

Ultraviolet Light Therapy Delivery Devices for Home Use

Policy # 00131

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Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

Note: Some of the content from retired medical policy 00699 Light Therapy for Vitiligo is included in medical policy 00131 Ultraviolet Light Therapy Delivery Devices for Home Use.

Note: Dermatologic Applications of Photodynamic Therapy is addressed separately in medical policy 00098.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider an in-home Ultraviolet B (UVB) light therapy delivery device to be **eligible for coverage**.**

Patient Selection Criteria

Coverage eligibility for an in-home Ultraviolet B (UVB) light therapy delivery device may be considered when **ALL** of the following criteria are met:

- The treatment is for **ONE** of the following conditions:
 - Atopic dermatitis, when topical treatment alone has failed; **OR**
 - Cutaneous T-cell lymphoma including mycosis fungoides and Sézary syndrome; **OR**
 - Pityriasis lichenoides; **OR**
 - Pruritus of hepatic disease; **OR**
 - Pruritus of renal failure; **OR**
 - Psoriasis, when topical treatment alone has failed; **OR**
 - Vitiligo, when topical treatment alone has failed.

AND

- The treatment meets **ALL** of the following criteria:
 - Treatment is conducted under a physician's supervision with regularly scheduled exams; **AND**

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- Treatment is expected to be long term (3 months or longer); **AND**
- The individual meets **ANY** of the following:
 - The individual is unable to attend office-based therapy due to a medical or physical condition (for example, confined to the home, leaving home requires special services or involves risk); **OR**
 - Office-based therapy has failed to control the disease, and it is likely that home-based therapy will be successful; **OR**
 - The individual suffers from frequent flares which require immediate treatment to control the disease.

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

The use of an in-home Ultraviolet B (UVB) delivery device for all other conditions not mentioned above when patient selection criteria are not met is considered to be **investigational**.*

Based on review of available data, the Company considers home ultraviolet light therapy using ultraviolet A (UVA) light devices for all indications to be **investigational**.*

Background/Overview

Summary

Home-based narrowband UVB therapy is an effective and evidence-based treatment for several dermatologic conditions such as atopic dermatitis, pityriasis lichenoides, psoriasis, vitiligo, cutaneous T-cell lymphoma, and pruritus related to hepatic or renal conditions. It offers comparable efficacy to office-based phototherapy for individuals requiring frequent treatments, but requires strict safety measures and routine medical oversight to mitigate risks like sunburn. However, UVA therapy remains unsuitable for home use due to the need for photosensitizers and the increased risks of complications.

Description of UV Light Therapy

UV light therapy is an established treatment for skin disorders that uses UV light alone, or in combination, with topical preparations or oral medications. UV therapy involves exposure of the individual's skin to ultraviolet A (UVA) or ultraviolet B (UVB) radiation using a specialized light source. As an alternative to UV therapy alone, some individuals respond to the Goeckerman or modified Goeckerman treatment, which is comprised of coal tar dressings in combination with exposure to UVB light.

Exposure to UV light, both in the natural and therapeutic setting, brings the risk of skin damage and an increased risk of skin cancer. It has long been known that exposure to UV light is a risk factor in the development of skin cancer. In 2025, a study by Fowler quantified a significant increase in skin mutational burden in individuals undergoing narrow-band UVB therapy. The selection of individuals undergoing UV therapy should be conducted thoughtfully and take multiple considerations into

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consideration, including minimal erythema dose, Fitzpatrick skin type, prior UV exposure, the condition being treated, and others.

UVA phototherapy is typically given in combination with a photosensitizer, most commonly psoralen. Psoralen makes the skin more sensitive to ultraviolet light when applied directly to the skin or taken orally. This combined approach is referred to as photochemotherapy or PUVA (Psoralen + UVA). PUVA is typically used for more severe cases of skin diseases that fail to respond to topical therapy. Due to higher risk of adverse reactions, PUVA therapy and UVA phototherapy without use of a photosensitizer are generally limited to the office setting (Archier, 2012).

