

SHOULD YOU BILL INSURANCE FOR THERAPEUTIC LIGHT THERAPY?

Options include cash-only, insurance,
and selling units for at-home use

BY ROB BERMAN, MBA

TIME TO READ: 8-10 MIN.

THE TAKEAWAY

Most health care providers charge cash for in-office light therapy procedures, but a number of CPT codes are also available for DCs to consider.

THERE ARE A VARIETY OF TYPES OF LIGHT THERAPY

AVAILABLE FOR YOUR PATIENTS. These range from therapeutic (pain and increased circulation) to Seasonal Affective Disorder (SAD), dermatology (typically using ultraviolet light) and photodynamic for killing cells.

PubMed has over 4,000 articles that outline research involving light, whether it is LED light therapy or lasers. Despite an overwhelming number of positive studies, not all insurance companies or other third-party payers will pay for these therapies.

Payments in the health care industry

Many providers will simply charge cash for the in-office procedures. The number of treatments will vary depending on the disease state and the underlying conditions of the patient.

The road to success leads through the patient being presented with a treatment plan they understand and agree

Before using any of the codes to describe light therapy, you should check with your participating carriers...

to follow. Confirm that the patient understands that insurance may not cover the treatments. You are selling the value of the service, which is independent of how insurance may apply in a given situation.

PRO TIP: Consider selling units for at-home usage instead of, or in addition to, in-office treatments. You would purchase wholesale and sell retail without insurance hassles. Chronic conditions would need ongoing treatments for longer periods of time.

Cash has its advantages as:

- ▶ You are paid immediately, even if you take the payments in installments;
- ▶ No insurance paperwork;
- ▶ Staff saves time handling all the billing and resulting insurance company questions, denials and delays.

- ▶ Does the code require a time component, usually 15 minutes per unit;
- ▶ Codes ending in “9” require more documentation.

Chiropractors have over the years utilized a variety of codes. Before using any of the codes to describe light therapy, you should check with your participating carriers to see if light therapy is allowed under the code you intend to utilize.

Below is a chart summarizing some CPT codes and whether they are attended, timed or require extra documentation:

CPT CODE	ATTENDED	TIMED EXTRA	DOCUMENTATION
97026	YES	NO	NO
97032	YES	YES	NO
97039	YES	NO	YES
97112	NO	YES	NO
97139	YES	NO	YES
97799	NO	NO	YES

Here’s how you would file the codes for payment:

97026 — This CPT code is for infrared light therapy. Billing might look like “97026: Attended infrared light therapy,” or “97026: Attended infrared therapy.”

PROS AND CONS: Light therapy is generally designed to be unattended and 20 minutes or more in duration. You would be dedicating a staff member to stay in the room with a modality that does not require their presence.

97032 — This CPT code is for attended electronic photonic stimulation (15 minutes). Billing might look like “97032: Attended electronic photonic stimulation,” or “97032: FDA cleared photonic stimulation.”

PROS AND CONS: Light therapy is generally 20 minutes or more, so you are covered on the minimum time. The patient chart will need to be notated as to starting and ending time. Be sure to notate body part(s) treated. You would be dedicating a staff member to stay in the room with a modality that does not require their presence.

9 CODES ENDING IN “9” REQUIRE AN ADDITIONAL ONE PAGE OF DOCUMENTATION



Trying the insurance route

There are not any specific CPT codes for therapeutic light therapy. Regardless of which code you choose, always include a statement describing the treatment and therapy.

When you think about the variety of CPT codes available to you, consider:

- ▶ Attended versus unattended;

Consider selling units for at-home usage instead of, or in addition to, in-office treatments.

97039 — This CPT code is for an unlisted modality with constant attendance. Billing might look like, “97039: Attended infrared therapy,” or “97039: Attended light therapy.”

PROS AND CONS: The “unlisted” nature of the code can result in rejection or hand audits. Since the code ends in “9” an additional one page of documentation will be necessary. Include a description of the services and the name of the device. You would be dedicating a staff member to stay in the room with a modality that does not require their presence.

97112 — This CPT code is for neuromuscular reeducation (15 minutes). Billing might look like, “97112: Neuromuscular reeducation,” or “97112: Neuromuscular reeducation with light therapy.”

PROS AND CONS: No staff attendance is required. Light therapy is generally 20 minutes or more, so you are covered on the minimum time. The patient chart will need to be notated as to starting and ending time. Be sure to notate body part(s) treated.

97139 — This CPT code is an unlisted therapeutic procedure with constant attendance. Billing might look like, “97139: Unlisted therapeutic procedure with FDA cleared light therapy — constant attendance.”

PROS AND CONS: The “unlisted” nature of the code can result in rejection or hand audits. Since the code ends in “9” an additional one page of documentation will be necessary. Include a description of the services and the name of the device. You would be dedicating a staff member to stay in the room with a modality that does not require their presence.

97799 — This CPT code is for physical medicine and rehabilitation unlisted service or procedure. Billing might look like “97799: Unlisted service or procedure performed with FDA cleared light therapy.”

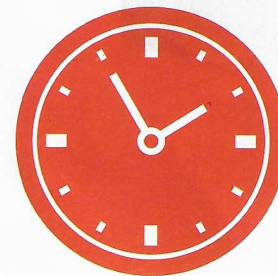
PROS AND CONS: The “unlisted” nature of the code can result in rejection or hand audits. Since the code ends in “9” an additional one page of documentation will be necessary. Include a description of the services and the name of the device.

Insurance coding factors for consideration:

- ▶ More documentation is better than less documentation.
- ▶ Codes ending in “9” require a note of explanation, such as “FDA cleared light therapy.”

- ▶ Timed CPT codes require start and stop times.
- ▶ Policies vary state to state and plan to plan among private payers.
- ▶ If you are billing insurance, then notify the patient in advance that the service may not be covered. The patient needs to understand their financial liabilities.

20
LIGHT THERAPY
IS GENERALLY 20
MINUTES OR MORE



Is Medicare a good option?

No. Medicare is not known for paying for light therapy. Should a patient request you submit to Medicare then use your local Medicare carrier’s recommended CPT code for light therapy and add a GY modifier for denial purposes.

GY is shorthand for “items or services statutorily excluded or does not meet the definition of any Medicare benefit.” GY coding is indispensable because the Medicare Explanation of Benefits needs to show “PR” remark (patient responsibility), not “CO” remark (contractual obligation).

Many private payers do not cover in-office light therapy. Therefore, most of your colleagues have found it easier to simply charge cash. As always, good documentation is necessary. And, remember if you sell a unit for at-home usage you can charge cash. **CE**

ROB BERMAN, MBA, is a partner at Energia Medical LLC, a national distributor of light therapy pads and controllers. He helps health care providers improve patient outcomes while increasing provider income. He has held a variety of sales and marketing positions during his career, which include building and managing a marketing department, directing product development and product management for multiple organizations, and serving as a general manager for a variety of business units. He can be contacted at 860-707-4220, rob@energiamedical.com or energiamedical.com.