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Dermatologic Applications of Photodynamic Therapy
Corporate Medical Policy

File name: Dermatologic Applications of Photodynamic Therapy
File code: UM.SURG.14
Origination: 08/2016
Last Review: 01/2018
Next Review: 01/2019
Effective Date: 08/01/2018

Description/Summary

Photodynamic therapy (PDT) refers to light activation of a photosensitizer to generate highly reactive intermediaries, which ultimately cause tissue injury and necrosis. Photosensitizing agents, administered orally or intravenously, have been used in nondermatologic applications and are being proposed for use with dermatologic conditions such as actinic keratoses and nonmelanoma skin cancers.

There is evidence from randomized controlled trials (RCTs) that PDT is an effective treatment for selected patients with actinic keratoses of the face and scalp compared with placebo or cryotherapy. The evidence to date suggests that PDT is less effective than surgery and radiotherapy and of similar efficacy to cryotherapy for treating low- risk basal cell carcinoma (BCC) (eg, superficial and nodular). Moreover, the evidence suggests that cosmetic outcomes are better after PDT compared with surgery and cryotherapy. Evidence from RCTs suggests that, in patients with Bowen disease (BD), PDT has similar or higher efficacy compared with cryotherapy and 5-fluorouacil (5-FU), and better cosmetic outcomes. Thus, PDT may be considered medically necessary for treating nonhypertonic actinic keratoses of the face and scalp and for treating low-risk BCC and BD when surgery and radiation are contraindicated.

There is insufficient evidence that PDT improves the net health outcome for other dermatologic conditions compared with accepted treatments, and therefore they are considered **investigational**.

Policy

Coding Information

Photodynamic therapy typically involves 2 office visits: one to apply the topical ALA and a second visit to expose the patient to blue light. The second physician office visit, performed solely to administer blue light, should not warrant a separate Evaluation and Management CPT code. Photodynamic protocols typically involve 2 treatments spaced a week apart; more than 1 treatment series may be required.

Click the links below for attachments, coding tables & instructions.
Attachment I- Code Table & Instructions

When a service may be considered medically necessary

Photodynamic therapy may be considered **medically necessary** as a treatment of:

- Nonhyperkeratotic actinic keratoses of the face and scalp.
- Low-risk (eg superficial and nodular) basal cell skin cancer only when surgery and radiation are contraindicated.
- Bowen disease (squamous cell carcinoma in situ) only when surgery and radiation are contraindicated.

When a service is considered investigational

Photodynamic therapy is considered **investigational** for other dermatologic applications, including, but not limited to, acne vulgaris, high-risk basal cell carcinomas, hidradenitis suppurativa and mycoses.

When a service is considered a Benefit Exclusion

Photodynamic therapy as a technique of skin rejuvenation or hair removal or cosmetic indication is considered **a benefit exclusion therefore not covered**.

Policy Guidelines

Surgery or radiation is the preferred treatment for low-risk basal cell cancer and Bowen disease (see Rationale section). If photodynamic therapy is selected for these indications because of contraindications to surgery or radiation, patients and physicians need to be aware that it may have a lower cure rate in comparison with surgery or radiation.

Reference Resources

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Related Policy

Light Therapy for Psoriasi

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

08/2016	New policy. Adoption of BCBSA MPRM# 2.01.44
08/2017	Updated references. Updated related policy section.
01/2018	Updated descriptor on 96567 code and added 96573 & 96574 effective 01/01/2018.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors **Date Approved**

Gabrielle Bercy-Roberson, MD, MPH, MBA
Senior Medical Director
Chair, Health Policy Committee

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Attachment I
Code Table & Instructions

The following codes will be considered as Medically Necessary when applicable criteria have been met.			
Code Type	**Number**	**Brief Description**	**Policy Instructions**
CPT®	96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (e.g., lip) by activation of photosensitive drug(s), each phototherapy exposure per day	Prior Approval Required
CPT®	96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	
CPT®	96574	Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	
HCPCS	J7308	Aminolevulinic acid hydrochloric acid for topical administration, 20%, single unit dosage form (354 mg)	
HCPCS	J7309	Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 gram	