UVB light can be categorized as wide-band (or broad-band) and narrow-band, which refers to the range of wavelengths included in the UV light source. The wide-band devices deliver full spectrum UVB light. The narrow-band devices deliver a very narrow range of the UV light spectrum, focusing on the specific wavelengths most effective for the treatment of disease. In contrast to PUVA therapy, UVA therapy without photosensitizers and UVB therapy do not appear to increase skin cancer risk. In a retrospective study of 3506 individuals with a variety of skin conditions (mostly psoriasis or eczema) treated with UVB phototherapy, there was no significant difference in the incidence of skin cancer in treated individuals compared to the general population (Wang, 2024). Mean follow-up duration was 7.3 years. Likewise, no cumulative dose-response correlation between UVB exposure and skin cancer was observed.

Narrow-band UVB (NB-UVB) treatment is typically offered using a light “booth” or “light box” several times a week for as long as the condition persists. This may be for the lifetime of the individual. In the past, most individuals needed to visit a doctor’s office or other facility for these treatments. However, UVB treatment is available for home use under strict physician supervision.

The supervision of a physician is needed to make sure that the dose of UV light delivered to the treatment area is in the therapeutic range but does not exceed safe levels. Skin cancer screening, skin typing, or phototesting is usually performed prior to treatment to determine the appropriate UV radiation dose. Multiple sessions over 3 or more months are often required to produce clearing of skin lesions. During UV light therapy, individuals need regular medical assessments to evaluate the effectiveness of the therapy and to monitor for the development of side effects such as sunburn, pruritus (itching), photoaging, and, when photosensitizers are used, liver or kidney disease.

UVB home therapy devices

Most individuals undergoing UV treatment can be treated in the office or home. Home therapy with UVB light is an alternative for those who require treatments at a frequency that makes office visits overly burdensome. Concerns regarding over-exposure to unsafe levels of UVB radiation in the home setting have been addressed with the evolution of integrated security features such as digital timers, lockouts, preprogrammed treatment protocols, and exposure counters. As with UVB therapy performed in the office, routine clinical evaluation should be conducted for individuals undergoing home therapy to ensure that exposure is kept to the minimum level compatible with adequate control of disease and the prevention of complications.

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Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Atopic dermatitis (AD)

The initial treatment of AD typically consists of topical and non-pharmacological therapies as well as modifications in individual environments or occupations. Phototherapy is limited to those whose symptoms are not adequately controlled by the initial treatment modalities. There are numerous treatment protocols, but in general, individuals are dosed according to their minimal erythema dose and/or Fitzpatrick skin type. The AAD (2014) notes “Phototherapy can be administered on a scheduled but intermittent basis over time, or more continuously as maintenance therapy, for patients with refractory or chronic disease.”

Cutaneous T-cell lymphoma (CTCL)

Non-Hodgkin lymphoma includes two types of cutaneous lymphomas, T-cell lymphomas (CTCLs) and B-cell lymphomas (CBCLs), with CTCLs accounting for the majority of cutaneous lymphomas. According to the National Comprehensive Cancer Network^{®†} (NCCN) Clinical Practice Guidelines (CPGs) in Oncology^{®†} for Primary Cutaneous Lymphomas, Mycosis Fungoides (MF) is the most common CTCL while Sézary syndrome (SS) accounts for less than 5% of CTCL cases (2025). MF is considered an indolent malignancy and generally is associated with a slow progression while the median survival of SS is only 32 months from diagnosis (Trautinger, 2006). While CTCLs develop in the skin, the disease can progress and involve other areas such as lymph nodes, blood or visceral organs. Prognosis and treatment are dependent upon several factors including, but not limited to extent and type of skin involvement, overall stage, whether extracutaneous disease is present and peripheral blood involvement (NCCN, 2025).

