Photodynamic Therapy for the Treatment of Skin Lesions

I. Policy

University Health Alliance (UHA) will reimburse for photodynamic therapy for the treatment of skin lesions when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Photodynamic therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) for the treatment of:
   1. Nonhyperkeratotic actinic keratoses of the face and scalp;
   2. Superficial basal cell skin cancer only when surgery and radiation are contraindicated;
   3. Bowen’s disease (squamous cell carcinoma in situ) only when surgery and radiation are contraindicated;

B. Surgery or radiation are the preferred treatment for low-risk basal cell cancer and Bowen disease. If photodynamic therapy is selected for these indications because of contraindications to surgery or radiation, patients should be made aware that it may have a lower cure rate than surgery or radiation.

C. Photodynamic therapy typically involves 2 office visits: one to apply the topical aminolevulinic acid 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.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member’s individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Photodynamic therapy is not covered for the treatment of other dermatologic applications, including but not limited to, acne vulgaris, non-superficial basal cell carcinomas, hidradenitis suppurativa, or mycoses, due to the lack of scientific evidence demonstrating improved health outcomes.

B. Photodynamic therapy as a treatment of rosacea or as a technique of skin rejuvenation, hair removal, or other cosmetic indication is not a covered benefit.
C. Photodynamic therapy for actinic keratoses is limited to use on nonhyperkeratotic lesions on the face and scalp. Use for hyperkeratotic lesions and use on other body areas is not covered.

IV. Administrative Guidelines

A. Prior authorization is not required:

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<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>96567</td>
<td>Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day</td>
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<tr>
<td>96573</td>
<td>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</td>
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<tr>
<td>96574</td>
<td>Debridement of premalignant hyperkeratotic lesion(s) (i.e., 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</td>
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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tr>
<td>J7308</td>
<td>Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)</td>
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<tr>
<td>J7309</td>
<td>Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 g</td>
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<tr>
<td>J7345</td>
<td>Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg</td>
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V. Policy History

Policy Number: MPP-0001-111101
Current Effective Date: 10/16/2018
Original Document Effective Date: 11/01/2011
Previous Revision Date: 03/01/2015
PAC Approved Date: 11/01/2011
Previous Policy Title: Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions