Eli's Rehab Report

Think J0585 Is a Catchall Botox Code? You May Be Throwing Away $340 Per Vial

Hint: Look for special Myobloc code, experts say

If you report Botox type B (BTB) using the Botox type A HCPCS code, you're not only coding incorrectly but also throwing away money. Each vial of Botox type B will get you about $340 more than each vial of Botox type A, so it's essential that you report the correct Botox supply code in addition to BTB administration.

Diagnosis Options Increasing, but Check With Payers

Medicare and other payers recently increased the number of diagnoses allowable for BTB, also known by its trade name, Myobloc. Initially, most insurers covered Myobloc only to reduce the abnormal head position and neck pain associated with cervical dystonia (also known as spasmodic torticollis, 333.83). At that point, reporting the drug for other conditions resulted in claim denials.

Many carriers now allow Myobloc payment for other diagnoses, such as blepharospasm (333.81) and spastic hemiplegia (342.11-342.12). More than a dozen carriers, in fact, cover BTB for the same diagnoses as they cover for type A botulinum toxin, including common migraines (346.11) and writers' cramp (**ICD-9 333.84**). (See our article "How Does Your State Measure Up?" on page 20 for more information about local policies.)

Most carriers initiated these policies with little difficulty. "For [most] providers, there have been no recent problems with Myobloc claims, and reimbursement has been adequate," says **Steve Gollomp, MD**, clinical professor at Thomas Jefferson University. Medicare providers offer the most reasonable compensation of all payers, Gollomp says.

Tip: To increase the likelihood of claims success, you should obtain precertification information through the help line of Elan Biopharmaceuticals (Myobloc's manufacturer). "You should call your patients' insurers beforehand to find out their conditions for reimbursing the injections," says **Marvel J. Hammer, RN, CPC, CHCO**, owner of MJH Consulting, a healthcare reimbursement consulting firm in Denver.

Note: You can reach the Elan Biopharmaceuticals customer support line at (888) 461-2255.

Use Chemodenervation Codes for Administration

You should select the appropriate injection code when administering Botox type A or BTB based on location. The most common injection codes include:

1. 64612 - Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
2. 64613 - ... cervical spinal muscle(s) (e.g., for spasmodic torticollis)
3. 64614 - ... extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
4. 67345 - Chemodenervation of extraocular muscle.

Medicare carriers reimburse for these codes once per injection site. CIGNA Medicare'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."

If you inject both sides of the face, therefore, you can append modifier -50 (Bilateral procedure) to the appropriate CPT code. Most payers consider the spine to be unilateral, however, and will not accept modifier -50 for bilateral spinal injections.

Report J0587 - Not J0585 - for Myobloc

When you inject a patient with Botox type A, you should report J0585 (Botulinum toxin type A, per unit). If you inject Botox type B, report J0587 (Botulinum toxin type B, per 100 units).

Warning: Double-check your supply code. HCPCS lists the code for Botox type A (J0585) just before the Myobloc code. If you list the wrong drug, your entire claim could face rejection. And, because most payers pay about $3.43 more per unit of Myobloc than for Botox type A, you could be shorting your practice significant dollars.

You should report Botox type A per unit injected. For example, if you inject 40 units, you should report 40 units of the drug.

But the descriptor for J0587 reads "per 100 units." Therefore, if the physician injects 100 units of the drug, you should report only one "unit" of the drug on the claim form. But physicians commonly administer more than 100 units of Myobloc per session. For example, if the physiatrist injects 5,000 units of Myobloc, you should report 50 units for the service.

Tip: Some payers do not allow you to list three digits in the "units" column of their claim forms. When billing for 100 units of Botox type A or B, you should enter 99 units on the first line and one unit of the drug on the next line.

Once the physician 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. If you split a vial among several patients, you should report only the amount you inject to each patient on his or her claim form.
If any of the medication remains in the vial after you inject the last patient, you should report the discarded 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.

Test Yourself: Assign the Appropriate Botox Code

Suppose your physiatrist injects 95 units of Botox type A to the right and left semispinalis capitis, the right splenius capitis, and the right and left levator scapulae. You report 64640-50 and 100 units of J0585 for the drug, but your carrier denies the claim and you're left wondering why.

Coding Makeover: Code 64640 describes nerve destruction to peripheral or branch nerves not described by codes 64612-64614, but you performed injections to neck muscles, which CPT describes with 64613. You therefore reported an incorrect CPT code, which explains why Medicare denied your claim.

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 64640 (which often include 340, Multiple sclerosis). Although your practice might be tempted to report 64640 for Botox injections to multiple sites because it pays nearly $100 more than reimbursement for 64613, this is not correct coding.

Because you performed spinal injections, you cannot report the bilateral modifier. Your claim, therefore, should read 64613, J0585 x 100 units.

Codify
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