Multiple Sclerosis

Treatment with UVB radiation has been investigated as a way to limit the development of multiple sclerosis (MS) and to improve symptoms. Hart and colleagues (2018) performed a study of 20 individuals with neurological symptoms that are predecessor to MS known as clinically isolated syndrome (CIS). All participants received vitamin D₃ supplementation and half also received UVB therapy. At 1 year, 100% of those in the no phototherapy arm and 70% in the phototherapy arm had converted to MS, but this difference was not statistically significant. Essa and colleagues (2023) studied 47 individuals with relapsing-remitting MS. A total of 24 participants received UVB treatment sessions for 4 weeks while 23 other participants took vitamin D₃ supplementation for 12 weeks. Postural control and cognitive function were tested before and after treatment. Although both groups showed improvement following treatment, there were no statistically significant differences between the two groups for any tested measure following treatment. Current evidence is insufficient to support the use of UVB as a treatment for MS.

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Mycosis Fungoides and Sézary syndrome

Ultraviolet light therapy is an established treatment of MF and therapies have included UVB (broad-band and narrow-band) and UVA treatments (Hodak, 2015). Phototherapy can be used at various stages of MF, either alone or in combination with systemic therapy (Hodak, 2015). The 2025 NCCN CPGs for Primary Cutaneous Lymphomas include a 2A indication for UVB therapy for patch/thin plaques in MF/SS with limited/localized or generalized skin involvement. In addition, NCCN includes a 2A indication for UVB in stage III MF/SS, noting that while generalized skin directed therapies may not be well tolerated in this population, phototherapy can be used successfully. The CPGs note that NB-UVB treatment is available in office or as a home panel or unit.

Because MF is rare, there are very few appropriately powered randomized controlled trials (RCTs) that assess its effectiveness. Most recommendations are based on small studies, case series, or expert opinion. Olsen and colleagues (2016) reported the results of three studies that included home broad-based UVB therapy. These studies included a total of 109 individuals who presented with stage 1A or 1B MF. Home treatments included daily phototherapy while office-based treatments were carried out 3 times per week. A total of 58 individuals received home-based therapy, with 48 of these 58 individuals receiving only home-based therapy and the remaining 10 individuals receiving home therapy after office-based therapy. The authors noted that maintenance regimens within the studies varied and likely affected response duration. Relapse was uncommon while individuals were on maintenance phototherapy (2/18), but was more common once maintenance phototherapy was discontinued (12/23). The authors found that individuals using home-based phototherapy were much more likely to continue maintenance phototherapy than individuals who received office-based phototherapy.

Pityriasis lichenoides

UVB has also been recommended as a treatment for several other conditions. Pityriasis lichenoides is a rare collection of skin disorders that have been reported to progress to cutaneous lymphoma or an ulceronecrotic presentation, both of which carry a significant risk of mortality. Treatment is difficult and aggressive approaches are usually recommended. According to one source, the use of UVB phototherapy has been the most successful treatment method and is considered first-line therapy (Khachemoune, 2007).

Pruritus of hepatic or renal disease

Pruritus associated with hepatic disease and renal failure are difficult to treat. Management is primarily focused on the treatment of the underlying symptoms such as pain and itching. Several treatment options are currently used, and UVB phototherapy has become widely accepted as an important tool in the management of these conditions (Wang, 2010).

Psoriasis

Koek and colleagues (2009) conducted a randomized controlled single-blind trial comparing office-based UVB treatment with home therapy for individuals with plaque or guttate psoriasis. This study involved 196 participants who were evaluated through the initial therapy, with the first 105 participants followed for an additional 12 months post-treatment. The authors reported that both treatments provided significant improvement from baseline, with home therapy being non-inferior

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to office-based treatment as measured by the psoriasis area and severity index (PASI) and the self-administered psoriasis area and severity index (SAPASI). No significant differences between groups were reported for total cumulative radiation dose or short-term side effects.

