Eli's Rehab Report

READER QUESTIONS: Weigh Your Modifier Options for Botox

Question: We are having trouble with Medicare paying for the **CPT 95870** . My physiatrist performs this as guidance for Botox injection. We have used modifier 59 (Distinct procedural service) with denial and modifier 51 (Multiple procedures) with denial. The physiatrist did four units because he injected all four extremities. Should we not use a modifier? Can we bill for 4 units?

Kansas Subscriber

Answer: Information from the Kansas/Nebraska Medicare Web site states that if your physiatrist performs an EMG to facilitate localization before botulinum injection, you should use the nonspecific code 95999 (Unlisted neurological or neuromuscular diagnostic procedure). You should provide a description of the procedure on the claim form. They provide an example of "EMG localization in conjunction with J0585 (Botulinum toxin type A, per unit)."

This Web site also states you should report only 1 unit regardless of the number of muscles studied and they will allow payment equivalent to code 95870 (Needle electromyography; limited study of muscles in one extremity or non-limb [axial] muscles [unilateral or bilateral], other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters).