Quartz

Photodynamic Therapy
Last Revision/Review Date: January 15, 2020 **P&P # C.6.15**

Policy

The Medical Management Department reviews referral requests for authorization of photodynamic therapy.

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

A. Documentation Required:

In order to facilitate the authorization process referral requests must include **ALL** the following:

1. Detailed physical exam and patient medical history; including physical or physiological indication(s) for PDT;
2. Reports of appropriate clinical studies/test/interventions to confirm the degree of the impairment;
3. Photographs or descriptive measurement (if applicable to request) of the anomaly;
4. Treating physician's plan of care (proposed procedures) which must include the expected outcomes of improvement as a result of the treatment.

B. Criteria for Medical Necessity:

1. Photodynamic therapy is considered medically necessary for treatment of Non-Melanoma Skin Tumors using topical photosensitizers for **ONE** of the following pre-malignant and primary non-metastatic lesions:
   a. Basal cell carcinoma; **OR**
   b. Cutaneous lesions of Bowen's disease; **OR**
   c. Refractory actinic keratosis (AK) that has failed conservative measures such as topical agents (fluorouracil or imiquimod) or cryosurgery; **OR**
   d. Field treatment for multiple AK of the head and neck.
2. Photodynamic therapy is considered medically necessary for the treatment of **ANY** of the following cancers:
   a. Esophageal Cancer:
      i. Barrett's esophagus with high-grade dysplasia in patients who are not candidates for esophagectomy; **OR**
      ii. Completely obstructing esophageal cancer; **OR**
      iii. Partially obstructing esophageal cancer, in members who cannot be satisfactorily treated with Nd:YAG laser therapy.

b. Lung Cancer:
    i. Completely obstructing endobronchial non-small cell lung cancer; **OR**
    ii. Microinvasive endobronchial non-small cell lung cancer at an early stage, for whom surgery and radiotherapy are not indicated; **OR**
    iii. Partially obstructing endobronchial non-small cell lung cancer.
c. Cholangiocarcinoma in combination with palliative stenting of inoperable cholangiocarcinoma.

C. Indications Considered Experimental, Investigational or not Medically Necessary: (*Not an all-inclusive list*):

PDT for the treatment of any of the following conditions:

a. Acne vulgaris
b. Disseminated superficial actinic porokeratosis
c. Hirsutism
d. Hyperkeratotic actinic keratoses
e. Nodular basal cell carcinoma
f. Photoaging (i.e., photodamage or dermatoheliosis)
g. Psoriasis
h. Sebaceous gland hyperplasia
i. Squamous cell carcinoma
j. Wart

CPT/HCPCS Codes

96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa by activation of photosensitive drug(s), each phototherapy exposure session.

REFERENCES

Aird GA, et al. Light and laser treatment modalities for disseminated superficial actinic porokeratosis: a systematic review. Lasers in Medical Science. 2017;32(4):945-952.

Foley K, Gupta AK, Martin G., et al. Topical Treatments and Photodynamic Therapy for Actinic Keratosis of the Face and Scalp. Cochrane Database of Systemic Reviews. Published 22 October 2019-Intervention Protocol.

Barbaric J, et al. Light therapies for acne. Cochrane Database of Systematic Reviews. Published Sept 27, 2016.

Center for Medicare and Medicaid Services (CMS). Actinic keratoses treatment (#CAG-00049). Decision Memorandum. Medicare Coverage Policy ~ Decisions. Baltimore, MD: CMS; July 19, 2001. Available at: http://www.hcfa.gov/coverage/8b3-t4.htm.

Gupta AK, Paquet M, et al., Interventions for actinic keratoses. Cochrane Database of Systematic Reviews 2012, Issue 12.

Hayes, Inc. Photodynamic Therapy for Actinic Keratosis and Squamous Cell Carcinoma in Situ, Technology Review, November 4, 2010. Archived December 04, 2015.

Hayes, Inc. Photodynamic Therapy for Nonmelanoma Skin Cancer, Medical Technology Directory, October 19, 2010. Updated October 16, 2014. Archived November 19, 2015.

National Comprehensive Cancer Network Clinical Practice Guidelines. Nccn/org

- Hepatobiliary Cancers. V.1.2019. December 17, 2018.

UpToDate® Treatment and Prognosis of Basal Cell Carcinoma at Low Risk for Recurrence, Aasi S,

UpToDate® Treatment of Actinic Keratosis, Jorizzo J, May 21, 2019

UpToDate® Treatment of Superficial Esophageal Cancer, Wright C., Saltman J. December 13, 2018

UpTODate® Barrett's Esophagus: Treatment with Photodynamic Therapy. Davila M, Van Dam J. July 25, 2018

UpToDate® Endobronchial Photodynamic Therapy in the Management of Airway Disease in Adults. LoCicero J, Murgu S. April 18, 2019

UpToDate® Treatment Options for Locally Advanced Unresectable but Nonmetastatic Cholangiocarcinoma. Andersen C, Stuart K, Palta M. May 25, 2018

UpToDate® Photodynamic Therapy, Maytin E, Warren C, July 30, 2018