UVA and UVB radiation. In contrast, photochemotherapy or psoralens in conjunction with ultraviolet A (PUVA), is the therapeutic use of radiation in combination with a photosensitizing chemical. Treatment with these modalities may involve partial or whole-body exposure.

Photochemotherapy has been used for a large number of skin diseases, but confirmed data of its usefulness is available in only a relatively few.

Light therapy for vitiligo includes both targeted phototherapy and photochemotherapy with psoralen plus ultraviolet A (PUVA). Targeted phototherapy describes the use of ultraviolet light that can be focused on specific body areas or lesions. PUVA uses a psoralen derivative in conjunction with long wavelength ultraviolet A (UVA) light (sunlight or artificial) for photochemotherapy of skin conditions.

Vitiligo is an idiopathic skin disorder that causes depigmentation of sections of skin, most commonly on the extremities. Depigmentation occurs because melanocytes are no longer able to function properly. The cause of vitiligo is unknown; it is sometimes considered to be an autoimmune disease. The most common form of the disorder is nonsegmental vitiligo (NSV) in which depigmentation is generalized, bilateral, symmetrical, and increases in size over time. In contrast, segmental vitiligo (SV), also called asymmetric or focal vitiligo, covers a limited area of skin. The typical natural history of vitiligo involves stepwise progression with long periods in which the disease is static and relatively inactive, and relatively shorter periods in which areas of pigment loss increase.

There are numerous medical and surgical treatments aimed at decreasing disease progression and/or attaining repigmentation. Topical corticosteroids, alone or in combination with topical vitamin D3 analogs, is a common first-line treatment for vitiligo. Alternative first-line therapies include topical calcineurin inhibitors, systemic steroids, and topical antioxidants.

Treatment options for vitiligo recalcitrant to first-line therapy include, among others, PUVA and targeted light therapy. PUVA uses a psoralen derivative in conjunction with long wavelength ultraviolet A light (sunlight or artificial) for photochemotherapy of skin conditions. Psoralens are tricyclic furocoumarin that occur in certain plants and can also be synthesized. They are available in oral and topical forms. Oral PUVA is generally given 1.5 hours before exposure to UVA radiation. Topical PUVA therapy refers to directly applying the psoralen to the skin with subsequent exposure to UVA light. With topical PUVA, UVA exposure is generally administered within 30 minutes of psoralen application.

Potential advantages of targeted phototherapy include the ability to use higher treatment doses and to limit exposure to surrounding tissue. Broadband (BB)-ultraviolet B (UVB) devices, which emit wavelengths from 290 to 320 nm, have been largely replaced by narrowband (NB)-UVB devices. NB-UVB devices eliminate wavelengths below 296 nm, which are considered erythemogenic and carcinogenic but not therapeutic. Original NB-UVB devices consisted of a Phillips TL-01 fluorescent bulb with a maximum wavelength (lambda max) at 311 nm.
Subsequently, xenon chloride (XeCl) lasers and lamps were developed as targeted NB-UVB treatment devices; they generate monochromatic or very NB radiation with a lambda max of 308 nm. Targeted phototherapy devices are directed at specific lesions or affected areas, thus limiting exposure to the surrounding normal tissues. They may therefore allow higher dosages compared with a light box, which could result in fewer treatments.

**Policy:**

**Ultraviolet A or B therapy meets** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage in the treatment of the following conditions:
- Atopic dermatitis
- Chronic urticaria
- Eczema
- Lichen planus
- Mycosis fungoides (cutaneous T-cell lymphoma)
- Pityriasis lichenoides
- Pityriasis rosea
- Pruritus of renal failure
- Psoriasis
- Vitiligo
- Localized scleroderma

**Ultraviolet B light therapy administered in the home meets** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage of the following conditions and when conducted under a physician’s supervision with regularly scheduled exams:
- Atopic dermatitis-mild to moderate forms when standard treatment has failed
- Lichen planus
- Mycosis fungoides
- Pityriasis lichenoides
- Pruritus of hepatitis disease
- Pruritus of renal failure
- Psoriasis-mild to moderate forms when standard treatment has failed
- Severe atopic dermatitis
- Severe psoriasis

**Ultraviolet B light therapy administered in the home does not meet** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage for conditions not listed above.

