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Eli's Rehab Report

Follow These 3 Steps to Botulinum Coding Perfection

Tip: Use chemodenervation code only once per session for Medicare

Not knowing the difference between Botox and Myobloc as well as not reporting unused units could be costing your practice money. Follow these three easy steps and make coding compliance for Botox and Myobloc a snap:

Step 1: Choose Your HCPCS Code

You have to know the difference between **J0585** and **J0587** .

In a nutshell: For one thing, the Botox code J0585 (Botulinum toxin type A, per unit) reimburses per unit, while the Myobloc code J0587 (Botulinum toxin type B, per 100 units) reimburses per 100 units.

In addition to the different units in the codes, you should be aware that Botox only comes in one vial size--100 units--but Myobloc has three sizes: 2,500 units, 5,000 units or 10,000 units. So the number of units you'd bill will vary depending on which quantity your provider injected: 25 units, 50 units or 100 units for J0587.

Tip: Some payers do not allow you to list three digits in 24G of the CMS 1500 form or the "units" column of the claim forms. If your billing software is not capable of printing three digits in this field or if the payer is not capable of processing three digits, then when billing for 100 units of botulinum type A or B, you should enter 99 units on the first line and one unit of the drug on the next line.

FYI: Once the physiatrist reconstitutes Botox type A or B, the drugs have only a four-hour shelf life. Because these medications are very expensive, insurers recommend that you schedule Botox patients back-to-back, says **Anne M. Dunne, RN, MBA, MSCN**, practice administrator for South Shore Neurologic Associates PC/Brookhaven in Bay Shore, N.Y. Keep in mind: If you split a vial among several patients, you should report only the amount you inject to each patient on his claim form.

If any of the medication remains in the vial after you inject the last patient, the remaining drug is discarded, and you should report the wasted units on the last patient's claim.

If you don't split the vial among patients and you inject just one patient and discard the rest of the vial, you can report all 100 units on that patient's claim form. Be sure to document in the patient's record how many units you injected and how many you discarded, Dunne adds.

Some carriers have specific guidelines. For example, Trailblazer requires that providers append modifier JW (Drug amount discarded/not administered to any patient) to the supply code when reporting wasted drugs.

Example: If one patient receives 65 units of J0585 and a subsequent patient receives 30 units of J0585, you will have five unavoidable wastage units for the second patient. Taking that wastage into account, you should report 35 units for the second patient. Be sure the number of units you report and bill for each patient matches the documentation in each patient's chart, says **Marianne Wink-Sturgeon, RHIT, CPC, ACS-EM,** documentation, coding and compliance analyst at the University of Rochester Medical Center in New York.

Remember: Double-check your supply code. HCPCS lists the code for botulinum type A (J0585) just before the botulinum type B code (J0587). If you list the wrong drug, the reimbursement will be incorrect or your entire claim could face rejection. Best bet: Calculate the medication charge. That way you'll know if a coding error has shorted your

practice significant dollars.

Step 2: Determine the Injection Site

The site your physiatrist injected will determine the CPT code you should use and whether you should include any modifiers.

The most common injection codes include:

• 64612--Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)

• 64613--... neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia)

• 64614--... extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)

• 67345--Chemodenervation of extraocular muscle.

Medicare carriers reimburse for these codes once per "contiguous" injection site. Montana and North Dakota Medicare carrier Noridian's policy, for example, states, "Medicare will allow payment for one injection per site regardless of the number of injections made into the site.

A site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face, neck, etc. FYI: This is only a Medicare policy and may not apply to other payers.

Example: A physiatrist sees a patient diagnosed with torticollis to the right side (723.5, Torticollis, unspecified, or 333.83, Spasmodic torticollis). The physiatrist injects botulinum type A as follows: 40 units in sternocleidomastoid, 35 units in levator scapulae, 60 units in splenius capitis, and 65 units in multiple locations in the trapezius. You should report 64613 and J0585 with 200 units.

Keep in mind: If your physiatrist injects both sides of the face, you can append modifier 50 (Bilateral procedure) to the appropriate CPT code. Medicare considers the neck to be one "contiguous unit" and will not accept modifier 50 with 64613 for bilateral chemode-nervation of neck muscles.

Step 3: Select the Correct Diagnosis Code

You'll need to correctly link a diagnosis code to the procedure to meet medical-necessity requirements. Medicare and other payers increase the number of diagnoses allowable, so check your carrier's Local Medical Review Policy (LMRP) for a pertinent list.

Example: Most carriers list specific diagnoses that they will reimburse when linked with 64613 (such as 333.83, Spasmodic torticollis) that don't always overlap with the acceptable diagnoses for destruction code 64640 (Destruction by neurolytic agent; other peripheral nerve or branch), which often include 729.1, Myalgia.