

Should I Bill For Laser Therapy?

By Rob Berman

The single most frequently asked question about lasers involves insurance payments. Numerous studies indicate that laser therapy is effective for pain, inflammation, and tissue repair. Despite the body of research, some insurance companies do not pay for laser therapy. Why? They deem it “experimental.” Remember that FDA clearance does not indicate or equal effectiveness.

What Are Your Colleagues Doing?

Many DCs are simply charging cash for the procedures. They often sell the services in packages of five or 10 treatments. Prices range from \$20 per individual treatment to more than \$100 per treatment.

The advantages of cash are:

- Immediate collection of the entire payment for five or 10 treatments.
- No insurance paperwork.
- Less office time handling the patient’s paperwork.

Try Insurance?

CPT codes do not exist specifically for laser therapy, either “low-level laser therapy” or “high-power therapy.” Regardless of which code you chose, always include a statement describing the treatment and therapy.

Let’s take a look at CPT codes that chiropractors have utilized over the years. Different carriers may make different determinations. Therefore, before using any of the codes to describe laser therapy, you should check with your participating carriers to see if laser therapy is allowed under the code you intend to utilize.

S8948

There is a HCPCS Level II code S8948 that does reference the service. Therefore, S8948 should be your “go to code.” The CPT code is described as the application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes.

The code includes a time component. Prior to using “S” codes on insurance claims to private payers, you should consult with the payer to confirm that the “S” codes are acceptable.

97026

This CPT code is for infrared light therapy. However, when you dig deeper, you will see it is the code for heat lamp.



Generally, reimbursement is lower than that for other codes. Billing might look like, “97026: Attended infrared light therapy,” or, “97026: Attended infrared therapy.”

97032

This CPT code is for attended electronic photonic stimulation (15 minutes). The code includes a time component. Therefore, you must write down the start and finish times in the patient’s chart. Make brief notes about your treatment protocol and the areas of the body that were treated. Billing might look like, “97032: Attended electronic photonic stimulation,” or, “97032: FDA cleared laser photonic stimulation.”

97039

This CPT code is for an unlisted modality with constant attendance. The “unlisted” nature of the code can result in rejection or hand audits. The fact that it ends in “9” requires documentation. Make sure to include a one-page description of the services provided and a description of the device. An explanatory notation such as “FDA cleared laser therapy” is helpful. Billing might look like, “97039: Attended infrared therapy,” or, “97039: Attended laser therapy.”

97112

This CPT code is for neuromuscular reeducation (15 minutes). The code includes a time component. Therefore, you must write down the start and finish times in the patient’s chart. Make brief notes about your treatment protocol and areas of the body that were treated. Billing might look like, “97112: Neuromuscular reeducation,” or “97112: Neuromuscular reeducation with laser therapy.”

97139

This CPT code is for an unlisted therapeutic procedure with constant attendance. The “unlisted” nature of the code can result in rejection or hand audits. The code indicates one-on-one treatment from a provider to a patient. Make sure to include a one-page description of the services provided and a description of the device. The code ends in a “9,” so include a notation such as, “FDA cleared laser therapy.” Billing might look like,

“97139: Unlisted therapeutic procedure with FDA cleared laser — constant attendance.”

97799

This CPT code is for physical medicine and rehabilitation unlisted service or procedure. The general nature of the code and the “unlisted” nature of the code can result in rejection or hand audits. The fact it ends in “9” requires documentation. Make sure to include a one-page description of the services provided and a description of the device. An explanatory notation such as “FDA cleared laser therapy” is helpful. Billing might look like, “97799: Unlisted service or procedure performed with FDA cleared laser therapy.”

Key Insurance Coding Considerations

- Extra documentation always helps.
- Codes ending in “9” require a note of explanation, such as “FDA cleared laser therapy.”
- Document start and finish times for timed CPT codes.
- Check on reimbursement policies with private payers. Policies can vary from state to state and plan to plan.
- Alert patients that insurance may not provide coverage and that the patient is responsible for payment. The medical review policy for each carrier should be consulted in advance to best determine the likelihood of insurance coverage.

What About Medicare?

If a Medicare patient requests that you submit the claim for laser therapy, then send the claim to Medicare and use your local Medicare carrier’s recommended CPT code for laser therapy with the GY modifier for denial purposes.

GY stands for “items or services statutorily excluded or does not meet the definition of any Medicare benefit.” GY coding is critical because you want the Medicare explanation of benefits to have the “PR” remark (patient responsibility), not the “CO” remark (contractual obligation). Medicare is a public payer, not a private payer, so the CPT Code S8948 is not valid.

Summary

You must evaluate how insurance may pay for laser therapy in your office. Many chiropractors have found it easier to simply charge cash. Either way, good documentation is necessary.



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