Coverage and coding

GUIDELINES FOR PHOTODYNAMIC THERAPY

Medicare coverage is nationwide and governed by a National Coverage Determination (NCD). The NCD may be found at www.cms.hhs.gov/mcd/. Some local Medicare contractors have developed Local Coverage Decisions that provide additional coverage criteria. Always check local coverage for Medicare.

Private insurance coverage varies based on patient's plan; all major companies (Aetna, Cigna, United Health Care, and BCBS) have coverage varying by state.

For more information, call 866-369-9290

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COVERAGE

Effective January 1, 2018, The American Medical Association (AMA) CPT® Editorial Panel approved the addition of two new CPT codes for Photodynamic Therapy.

As the designated standard for the electronic reporting of physician and other health care professional services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CPT codes are updated annually and effective for use on January 1 of each year. The AMA prepares each annual update so that the new CPT books are available in the fall of each year preceding their effective date to allow for implementation.

CODING

DIAGNOSIS

The provider is required to report the most appropriate diagnosis code based upon the patient's condition and reason for treatment.

L57.0 = ICD-10-CM DIAGNOSIS CODE FOR ACTINIC KERATOSIS (AK)

TREATMENT CODING

CPT CODES* — PDT TREATMENT	
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa (eg, lip) by 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) 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

***It is up to the providers' discretion to use the appropriate code for the PDT therapy used and treatment performed.**

NATIONAL DRUG CODE (NDC)

When billing physician-administered drugs, some payers require the 11-digit National Drug Code (NDC) to be captured on claims along with the product qualifier N4, unit of measure qualifier (units 'UN', international units 'F2', gram 'GR', or milliliter 'ML'), and quantity of units billed.

This information must be captured on claims in a specific format. Here are instructions for properly entering NDC on claims:

ELECTRONIC CLAIMS (ANSI 5010 837P)

Product ID Qualifier	Enter **N4** in this Field	2410	LIN02
National Drug Code	Enter 11-digit NDC billing format **XXXXXXXXXXX**	2410	LIN03
National Drug Code Unit Count	Enter Quantity (number of NDC units) **1**	2410	CTP04
Unit of Measurement	Enter NDC unit of measure as **UN**	2410	CTP05

CMS-1500 PAPER CLAIM FORM

In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service. Therefore, for the NDC should be captured as **XXXXXXXXXXX UN 1.**

EVALUATION AND MANAGEMENT (E&M)

The appropriate E&M code reported is based upon patient history, patient examination, level of medical decision making, and dimensions of counseling. When E&M services are required on the same date of service as PDT therapy, the use of a -25 modifier is required for the E&M visit. The E&M must be mapped to the appropriate diagnosis for the service on the claim. The modifier should always be reported in accordance with E&M and modifier guidelines.

-25	Significant, separately identifiable E&M service (ie, visit) by the same physician on the same day of the procedure or other service

Physicians are responsible for compliance with individual insurance company billing and reimbursement requirements. Physicians should use independent judgment when selecting codes that most appropriately describe the services rendered to a patient. Procedure coding should be based upon medical necessity and procedures and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in a given case. Sun Pharmaceuticals and its affiliates make no guarantee of coverage or reimbursement of fees. Actual reimbursement may vary by geographic region and payer. Contact your local Medicare Fiscal Intermediary, Carrier, or CMS for specific information that is subject to continuous change. To the extent that you submit cost information to Medicare, Medicaid, or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments.

Important considerations

When determining patient eligibility for initiation of treatment with PDT please consider the following questions:

1. Does the patient have a diagnosis of actinic keratosis (L57.0)?
2. Have you verified patient eligibility and benefits?
   - If necessary, have you initiated a prior authorization, pre-certification, or pre-determination? Have you used www.SunAccessSupport.com on your behalf?
   - Do you have a plan of care and medical necessity for treatment? (For example: Have you included the expected area to be treated, number of treatment sessions?)
3. Do you have adequate medical documentation including patient history, treatment area, approximate number of lesions, and lesion characteristics?
4. Have you scheduled the patient and reviewed the process, time, and financial responsibility?
5. Have you informed the patient of post-PDT care instructions ?

Find additional support resources visit **www.SunAccessSupport.com**

PAYMENT

Medicare payment for physician-administered drugs is based upon the products' Average Sales Price (ASP) plus six percent. Medicare carriers receive quarterly updates of the ASP for drugs directly from the Centers for Medicare and Medicaid Services (CMS). The Medicare allowables are subject to change each year at the beginning of each quarter (January, April, July and October 1). It may also vary based upon the geographic payment locality adjuster for the area. The current reimbursement rate can be found on the CMS website at: www.cms.gov/mcrpartbdrugavgsalesprice/.

Private Insurance varies but traditionally most private payers reimburse based on a percentage off of the Average Wholesale Price (AWP). More recently private insurers have begun using the Medicare Allowable as a baseline for reimbursement.

Light treatment

Report 96567, 96573 or 96574 PDT treatment per day*

This code should be used to report a single PDT treatment, per patient, per day, regardless of length or number of lesions treated.

Medicare reimbursement in a **private practice** setting is typically updated at the beginning of each year.

Medicare reimbursement in a **hospital outpatient setting** is updated at the beginning of each year. Payment in this site of service falls into an Ambulatory Payment Classification (APC) group based upon the median cost of all procedures in the particular APC group. 96567 maps into APC 5051. The American Medical Association (AMA)CPT Editorial Panel recently approved the addition of two new codes, 96573 and 96574, for Photodynamic Therapy effective January 1, 2018. APC mapping for these two new codes can be located at the link below once the 2018 file is posted. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html?DLSort=2&DLEntries=10&DLPage=1&DLSortDir=descending.

Private Insurance reimbursement will vary based upon the patient's insurance plan and the payer's coverage policy.

***It is up to the providers' discretion to use the appropriate code for for the PDT therapy used and treatment performed.**

Quick-step Guide

1. Do you have a fee schedule in place?
   Do you know your contracted rates or allowed amounts for payors?
   Have you submitted a Private Payor Research form to SunAccessSupport?
2. Are you familiar with the CPT code landscape for PDT?
   96567, 96573 and 96574 for Light procedures
3. Do you have a treatment care plan in place?
   Does that include medical necessity documentation?
4. Have you verified benefits?
   Have you utilized SunAccessSupport.com?
5. Have you determined if a prior authorization is a needed?
6. Is the patient scheduled and are they aware of their financial responsibility?
7. Is your staff trained and prepared to treat the patient?
8. Is the billing department prepared to submit the claim including both codes and NDC?
9. Have you performed a periodic financial review including all sources of reimbursement (patient responsibility, primary and secondary insurance)?

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