

## Eli's Rehab Report

## You Be the Coder: Keep Your Botox Coding Practices Up to Date

**Question:** How should I code a Botox injection of 100 units? I know J0585 is the code for the Botox, but which procedure code should I use for the injection/destruction, if any? Should I use 64640?

Tennessee Subscriber

**Answer:** The CPT code for chemodenervation of extremities and/or trunk muscles (such as for dystonia, cerebral palsy or multiple sclerosis) is 64614 (Chemodenervation of muscle[s]; extremity[s] and/or trunk muscle[s] [e.g., for dystonia, cerebral palsy, multiple sclerosis]) rather than 64640 (Destruction by neurolytic agent; other peripheral nerve or branch).

Code 64640 is for destruction of other peripheral nerve or branch. Chemodenervation is not a destructive procedure but rather a prolonged interruption of the motor nerve communication pathway.

**Keep in mind:** For 2006, CPT modified <u>CPT 64613</u>'s description from cervical spinal muscles to neck muscles and included the example of spasmodic dysphonia. If the provider performs percutaneous injection of the larynx, you would use 64613 rather than an unlisted-procedure code.

Likewise, you should remember that you have two new codes for 2006 for chemodenervation needle guidance:

- 1. +95873--Electrical stimulation for guidance in conjunction with chemodenervation (list separately in addition to code for primary procedure)
- 2. +95874--Needle electromyography for guidance in conjunction with chemodenervation (list separately in addition to code for primary procedure).

Both of these are add-on codes, and you would use them only with 64612-64614. There are additional parenthetical notes in the CPT manual that you may want to review. Coding with 95870 (Limited EMG study ) is no longer appropriate if the provider performed these services for needle guidance only.

**Best bet:** You must code your diagnosis according to your documentation. You'll find that ICD-9 codes that will support medical necessity will vary based on the payer. So check with your payer to see if the diagnosis you reported based on your documentation will support the procedure.