Codify
BY AAPC

Eli's Rehab Report

READER QUESTION: Report Botox Once per Procedure

Question: My physiatrist performed a peripheral nerve branch chemodenervation with Botox in the paraspinous lumbar muscle. He injected 150 units of Botox into 13 different sites. How should I bill this?

Pennsylvania Subscriber

Answer: You should report 64614 (Chemodenervation of muscle[s]; extremity[s] and/or trunk muscle[s] [e.g., for dystonia, cerebral palsy, multiple sclerosis]) only once per procedure. For example, HGSA, a Pennsylvania Part B carrier, states that it will reimburse the injection code on a one-time basis only for each muscle you inject, regardless of the number of injections the physiatrist performs. You should also report 150 units of J0585 (Botulinum toxin part A, per unit) to reflect the drug that the physiatrist injected.

Most Medicare carriers only allow you to report Botox injections every 90 days. Other local carriers may not have these types of frequency stipulations but might state that after two injections, if the treatment is not effective, you cannot rebill it until a year has passed. You should therefore determine your carrier's frequency guidelines before you code this procedure.