Dermatology Coding Alert

Phototherapy: 96900 or 96910? The Answer Could Mean $70 for Each Vitiligo Treatment

Avoid misrepresenting phototherapy services by following this expert advice.

Is your dermatologist treating vitiligo or dychromia patients with phototherapy? If so, you need to dig into your physician's documentation to determine what type of light, wavelength, and materials he used. Check out these two frequently asked questions and combat both E/M and multiequipment correct coding initiative (CCI) situations with this expert advice.

Evaluate These Phototherapy + E/M Tips

If you're charging for an office visit on the same day as phototherapy, your reimbursement may depend on whether your physician's documentation warrants a different diagnosis code. Payers may reimburse at times if the doctor sees the patient for a different problem, thus with a different diagnosis code, experts say.

Example: If your physician performs 99212 (Office or other outpatient visit for the evaluation and management of an established patient ... Physicians typically spend 10 minutes face-to-face with the patient and/or family) with phototherapy, you will bill it with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the E/M service. You can only consider reporting modifier 25 when coding an E/M service, **Janet Palazzo, CPC,** a coder in Cherry Hill, N.J., says. Remember your E/M documentation has to show medical necessity for the additional work.

Note: If you reported the nurse visit code 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician ...), your payer would likely consider it bundled into the light treatment.

Ask 2 Questions to Choose Best Light Therapy Code

For patients with vitiligo (709.01), your dermatologist may use narrow band UVB phototherapy.

The dermatologist administers phototherapy two to three times per week for several months until the patient achieves repigmentation of the skin. For this procedure, you need to pinpoint what types the physician used (UVA, UVB) and the varying wavelengths.

To choose the appropriate code, ask yourself these two questions:

Question 1: Did the dermatologist use tar or petrolatum combined with the light treatment?

If he did, then code 96910 (Photochemotherapy; tar and ultraviolet B [Goeckerman treatment] or petrolatum and ultraviolet B). During this procedure, the dermatologist administers ultraviolet B light, with dosages carefully increased as the treatment progresses, leading to longer times spent under the light source.

Watch out: When the patient applies the treatment herself, you would report 96900 (Actinotherapy [ultraviolet light]) instead.

Check your payer for their rules. For instance, Aetna considers treatments for vitiligo cosmetic if it does not affect the underlying condition and does not result in improved protection against skin cancer. Specifically, micropigmentation (tattooing) and depigmentation (with monobenzylether of hydroquinone/monobenzone) are considered cosmetic.

Question 2: Did the dermatologist prescribe psolarens combined with ultraviolet A (UVA) light therapy?

If so, then use 96912 (Photochemotherapy; psoralens and ultraviolet A [PUVA]). If your dermatologist doesn't use tars, petrolatum or psolarens with the light treatment, the code that remains is 96900.

The difference: UVA phototherapy is usually given in conjunction with a lightsensitizing tablet called psoralen (PUVA therapy). Sometimes a light-sensitizing cream or lotion containing psoralen can be used in localized skin areas (such as feet [topical PUVA]). On the other hand, UVB phototherapy utilizes the sunburning part of the UV spectrum.

Don't take risks: If you code either 96910 or 96912 when your dermatologist uses only a light source in the treatment or the patient applies a topical agent, you risk being accused of misrepresentation of service. It could constitute a fraudulent claim under the Federal False Claims Act.

Check Out These Phototherapy Rates

Good news: Most insurance carriers cover 96900. They usually do not have too many restrictions on this code, since it only pays about $20. (Note: This amount is what Medicare allows; other commercial carriers may pay a little bit more.) Medicare reimburses approximately $69 for 96910, while 96912 pays about $89. Code 96913 (Photochemotherapy [Goeckerman and/or PUVA] for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of a physician) pays approximately $123.

Push Equipment Codes

According to the Correct Coding Initiative (CCI), when the dermatologist uses more than one piece of equipment or device for the treatment, you can bill each piece with the appropriate modifier (such as 59, Distinct procedural service) and documentation to justify the report.

You may be able get full or partial reimbursements for the equipment, but it may entail some persistence and effort. The key is to check the insurance coverage and meet the required documentation.

When the device is sold to the patient for home use, it may be important to know what type is used with the treatment by referring to the following CPT/HCPCS codes:

- E0691 -- UV light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less
- E0692 -- UV light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel
- E0693 -- UV light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel
- E0694 -- UV multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection
- A4633 -- Replacement bulb/lamp for UV light therapy, each.

This would only apply to selling the equipment, not for treatment in the office, notes **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO,** owner of PB Healthcare Consulting and Education Inc. in Watauga, Texas.

Survey says: In a 2006 survey of the National Association of Managed Care Physicians (NAMCP), more than 50 percent of the 3,500 responding MCOs (managed care organizations) said that they required prior authorization for phototherapy. About 25 percent of the MCOs covered the procedure with no prior authorization or copayments, 14 percent required copayments, and 12 percent offered no coverage at all.