Sentara Health Plans

Medicaid

Ultraviolet Light Therapy System for Home Use, DME 60

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

Ultraviolet Light Therapy System (UVB) include bulbs/lamps, timer and eye protection used for home treatments for dermatologic disorders. The device provides ultraviolet radiation directly which photoactivates with topical medications applied to the body. They come in various sizes such as hand-held devices, 4-foot panel, 6-foot panel and 6-foot cabinets.

Other common names: Home use devices, Goeckerman treatment, UVB or narrowband UVB (NB-UVB)

Criteria:

Ultraviolet Light Therapy System (UVB) is considered medically necessary for **ALL** of the following:

- Individual has **1 or more** of the following conditions
  - Atopic dermatitis – ALL forms when standard treatment has failed
  - Cutaneous T-cell lymphoma
  - Lichen planus
  - Morphea (circumscribed scleroderma)
  - Mycosis fungoides/Sézary syndrome
  - Pityriasis lichenoides
  - Pruritus of hepatic disease
  - Pruritus of renal failure
  - Psoriasis - ALL forms when standard treatment has failed
- Individual has indications of **ALL** of the following

- Prescribed by the treating clinician
- Individual has not responded to more conventional treatment
- Individual has had office treatment for 30 days with documented improvement
- An appropriately sized (e.g. hand wand for hand, two-foot panel for lower leg**) ultraviolet B (UVB) home phototherapy device for area of treatment
- Being used as an alternative to office-based phototherapy
- Costs of in-office treatment exceed those of a home phototherapy unit
- Long term therapy required, expected to be long term (3 months or longer)
- Treatment is supervised under a physician~~'s, supervision~~ with regularly scheduled exams
- The individual meets **1 or more** of the following:
    - The individual Medical and other factors justify treatment at home and is unable to attend office-based therapy due to a serious medical or physical condition (for example, confined to the home, leaving homerequires special services or involves unreasonable risk)
    - Office based therapy has failed to control the disease and it is likely that home based therapy will be successful
    - The individual suffers from severe psoriasis with a history of frequent flares which require immediate treatment to control the disease.

Ultraviolet Light Therapy System for Home Use is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- In-home UVB delivery device for all other indications not listed on policy
- History of lupus erythematosus
- History of xeroderma pigmentosum
- History of UV-sensitive dermatitis
- History of a photo allergy disorder
- Home ultraviolet light therapy using ultraviolet A (UVA) light devices
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Document History:

Revised Dates:

- 2025: May – Implementation date of August 1, 2025. Criteria updated references updated.
- 2025: April – Revision of criteria and housekeeping
- 2022: July, August

Reviewed Dates:

- 2026: May – annual review. Implementation date of October 1, 2026. No changes in criteria. Update references
- 2024: May – no changes references updated
- 2023: May

Origination Date: May 2022

Coding:

Medically necessary with criteria:

Coding	Description
E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft 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

Considered Not Medically Necessary:

Coding	Description

	None

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements
  - Pre-certification by the Plan is required.
  - **Please refer to Prior Authorization List for most up to date requirement Search PAL List: Sentara Health Plans**
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of EPSDT Supplement B (updated 5.19.22) Final.pdf
  - **Documentation Requirements** DME Chapter IV (updated 5.23.25) Final.pdf appendix-b-21-excel-version-with-all-categories-of-appendix-b-july-2025.xlsx
    - All durable medical equipment (DME) and supplies must be ordered by a practitioner on the form: CMN/DMAS-352 (revised 2017) and must be medically necessary to treat a health condition. The CMN/DMAS352 may be completed by the practitioner, DME provider, or other health care professionals, but the practitioner must sign and date the completed Certification of Medical Necessity (CMN).
    - The CMN and any supporting verifiable documentation must be completed (signed and dated by the practitioner) within 60 days.

- The CMN shall be valid for a maximum period of six (6) months for Medicaid individuals under 21 years of age. The CMN shall be valid for a maximum period of twelve (12) months for Medicaid individuals 21 years and older.

- **Repair vs. Replacement Guidelines**
  - If individual owned equipment needs to be replaced prior to the service limit (Per Appendix B) expiring the provider will be required to justify and obtain service authorization.
  - Documentation for service authorization should include the required information as stated in this manual and the provider shall also include additional documentation as stated below:
    - What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
    - The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective; and
    - If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.
- **Rental vs. Purchase Guideline**
  - When determined to be cost effective by SHP, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165)
  - When usage is anticipated to be long-term, and the individual's need or condition is not expected to change, the items must be considered for purchase

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2026). Retrieved 3 2026, from Hayes: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Ultraviolet%2520Light%2520Therapy%2520System%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%252

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Clinical guidelines. (2026). Retrieved 3 2026, from American Board of Dermatology (ABD) or American Osteopathic Board of Dermatology (AOBD): https://www.aad.org/member/clinical-quality/guidelines#

NCD Durable Medical Equipment Reference List (280.1). (2025, 10). Retrieved 3 2026, from CMS: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=190&ncdver=4&keywordtype=starts&keyword=Durable&bc=0

NCD: Treatment of Psoriasis (250.1). (Longstanding). Retrieved 3 2026, from CMS: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=88&ncdver=1&keywordtype=starts&keyword=psor&bc=0

UVB phototherapy (broadband and narrowband). (2026, 2). Retrieved 3 2026, from UpToDate: https://www.uptodate.com/contents/uvb-phototherapy-broadband-and-narrowband?search=UVB&source=search_result&selectedTitle=1~103&usage_type=default&display_rank=1

Keywords:

SHP Ultraviolet Light Therapy System for Home Use, SHP Durable Medical Equipment 60, Atopic dermatitis, Lichen planus, Mycosis fungoides, Pityriasis lichenoides, Pruritus of hepatic disease, Pruritus of renal failure, Psoriasis, Severe atopic dermatitis, Severe psoriasis