Unrue and colleagues (2019) conducted a multicenter, prospective, open-label, interventional study to assess the treatment efficacy, adherence, and satisfaction of an ultraviolet home phototherapy system. The study included 8 participants with stable plaque psoriasis. Matched control and study lesions were assessed on each participant. All participants that completed the 10-week study experienced an improvement in the treated lesions with a mean improvement of 57% in Psoriasis Severity Index (PSI; $p < 0.0001$ vs. baseline, and $p < 0.0002$ compared to the control lesions). Control lesions did not significantly change in PSI over the study period with a mean change of 9% ($p = 0.1411$). No adverse events were reported. Treatment adherence was 96%. These results indicated that the home phototherapy system was a safe and effective monotherapy to manage plaque psoriasis in this group of participants.

The Joint American Academy of Dermatology (ADA)/National Psoriasis Foundation (NPF) guidelines of care for the management and treatment of psoriasis with phototherapy (2019) included the following recommendation:

Recommend No. 1.8

Home NB-UVB phototherapy is recommended for appropriate patients with generalized plaque psoriasis as an alternative to in-office NB-UVB phototherapy. (Strength of recommendation: B; Level of evidence: I)

In 2022, Cohen and colleagues performed a systematic review of the use of home-based devices for the treatment of skin conditions. A total of 4 RCTs evaluating home UVB phototherapy for psoriasis were included (Franken, 2015; Koek, 2009; Paul, 1983; Unrue, 2019). Conflicting evidence was identified for the efficacy of home-based UVB compared to traditional clinic-based administration. Three studies reported either significant improvements in PASI or PSI scores with home UVB use compared to controls, or non-inferiority of home therapy to office-based treatment. However, a study by Paul and colleagues (1983) showed the opposite outcome: while 90% of participants who were treated in a clinic with phototherapy experienced complete clearance of psoriasis lesions, only 40% of participants treated at home achieved the same result. Similar to the ADA/NPF guidelines, the review gave a grade of recommendation of B for home phototherapy (UVB) devices for psoriasis.

In 2024, Gelfand and colleagues published results from the Light Treatment Effectiveness (LITE) study, an open-label, parallel-group, noninferiority randomized clinical trial. This multicenter trial was conducted at 42 academic and private dermatology practices in the U.S. The objective was to compare the effectiveness of home- and office-based NB-UVB phototherapy for psoriasis. Participants were 12 years and older with plaque or guttate psoriasis randomized to receive a home NB-UVB machine or routine care with office-based NB-UVB for 12 weeks, followed by 12 weeks of observation. A total of 783 participants were enrolled: 393 received home-based phototherapy and 390 received office-based phototherapy. The main outcomes were Physician Global Assessment (PGA) score of 1 or lower (clear/almost clear skin) and Dermatology Life Quality Index (DLQI)

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score of 5 or lower (no to small effect on quality of life) at week 12. Results showed that 32.8% of individuals receiving home-based phototherapy and 25.6% of individuals receiving office-based phototherapy achieved clear/almost clear skin, and 52.4% and 33.6% achieved DLQI of 5 or lower, respectively. Home-based phototherapy was noninferior to office-based phototherapy for PGA and DLQI in the overall population and across all skin phototypes (a classification based on the amount of melanin in the skin). Home-based phototherapy, compared to office-based phototherapy, was associated with better treatment adherence (51.4% vs. 15.9% of participants, $p < 0.001$). There was no evidence of misuse of home-based phototherapy based on dosing data captured from the machines, and there were no discontinuations due to adverse events in either group. The results indicate that home-based phototherapy was as effective as office-based phototherapy for plaque or guttate psoriasis in everyday clinical practice and had less burden to individuals.

