Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions

I. Policy

University Health Alliance (UHA) will reimburse for photodynamic therapy for the treatment of actinic keratoses and other 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. 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 required:

1. For the treatment of nonhyperkeratotic actinic keratoses of the face and scalp, clinical notes documenting nonhyperkeratotic lesions and the location of the area being treated must be included in the prior authorization request. While ICD-9 code 702.0 is for actinic keratosis, it does not designate location or characteristics of lesions.

2. For superficial basal cell skin cancer and Bowen’s disease, documentation supporting that surgery and radiation are contraindicated must be submitted.

B. To request prior authorization, please go to UHA’s website:
http://www.uhahealth.com/forms/form_photodynamic.pdf and submit it:

**Via Fax:** 1-866-572-4384

**Via Mail:**
UHA Health Care Services
700 Bishop Street, Suite 300
Honolulu, HI 96813

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<th>Description</th>
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<tr>
<td>96567</td>
<td>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 session</td>
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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>
<th>ICD-9-CM Code</th>
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<td>702.0</td>
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<td>L57.0</td>
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V. Policy History

**Policy Number:** M.MIS.02.111101

**Current Effective Date:** 03/01/2015

**Original Document Effective Date:** 11/01/2011

**Previous Revision Date:** 03/01/2015