**PUVA therapy meets** Blue Cross and Blue Shield of Alabama’s medical criteria for coverage of the following conditions:
- Acute/chronic pityriasis lichenoides
- Atopic dermatitis
- Eczema
- Lichen planus
- Mycosis fungoides (cutaneous T-cell lymphoma)
- Psoriasis
- Vitiligo

Effective for dates of service on or after April 1, 2007:

Excimer laser treatment of vitiligo of the face, neck, trunk, abdomen, back and/or proximal limbs meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage up to three sessions per week for 12 weeks.

Excimer laser treatment of vitiligo of the distal limbs and bony prominences (i.e. fingers, wrists, elbows, knees) does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage.

Refer to policy #009 for laser phototherapy (excimer laser) for the treatment of localized psoriasis.

Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administer benefits based on the member’s contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:
Ultraviolet treatments are given with different wavelengths, depending on the condition and response to treatment. Broad band UVB (290-320nm), narrow band 311-nm UVB, PUVA (psoralen with UVA 320-400nm) and UVA1 (340 to 400nm) are available. Ultraviolet wavelengths cause erythema, desquamation, and pigmentation and may cause a temporary suppression of basal cell mitosis followed by a rebound increase in cell turnover. Both forms of UVB and PUVA are used for psoriasis and vitiligo, but other conditions such as nummular and atopic dermatitis, pruritus due to uremia, and cutaneous T-cell lymphoma are treated with this therapy. High-dose UVA-1 is used to treat atopic dermatitis, localized scleroderma, and mastocytosis. Common minor toxicities associated with PUVA include erythema, pruritus, irregular pigmentation and gastrointestinal tract symptoms; these generally can be managed by altering the dose of psoralen or UV light. Potential long-term effects include photoaging and skin cancer, particularly squamous cell carcinoma (SCC) and possibly malignant melanoma. The risk of skin cancer has been found to be related to the lifetime cumulative exposure to oral PUVA and may be higher in people with lighter skin types. For example, one study found that patients treated with at least 337 PUVA treatments had at least a 100-fold increase in risk of SCC compared to general population incidence rates. In addition, the risk of malignancy was nearly three times higher in individuals with Fitzpatrick skin Types I and II, compared to those with Types III and IV. Thus, an attempt is made to reduce the total exposure, especially in lighter skin types, such as limiting the number of treatments and/or avoiding maintenance treatment. There is also a concern from animal studies about a potential risk of cataract development and eye protection is recommended.
In some cases, UVB phototherapy may be transitioned to home use if the individual has extensive, widespread disease (e.g., psoriasis) that is going to require long-term use, and the phototherapy has been proven to be effective. Home devices emitting predominantly UVB phototherapy are used primarily for the treatment of psoriasis and require that the patient be motivated, reliable, and adherent to instructions, able to administer the treatment correctly, keep records of exposure, and attend regular follow-up visits.

The effectiveness of excimer laser therapy is attributed to the induction and secretion of cytokines, T-cell mediated apoptosis or immunomodulatory mechanisms. It is also hypothesized that inactive melanocytes in the outer root sheath of the hair follicles are stimulated to proliferate and migrate by the irradiation and thus reproduce repigmentation. This theory helps explain the ineffectiveness of excimer laser treatments on bony prominences as there are fewer hair follicles on these areas. The use of high cumulative energy doses needed to treat these areas increases the risk of UV-induced carcinogenesis.

**Psoriasis**

In 2009, Koek et al reported on a single-blind randomized controlled trial, that 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 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.

In 2009, Sivanesan et al published a double-blind RCT evaluating the efficacy of 8-MOP PUVA treatment in patients 18 years and older who had moderate to severe psoriasis affecting at least 10% of their body surface area. Individuals with a history of serious side effects from oral PUVA, phototoxic reactions, or cancer, including skin cancer, were excluded. The study included 40 patients, 30 randomly assigned to receive PUVA and ten to receive UVA plus placebo psoralens. After a washout period of two weeks for topical psoriasis medications and four weeks for phototherapy and systemic therapies, patients were treated three times a week for 12 weeks. A total of 28 patients completed the study, 21 in the PUVA group and seven in the UVA plus placebo group. The primary outcome was at least a 75% improvement in the Psoriasis Area and Severity Index (PASI) score (PASI 75). In an intention to treat (ITT) analysis with the last observation carried forward to analysis at 12 weeks, 19 of 30 (63%) in the PUVA group and 0 of 10 (0%) in the UVA with placebo group achieved at least a 75% improvement in the PASI 7 score (p<0.001). In the per protocol analysis, 18 of 21 (86%) in the PUVA group and 0 of 7 (0%) in the placebo group achieved PASI 75. There were no serious adverse effects. The study found a dramatic treatment benefit with PUVA compared to UVA plus placebo; however, there was substantial drop-out and no long-term follow-up.
In 2010, Dayal et al published an RCT conducted in India that compared the safety and efficacy of PUVA and narrow-band UVB (NBUVB) in treating chronic plaque psoriasis. A total of 60 patients were randomly assigned to receive twice weekly 8-methoxsalen oral PUVA (n=30) or twice weekly NBUVB phototherapy (n=30) for three months. After the three-month treatment period, all patients in both groups had at least 75% clearance of psoriasis or complete clearance. The PASI score did not differ significantly between groups (mean of 1.39 in the PUVA group and 1.61 in the NBUVB group). The mean number of treatments to achieve clearance was significantly higher in the NBUVB group than the PUVA group, 16.4 and 12.7, respectively. However, the mean cumulative clearance dose was significantly higher in the PUVA group than the NBUVB group, 7.4 J/cm² and 1.2 J/cm², respectively.

