Dermatology Coding Alert

3 Questions to Help You Improve Your Botox Injection Pay

Keep track of your toxin units

If your dermatology practice is using botulinum toxin (Botox) injections, make sure you know the injection site, the toxin units, and the related services your dermatologist performs, or you could be losing out unnecessarily on hard-earned pay. Here are three questions for you to use to check your Botox billing accuracy:

Are You Billing for the Medication and the Injection?

You should first determine the injection site, because the CPT codes refer to different anatomic locations for your dermatologist\'s procedures. For instance, if the dermatologist injects a muscle in the patient\'s face, you would report 64612 (Chemo-denervation of muscle[s]; muscle[s] innervated by facial nerve [e.g., for blepharospasm, hemifacial spasm]). Chemodenervation means that the effect of the Botox injection is largely or completely reversible. The physician injects the toxin directly into the muscle through an electrode, without destroying the nerve.

For trunk muscle injections, you should use 64614 (... extremity[s] and/or trunk muscle[s] [e.g., for dystonia, cerebral palsy, multiple sclerosis]).

According to CPT, you should report codes 64612-64614 once, even though the physician performs multiple injections along a particular muscle. Physicians will typically inject several muscles. If the dermatologist injects Botox into a muscle not listed in the codes above, report an unlisted-procedure code (64999, Unlisted procedure, nervous system), coding experts say.

Remember: Check with your local Medicare carrier about injection-site definitions because Medicare\'s site definitions vary from state to state. For example, some Medicare policies define a site as a functional muscle group (a group of muscles that work together to create a single movement, such as the biceps or triceps in the upper arm). But others define a site as a contiguous body part (any of the four limbs, the torso, the neck and the face). Still other policies have no definition at all. Medicare will reimburse for only one injection per site.

Are You Billing the Correct Units?

When billing for Botox units used, make sure you report both the used and unused units. Medicare generally encourages offices to schedule more than one botulinum toxin patient at a time to prevent wasting the medication. The Medicare Carriers Manual states, \"If a vial is split between two patients, the billing in these instances must be for the exact amount of botulinum toxin A used for each patient using code J0585. If there is any botulinum toxin unused after injecting multiple patients, the remainder can be appropriately billed as wastage on the claim of the last patient injected.\"

Individual Medicare carriers may vary in their requirements for reporting toxin units, so check with your payer before filing. For instance, in Tennessee, \"Cigna Medicare has instructed us to use code J0585 (Botulinum toxin type A, per unit) as the HCPCS code for the actual drug itself,\" says **Christine Liles, CPC**, insurance supervisor at the Knoxville Dermatology Group in Knoxville, Tenn. To bill this, Cigna requires that you put the amount of units administered in the days/units column, Liles says.

Coding example: Your Botox supply may require constitution of 100 units. If you have three Medicare patients scheduled for injections on the same day, and they are all due to receive 30 units, you bill the first two at 30 units and the last patient at 40 units - 30 as the given amount and 10 units as the amount wasted. The medical record must

document exactly how much was given to each patient and how much was wasted, Liles says. Billers should check their carrier\'s medical policies to determine the exact rules in their states.

The Medicare Carriers Manual also specifies, \"Part B carrier providers should indicate the amount wasted in the electronic claims Notepad section, or in the Remarks field of the HCFA-1500 form. Part A providers must include the name of the drug, the amount injected, the amount wasted (if applicable), and the route of administration. Whenever unused botulinum toxin type A is billed, both the amount of the agent administered and the amount discarded must be documented in the patient\'s medical record.\" But there are exceptions. For example, Liles explains that in Tennessee, Cigna Medicare does not specify that the amount wasted must be included on the claim form.

Have You Captured All the Related Services?

You can report several related procedures with Botox injections, but be warned - there are limits. For instance, do not automatically bill an E/M service when providing Botox injections, or your claims will be denied. Typically, patients are scheduled ahead of time for the Botox injections. Because the physician evaluated the patient for the Botox procedure prior to the scheduled injection date, you can bill a separate E/M service if the dermatologist sees the patient after treatment such as acne care, coding experts say. In such an instance, append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the applicable E/M code, says **Ken Martin**, reimbursement manager for Allergan, the manufacturer of Botox, in Irvine, Calif. Documentation must clearly support the medical necessity and separately identifiable nature of the E/M service.

Note: Do not bill separately for injection administration (90782, Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular). This is included in Botox codes, and reporting this service separately will result in claim denials or accusations of double-dipping.