

Phototherapy Coding and Documentation in the Time of Biologics



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PRACTICE POINTS

- Understanding of performance and documentation standards for phototherapy services is critical to proper billing and reimbursement.
- In-office application of topical products is integral to photochemotherapy services.

In this era of biologics for psoriasis with ever-increasing effectiveness and safety as well as patients who have less and less time to visit the physician's office, it would seem that the days of in-office UV treatments would be numbered. However, rumors of the demise of phototherapy may be greatly exaggerated. Phototherapy is still one of the safest and most cost-effective treatments for psoriasis and other dermatoses.¹ Its use often is a prerequisite for biologic therapy, and it may be the only therapeutic option for certain subsets of patients, such as children, pregnant women, and immunosuppressed patients. Moreover, narrowband UVB technology has breathed new life into phototherapy, with better efficacy and less long-term risk. Although the utilization of psoralen plus UVA (PUVA) light therapy has indeed decreased over the last 2 decades, the use of UVB therapies continues to increase dramatically.²

Phototherapy Codes

There are 4 chief *Current Procedural Terminology (CPT)* codes for reporting phototherapy services: (1) 96900: actinotherapy (UV light treatment); (2) 96910: photochemotherapy, tar, and UVB (Goeckerman treatment) or petrolatum and UVB; (3) 96912: photochemotherapy and PUVA; and (4) 96913: photochemotherapy (Goeckerman and/or PUVA) for severe photosensitive dermatoses requiring at least 4 to 8 hours of care under direct supervision of the physician.³

There is lack of specificity of the *CPT* code descriptions for phototherapy. Moreover, insurer guidance for documentation for phototherapy is vague to nonexistent,

and of course whenever the use of any medical service increases, insurer scrutiny is sure to follow. Therefore, it is not surprising that dermatology practices have reported that private insurers as well as Medicare are auditing medical records for phototherapy treatments.⁴ In fact, recently we have seen a Midwest private insurer demand payment from dermatologists for hundreds of 96910 phototherapy services, which the insurer asserted should have been coded as 96900 because topical therapies were not applied by the dermatology staff. The insurer did not just evaluate medical records but also contacted patients directly and asked how services had been provided. Clearly, more detailed guidance for dermatologists and insurers on documentation and performance standards for each phototherapy service is needed.

Existing coding guidance for phototherapy indicates that actinotherapy (96900) defines the basic service of treating a patient with a UV light unit.⁵ Actinotherapy does not involve application of topical medications while the patient is in the office.

In contrast, photochemotherapy (96910) implies addition of a chemo agent to phototherapy. Despite the somewhat nonspecific nature of the code descriptor, it is apparent that application of photoenhancing agents such as tar, petrolatum, or distillates of petrolatum meet the requirements of 96910. The *Coder's Desk Reference for Procedures 2017* describes 96910 as "the physician uses photosensitizing chemicals and light rays to treat skin ailments."⁶ Application of light-enhancing topical products should occur within the office by either staff or the patient. In fact, examination of practice expense data from the Centers for Medicare & Medicaid Services indicated that the 96910 code includes payment for clinical staff time to apply topical products as well as the cost of the topical agent(s).⁷

The PUVA code 96912 is defined by the use of photosensitizing psoralen medication, which can be administered topically or orally, followed by UVA treatment. In my experience, PUVA has similar performance standards with

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in-office application of psoralen, if applicable. If application of topical photoenhancing products occurs outside the office, the requirements of photochemotherapy are not met, and 96900 should be reported.

The 96913 code defines prolonged phototherapy service with intensive topical therapy requirements and multiple phototherapy sessions per day.³ This code is rarely reported (average of fewer than 100 times in the Medicare population per year), and most insurers do not reimburse this service.

Protecting Yourself From an Audit

In my experience, review of private insurer audits of phototherapy services has yielded important lessons. First, having a written standard operating procedure in place regarding the performance of phototherapy services and how application of topicals will be handled has been helpful in audit defense. The other key to beating audits for phototherapy services is to have detailed documentation or a flowchart in the medical record regarding the topical agent and the light administration. The medical record should include what topical agent was applied, if any; whether the topical agent was applied in the office; where the topical product was applied; and who applied the topical product. Sometimes topical product application by a physician or staff is not feasible because of patient preference or the site of application. If the patient applied the topical, document that assistance was offered and refused, along with what type of UV light was used and the dosage. Inclusion of these elements in the medical record provides

a clear picture of the delivery of the phototherapy service and will aid in responding to medical record audit.

Final Thoughts

Phototherapy is a critical treatment modality that continues to be utilized frequently in the expanding armamentarium of treatments for dermatoses. Phototherapy is performed almost exclusively by dermatologists and allows dermatologists to offer a unique level of care and value in the treatment of skin disease. Careful documentation, a written standard operating procedure, and adherence to proper performance standards will allow dermatologists to be compensated fairly for this important treatment modality and pass audits that are likely to occur.

REFERENCES

1. Lapolla W, Yentzer BA, Bagel J, et al. A review of phototherapy protocols for psoriasis treatment. *J Am Acad Dermatol*. 2011;64:936-949.
2. Simpson GL, Yelverton CB, Rittenberg S, et al. Do utilization management controls for phototherapy increase the prescription of biologics? *J Dermatolog Treat*. 2006;17:359-361.
3. *Current Procedural Terminology 2017, Professional Edition*. Chicago IL: American Medical Association; 2016.
4. American Academy of Dermatology Association. Insurers review billing for photochemotherapy (CPT 96910). *Derm Coding Consult*. Spring 2009;13:4.
5. American Academy of Dermatology Association. Coding Q&A's. *Derm Coding Consult*. Spring 2007;11:5, 7, 8.
6. *Coders' Desk Reference for Procedures 2017*. Chicago, IL: Optum360; 2017.
7. Relative Value Scale Update Committee Database. Chicago, IL: American Medical Association; 2016.