No studies were identified that compared home-based PUVA to office-based PUVA. A 2010 review of various types of home phototherapies for psoriasis did not discuss any studies on PUVA delivered at home.

**Vitiligo**

In 2010, Whitton et al published a Cochrane review of randomized controlled trials (RCTs) on treatments for vitiligo. The investigators searched the literature through November 2009 and identified five trials on excimer laser therapy. None of these trials included a control group of individuals who did not receive excimer therapy, so the effect of laser therapy cannot be isolated. Four trials compared the combination of excimer laser therapy and a topical therapy with excimer lasers alone or excimer lasers plus a placebo topical treatment. The fifth trial compared different frequencies of excimer laser treatment (once, twice, three times weekly). The Cochrane investigators did not pool findings of the studies on laser therapy for vitiligo.

Studies continue to be published that compare different types of targeted phototherapy; these studies do not allow us to draw conclusions about the efficacy of targeted phototherapy. For example, in 2013 Shi et al treated patients with either an excimer laser or an excimer lamp and did not find differences in repigmentation rates. To adequately evaluate the impact of laser treatment or other targeted phototherapy treatment on vitiligo; RCTs are needed that include a comparison group of patients who receive a treatment other than targeted phototherapy (ie, an alternative treatment, no treatment, sham treatment). Subsequent to the publication of the Whitton et al Cochrane review, two RCTs with this design have been published and are described next.

The two trials were conducted by the same research group in Italy. In 2012, Nistico et al published a non-blinded RCT that included 53 patients with localized and generalized vitiligo. Patients were randomly assigned to one of three treatments for 12 weeks: 1) Excimer laser plus vitamin E (n=20); 2) excimer laser plus topical 0.1% tacrolimus ointment and vitamin E (n=20); 3) vitamin E only (control group, n=13). All patients in the two excimer laser groups completed treatment; one patient in the control group dropped out. Before and after treatment, two independent clinicians rated clinical response; 51% to 75% repigmentation was considered a ‘good’ response and >75% repigmentation was considered an ‘excellent’ response. The proportion of patients with a good or excellent response was 11/20 (55%) in the laser plus vitamin E group, 14/20 (70%) in the laser E plus tacrolimus plus vitamin E group, and 0 in the control group. The rate of good or excellent response did not differ significantly between the
groups that received excimer laser therapy with and without topical treatment \( (p=0.36) \). The response rate was significantly better in both groups receiving laser treatment compared with the control group \( (p<0.001) \).

The Italian research group also published a similar 12-week study in 2009 in which topical 4% khellin ointment was used instead of tacrolimus ointment. This study included 48 patients (16 per group), of which 45 (94%) completed treatment. The proportion of patients with a good or excellent response (see previous definitions) was 14/16 (88%) in the excimer laser plus vitamin E group, 14/16 (88%) in the excimer laser plus khellin plus vitamin E group, and 1/16 (6%) in the vitamin E only (control) group. The clinical response rates in the two groups receiving laser treatment were significantly higher than in the control group.

Most published RCTs evaluating targeted phototherapy for vitiligo treated patients in all groups with targeted phototherapy and thus the effect of phototherapy treatment cannot be isolated. Only two small RCTs compared excimer laser therapy to a different intervention; these found that excimer laser treatment produced better results than the comparison intervention (vitamin E or UVA).

