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Area:	
Lines Of Business:	*All Lines of Business*

Actinic Keratosis

PURPOSE:

The policy is to outline the appropriate treatments for actinic keratosis which has a high likelihood of developing into squamous cell carcinoma.

DEFINITIONS:

Actinic Keratosis: Keratinocyte neoplasms occurring on skin that has had long-term exposure to ultraviolet radiation.

PROCEDURE:

The following treatments for actinic keratosis may be considered medically necessary:

1. Cryosurgery; or
2. Laser therapy; or
3. Photodynamic therapy (PDT)
4. Topical medications including topical diclofenac gel, imiquimod cream, ingenol mebutate gel, 5-fluorouracil [5-FU], or tirbanibulin.
5. Chemical peels (medium-depth and deep), and dermabrasion when both of the following are met:
    a. There are greater than 10 AK lesions or severe diffuse AK lesions present; and
    b. Failure, contraindication or intolerance to one or more conventional field therapy treatments (e.g., topical 5-fluorouracil [5-FU, Efudex], topical diclofenac, photodynamic therapy [PDT], topical imiquimod [Aldara]); or
6. Shave excision, curettage and electrodesiccation when either of the following are met:
    a. Progression to squamous cell carcinoma (SCC) is suspected; or
    b. Failure, contraindication or intolerance to one or more conventional field therapy treatments (e.g., topical 5-fluorouracil [5-FU, Efudex], topical diclofenac, photodynamic therapy [PDT], topical imiquimod [Aldara]).

The use of any of the above treatments for indications other than actinic keratosis is considered cosmetic, and therefore non-covered.

Superficial chemical peels and dermabrasion for actinic keratosis is considered cosmetic, and therefore, non-covered.

CODING:

CPT Code	Description
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15789	Chemical peel, facial; dermal
15793	Chemical peel, nonfacial; dermal
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day
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 acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7309	Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 g
J7345	Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg

ICD-10 Code	Description
L57.0	Actinic keratosis

Non-Covered Codes:

CPT Code	Description
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary

CPT Code	Description
	procedure)
15788	Chemical peel, facial; epidermal
15792	Chemical peel, nonfacial; epidermal

REFERENCES:

Eisen DB, Asgari MM, Bennett DD, et al. Guidelines of care for the management of actinic keratosis. J Am Acad Dermatol. 2021;85(4):e209-e233. Accessed January 27, 2022.

American Cancer Society. Treating Actinic Keratosis and Bowen Disease. February 22, 2021. Accessed January 27, 2022.

American Academy of Dermatology Association (AAD). Actinic Keratosis: Diagnosis and Treatment. Last updated October 21, 2021. Accessed January 27, 2021.

Berman, B. Treatment of Actinic Keratosis. In: UpToDate. Last updated July 13, 2021. Accessed January 27, 2021.

RELATED POLICIES:

Please review the pharmacy Topical Medications for Actinic Keratosis Preferred Step Therapy Policy and Actinic Keratosis — Topical Photodynamic Medications Preferred Step Therapy Policy for additional information. These policies are located in the Provider Portal under Policies > Medicaid, Commercial and ASO Drug Policies (login required). Please note, these policies are not applicable to Medicare.

DISCLAIMER:

This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy is intended to address medical necessity guidelines that are suitable for most individuals. Each individual's unique clinical situation may warrant individual consideration based on medical records. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

All revision dates:

Attachments

No Attachments