# Eli's Rehab Report

## New Botox Coding Opens Door to Added Reimbursement

"Botulinum Toxin Type A (botox) is being employed more often to treat patients whose pain or spasms have not been helped by other techniques. Until now, however, coding professionals have been stymied because the available codes for botox injections often did not coincide with the site of treatment. Fortunately, CPT 2001 includes a new CPT code for trunk and extremities, 64614 (chemodenervation of muscle[s]; extremity[s] and/or trunk muscle[s] [e.g., for dystonia, cerebral palsy, multiple sclerosis]) and changes in the wording for 64612 (chemodenervation of muscle[s]; muscle[s] innervated by facial nerve [e.g., for blepharospasm, hemifacial spasm]), which also affected **CPT 64613** ( cervical spinal muscle[s] [e.g., spasmodic torticollis]).

Because botox initially was used mainly by cosmetic surgeons, related CPT codes most accurately described the procedures they performed on patients faces and not those areas treated by physiatrists, such as the extremities. Its been hard to code for botox injections because the closest matching codes didnt necessarily cover what our pain management staff was doing, says **Carla Thiboudeux, CPC,** a coder with Tejas Anesthesia in San Antonio. This new code will hopefully alleviate any problems and confusion with reimbursement from third-party payers.

Many third-party payers, however, have not yet published guidelines for billing 64614. At press time, only Empire Medicare (New Jersey, New York) and First Coast Service Options (Florida) have published lists of accepted diagnosis codes for 64614.

**Ken Martin,** reimbursement manager for Allergan, the manufacturer of botox in Irvine, Calif., recommends that coders not use 64614 until the list of accepted ICD-9 codes has been published by Medicare, which probably will be in April 2001. Coders also need to be aware that the creation of 64614 does not automatically replace 64640 (destruction by neurolytic agent; paravertebral facet joint nerve; other peripheral nerve or branch), which previously was used to report extremities. Code 64640 will remain linked to some ICD-9 codes, which is another list that has not been published.

Any way you look at it, billing botox is a challenge, says **Jean Pollard,** owner of Green Wood Billing Agency, a medical billing firm in Tranquility, Sussex County, N.J., which handles the billing for four physiatrists. I recently received the new diagnosis listing from Medicare, which details the reimbursable diagnosis codes for botox, and Medicare will not reimburse for any other diagnoses submitted. On one claim, I did not use an ICD-9 from their list, and they did deny it.

**Billing for Medication**

When billing for the medication injected, use J0585 (botulinum toxin type A, per unit). Enter the number of units used in block 24G of the HCFA 1500 claim form. Botox is available in vials, each of which contains 100 units of the drug. Practices are encouraged to schedule more than one patient to receive botox at a time to prevent waste because of the drugs short life span after reconstitution.

**Sheldon Schmidt, CPC,** a biller at Badger Billing Service, a medical billing firm in Mequon, Wis., reports that if a vial is split between two patients, the billing in these instances must be the exact amount of botox used on each patient. According to New Jersey, Oklahoma, Iowa and other Medicare policy statements, If there is any toxin unused after injecting multiple patients, the remainder can be appropriately billed as wastage on the claim of the last patient injected.

**Billing for Injection and EMG**

When reporting the botox injection, the coder should start by determining the site of the injection because each CPT code refers to a different anatomical location. If an evaluation and management (E/M) service is performed during the same visit, the E/M would need to have modifier -25 (significant, separately identifiable evaluation and management

service by the same physician on the same say of the procedure or other service) attached to it. The drug would be billed using HCPCS code J0585. The following are examples of the appropriate use for each botox CPT code:

A new Bells palsy patient presents with facial muscle spasms on the left side of the face. The physiatrist examines the patient and injects botox into the left-side facial muscles. This would be coded as:

99202-25 for the office visit
64612-LT for the botox injection to the left side of the face
J0585 for the drug
351.0 diagnosis code for Bells palsy