Vitiligo

Vitiligo is an acquired depigmenting disorder characterized by well-defined white macules and patches on the skin due to loss of melanocytes. It is relatively common, affecting roughly 0.5-1% of the global population (Al-Smadi, 2023). In the United States, recent studies estimate an overall vitiligo prevalence around 0.76%- 1.11% (including undiagnosed cases). This equates to roughly 1.9 to 2.8 million U.S. adults as of 2020. Both sexes and all ethnic groups are affected at similar rates, though the condition may be more conspicuous on darker skin. Vitiligo can begin at any age but usually starts in childhood or young adulthood. About 50% of affected persons develop vitiligo by 20 years of age. Family history plays a role in some cases (approximately 20% have an affected relative), and vitiligo is often associated with other autoimmune diseases (especially thyroid disorders). The psychosocial impact is significant. Visible lesions can lead to stigma, low self-esteem, and reduced quality of life for many of those affected, underscoring the importance of effective management.

There is no permanent cure for vitiligo; management aims to stop or slow the spread of depigmentation and to restore skin color (repigmentation) as much as possible. An individualized treatment plan is essential. Dermatologists consider the individual's age, extent and distribution of vitiligo, rate of progression, and impact on quality of life when choosing therapy. Some people with very limited vitiligo or those unbothered by their patches may opt for no medical treatment (using cosmetic camouflage instead), but many seek active treatment to regain pigment.

For localized vitiligo (limited areas), topical corticosteroids and topical calcineurin inhibitors (e.g., tacrolimus or pimecrolimus) are first-line treatments. These immunomodulating agents help suppress the immune attack on melanocytes and can induce repigmentation over months of use. Mid- to high-potency corticosteroid creams or ointments are typically applied to affected patches (often daily or twice daily) for a course of a few months. Corticosteroids can often restore pigment, especially on the face or trunk, but prolonged use may cause skin atrophy or other side effects, so treatment courses are usually limited or intermittent. Topical calcineurin inhibitors, which do not cause skin atrophy, are especially useful for sensitive areas like the face or intertriginous zones and have shown similar efficacy to steroids for vitiligo repigmentation. These topical therapies can be augmented by phototherapy for better results.

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Narrowband ultraviolet B (NB-UVB) phototherapy is a cornerstone treatment for moderate to widespread vitiligo. Exposing the skin to NB-UVB light (311 nm) two or three times per week can stimulate melanocyte activity and migration, leading to gradual repigmentation of vitiliginous areas. Phototherapy is often combined with topical agents. For example, a topical steroid or calcineurin inhibitor and then NB-UVB has a synergistic effect. This form of photochemotherapy is different from the Psoralen + UVA (PUVA) therapy described above for psoriasis and does not share PUVA's risks for adverse events. A randomized trial showed that NB-UVB plus a topical agent (steroid or vitamin D analog) achieved greater repigmentation than phototherapy alone (Al-smadi, 2023). Treatment typically needs to continue for at least 3-6 months before significant improvement is seen, and optimal results may require 12 or more months of consistent therapy. For small, well-defined lesions, targeted phototherapy (excimer laser, a form of 308 nm UVB) can be used on individual spots.

Severe or rapidly progressive vitiligo may require short courses of systemic corticosteroids to halt autoimmune activity and stabilize disease. Traditionally, most other treatments were used off-label, but a major recent advance has been the development of Janus kinase (JAK) inhibitor therapy. In July 2022, the U.S. FDA approved ruxolitinib 1.5% cream (Opzelura) as the first and only medication specifically indicated for repigmentation in vitiligo (FDA, 2022). Ruxolitinib, a topical JAK1/JAK2 inhibitor, is applied twice daily to affected areas (up to 10% body surface area) and can produce repigmentation, particularly on facial vitiligo, with results visible by about 24 weeks in many treated individuals.

Shan and colleagues (2014) published the results of UVB home phototherapy for vitiligo in a prospective uncontrolled trial (n=93). Treatments were administered 3 times each week at variable dosages. Follow-up was conducted every 3 months up to 1 year to evaluate repigmentation and the occurrence of complications. At 1 year of follow-up, 35 participants (38%) achieved excellent repigmentation, 16 (17%) achieved good repigmentation, 15 (16%) showed moderate repigmentation, 16 (17%) had poor repigmentation, and 11 (12%) had no repigmentation. A total of 25 (27%) individuals discontinued treatment due to poor repigmentation. This study was hampered by several design limitations including a lack of randomization and a lack of appropriate comparator groups.