The 2010 Cochrane review of trials on treatments for vitiligo, previously discussed in the section on targeted phototherapy, identified ten RCTs evaluating oral PUVA. Two trials assessed oral PUVA alone, and eight assessed PUVA in combination with other treatments e.g., calcipotriol, azathioprine, polypodium leucotomos, khellin, or surgical treatment. Seven of the eight studies used nine methoxypsoralen. Six trials were identified on oral PUVA plus sunlight; two of these used placebo as the comparison. Due to differences among studies, findings of trials on oral PUVA and on oral PUVA plus sunlight were not pooled.

An earlier meta-analysis of treatments for vitiligo was published in 1998 by Njoo et al. A pooled analysis of two RCTs on oral un-substituted psoralen plus sun for generalized vitiligo (total \( n=97 \)) found a statistically significant treatment benefit of active treatment compared with placebo (pooled odds ratio \[ OR = 19.9, 95\% CI, 2.4 to 166.3 \]). A pooled analysis of three RCTs, two on oral methoxsalen plus sun and one on oral trioxsalen plus sun (total \( n=181 \)) also found a significant benefit of active treatment versus placebo on generalized vitiligo \( (OR=3.8, 95\% CI, 1.3 to 11.3) \). All studies were published before 1985, had relatively small sample sizes (confidence intervals were wide), and used sun exposure rather than artificial UVA.

In 2007, Yones et al published a RCT using a psoralen formulation available in the U.S. The study used data on 56 patients in the U.K. who had non-segmental vitiligo. Outcome assessment was blinded. Patients were randomly assigned to receive twice-weekly treatments with 8-MOP psoralen plus UVA \( (n=28) \) or NBUVB therapy \( (n=28) \). In the PUVA group, the starting dose of irradiation was 0.5 J/cm\(^2\), followed by 0.25 J/cm\(^2\) incremental increases if tolerated. Patients were evaluated after every 16 sessions and followed for up to one year. Treatment was discontinued if there was complete or near complete resolution of vitiligo, no or minimal improvement after 32 treatments, completion of 200 lifetime treatments, or upon patient request. All patients were included in the analysis. The median number of treatments received was 49 in the PUVA group and 97 in the NBUVB group. At the end of treatment, the median improvement
body surface area with vitiligo (BSA-V) was 23% in the PUVA group and 61% in the NBUVB group. In addition, five of 25 (20%) of patients in the PUVA group and eight of 25 (32%) in the NBUVB group had at least 75% improvement in BSA-V at the end of follow-up. The authors did not provide p-values in their outcome table. They stated though, that the difference in improvement in BSA-V did not differ significantly between groups. A total of 24 (96%) patients in the PUVA group and 17 (68%) in the NBUVB group developed erythema at some point during treatment; this difference was statistically significant, p=0.02.

A 2013 RCT used a psoralen formulation available in India, which has the active ingredient methoxsalen; this ingredient is available in the U.S. The study included 45 patients with vitiligo covering more than 5% of their body surface area; 40 patients completed the study. Patients were randomized to receive three weekly treatments of either NB-UVB or PUVA. Treatments continued for 60 sessions or six months, whichever came first. At the end of follow-up, the mean percentage reduction in the Vitiligo Area Severity Index (VASI) score was 21.7 in the NB-UVB group and 29.2 in the PUVA group. The difference between groups in the VASI score was statistically significant, favoring the PUVA group, p=0.04. Four patients in the NB-UVB group and ten in the PUVA group developed adverse effects; none of these were serious enough to lead to discontinuation of phototherapy.

There is some evidence from randomized studies, mainly those published prior to 1985, that PUVA is more effective than placebo for treating vitiligo. The limited number of studies comparing PUVA with NB-UVB have had mixed findings.

Summary
One recent RCT, with limitations such as a high drop-out rate, found a dramatic benefit of PUVA for treating psoriasis compared to placebo psoralen plus UVA; this study used the FDA-approved agent 8-MOP and was conducted in the United States. Findings from other randomized trials are mixed. However, PUVA for severe treatment-resistant psoriasis is well-accepted and is recommended by the American Academy of Dermatology. There is a lack of evidence that home-based PUVA for treating psoriasis is as safe or effective as office-based treatment.

There is some evidence from randomized studies, mainly those published prior to 1985, that PUVA is more effective than placebo for treating vitiligo. PUVA for vitiligo is recommended in British guidelines for adults who do not respond to more conservative treatments. Based on the available evidence and clinical guidelines, PUVA may be considered medical necessary in patients with vitiligo who have not responded adequately to conservative therapy.

