1. **Purpose**
   The purpose of this policy is to establish the criteria for the medically necessary use of ultraviolet light therapy.

2. **Definitions**
   Ultraviolet light therapy incorporates the use of specific light emitting diodes or lamps which emit ultraviolet light.

3. **Statement of Policy**
   3.1. The determination of medical necessity for the use of ultraviolet light therapy is always made on a case-by-case basis.

   3.2. Certain forms of ultraviolet light therapy may be indicated in the treatment of a variety of dermatological conditions and certain sleep disorders. There is no scientific evidence of efficacy for the use of ultraviolet light therapy for complaints or conditions not noted above and is, therefore, **considered not medically necessary**.

4. **References**
   4.1. **Scientific:**
   The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding ultraviolet light therapy and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


4.2. Related Triad Medical Policies:

- **TMMP 18 - Medical Necessity**
- **TMMP 10 - Use of Passive and Active Care**
- **TMMP 13 – Use of Adjunctive Modalities and / or Therapeutic Procedures**

**CPT Codes**

This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>97028</td>
<td>Application of a modality to 1 or more areas; ultraviolet.</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes.

**Table of Revisions**

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
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<tbody>
<tr>
<td>10/11/2013</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Punctuation corrected in §3.2. Description of CPT Code 97028 updated.</td>
</tr>
<tr>
<td>11/16/2012</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>07/22/2011</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. §3.2 changed language to read “is considered not medically necessary” instead of “may be considered…” to be consistent with other medical policies with the same §. Removed §5. Attachments and 5.1 Provider Manual as the provider manual has been re-written administratively. §4.2 added reference to TMMP 13 – Use of Adjunctive</td>
</tr>
</tbody>
</table>
Triad's Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant's benefit plan document shall supersede the information contained in Triad's Medical Policies.