In 2017, Bae and colleagues reported results of a systematic review and meta-analysis of studies of phototherapy for vitiligo. A total of 29 prospective studies reporting outcomes for 1201 individuals undergoing NB-UVB phototherapy were included. Primary outcomes were assessed as mild ($\geq 25\%$), moderate ($\geq 50\%$), or marked ($\geq 75\%$) repigmentation responses on a quartile scale. The results were reported as follows:

Response Level	Time Point	% Response	95% Confidence Interval	Number of Individuals	Number of Studies
At least mild	3 months	62.1%	46.9% - 77.3%	130	3
At least mild	6 months	74.2%	68.5% - 79.8%	232	11

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At least mild	12 months	75.0%	60.9% - 89.2%	512	8
Marked	3 months	13.0%	2.1% - 23.9%	106	2
Marked	6 months	19.2%	11.4% - 27.0%	266	13
Marked	12 months	35.7%	21.5% - 49.9%	540	9

The authors concluded that long duration NB-UVB phototherapy enhances treatment response in vitiligo. However, home-based phototherapy was not specifically addressed in this analysis.

A single-center prospective cohort study enrolled 94 individuals with non-segmental vitiligo to evaluate the efficacy and safety of home and outpatient NB-UVB therapy (Zhang, 2019). Over a period of 6 months, 48 participants received treatment at home while another 46 received outpatient treatment. Primary outcomes included efficacy, quality of life and adverse events. Overall, results were similar at 6 months between groups with higher efficacy seen on some measures for the outpatient group.

In 2020, Liu and colleagues published the results of a randomized pilot trial evaluating the efficacy and safety of NB-UVB phototherapy at home compared to hospital management of limited new-onset vitiligo. A total of 100 individuals with new-onset vitiligo (< 3 months) and < 5% body surface area involvement were randomized to either a home-based or a hospital-based treatment group. Participants received UVB phototherapy 3 times a week. At study-end (8 weeks), home- and hospital-based treatment showed similar efficacy but the frequency of adverse events, such as painful erythema, burning, blistering, and excessive hyperpigmentation, were increased in the home-based cohort. The authors noted that some in the home cohort intentionally extended their treatments in an effort to increase efficacy and recommended that attention be paid to avoid overexposure.

In 2021, Ashraf and colleagues published the results of a systematic review of three RCTs addressing home-based phototherapy for vitiligo. Two studies compared home-based with institution-based phototherapy, and one study compared home-based phototherapy with placebo. A total of 195 participants were included. The primary outcome was the effectiveness of home-based phototherapy in achieving repigmentation. Secondary outcomes were adverse effects of treatment, relapse rates and cost comparisons of institution- vs. home-based phototherapy. Therapy regimes varied between studies with four different types of NB-UVB devices used. Variable rates of repigmentation were achieved across studies but there was no significant difference in repigmentation rates between the groups. Adherence to treatment schedules was significantly better in home-based groups although adverse effects were also significantly higher in groups with home-based treatment vs. institution-based treatment (5% vs. 0% and 26% vs. 10%; two trials, 166 participants; RR, 4.69, 95% CI, 2.16-10.21; $p < 0.0001$). These adverse effects included excessive hyperpigmentation, blistering and enlargement of vitiligo patches. No data were reported on long-term maintenance of treatment benefits. The authors concluded that “data were insufficient to form conclusions on effectiveness” of home-based treatment and that it would be difficult to recommend home-based treatment in clinical practice due to the higher risk of adverse events.