Practice Guidelines and Position Statements
The American Academy of Dermatology sponsored a series of guidelines on the treatment of psoriasis. Recommendations on PUVA from the guideline on use of phototherapy and photochemotherapy, published in 2009, are as follows:

- Systemic PUVA with ultraviolet A is indicated in adults with generalized psoriasis who are resistant to topical therapy.
- There are no studies in children; systemic PUVA may be used with caution in individuals less than 18 years.
• Systemic PUVA is contraindicated in patients with known lupus erythematosus, porphyria or xeroderma pigmentosum.
• Caution is recommended for several groups of patients including those with skin types I and II, and pregnant and nursing women.

In 2008, a guideline on the diagnosis and management of vitiligo was published by several organizations in the U.K. including the British Association of Dermatologists, the Royal College of Physicians of London and the Cochrane Skin Group. The guideline included the following statements:

1. PUVA therapy should be considered for treatment of vitiligo only in adults who cannot be adequately managed with more conservative treatments. PUVA is not recommended in children. *Grade of recommendation D, Level of evidence 4*

2. If phototherapy is to be used for treating nonsegmental vitiligo, NB-UVB should usually be used in preference to oral PUVA. *Grade of recommendation A, Level of evidence 1+

3. A trial of PUVA therapy should be considered only for adults with widespread vitiligo, or localized vitiligo associated with a significant impact on patient's QoL [quality of life]. Ideally, this treatment should be reserved for patients with darker skin types. *Grade of recommendation D, Level of evidence 3*

4. Before starting PUVA treatment patients should be made aware that there is no evidence that this treatment alters the natural history of vitiligo. They should also be made aware that not all patients respond, and that somebody sites, such as the hands and feet, respond poorly in all patients. They should also be informed of the limit to the number of treatments due to possible side-effects. *Grade of recommendation D, Level of evidence 3*

In 2013, consensus guidelines on management of vitiligo were published by the European Dermatology Forum. The guidelines state that oral PUVA is commonly used in adults with generalized vitiligo as second-line treatment. The guideline also state that targeted phototherapy is indicated for localized vitiligo, particularly small lesions of recent onset and childhood vitiligo, to avoid adverse effects due to total body irradiation and when total body irradiation is contraindicated. The guidelines were based on expert opinion and not on a systematic review of the literature.

**Key Words:**
Phototherapy, photochemotherapy, UVA, UVB, PUVA, ultraviolet A, ultraviolet B, excimer laser phototherapy, excimer laser, 308-nm excimer laser, 308-nm xenon chloride excimer laser

**Approved by Governing Bodies:**
There are multiple devices that have received 510K approval by the FDA.
**Benefit Application:**
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

ITS: Home Policy provisions apply
FEP contracts: Special benefit consideration may apply. Refer to member’s benefit plan. FEP does not consider investigational if FDA approved and will be reviewed for medical necessity.

**Coding:**
CPT Codes:  
96900 Actinotherapy (ultraviolet light)  
96910 Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B  
96912 Photochemotherapy; psoralens and ultraviolet A  
96913 Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings)  
96920 Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm  
96921 ;250 sq cm to 500 sq cm  
96922 ;over 500 sq cm  

HCPCS:  
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 six foot cabinet, includes bulbs/lamps, timer and eye protection

**References:**


**Policy History:**
Medical Policy Group, January 2007 (1)
Medical Policy Administration Committee, March 2007
Available for comment March 23-May 7, 2007
Medical Policy Group, June 2007 (2)
Medical Policy Administration Committee, June 2007
Available for comment June 30-August 13, 2007
Medical Policy Group, May 2009 (4)
Medical Policy Administration Committee, June 2009
Available for comment May 15-June 27, 2009
Medical Policy Group, July 2009 (2)
Medical Policy Administration Committee, August 2009
Available for comment August 10-September 23, 2009
Medical Policy Group, November 2011 (2): Updated Key Points & References
Medical Policy Group, December 2011 (3): 2012 Coding Update; Verbiage change to code E0691
Medical Policy Panel, March 2013
Medical Policy Group, April 2013 (3): Updated Key Points and References; no change in policy statement
Medical Policy Panel, April 2014
Medical Policy Group, April 2014 (3): Updated Description, Key Points & References; no change in policy statement

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member’s plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield’s administration of plan contracts.