Dermatologic Applications of Photodynamic Therapy

Policy # 00098
Original Effective Date: 06/05/2002
Current Effective Date: 12/11/2019

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: Light Therapy for Psoriasis is addressed separately in medical policy 00131.

Note: Oncologic Applications of Photodynamic Therapy, Including Barrett's Esophagus is addressed separately in medical policy 00234.

Note: Photodynamic Therapy for Choroidal Neovascularization is addressed separately in medical policy 00097.

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

• Benefits are available in the member’s contract/certificate, and
• Medical necessity criteria and guidelines are met.

Based on review of available data, the Company may consider photodynamic therapy (PDT) to be eligible for coverage.**

Patient Selection Criteria
Coverage eligibility will be considered for any of the following conditions:

• Actinic keratoses of the face and scalp, or
• Low-risk (e.g. superficial and nodular) basal cell skin cancer only when surgery and radiation are contraindicated; or
• Cutaneous squamous cell carcinoma in situ (Bowen disease) only when surgery and radiation are contraindicated.
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When Services Are Not Covered
The use of photodynamic therapy (PDT) as a technique of skin rejuvenation, hair removal, or other cosmetic indications is not covered. **

When Services Are Considered Investigational
Note: Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers photodynamic therapy (PDT) for other dermatologic applications, including, but not limited to the following to be investigational:*

- Acne vulgaris
- High-risk basal cell carcinomas
- Hidradenitis suppurativa
- Mycoses

Based on the review of available data, the Company considers the use of photodynamic therapy (PDT) when patient selection criteria are not met to be investigational.*

Policy Guidelines
Surgery and radiation are the preferred treatments 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 and physicians need to be aware that it may have a lower cure rate than surgery or radiation.

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.

Background/Overview
Photodynamic Therapy

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PDT refers to light activation of a photosensitizer to generate highly reactive intermediaries, which ultimately cause tissue injury and necrosis. Two common photosensitizing agents are 5-aminolevulinic acid (5-ALA) and its methyl ester, methyl aminolevulinate. When applied topically, these agents pass readily through abnormal keratin overlying the lesion and accumulate preferentially in dysplastic cells. The agents 5-ALA and methyl aminolevulinate are metabolized by underlying cells to photosensitizing concentrations of porphyrins. Subsequent exposure to photoactivation (maximum absorption at 404 to 420 nm and 635 nm) generates reactive oxygen species that are cytotoxic, ultimately destroying the lesion. PDT can cause erythema, burning, and pain. Healing occurs within 10 to 14 days, with generally acceptable cosmetic results. PDT with topical ALA has been investigated primarily as a treatment of actinic keratoses.

**FDA or Other Governmental Regulatory Approval**

**U.S. Food and Drug Administration (FDA)**

In 1999, Levulan® Kerastick™, a topical preparation of ALA, in conjunction with illumination with the BLU-U™ Blue Light Photodynamic Therapy Illuminator, was approved by the U.S. Food and Drug Administration (FDA) for the treatment of nonhyperkeratotic actinic keratoses of the face and scalp. The product is applied in the physician’s office. FDA product code: MVF.

In 2016, the FDA approved Ameluz® (aminolevulinic acid hydrochloride) gel, 10% (BF-200 ALA; Biofrontera AG) in combination with PDT using BF-RhodoLED lamp, to be used for the lesion-directed and field-directed treatment of actinic keratoses of mild-to-moderate severity on the face and scalp. The treatment is to be administered by a health care provider.

