

LEVULAN[®] PDT Procedures Coding & Billing Guide

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The information contained in this document is provided to assist health care facilities understand reimbursement guidelines and procedures. It is intended to help obtain accurate coverage and reimbursement for medically necessary health care services provided to patients under physician orders. It is not intended to increase or maximize reimbursement. Should you have questions regarding coding and reimbursement, please contact us at DUSA@dusadelivers.com.

The information referenced is based upon coding experience and research of current coding practices and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services and supplies provided, the regulations of insurance carriers and any local, state or federal laws that apply to the supplies and services rendered.

Although a particular service or supply may be considered medically necessary, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered by any payer. Each payer and benefit plan contains its own specific provisions for coverage and exclusions. Please consult individual payers to determine policy specific guidelines and whether there is any exclusion or other benefit limitations applicable to a particular service or supply.

Introduction

Physicians that code and bill for Photodynamic Therapy (PDT) procedures using the Levulan[®] Kerastick[®] should review and include on claim all documentation that accurately reflect the patient's condition, including appropriate diagnosis codes (ICD-9 code), CPT procedure and HCPCS codes. Coding to be considered for PDT therapy is listed below.

ICD-9 Diagnosis Coding

The most common diagnosis code for PDT therapy is as follows:

ICD-9	Description
702.0	Actinic Keratosis (AK lesions)

This information is provided for educational purposes only
Always code appropriately based upon procedures performed and medical necessity
Be aware of local coverage policies and correct coding initiative quarterly updates
Actual reimbursement will vary by geographic region and payer • Contact local carriers for specific coding guidelines for any procedure
CPT codes, descriptions and other data only are copyright AMA

Levulan[®]

CPT/HCPCS	Description	Notes
J7308	Aminolevulinic Acid HCl, for topical administration 20%, single unit dosage form (354 mg)	<p>Reimbursement for the Levulan Kerastick will be dependent upon the payer's payment policy. Contact the payer to obtain specific payment/allowable information and/or precertification requirements.</p> <p>Medicare Physician Office Payment: For Medicare physician office based procedures the basis of payment is Average Sales Price (ASP) plus six percent. ASP will be updated quarterly by Centers for Medicare and Medicaid Services (CMS).</p> <p>Medicare Hospital Outpatient: Payment rates for drugs have been established by Medicare based upon Medicare legislation. For Medicare hospital outpatient the basis of payment is Average Sales Price (ASP) plus six percent. ASP will be updated quarterly by Centers for Medicare and Medicaid Services (CMS).</p> <p>Many private insurance companies reimburse using a formula based on a percentage of the average wholesale price (AWP).</p>

BLU-U Light Therapy

CPT/HCPCS	Description	Notes
96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (e.g. lip) by activation of photosensitive drug(s), each phototherapy exposure session	<p>This CPT Code is billed once per light exposure session regardless of how many lesions are treated or how long the light exposure session lasts. (<i>CPT Changes: An Insider's View 2002, American Medical Association.</i>)</p> <p>Medicare Physician Payment: The national average Medicare Physician Fee Schedule allowable for this service is determined by Medicare annually. A physician's actual payment will vary based upon the geographic payment locality adjuster for the area.</p> <p>Medicare Hospital Outpatient Payment: CPT 96567 falls into APC 0015. The APC payment rate is based upon the median cost of all procedures in this APC group.</p>

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Evaluation and Management (E/M) Services

The billing of E/M services (e.g. evaluation and management services by the physician in conjunction with a patient visit) is appropriate if the physician provides the evaluation and management services as described in the applicable E/M code.

For Medicare, E/M services are not permitted to be reported on the same date of service that PDT (CPT 96567) is performed. You may report an E/M code if an unrelated condition is treated or evaluated during the same visit as PDT. This will require a secondary diagnosis on the claim related to the E/M visit. A modifier -25 may be required.

Modifier Use Guidelines

It is recommended that the “-25” modifier be appended to the E/M service (e.g. visit) if billed on the same date of service as a primary procedure. Although some insurance carriers will not pay an E/M service (e.g. visit) on the same date of service as a procedure, if the diagnosis for the E/M visit is unrelated to the procedure treatment. If the diagnosis code is the same for both the E/M service and the procedure, the E/M service should still be billed, if it is medically necessary.

-25: Significant, separately identifiable Evaluation and Management (E/M) service (e.g. visit) by the same physician on the same day of the procedure or other service.

Coding and Reimbursement Questions

If you have specific coding and reimbursement questions, please contact the DUSA Pharmaceuticals Coding and Reimbursement Customer Support at 1-866-369-9290 or DUSA@dusadelivers.com. If you would like to fax your requests, the Customer Support direct fax line is 215-369-9198.

The presence of a CPT code or HCPCS product code does not by itself guarantee coverage or payment at a particular level. Insurers have widely varying coverage and payment policies. You should always confirm with individual insurance companies the codes to bill and the coverage policies that will apply to a particular patient.

DUSA does not guarantee that the use of this information presented above will ensure coverage or payment for the product or the procedure. This document is for educational purposes only. Physicians should use independent judgment when selecting codes that most appropriately describe the services rendered to a patient. Physicians are responsible for compliance with individual insurance company billing and reimbursement requirements.

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