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HMP COMMUNICATIONS

Feature: Adding a Subspecialty with Ease Spotlight on: Phototherapy

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Current Issue

In this series, we'll explore key clinical and practical components you'll need to know to successfully incorporate subspecialty services into your practice.

Are you considering adding phototherapy services to your practice? This type of therapy can be added at relatively little expense compared to other subspecialties within dermatology and can be added as a unit to a pre-existing dermatology practice.

Already, about 3,000 dermatologists, or roughly one-third of the dermatologists in the country, offer phototherapy services to their patients.

By adding phototherapy to the capabilities of a practice, you can significantly affect the breadth of patients you treat, offering significant benefits to patients with a variety of skin conditions, including psoriasis, atopic dermatitis, vitiligo and cutaneous T-cell lymphoma.

The most well known use of phototherapy is in the treatment of psoriasis. Phototherapy is the first line of treatment for many patients with moderate-to-severe psoriasis because of its efficacy, safety and cost.

In this article, we'll take a look at some of the key, basic information you'll need to know in order to add a phototherapy unit to your practice. We'll cover training information,

necessary equipment and discuss scheduling and reimbursement issues.

Training to Provide Phototherapy

There is no formal phototherapy fellowship program. Exposure to phototherapy begins during a physician's dermatology residency. In residency, an individual should pay particular attention to the differing doses of light given to varied skin types. This distinction is important because the most significant side effect of phototherapy, burning, can be avoided if the clinician is aware of treatment limits. In addition to this early learning, the National Psoriasis Foundation (NPF) and American Academy of Dermatology (AAD) offer courses that help physicians learn more about phototherapy and its use in psoriasis.

An efficient phototherapy unit is highly dependent on the phototherapist. An experienced phototherapist can handle the supervision of two light boxes at a time. The degree requirement for a phototherapist varies from state to state, ranging from none to R.N.

A well-trained phototherapist will be able to put patients at ease, educate them about phototherapy, and administer treatment following physician-directed protocols with a high level of safety. The phototherapist will also assess patients for signs of phototoxicity (burning, redness) prior to each session.

The physician is primarily responsible for training the phototherapist. The National Psoriasis Foundation, in conjunction with the Dermatology Nurses Association, holds excellent courses for phototherapists. In addition, book and video training programs on PUVA are available from the manufacturer of methoxsalen (Oxsoralen-Ultra), Valeant Pharmaceuticals (800-548-5100).

Often, dermatologists with well-established phototherapy units will gladly host and help educate another practice's new phototherapist. Similarly, an experienced phototherapist can be brought in to train new personnel. Furthermore, dermatologists may also share the phototherapy protocols they use in their practice. Another helpful resource is Zanolli's Phototherapy Treatment Protocols: For Psoriasis and Other Phototherapy Responsive Dermatoses, which contains formal phototherapy treatment protocols that can be adapted by dermatologists starting their own phototherapy units.

Training is important because these nurses play a critical role in deciding whether the patient's light dose should be held the same or increased. Moreover, phototherapists must calibrate each light box once a month.

Of course, factor in time for both you and your phototherapist to overcome the learning curve associated with adding phototherapy to your practice. When training a nurse to become a phototherapist, expect that it will take at least 3 months of training before he or she will be able to treat a patient on his or her own. You'll also need to treat a few patients to familiarize yourself with the mechanics of the phototherapy device. Even after that, though, it will probably take about a year of treating patients and gauging their therapeutic responses to get a true sense of how to select the best candidates for this type of therapy.

Baseline



After 2 Weeks



After 4 Weeks



This patient received a course of broadband UVB phototherapy in conjunction with topical tar treatment. Within 4 weeks of 5 times a week treatment, near clearing is seen. Top: the patient at baseline; middle: after 2 weeks (10 treatments); bottom: after 4 weeks (20 treatments).

Clinic Operations

The philosophy of phototherapy is to achieve clearing and remission for a certain time period. The two most common forms of light therapy are narrow-band ultraviolet B (UVB) and psoralen plus ultraviolet A (PUVA).

Broad-band UVB is still used by many dermatologists, but narrow-band has generally replaced broad-band for those starting new phototherapy units. In narrow-band UVB, the wavelengths of light found most effective in the treatment of disease, 311 nm, is given to the patient.

For PUVA, 8-methoxypsoralen is given 1.5 hours before light therapy. The patient is then exposed to UVA between 320 nm to 400 nm.