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Thomas and colleagues (2021) reported the results of the Home Interventions and Light therapy for the treatment of Vitiligo Trial (Hi-Light Vitiligo Trial), an RCT which evaluated the comparative safety and effectiveness of a topical corticosteroid (TCS) and handheld NB-UVB therapy for the management of active limited vitiligo. The trial compared TCS (mometasone furoate 0.1% ointment) alone, NB-UVB alone, and TCS combined with NB-UVB. The primary outcome was treatment success at 9 months at a target patch assessed using the participant-reported Vitiligo Noticeability Scale. Target patch treatment success was noted in 17% (TCS alone), 22% (NB-UVB alone), and 27% (combination treatment) of participants. An adjusted between-group difference of 10.9% (95% CI, 1.0% to 20.9%; $p=0.032$; number needed to treat=10) showed that combination treatment was superior to TCS alone. NB-UVB alone was not superior to TCS with an adjusted between-group difference of 5.2% (95% CI, 4.4% to 14.9%; $p=0.29$; number needed to treat=19). Participants with greater than 75% adherence to treatment were more likely to achieve treatment success but experienced a loss of effects once treatment stopped. The results showed that combination therapy was more likely to produce improved treatment response. However, combination therapy was only successful in about one quarter of participants. Although 517 participants were randomized, primary outcome data was only available for 370 participants. Attrition rates were similar in all three treatment arms. Most attrition occurred in the first 3 months of follow-up. Many leaving the trial said they did so because they could not commit the time required for the treatment. The high attrition rate left this trial insufficiently powered to provide precise confidence limits for the outcomes.

The International Vitiligo Task Force has published expert recommendations for the diagnosis and management of vitiligo (van Geel, 2023). A consortium of 42 international vitiligo experts and 4 individuals with vitiligo worked together to develop a consensus management strategy intended to guide decision-making in clinical practice. In assessing therapeutic options, the task force concluded that NB-UVB (in office or home phototherapy) can be recommended in individuals with vitiligo with insufficient response to topical treatment and in extensive or rapidly progressive disease.

Khandpur and colleagues (2025) conducted a systematic review and meta-analysis of the clinical efficacy and safety of home-based handheld NB-UVB device therapy in vitiligo. A total of 13 studies including 557 individuals were assessed. The extent of repigmentation achieved over a median duration of 6 months (range 3-12 months) was determined to be as follows:

Extent of Repigmentation Over 6 Months (%)	Individuals With Observed % of Repigmentation (% and CI)
> 25%	63.6% (95% CI: 51.0-75.3%)
> 50%	40.8% (95% CI: 30.4-51.6%)
>75 %	15.4% (95% CI: 7.6-25.3%)

Three sessions per week resulted in significantly higher > 50% ($p<0.01$) and > 75% ($p=0.01$) repigmentation. Similar extents of repigmentation (good [> 50%] to excellent [> 75%]) were observed with both stable and active vitiligo. Altogether, 11.3% of participants showed no response to therapy. The most reported adverse event was erythema in 33.4% (95% CI: 19.3-49.2%) of treated individuals, with grade 3 and 4 erythema in 27 and 15 participants, respectively. The authors

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concluded that the NB-UVB device is suitable for home use with proper instructions and is an effective therapeutic option when the treatment frequency is 3 to 4 sessions per week.

There is increasing evidence supporting the benefits of home-based UVB phototherapy, and this treatment is generally accepted as a standard therapy for vitiligo.

UVA home therapy devices

The use of UVA as a home therapy has not been shown to be safe and effective when compared to the other alternatives, such as office or facility-based treatment UVA therapy or UVB therapy. The AAD (2014) notes that given the limited number of head-to-head trials, there is no definitive recommendation regarding which form of phototherapy is more effective. UVA therapy requires the concurrent use of photosensitizers, which greatly increase the risk of complications. UVB therapy does not involve the use of photosensitizers.

