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Reimbursement for Photobiomodulation of the Retina with the Valeda® Light Delivery System

Supplemental Questions & Answers
August 14, 2025

Q: May a medical assistant (MA) treat a patient using PBM upon the order of a physician?

A: The answer to this question depends on where you practice. The work that MAs are trained and capable of performing is limited. Even though MAs work directly with doctors, they can't give medical advice to patients – they only support medical staff. Even certified ophthalmic technicians are limited in their capabilities. State laws govern what MAs are permitted to do, but state laws differ and some states are stricter than others with regard to physicians directing MAs to treat patients. For example, California strictly limits MAs. Significantly, MAs do not function at the level of a qualified health care professional (*e.g.,* Physician Assistant, Nurse Practitioner). MAs are unlicensed while QHPs are licensed, may be credentialled with payors, and have more education, skill and capabilities.

During discussions with all of the Medicare Administrative Contractors in May 2025, the medical directors said that PBM should not be administered by MAs or ophthalmic technicians, even if supervised by a physician.

Q: May physicians file claims for 0936T if they do not personally perform the procedure?

A: No.

Q: Is there another way to file a claim when the procedure is administered by a medical assistant but supervised by an ophthalmologist?

A: Yes. CPT 97039 is "*The application of a modality that does not require direct (one-on-one [physician/QHP] patient contact*." This is an unlisted procedure code and will require extra documentation. One Medicare Administrative Contractor, CGS, has published a policy for this procedure (L34049, A57067) that refers to

"*auxillary personnel*" working "*incident to the services of a physician/NPP*". If the claim is paid, the amount will be very modest (<$35). Not recommended.

Q: Besides an ophthalmologist, who can perform PBM?

A: An optometrist, physician assistant (PA), or nurse practitioner (NP) may perform PBM if state laws and regulations permit it. If there is any doubt about scope of practice, check with the state licensing authorities for a definitive answer. We found just one state with a statute on this topic. The California Business and Professional Code §3401(a)(5)(F)(xii) states optometrists are permitted to, "*Use of noninvasive devices delivering intense pulsed light therapy or low-level light therapy that do not rely on laser technology, limited to treatment of conditions of the adnexa."* PBM is applied to the retina and not the adnexa.

Q: Does an optometrist receive different reimbursement for 0936T than an ophthalmologist?

A: No.

Q: Does a qualified health care professional (QHP), such as a PA or NP, receive different reimbursement for 0936T than an MD or OD?

A: It depends. When PBM is performed "incident to" a physician service then the reimbursement is identical for a QHP and an MD. When not "incident to" then the rate is 15% lower. "Incident to" requires all of the following: 1) credentialing of the QHP with the payor, 2) only established patients, 3) only PBM that is ordered by a physician, and 4) only PBM that is directly supervised by a physician on the premises (not necessarily the ordering physician).

Q: Is PBM exclusively a cash-pay or patient-pay procedure?

A: No. Sometimes it is covered by health insurance and claims are paid.

Q: May a physician or QHP choose not to file a claim for reimbursement?

A: No. A claim is required unless instructed by a payor not to file a claim or the patient instructs the physician not to file a claim by refusing to assign benefits.

Q: May a physician make PBM available to patients only for cash?

A: No. In most cases, it is an ethical violation to withhold PBM from patients with health insurance.

Q: May a physician charge the patient separately for the "click fee" for PBM?

A: No. The capital and variable cost of PBM is included in the professional fee.

Q: In the future, will PBM be covered by most or all health insurance plans?

A: It's likely to be covered because it treats a blinding condition; it's the only treatment available for early/intermediate dry AMD; it has been shown to be effective and improve vision; there is little risk involved; it is affordable.

Q: What payment rates have been reported to Corcoran for PBM?

A: We have seen payments between $150-225 for both eyes and $100-150 for one eye. Payments vary geographically and between payors.

Q: How many patients have early/intermediate dry AMD in the US?

A: There are 16.8M patients with early- and intermediate-stage dry AMD.