A new patient comes in complaining of his head being drawn to one side. The patient is examined, then given botox injections into the neck. This would be coded as:

99203-25 for the office visit
64613 for the botox injections to the neck
J0585 for the drug
723.5 diagnosis code for torticollis, unspecified

An established patient with cerebral palsy comes in for irregular movements of both arms. The patient is given botox injections into both arms to relax muscles and prevent spasms. This would be coded as:

99214-25 for the office visit
64614-50 for bilateral botox injections to both arms
J0585 for the drug
343.0-343.4 diagnosis codes for cerebral palsy

A new patient complains of writers cramp in his right hand. The patient is given botox injections into his right hand. This would be coded as:

99203-25 for the office visit
64640-RT for the botox injection to the right hand
J0585 for the drug
333.84 diagnosis code for organic writers cramp

If a physiatrist performs multiple injections into a single area, for example, the face, one unit of 64612 should be billed, no matter how many injections were done. If the physiatrist injects into the face and spine, both CPT codes (64612 and 64613) can be billed, and a modifier is not need-ed because each is specific to a different area of the body.

When both eyes or both sides of the face are injected, report modifier -50 (bilateral procedure) with these CPT codes to indicate bilateral services. If the upper and lower lid of the same eye or adjacent facial muscles are injected at the same time, the procedure is considered unilateral. Bilateral procedures will be considered only when both eyes or both sides of the face are injected. Append modifier left (-LT) or right (-RT) to CPT codes 64612 or 67345 (chemodenervation of extraocular muscle) when the services are unilateral.

**Note:** When billing code 64613 for a botox injection to the neck, modifier -50 cannot be used because the neck is considered one muscle.

Most states Medicares Part B Billing Manual for Physical Medicine and Rehabilitation allow electromyographic (EMG) guidance to ensure the proper needle location within the treated muscles. Each state Medicare carrier provides its own listing of allowable EMG codes for botox injections, but the most common of these are listed below:

92225 ophthalmoscopy, extended, with retinal drawing [e.g., for retinal detachment, melanoma], with interpretation and report; initial

95860 needle electromyography, one extremity with or without related paraspinal areas

95861 needle electromyography, two extremities with or without related paraspinal areas

95867 needle electromyography, cranial nerve supplied muscles, unilateral

95868 needle electromyography, cranial nerve supplied muscles, bilateral

95869 needle electromyography; thoracic paraspinal muscles

**Documentation Requirements**

Schmidt states that documentation for botox should include the following elements, which should be available to the carrier upon request:

Support for the medical necessity of the botox injection;
Dosage and frequency of the injections;
If an EMG was performed, support for the medical necessity of the EMG;
Support for the clinical effectiveness of the injections; and
Specify the site(s) injected.

**Reasons for Denial**

Denials can be the result of several reasons, including:

Giving botox injections for spastic or excess muscular contraction conditions more frequently than every 90 days;

Diagnosis code submitted does not support medical necessity, for example: migraine headaches (346.9x), myofascial pain (729.1), irritable colon (564.1), or biliary dyskinesia (575.8);

Injection given for treatment of wrinkles (701.8), which is considered cosmetic;

Injection performed in a place of service that is not approved by the payer; or

Two prior injections were given in a row at an appropriate dose without a satisfactory clinical response.

**Warning Regarding Botulinum Toxin Coding**

Physiatrists should be aware of a new botulinum toxin available on the market called Myobloc. Thus far, Myobloc has received federal Food and Drug Administration (FDA) approval only for use with cervical dystonia (337.0). Myobloc currently does not have a HCPCS code and cannot be billed using the code for botox (J0585). Also, botox is billed in the hundreds of units with 400 usually being the maximum, but Myobloc will be billed in the thousands of units up to 15,000. Coders who accidentally use the botox HCPCS code for Myobloc are going to see delays and denials due to the differences in cost, accepted diagnosis codes and the number of units billed. There is concern that if payers get confused regarding billing for botox and Myobloc that they will establish an interim stop payment and perform a manual review on any botox claim."