Dermatology Coding Alert

Read Your Botox Treatment Report With an Eagle's Eye

Don't miss 5 documentation essentials -- including sites and number of units.

When a dermatologist treats blepharospasm (the uncontrollable contracting of eyelid muscles) with Botox, grab one of those J codes and partner it with a chemodenervation procedure. As long as you get the coding process going smoothly -- which means submitting the right documentation and reporting the right combination of codes -- you'll be winking your way out of the usual hassles of the job.

For such a special application of ophthalmic reconstructive surgery, you should use 64612 (Chemodenervation of muscle[s]; muscle[s] innervated by facial nerve [e.g., for blepharospasm, hemifacial spasm]) along with J0585 (Injection, onabotulinumtoxinA, 1 unit). Bill J0585 per total units used, not per eye.

Reporting J0585 or J0587 (Injection, rimabotulinumtoxinB, 100 units) has not been a reimbursement problem, as long as you bill them correctly with the drug being paid. More to the point, many practices around the country have used them successfully without any trouble, maintains a physician in a medical practice association in Tennessee.

Draw the line: Append modifier JW (Drug amount discarded/not administered to any patient) to J0585 to indicate wasted Botox supply. However, do not use it for claims billing when the drug code description already includes the amount administered and the amount wasted.

Learn Guidelines to Your Advantage

According to **Lynnetta Williams, RHIT, CCS,** of the Department of Veterans Affairs in St Louis, you should peruse your physician's chart note, which must include:

• a diagnosis that supports medical necessity, and

• a notation that the patient has been unresponsive to conventional methods (such as medication and physical therapy) of controlling and/or treating spastic conditions.

Good idea: In addition, she says that the physician should not miss some essential details in the documentation, particularly:

• Number of injections: Keep in mind that each injection site for spasms may require multiple units of botulinum.

• Injection sites and **units injected at each site:** The payer will reimburse for only one injection code per site regardless of the number of needle passes made into the site (being defined as a single contiguous body part -- for example, the eyelid or elbow -- except when the procedure is bilateral). Proper documentation of multiple or complex injections can support and warrant additional reimbursement.

• Amount of medication wastage; and

• Results/response to the injections.

Your dermatologist's documentation is important, even at the E/M visit level. "As far as the visit goes, you can make up a form, questionnaire-type flow sheet. It depends on the cosmetic procedure as to what types of questions you wish to ask. We have different questions for Botox versus laser versus surgery procedures," says **Margie Knox, LPN, CDC,** business office manager and credentialing coordinator at Columbia Skin Clinic LLC in Columbia, S.C. Always remember your ABN if reporting cosmetic procedures on Medicare patients, Knox adds.

These references must guide your practice to a proper accounting of what takes place during the procedure, and consequently help you with coding the procedure.

Watch Your Number of Treatments

Treatments may be continued unless any two consecutive treatments with the appropriate or maximum dose failed to produce a satisfactory clinical response. It is generally not considered medically necessary to give botulinum toxin type A injections for spastic or excess muscular contraction conditions more frequently than every 90 days.

Reimburse by Site Per Body Part

Medicare allows reimbursement for blepharospasm on a per-eye-per-area basis. The number of injections on the same side is irrelevant, but make sure to report the code per area (i.e., right or left), Williams says.

You should also be able to tell if the procedure is unilateral, in which case you append the modifier LT (Left side) or RT (Right side). You consider bilateral procedure only when the dermatologist injects both sides.

Example: The dermatologist administered 12 Botox injections into the skin around one eye. You would report 64612 with modifier LT or RT on the first line of the CMS-1500 form. If the dermatologist administered Botox on both the right and left eyelids, report 64612-50 (Bilateral procedure).

Heads up: Through the changes made in recent years to the Medicare Physician Fee Schedule (MPFS), Medicare now allows payment of 64612 for bilateral procedures.

See Vial Administering Thru Medicare's Eyes

Medicare imposes some strict guidelines on vial usage. Prepare yourself for unwanted incidents with payers by brushing up on this example:

Example: If a vial is split between two patients, the billing must be for the exact amount used on each individual patient. Medicare does not allow billing for the full fee amount of botulinum toxin type A on each beneficiary when the vial is split between two or more patients. As always, it is important to document any drug spill in the patient's medical record, indicating date, time, amount wasted, and reason for wastage.