

MEDICAL POLICY

POLICY TITLE	ONCOLOGIC APPLICATIONS OF PHOTODYNAMIC THERAPY INCLUDING BARRETT'S ESOPHAGUS
POLICY NUMBER	MP 4.019

CLINICAL BENEFIT	<input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN. <input type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. <input type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE. <input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. <input checked="" type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. <input checked="" type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	2/1/2026

POLICY

One or more courses of photodynamic therapy may be considered **medically necessary** for the following oncologic applications:

- palliative treatment of obstructing esophageal cancer;
- palliative treatment of obstructing endobronchial lesions;
- treatment of early-stage non-small cell lung cancer in individuals who are ineligible for surgery and radiotherapy;
- treatment of high-grade dysplasia in Barrett's esophagus
- palliative treatment of unresectable cholangiocarcinoma when used with stenting.

Other oncologic applications of photodynamic therapy are considered **investigational** including, but not limited to, other malignancies and Barrett esophagus without associated high-grade dysplasia. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Cross-references:

MP 1.118 Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus

MP 2.068 Extracorporeal Photophoresis

MP 4.008 Photocoagulation Therapy for Treatment of AMD

MP 4.018 Dermatologic Applications of Photodynamic Therapy

MP 4.043 Treatments of the Prostate (Focal, Water Vapor, Aquablation, and Hydrogel Spacer)

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:

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<https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies>.

DESCRIPTION/BACKGROUND

Photodynamic therapy (PDT; also called phototherapy, photoradiotherapy, photosensitizing therapy, or photochemotherapy) is an ablative treatment that uses a photosensitizing agent to expose tumor cells to a light source of a specific wavelength for the purpose of damaging the cells. After administration of the photosensitizing agent, the target tissue is exposed to light using a variety of laser techniques. For example, a laser fiber may be placed through the channel of the endoscope, or a specialized modified diffuser may be placed via fluoroscopic guidance. Treatment for tumor cells occurs through selective retention of the photosensitizing agent and the selective delivery of light.

Photodynamic Therapy

PDT has been investigated for use in a wide variety of tumors, including esophageal, lung, cholangiocarcinoma, prostate, bladder, breast, brain (administered intraoperatively), skin, and head and neck cancers. Barrett esophagus also has been treated with PDT. PDT for focal treatment of prostate cancer is discussed in evidence review 4.043

Several photosensitizing agents have been used in PDT: porfimer sodium (Photofrin®), administered intravenously 48 hours before light exposure, and 5-aminolevulinic acid, administered orally 4 to 6 hours before the procedure. Aminolevulinic acid is metabolized to protoporphyrin IX, which is preferentially taken up by the mucosa. Clearance of porfimer occurs in a variety of normal tissues over 40 to 72 hours, but tumor cells retain porfimer for a longer period. Laser treatment of Barrett esophagus may be enhanced by the use of balloons containing a cylindrical diffusing fiber. The balloon compresses the mucosal folds of the esophagus, thus increasing the likelihood that the entire Barrett mucosa is exposed to light. All patients who receive porfimer become photosensitive and must avoid exposure of skin and eyes to direct sunlight or bright indoor light for 30 days.

Regulatory Status

Labeled indications for porfimer sodium (Photofrin; Pinnacle Biologics), as approved by the U.S. Food and Drug Administration (FDA), are as follows:

Esophageal Cancer

- Palliation of patients with completely obstructing esophageal cancer, or of patients with partially obstructing esophageal cancer who, in the opinion of their physician, cannot be satisfactorily treated with neodymium-doped yttrium aluminum garnet laser therapy.

Endobronchial Cancer

- Reduction of obstruction and palliation of symptoms in patients with completely or partially obstructing endobronchial non-small-cell lung cancer

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- Treatment of microinvasive endobronchial non-small-cell lung cancer in patients for whom surgery and radiotherapy are not indicated.

High-Grade Dysplasia in Barrett Esophagus

- Treatment of high-grade dysplasia in Barrett esophagus patients who do not undergo esophagectomy.

As of June 2025, oral 5-aminolevulinic acid has not received FDA approval as a photosensitizing agent for PDT. It is currently only indicated as an adjunct for the visualization of malignant tissue during surgery in individuals with glioma. Topical 5-aminolevulinic acid, used for the treatment of actinic keratoses, is addressed separately (evidence review 4.018).

This evidence review addresses only the non-dermatologic oncology applications of PDT and does not address its use in dermatologic applications, such as actinic keratosis and superficial basal cell cancer, or age-related macular degeneration. In addition, PDT should not be confused with extracorporeal photophoresis, which involves withdrawing blood from the patient, irradiating it with ultraviolet light, and then returning the blood to the patient. Extracorporeal photophoresis is addressed separately.

