Codify
BY AAPC

Eli's Rehab Report

READER QUESTIONS: Bust Through Botox Confusion

Question: Should I use **CPT 64613** for Botox injections? I thought most medications were "J" codes. Should I charge a flat fee for the injection?

Texas Subscriber

Answer: You should charge for both the injection procedure and the Botox (if the medication was a cost to your practice--in other words, your provider paid for it).

If your provider injected the botulinum into the patient's neck muscles for a muscle spasticity condition, you should report 64613 (Chemodenervation of muscle[s]; cervical spinal muscle[s] [e.g. for spasmodic torticollis]). The 2005 reimbursement by Medicare for 64613 ranges from about $170 to $230, based on your geographic location. The average sales price for one vial of Botox, 100 units, is about $491. The HCPCS code for Botox is J0585 (Botulinum toxin type A, per unit).

Red flag: Don't forget to note the difference in the units in J0585's code description. The patient may require more than 100 units but fewer than 200 units (two vials). Most payers will allow providers to charge for any unavoidable wastage, due to the short shelf life. Your provider should clearly document the quantity of units injected into specific muscles and wastage of any units. Best bet: Payers vary on what diagnoses support medical necessity, so be sure you preauthorize these services.

The only potential reason to charge a flat fee is if a patient's insurance will not cover the service and the patient agrees to pay out-of-pocket for the injection. The flat fee is more common in an elective cosmetic surgery application. Otherwise, you should separately code both the CPT and the HCPCS codes and report them on separate line items to the payer.