A 5-ALA patch technology is available outside of the United States through an agreement between Intendis (now Bayer HealthCare) and Photonamic. The 5-ALA patch is not approved by the FDA. Another variant of PDT for skin lesions is Metvixia® used with the Aktilite CL128 lamp, each of which received the FDA approval in 2004. Metvixia (Galderma; Photocure) consists of the topical application of methyl aminolevulinate (in contrast to ALA used in the Kerastick procedure), followed by exposure with the Aktilite CL128 lamp, a red light source (in contrast to the blue light source in the Kerastick procedure). Broadband light sources (containing the appropriate wavelengths), intense pulsed light (FDA product code: ONF), pulsed dye lasers, and potassium-titanyl-phosphate lasers have also been used. Metvixia is indicated for the treatment of nonhyperkeratotic actinic keratoses of the face and scalp in immunocompetent patients when used...
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with lesion preparation (débridement using a sharp dermal curette) in the physician's office when other therapies are unacceptable or considered medically less appropriate. FDA product codes: GEX and LNK.

**Rationale/Source**
Photodynamic therapy (PDT) refers to light activation of a photosensitizer to generate highly reactive intermediaries, which ultimately cause tissue injury and necrosis. Photosensitizing agents are being proposed for use with dermatologic conditions such as actinic keratoses and nonmelanoma skin cancers.

For individuals who have nonhyperkeratotic actinic keratoses on the face or scalp who receive PDT, the evidence includes randomized controlled trials (RCTs). The relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. Evidence from multiple RCTs has found that PDT improves the net health outcome in patients with nonhyperkeratotic actinic keratoses on the face or scalp compared with placebo or other active interventions. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have low-risk basal cell carcinoma who receive PDT, the evidence includes RCTs and systematic reviews of RCTs. The relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. Systematic reviews of RCTs have found that PDT may not be as effective as surgery for superficial and nodular basal cell carcinoma. In the small number of trials available, PDT was more effective than placebo. The available evidence from RCTs has suggested that PDT has better cosmetic outcomes than surgery. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have squamous cell carcinoma in situ who receive PDT, the evidence includes RCTs. The relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. RCTs have found that PDT has similar or greater efficacy compared with cryotherapy and 5-fluorouracil. Additionally, adverse events and cosmetic outcomes appear to be better after PDT. Few RCTs have compared PDT with surgery or radiotherapy; as a result, conclusions cannot be drawn about PDT compared with these other standard treatments.
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evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have non metastatic invasive squamous cell carcinoma who receive PDT, the evidence includes observational studies and a systematic review of observational studies. The relevant outcomes are overall survival, symptoms, change in disease status, quality of life, and treatment-related morbidity. Conclusions cannot be drawn from small, uncontrolled studies. RCTs are needed to determine the safety and efficacy of PDT for this condition. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have acne who receive PDT, the evidence includes RCTs and a systematic review. The relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. The available RCTs have not consistently found significantly better outcomes with PDT compared with other interventions, and a meta-analysis did not find significantly better results with PDT vs placebo. Several trials have found that PDT is associated with high rates of adverse events leading to the cessation of treatment. Trials tended to have relatively small sample sizes and used a variety of comparison interventions. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have noncancerous dermatologic skin conditions (eg, hidradenitis suppurativa, mycoses, port wine stain) who receive PDT, the evidence includes case series, systematic reviews of uncontrolled series, and an RCT for port wine stain. The relevant outcomes are symptoms, change in disease status, quality of life, and treatment-related morbidity. RCTs are needed to determine the safety and efficacy of PDT for these conditions. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements
Canadian Dermatology Association
The Canadian Dermatology Association (2015) published the following recommendations on the dermatologic use of photodynamic therapy (PDT):

- Basal cell carcinoma: PDT may be used for superficial basal cell carcinoma when nonsurgical treatment is desired, there are multiple carcinomas, and when
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- the cosmetic outcome is important. PDT is not appropriate for nodular basal cell carcinoma.
- Actinic keratosis: PDT is among the recommended treatment options for actinic keratosis, although the guidance includes the statement that cryosurgery or a surgical procedure are preferred for isolated actinic keratosis and hypertonic lesions.

National Comprehensive Cancer Network
The NCCN has published clinical practice guidelines on basal cell skin cancers and squamous cell skin cancers.

