

# LEVULAN<sup>®</sup> 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<sup>®</sup> Kerastick<sup>®</sup> should review and include on claim all documentation that accurately reflect the patients 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 codes for PDT therapy are as follows:

<b>ICD-9</b>	<b>Description</b>
702.0	Actinic Keratosis (AK lesions)
782.0	Disturbance of skin sensation (e.g. burning or prickling sensation, numbness, tingling)

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  
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## Levulan<sup>®</sup>

CPT/HCPCS	Description	Notes
<b>J7308</b>	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><b>Medicare Physician Office Payment:</b> 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><b>Medicare Hospital Outpatient:</b> 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
<b>96567</b>	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><b>Medicare Physician Payment:</b> 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><b>Medicare Hospital Outpatient Payment:</b> CPT 96567 falls into APC 016. 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.

### **Reporting E/M for Levulan Kerastick application to AK lesions**

Report an E/M code if an unrelated condition is treated or evaluated during the same visit. A modifier -25 may be required (see below 'General Coding Guidelines' for additional information regarding use of modifiers)

### **Reporting E/M for Photodynamic Therapy**

The billing of E/M services (e.g. evaluation and management services by the physician in conjunction with a patient visit) in addition to the photodynamic therapy service may be appropriate if the physician provides separate and distinct evaluation and management services as described in the applicable E/M code, on the date of the light exposure. A modifier -25 may be required (see below 'General Coding Guidelines' for additional information regarding use of modifiers)

**New Patients**, use CPT Codes 99201 to 99205, selecting the appropriate level (1-5) based on what was performed by the physician or an ancillary staff under the "incident to" Medicare requirements or other insurer guidelines.

**Established Patients**, use CPT Codes 99211 to 99215, selecting the appropriate level (1-5) based on what was performed by the physician or an ancillary staff under the "incident to" Medicare requirements or other insurer guidelines.

Coding and coverage for E/M services (e.g. visits) must meet the criteria established by the patient's insurer, which may include:

- The service must be medically necessary
- The service must be properly documented
- The service must be consistent with "incident to" billing guidelines (Medicare)
- The level of E/M service billed must be appropriate for the care rendered
- The service must be "above and beyond the other service(s) provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed"

In selecting the E/M level of service that is most appropriate for the care rendered, use the following criteria:

- The level of E/M service provided can be determined by meeting the criteria for the three key components of documentation. They are:
  - Patient History
  - Patient Examination
  - Level of Medical Decision Making

- Dimensions of Counseling**  
 Counseling is when 50% or more of the total physician face-to-face time with the patient (including the rendering of surgical, non-surgical, and laboratory services) is spent on discussion (e.g. counseling) with the patient, family members, or parties who have assumed responsibility for care of the patient. When more than 50% of the E/M service (e.g. visit) is dominated by counseling, then the level of care rendered during the E/M service can be selected based solely on the “total time” spent with the patient.

E/M services billed solely on the basis of counseling must clearly indicate the total amount of time spent with the patient. Total time includes the time spent taking the patient's history, performing the examination, medical decision making, any treatment rendered, and time spent counseling the patient and family members. Only physician time can be reported. Time spent by staff or ancillary staff cannot be included in the “time spent” component.

<b>Coding E&amp;M Services Based on Time</b>		
<b>E/M Level</b>	<b>New Patient Office Visits 99201 to 99205</b>	<b>Established Patient Office Visits 99211 to 99215</b>
Level 1	10 minutes	5 minutes
Level 2	20 minutes	10 minutes
Level 3	30 minutes	15 minutes
Level 4	45 minutes	25 minutes
Level 5	60 minutes	40 minutes

**Sample Documentation for the billing of E/M Services:**

Levulan Kerastick Application

An example of documentation to support the billing of an E/M services on the day that the Levulan Kerastick is applied, follows:

**Sample Documentation:** *Discussion of Levulan PDT, treatment options, risks of each treatment, benefits of each treatment, after care/follow-up on each treatment, scheduling and other logistical requirements with patient for 30 minutes. Applied Levulan to each distinct AK lesion.*

Photodynamic Therapy

Pain Management has been statistically shown to be a key factor in patient interaction/reaction during the BLU-U light exposure session. Pre-service or intra-service treatment for the management/alleviation of pain (e.g. application of ice packs, use of fans or other “cooling devices”, administration of anesthetics, and “psychological” input) should be clearly documented to support the billing of a CPT code for an E/M service on the same date of service as the PDT procedure CPT code is reported.

**Sample Documentation:** *Patient was seen for 16 minutes for PDT therapy for AK lesions on the right cheek. Reaction prior to light exposure was noted. Slight erythema noted. Darvocet 50 mg. was given 30 minutes prior to treatment. Six minutes into the treatment/exposure to the light source the patient experienced significant pain. Ice packs were applied and a cooling fan was used. No interruption in exposure time was necessary. Post exposure, the patient's pain ceased and post exposure instructions and follow up care was discussed with the patient.*

## **General Coding Guidelines**

### **Modifier Use**

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.

### **Incident to Guidelines**

It may be a common occurrence for physicians to have ancillary staff (e.g. nurses, medical assistants) actually perform the duties of administering elements of the PDT procedure for patients. This practice is acceptable as long as the physician is physically present in the office suite (i.e. available for direct supervision of the ancillary staff). The physician cannot be off-site at another location. The physician must be physically on-site at the same location where the ancillary staff is performing the duties assigned by the physician of administering elements of the PDT procedure. The physician must be immediately available for any kind of necessary assistance.

## **Answers to Your Specific 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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