RATIONALE

SUMMARY OF EVIDENCE

For individuals who have obstructing esophageal cancer who receive PDT as palliation, the evidence includes systematic reviews, randomized controlled trials (RCTs), and uncontrolled single-arm studies. Relevant outcomes are change in disease status, symptoms, quality of life, and treatment-related morbidity. A meta-analysis comparing PDT with neodymium-doped yttrium aluminum garnet (Nd:YAG) laser suggested that improvements in dysphagia are similar, although estimates are imprecise. Compared with the Nd:YAG laser, PDT is associated with a lower risk of perforation and a higher risk of adverse reactions to the light (e.g. photosensitivity). PDT plus argon plasma coagulation appears to prolong the time to recurrence of dysphagia as opposed to argon plasma coagulation alone. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have obstructing endobronchial cancer who receive PDT as palliation, the evidence includes RCTs and uncontrolled single-arm studies. Relevant outcomes are change in disease status, symptoms, quality of life, and treatment-related morbidity. Evidence from RCTs comparing PDT with Nd:YAG laser has generally supported reductions in symptoms using PDT similar to those using a laser. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have early-stage non-small-cell lung cancer (NSCLC) who are not candidates for surgery or radiotherapy who receive PDT, the evidence includes uncontrolled single-arm studies. Relevant outcomes are overall survival, disease-specific survival, change in

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disease status, quality of life, and treatment-related morbidity. There are few patients with early-stage non-small-cell lung cancer who are not candidates for surgery or radiotherapy. While several treatment methods (e.g., laser, electrocautery, cryotherapy, brachytherapy) are available for this population, studies comparing the treatment methods are not available. Case series of PDT include between 21 and 95 patients and have reported complete response rates ranging from 72% to 100%. Given the small size of this potential population and the ineligibility for standard surgical treatment or radiotherapy, it is unlikely that stronger evidence will become available. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with Barrett esophagus with high-grade dysplasia who receive PDT, the evidence includes 2 systematic reviews and 2 RCTs. Relevant outcomes are OS, disease-specific survival, change in disease status, quality of life, and treatment-related morbidity. One RCT compared PDT plus a proton pump inhibitor with a proton pump inhibitor alone and demonstrated higher response rates and lower risk of progression with cancer persisting during 5 years of follow-up for patients in the PDT plus proton inhibitor group. The results of the RCT also revealed that patients treated with PDT had significantly more complications, including a high rate of strictures. Another RCT compared PDT performed with different photosensitizers; results revealed that neither were valuable long-term treatments for dysplastic Barrett esophagus. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have unresectable cholangiocarcinoma who receive PDT plus stenting as palliation, the evidence includes systematic reviews, RCTs, and observational studies. Relevant outcomes are change in disease status, symptoms, quality of life, and treatment-related morbidity. Three small RCTs and several observational studies have found that PDT plus stenting is associated with the greater elimination of bile duct stenosis and improved survival benefit compared with stenting alone. One RCT comparing stenting plus chemotherapy and PDT with stenting plus chemotherapy without PDT reported longer progression-free survival, but not OS, with similar adverse event rates. Case series have suggested an improvement in the quality of life with PDT. The main complication of PDT in cholangiocarcinoma is cholangitis. Given the small size of this potential population, it is unlikely that stronger evidence will become available. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have other malignancies (e.g., gynecologic, bladder, head and neck, brain, soft tissue) who receive PDT, the evidence includes controlled observational studies and uncontrolled single-arm studies. Relevant outcomes are overall survival, disease-specific survival, change in disease status, quality of life, and treatment-related morbidity. The published literature on PDT for these malignancies is generally comprised small case series without comparator groups. The evidence is insufficient to determine that the technology results in an improvement in the net health outcomes.

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DEFINITIONS

N/A

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes								
31641	43229	96570	96571	J9600				

ICD-10-CM Diagnosis Codes	Description
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified
C22.1	Intrahepatic bile duct carcinoma
C34.00	Malignant neoplasm of unspecified main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung

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ICD-10-CM Diagnosis Codes	Description
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.80	Secondary malignant neoplasm of unspecified digestive organ
C78.89	Secondary malignant neoplasm of other digestive organs
D00.1	Carcinoma in situ of esophagus
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung
K22.711	Barrett's esophagus with high grade dysplasia

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POLICY NUMBER	MP 4.019

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Policy HISTORY

MP 4.019	02/14/2020 Consensus Review. Policy updated with literature review; references added. Policy statements unchanged.
	10/04/2021 Consensus Review. No change to policy statement. NCCN statement added. References updated.
	11/21/2022 Consensus Review. No change to policy statement intent, updated for clarity. References, formatting, and coding reviewed and updated.
	06/13/2023 Administrative Update. Added New Code 0398U Effective 07/01/2023.

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	08/17/2023 Consensus Review. No change to policy statement. Background updated. References reviewed and updated. Coding reviewed.
	01/19/2024 Administrative Update. Clinical benefit added.
	09/11/2024 Consensus Review. No change to policy statement. Cross Referenced policies, Background, Rational and References updated. Removed CPT code 0398U.
	08/07/2025 Consensus Review. No change to policy statement. NCCN statement removed. Cross- referenced policies, Background and References updated.

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