For basal cell skin cancer, NCCN (v.1.2019) made the following recommendations: “In patients with low-risk, superficial basal cell skin cancer, where surgery and radiation are contraindicated or impractical, therapies such as topical 5-fluorouracil, topical imiquimod, photodynamic therapy (eg, aminolevulinic acid [ALA], porfimer sodium), or vigorous cryotherapy may be considered, even though the cure rates may be lower than with surgical treatment modalities.”

For squamous cell skin cancers, NCCN (v.2.2019) made the following recommendations: “In patients with SCC [squamous cell carcinoma] in situ (Bowen’s disease) alternative, therapies such as topical 5-fluorouracil, topical imiquimod, photodynamic therapy (eg, ALA, porfimer sodium), or vigorous cryotherapy may be considered, even though the cure rates may be lower than with surgical treatment modalities.”

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
The Centers for Medicare & Medicaid Services’ 2001 coverage policy on treatment of actinic keratosis noted:

“Various options exist on treating AKs [actinic keratosis]. Clinicians should select an appropriate treatment based on the patient’s history, the lesion’s characteristics, and the patient’s preference for specific treatment…. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy...
Medicare covers the destruction of actinic keratosis without restrictions based on lesion or patient characteristics.”

**Ongoing and Unpublished Clinical Trials**
Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
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<tr>
<td>NCT02685592</td>
<td>Photodynamic Therapy for Lentigo Maligna Using 5-aminolevulinic Acid Nanoemulsion as a Light Sensitizing Cream (LM PDT)</td>
<td>10</td>
<td>Mar 2018</td>
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<tr>
<td>NCT03025724a</td>
<td>Photodynamic Therapy for Treatment of Cutaneous Squamous Cell Carcinoma in Situ</td>
<td>40</td>
<td>Jan 2020</td>
</tr>
<tr>
<td>NCT02144077</td>
<td>A Randomized, Observer Blind, Multinational Phase III Study to Evaluate the Safety and Efficacy of BF-200 ALA (Ameluz®) in Comparison to Metvix® in the Treatment of Non-aggressive Basal Cell Carcinoma (BCC) With Photodynamic Therapy (PDT)</td>
<td>281</td>
<td>Sep 2020</td>
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</table>
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<tr>
<td>NCT02367547a</td>
<td>Superficial Basal Cell Cancer's Photodynamic Therapy: Comparing Three Photosensitises: Hexylaminolevulinate and Aminolevulinic Acid Nano Emulsion Versus Methylaminolevulinate</td>
<td>117</td>
<td>Dec 2022</td>
</tr>
<tr>
<td>NCT03511326a</td>
<td>Subject Reported Outcomes on Satisfaction, Safety and Efficacy With Luxerm® in the Field-directed Treatment of Thin or Non-hyperkeratotic and Non-pigmented Actinic Keratosis of the Face or the Scalp</td>
<td>50</td>
<td>Nov 2017 (completed)</td>
</tr>
<tr>
<td>NCT01482104</td>
<td>A Randomized Controlled Blinded Multi-centre Study of Photodynamic Therapy With Methyl-aminolevulinate Comparing a Simplified Regime With the Approved Regime in Patients With Clinical Low-risk</td>
<td>277</td>
<td>Oct 2017 (completed)</td>
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</tbody>
</table>
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<tr>
<td>NCT02647151</td>
<td>Comparative Intraindividual Study, About the Efficacy and Safety of Treatment of Actinic Keratoses With Photodynamic Therapy Between Acid Methyl Aminolevulinate Cream and Aminolevulinic Gel</td>
<td>50</td>
<td>Mar 2016 (unknown)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

a Denotes industry-sponsored or cosponsored trial.

