



MASSACHUSETTS

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Medical Policy Light Therapy for Vitiligo

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Policy Number: 911
BCBSA Reference Number: 2.01.86

Related Policies

- Dermatologic Applications of Photodynamic Therapy, #[463](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

PUVA for the treatment of vitiligo which is not responsive to other forms of conservative therapy (e.g., topical corticosteroids, coal/tar preparations, and ultraviolet light) may be considered **MEDICALLY NECESSARY**.

PUVA for the treatment of vitiligo on the face, neck and hands may be considered **MEDICALLY NECESSARY**.¹

UV-B phototherapy for the treatment of vitiligo on the face, neck and hands may be considered **MEDICALLY NECESSARY**.²

Targeted phototherapy is considered **INVESTIGATIONAL** for the treatment of vitiligo under all other circumstances.

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.

	Outpatient
Commercial Managed Care (HMO and POS)	No
Commercial PPO and Indemnity	No
Medicare HMO BlueSM	No
Medicare PPO BlueSM	No

CPT Codes / HCPCS Codes / ICD-9 Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code 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 as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

CPT Codes	Code Description
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
96912	Photochemotherapy; psoralens, and ultraviolet A (PUVA)

ICD-9 Diagnosis Codes

ICD-9-CM diagnosis codes:	Code Description
374.53	Hypopigmentation of eyelid
709.01	Vitiligo

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
H02.731	Vitiligo of right upper eyelid and periocular area
H02.732	Vitiligo of right lower eyelid and periocular area
H02.733	Vitiligo of right eye, unspecified eyelid and periocular area
H02.734	Vitiligo of left upper eyelid and periocular area
H02.735	Vitiligo of left lower eyelid and periocular area
H02.736	Vitiligo of left eye, unspecified eyelid and periocular area
H02.739	Vitiligo of unspecified eye, unspecified eyelid and periocular area
L80	Vitiligo

Description

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.

Background

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 furocoumarins 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-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.

Summary

Light therapy for vitiligo includes both targeted phototherapy and psoralen plus ultraviolet A (PUVA). There is some evidence from randomized studies, mainly those published before 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 medically necessary in patients with vitiligo who have not responded adequately to conservative therapy.

For targeted phototherapy, there is a lack of clinical trial evidence that compares this technique with more conservative treatments or no treatment/placebo, with only 1 small RCT identified. This evidence is insufficient to determine the efficacy of targeted phototherapy, and it is therefore considered investigational.

Policy History

Date	Action
10/2014	Language on PUVA for the treatment of vitiligo on the face, neck and hands transferred from Medical Policy 059, Phototherapy. Coding information clarified Effective 10/1/2014.
7/2014	New references added from BCBSA National medical policy.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
5/2013	New references from BCBSA National medical policy.
2/2013	New policy describing coverage and non-coverage.
1/2005	Coverage added for treatment of vitiligo on the face, neck and hands. Effective 4/2005.
4/2004	Coverage added for UV-B phototherapy for patients with vitiligo on the face, neck and hands. Effective 8/2004.
1/2001	Coverage added for PUVA for vitiligo on the hands.
2/1999	Coverage added for vitiligo on the face and neck. Effective 3/1/1999.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

1. Whitton ME, Pinart M, Batchelor J et al. Interventions for vitiligo. *Cochrane Database Syst Rev* 2010; (1):CD003263.
2. Shi Q, Li K, Fu J et al. Comparison of the 308-nm excimer laser with the 308-nm excimer lamp in the treatment of vitiligo--a randomized bilateral comparison study. *Photodermatol Photoimmunol Photomed* 2013; 29(1):27-33.
3. Nistico S, Chiricozzi A, Saraceno R et al. Vitiligo treatment with monochromatic excimer light and tacrolimus: results of an open randomized controlled study. *Photomed Laser Surg* 2012; 30(1):26-30.
4. Saraceno R, Nistico S, Capriotti E et al. Monochromatic excimer light 308nm in monotherapy and combined with topical khellin 4% in the treatment of vitiligo: a controlled study. *Dermatol Ther* 2009; 22(4):391-4.
5. Njoo MD, Spuls PI, Bos JD et al. Nonsurgical repigmentation therapies in vitiligo. *Arch Dermatol* 1998; 134(12):1532-40.
6. Yones SS, Palmer RA, Garibaldinos TM et al. Randomized double-blind trial for treatment of vitiligo. *Arch Dermatol* 2007; 143(5):578-84.
7. Bansal S, Sahoo B, Garg V. Psoralen-narrowband UVB phototherapy in treatment of vitiligo in comparison to narrowband UVB phototherapy. *Photodermatol Photoimmunol Photomed* 2013.
8. Gawkrödger DJ, Ormerod AD, Shaw L et al. Guideline for the diagnosis and management of vitiligo. *Br J Dermatol* 2008; 159(5):1051-76. .
9. Taieb A, Alomar A, Bohm M et al. Guidelines for the management of vitiligo: the European Dermatology Forum consensus. *Br J Dermatol* 2013; 168(1):5-19.

Endnotes

¹ Medical Policy Group 1999 and 2001 - Severe vitiligo increases the risk for skin cancer. Other areas of the body are more amenable to being covered by clothing.

² Based on expert opinion