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Policy History

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03/21/2002	Medical Policy Committee/review
03/25/2002	Managed Care Advisory Council approval.
06/24/2002	Format revision. No substance change to policy
03/08/2004	Medical Director review
03/16/2004	Medical Policy Committee review. Format revision. Phototherapy medical policy deleted. Policy specific to ultraviolet light and laser treatment of skin conditions formulated.
03/29/2004	Managed Care Advisory Council approval
03/01/2005	Medical Director review
03/15/2005	Medical Policy Committee review
04/04/2005	Managed Care Advisory Council approval
11/02/2005	Medical Director review
11/15/2005	Medical Policy Committee review. Format revision. FDA approval information added. Updated coverage eligibility to include use of UVB in treatment of psoriasis.
01/26/2006	Quality Care Advisory Committee approval
05/03/2006	Medical Director Review
05/17/2006	Medical Policy Committee Review. UVB has been removed from policy.
04/04/2007	Medical Director review

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04/18/2007	Medical Policy Committee approval. Coverage eligibility unchanged.
11/07/2007	Medical Director review
11/15/2007	Medical Policy Committee approval. Replaced policy including title changed from Ultraviolet Light, Including Laser Therapy, for Skin Conditions.
11/05/2008	Medical Director review
11/18/2008	Medical Policy Committee approval. Targeted phototherapy for the first line treatment of mild psoriasis and generalized psoriasis or psoriatic arthritis is now considered to be investigational.
11/12/2009	Medical Policy Committee approval
11/18/2009	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/04/2010	Medical Policy Committee review
11/16/2010	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/03/2011	Medical Policy Committee review
11/16/2011	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/01/2012	Medical Policy Committee review
11/28/2012	Medical Policy Implementation Committee approval. Title changed from "Targeted Phototherapy for Psoriasis" to "Light Therapy for Psoriasis". Added new eligible for coverage statement. "PUVA for the treatment of severe, disabling psoriasis, which is not responsive to other forms of conservative therapy (e.g., topical corticosteroids, coal/tar preparations, and ultraviolet light), is considered to be eligible for coverage."
11/07/2013	Medical Policy Committee review
11/20/2013	Medical Policy Implementation Committee approval. No change to coverage.
11/06/2014	Medical Policy Committee review
11/21/2014	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/03/2015	Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
10/29/2015	Medical Policy Committee review
11/16/2015	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/03/2016	Medical Policy Committee review
11/16/2016	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
11/02/2017	Medical Policy Committee review
11/15/2017	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/08/2018	Medical Policy Committee review
11/21/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

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02/06/2019	Coding update
11/07/2019	Medical Policy Committee review
11/13/2019	Medical Policy Implementation Committee approval. Added “When Services May Be Eligible for Coverage” and a “When Services Are Not Medically Necessary” sections for home ultraviolet light box therapy.
11/05/2020	Medical Policy Committee review
11/11/2020	Medical Policy Implementation Committee approval. Removed “box” from ultraviolet light box therapy to read ultraviolet light therapy in the eligible for coverage and not medically necessary statements. Coverage eligibility unchanged.
11/04/2021	Medical Policy Committee review
11/10/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/03/2022	Medical Policy Committee review
11/09/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/02/2023	Medical Policy Committee review
11/08/2023	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/01/2024	Medical Policy Committee review
02/14/2024	Medical Policy Implementation Committee approval. Title changed from “Light therapy for Psoriasis” to “Ultraviolet Light Therapy Delivery Devices for Home Use”. Extensive revisions made to the policy.
02/06/2025	Medical Policy Committee review
02/12/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/05/2026	Medical Policy Committee review
02/11/2026	Medical Policy Implementation Committee approval. Added an eligible for coverage criterion for the use of in-home Ultraviolet B light therapy delivery device for vitiligo, when topical treatment alone has failed. The Supplemental Information section was removed.

Next Scheduled Review Date: 02/2027

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)[‡], copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

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CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	No codes
HCPCS	E0691, E0692, E0693, E0694
ICD-10 Diagnosis	All related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and

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- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and 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.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan’s authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan’s pharmacy benefit.