References

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15. Yazdanyar S, Zarchi K, Jemec GBE. Pain during topical photodynamic therapy - comparing methyl aminolevulinate (Metvix(R)) to aminolaevulinic acid (Ameluz(R)); an intra-individual clinical study. Photodiagnostics Photodyn Ther. Aug 02 2017. PMID 28780136


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Current Effective Date: 12/11/2019
05/16/2002  Medical Policy Committee review
06/05/2002  Managed Care Advisory Council approval
05/04/2004  Medical Director review
05/18/2004  Medical Policy Committee review. Format revision. No substance change to policy.
06/28/2004  Managed Care Advisory Council approval
06/07/2005  Medical Director review
07/15/2005  Managed Care Advisory Council approval
06/05/2006  Medical Director review
06/21/2006  Medical Policy Committee approval. Format revisions, FDA/Governmental, No change in policy statement.
11/07/2007  Medical Director review
11/15/2007  Medical Policy Committee approval. Title changed and policy replaced.
12/03/2008  Medical Director review
12/17/2008  Medical Policy Committee approval. No change to coverage eligibility.
12/04/2009  Medical Policy Committee approval
12/16/2009  Medical Policy Implementation Committee approval. No change to coverage eligibility
11/04/2010  Medical Policy Committee approval
11/16/2010  Medical Policy Implementation Committee approval. Removed the restriction of face and scalp from the criteria for treatment of non-hyperkeratotic actinic keratoses.
12/08/2011  Medical Policy Committee review
12/06/2012  Medical Policy Committee review
12/19/2012  Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/23/2013  Updated coverage eligibility statement when patient selection criteria not met
12/12/2013  Medical Policy Committee review
12/18/2013  Medical Policy Implementation Committee approval. No change to coverage.

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12/04/2014 Medical Policy Committee review
12/17/2014 Medical Policy Implementation Committee approval. “for other dermatologic applications, including, but not limited to the following” was added to the investigational statement.

08/03/2015 Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
12/03/2015 Medical Policy Committee review
12/16/2015 Medical Policy Implementation Committee approval. No change to coverage.
12/01/2016 Medical Policy Committee review
12/21/2016 Medical Policy Implementation Committee approval. Changes to language in policy statements: Superficial or nodular changed to Low-risk and non-superficial changed to high-risk.

01/01/2017 Coding update: Removing ICD-9 Diagnosis Codes
12/07/2017 Medical Policy Committee review
12/20/2017 Medical Policy Implementation Committee approval. No change to coverage.
01/01/2018 Coding update
12/06/2018 Medical Policy Committee review
12/19/2018 Medical Policy Implementation Committee approval. Removed the word non hyperkeratotic from coverage statement. Added policy guidelines.
12/05/2019 Medical Policy Committee review
12/11/2019 Medical Policy Implementation Committee approval. Deleted the specification of face and scalp from eligible for coverage requirement in the statement for actinic keratosis.

Next Scheduled Review Date: 12/20/2020

Coding
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Codes used to identify services associated with this policy may include (but may not be limited to) the following:

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code</th>
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<tr>
<td>CPT</td>
<td>96567, 96573, 96574</td>
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<td>HCPCS</td>
<td>J7308, J7309, J7345</td>
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<td>A00.0, B48.1, B48.8, C44.00-C44.09, C50.011-C50.019, C84.00-C84.09, D04.0-D04.9, D06.0-D06.9, L11.8-L11.9, L57.0, L57.2, L57.4, L66.4, L70.0-L70.9, L72.0, L72.2-L72.9, L73.0, L73.2, L74.52, L74.8, L75.0-L75.1, L75.8, L82.0, L85.8, L87.1, L87.8, L90.3-L90.4, L90.8, L91.8, L92.2, L94.8, L98.5-L98.6, L99, N49.0</td>
</tr>
</tbody>
</table>

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and
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whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or

B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
   1. Consultation with the Blue Cross and Blue Shield Association technology assessment program (TEC) or other nonaffiliated technology evaluation center(s);
   2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
   3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
   A. In accordance with nationally accepted standards of medical practice;
   B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
   C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.