Dosing regimens and treatment protocols. Both of these modalities are generally begun at about two-thirds the dose needed to cause a mild erythema reaction. The absolute dose given varies with individual sun-reactive type. The dose is increased 10% to 15% with each treatment. Treatments are given three times per week. The duration of time commitment for the patient is around 15 to 20 minutes including time for undressing, etc.

By the time of the twenty-fifth therapy, the patient can often take up to 30 minutes. Often, patients go into remission after therapy of around 3 months for narrow-band UVB and 6 months to 1 year for PUVA. Patients may require maintenance therapy once a week in order to prolong remission.

Purchasing equipment for a phototherapy unit. The equipment needed for a phototherapy unit are light boxes that emit UVA and UVB. The light boxes cost about \$15,000 each. The replacement cost of the bulbs for the light boxes must be considered as well. For narrow-band UVB, the unit usually has 42 bulbs. Each bulb costs around \$125 each and lasts about 6 months. The replacement of the bulbs will cost around \$6,000 every 6 months in a busy phototherapy practice. PUVA bulbs, on the other hand, are less expensive, costing \$25 each and lasting 9 months. The other equipment option is to purchase a unit that emits both UVA and UVB. The drawback of this method is that treatments will take twice as long. In order to maintain patient flow in a busy phototherapy clinic, it's best to purchase two of both UVA and UVB light boxes. This

practice allows for an alternative in case a light box isn't functioning. Furthermore, if patients miss a few weeks of therapy, they often need to start the whole process again.

Other items needed are protective wear for patients, including protective eyewear, jockstrap for men and zinc oxide for sensitive areas, such as nipples and lips.

Allotting enough space in your practice for phototherapy units. Assuming that you'll probably want to start out with a couple of light boxes, you'll need to dedicate one patient exam room to the equipment. One 10-foot by 12-foot room should be adequate enough, and you can expand from there as necessary.

Getting the word out. If you already have a lot of psoriasis patients in your practice, you won't have to do much to promote phototherapy services. As soon as patients know you offer phototherapy, the word gets out, and you'll find that you not only have interest among your own patients but that you get referrals from family practitioners as well as other dermatologists who don't have large psoriasis patient populations in their practices.

Scheduling patients for phototherapy. Scheduling for the clinic is another important issue. Phototherapy is a treatment that must be given several times a week and it is not practical for patients to miss work every time. Thus, it's important for clinics to be open beyond the 8 a.m. to 5 p.m. timeframe.

One dermatologist opens his phototherapy unit at 6 a.m. and closes at 7 p.m. He notes that 75% of his phototherapy occurs between 6 a.m. to 9 a.m. and 4 p.m. to 7 p.m.

A caveat to be aware of is that Medicare requires the physician to be on the premises in order to bill for services. This restriction is not often a problem since most Medicare patients are retired and can be fit into the 8 a.m. to 5 p.m. timeframe. Most other insurance plans don't have similar restrictions. Another way to overcome this problem is for the physician to stay one night per month or on a Saturday.

Reimbursement Issues

The physician bills on a per treatment basis. The billing document should contain an ICD-9 diagnosis code appropriate to phototherapy (696.1 for psoriasis). The different CPT codes used are 99211 (nursing code), 96910 (UVB therapy), 96912 (PUVA), and 96913 (physician

code). The nursing billing code can be used in addition to the phototherapy code when there is a medical decision being made by the nurse in terms of evaluating burns, new drugs, lapse in treatment or any other problems.

The average reimbursement is about \$60 per patient. Usually, four patients can be seen in an hour if the practice has two light boxes. In the overall scheme of things, it's helpful for a physician providing phototherapy to be involved with the maximum amount of managed care plans because it allows patients the best access to care, especially if that physician's practice is serving the phototherapy needs for the entire community. Because of the numerous visits to the office even within a week, patients may find it prohibitively expensive to pay for an entire course of therapy out-of-pocket.

Offering this Service

With all the excitement about new treatments for psoriasis, now is a great time to consider adding phototherapy. Equipment is generally quite affordable and minimal space and staffing are needed to keep a phototherapy unit up and running. In addition, with its long record of safety and efficacy, phototherapy is a valuable treatment resource for many dermatology patients — and one that patients may utilize several times each year for multiple courses of therapy.

Resources

Books

Psoriasis eds Mark Lebowhl and Michael Zanolli

Zanolli et al: Phototherapy Treatment Protocols: For Psoriasis and Other Phototherapy Responsive Dermatoses

Websites

National Psoriasis Foundation:
www.psoriasis.org

American Academy of Dermatology:
www.aad.org

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