OVERVIEW
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.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
BlueCHIP for Medicare
Photodynamic therapy is medically necessary as a treatment for the destruction of actinic keratoses without restrictions based on lesion or patient characteristics.

Commercial Products
Photodynamic therapy is medically necessary as a treatment of nonhyperkeratotic actinic keratoses of the face and scalp, superficial basal cell skin cancer only when surgery and radiation are contraindicated, and for the treatment of Bowen disease (squamous cell carcinoma in situ) only when surgery and radiation are contraindicated.

Photodynamic therapy is not medically necessary for other dermatologic applications, including but not limited to, acne vulgaris, nonsuperficial basal cell carcinomas (BCC), hidradenitis suppurativa and mycoses, or as a technique of skin rejuvenation, hair removal, or other cosmetic indications as there is insufficient peer-reviewed scientific literature that demonstrates the procedure/service is effective.

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable medical and not medically necessary benefits/coverage.

BACKGROUND
Photodynamic therapy refers to light activation of a photosensitizing agent light to produce photochemical effects in the target area. The evidence to date suggests that the net health outcome is better with surgery than with PDT for treating basal cell carcinoma. For superficial BCC, the evidence is sufficient to conclude that PDT has a similar efficacy to cryotherapy and better cosmetic outcomes. In addition, there is evidence from randomized controlled trials that PDT is an effective treatment for selected patients with actinic keratoses of the face and scalp compared to placebo or cryotherapy. There is insufficient evidence that PDT improves the net health outcome for nodular BCC and other dermatological conditions compared to accepted treatments. Thus, PDT may be considered medically necessary for treating selected patients with actinic keratoses, superficial BCC, and Bowen disease, but is considered not medically necessary for all other dermatologic indications.
Surgery or radiation is the preferred treatment for superficial basal cell cancer and Bowen disease. If PDT 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. Photodynamic
therapy typically involves two office visits: one to apply the topical aminolevulinic acid (ALA), and a second
visit to expose the patient to blue light. The second office visit, performed solely to administer blue light,
should not warrant a separate Evaluation and Management CPT code. Photodynamic protocols typically
involve two treatments spaced a week apart; more than one treatment series may be required.

CODING
BlueCHiP for Medicare
The following codes are considered medically necessary when filed with the diagnosis code listed below:

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 session.

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

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,

J7308 Aminolevulinic hydrochloric acid for topical administration, 20%, single unit dosage form (354 mg)
J7309 Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 gram
J7345 Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg,

ICD-10 L57.0

Commercial Products
The following codes are considered not medically necessary when filed with the one of the diagnosis codes in
the attachment below:

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 session.

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

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,

J7308 Aminolevulinic hydrochloric acid for topical administration, 20%, single unit dosage form (354 mg)
J7309 Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 gram
J7345 Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg,
The following ICD10 codes are medically necessary when filed with the CPT code listed above:

ICD10 codes: Medically Necessary Indications
L03.213
L57.0
C44.0-C44.9
D04.0-D04.9

RELATED POLICIES
Not applicable

PUBLISHED
Provider Update, February 2019
Provider Update, March 2017
Provider Update, May 2016
Provider Update, May 2015
Provider Update, July 2008

REFERENCES