Q: If all of the eligible dry AMD patients are treated with PBM at the recommended rate of 27 times per year, how many treatment sessions are there?

A: That would be 453.6M treatment sessions per year (16.8M x 27).

Q: For a single ophthalmologist with about 1,000 dry AMD patients, how many PBM treatment sessions may occur in one year?

A: Approximately 27,000 if they are all treated at the recommended rate (27 times/yr).

Q: How many treatment sessions can be performed in one year with a single Valeda® instrument at the rate of three per hour (20 minutes each)?

A: 6,240 (3 per hr x 8 hrs per day x 5 days per week x 52 weeks per yr).

Q: How much revenue does that represent if half the patients are treated in just one eye at $120 and half at $180 per session for both eyes?

A: $936,000 (3,120 x $120 + 3,120 x $180)

Q: Can an MD, OD, PA, or NP operate more than one Valeda® instrument concurrently?

A: Yes. An ophthalmologist has shown that two Valeda® instruments, adjacent to each other, can be effectively operated simultaneously.

Q: How many Valeda® instruments operating full time are required to administer 27,000 PBM treatment sessions?

A: 4.3 instruments (27,000 divided by 6,240).

Q: How should we report 0936T if both eyes are treated on the same day?

A: CPT instructs, *For bilateral procedure, report 0936T with modifier 50.*

Q: Should an eye exam occur on the same day as a PBM treatment?

A: A discussion with the patient during an abbreviated eye examination is warranted to check for any progress since the last treatment, new complaints, comorbidities requiring attention, or unexpected problems.

Q: Must a physician do an eye exam before ordering a PBM series (9 treatment sessions)?

A: Yes. PBM is a minor procedure that requires an evaluation and informed consent.

Q: If an eye exam and PBM treatment occur on the same day, how are they reimbursed?

A: The eye exam on a day of minor procedure is not paid separately unless it is performed for a separate, distinct, and unrelated reason from the treatment. (Modifier -25 rules apply.)

Q: After 9 treatment sessions in 4 months, should the patient be re-evaluated before starting another series?

A: Yes. Confirm eligibility.

Q: Is an OCT or OCT-A required to plan PBM?

A: Not required, but very helpful. Fundus photos and fundus autofluorescence are alternatives.

Q: Is PBM indicated for any other conditions than early or intermediate dry AMD?

A: Not at present.

Q: When PBM is used to treat an eye with both wet and dry AMD, is this on-label or off-label use?

A: Off-label because this is not part of the indications for use of the Valeda® Light Delivery System. Typically, an off-label use is not covered by health insurance and the patient is financially responsible for those PBM treatments.

Q: If PBM is used to treat a patient with wet AMD in one eye and intermediate dry AMD in the opposite eye, is this on-label or off-label use?

A: On-label for the eye with intermediate dry AMD because it is part of the indications for use of the Valeda® Light Delivery System. Typically, an on-label use is covered by health insurance. Off-label for the eye with wet AMD because this is not part of the indications for use of the Valeda® Light Delivery System. Typically, an off-label use is not covered by health insurance and the patient is financially responsible for those PBM treatments.

Q: If PBM is used to treat an eye with intermediate dry AMD as well as center-involving geographic atrophy, is this on-label or off-label use?

A: Off-label because this is not part of the indications for use of the Valeda® Light Delivery System. Typically, an off-label use is not covered by health insurance and the patient is financially responsible for those PBM treatments.

Q: If PBM is used to treat an eye with early dry AMD and 20/20 BCVA, is this on-label or off-label use?

A: Off-label because 20/20 vision is not part of the indications for use of the Valeda® Light Delivery System. Typically, an off-label use is not covered by health insurance and the patient is financially responsible for those PBM treatments.

Q: From a patient's perspective, how important is one line of vision on an ETDRS chart?

A: Very important. 20/40 and 20/50 are separated by 1 line on an eye chart. In some states, a patient cannot drive with 20/50 vision but can drive with 20/40.

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