Sentara® Health Plans

Commercial

Ultraviolet Light Therapy System for Home Use, DME 60

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Effective Date	10/1/2026
Next Review Date	6/2027
Coverage Policy	DME 60
Version	6

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

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

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. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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 Commercial 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:
  - 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.
  - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.
  - **MUST SEE MEMBER BENEFIT FOR DETERMINATION.** We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

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

(2026). Retrieved 3 2026, from DMAS: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/procedure-fee-files-cpt-codes/

(2026). Retrieved 3 2026, from EviCore: https://www.evicore.com/provider/clinical-guidelines-details?solution=durable%20medical%20equipment&hPlan=EviCore%20by%20Evernorth

29th Edition. (2026). Retrieved 3 2026, from MCG: https://careweb.careguidelines.com/ed29/

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