Part B Insider (Multispecialty) Coding Alert

CPT® 2013: Don't Miss the Updated Chemodenervation Codes -- Including One for Migraine Treatment

Plus: Many E/M and some pain pump codes cover more providers now.

You won't find your neurology and pain management claims feeling left out with the CPT® 2013 revisions, thanks to several additions that will improve your chemodenervation coding accuracy and other claims as well.

Be Confident With Reporting Multiple 64612s

CPT® 2013 clarifies longstanding questions from coders and pain management specialists regarding 64612 usage. The code describes chemodenervation of muscles innervated by the facial nerve to treat conditions such as blepharospams (333.81, Other extrapyramidal disease and abnormal movement disorders; blepharospasm) or hemifacial spasm (351.0, Facial nerve disorders; Bell's palsy).

Opinions have varied regarding whether you can legitimately report 64612 multiple times if the physician performs chemodenervation on the facial nerve (cranial nerve VII) during the same encounter. The Medicare Physician Fee Schedule (MPFS) lists 64612 as a code that allows bilateral reporting, but the revised descriptor for 2013 puts the question to rest: 64612 (Chemodenervation of muscle[s]; muscle[s] innervated by facial nerve, unilateral [e.g., for blepharospasm, hemifacial spasm]).

Bottom line: You can report two units of 64612 if your physician administers chemodenervation to muscles innervated by the facial nerve on both sides of the patient's face. Indicate the situation on Medicare claims by appending modifier 50 (Bilateral procedure) to 64612. For non-Medicare payers, report 64612 on two separate lines with modifiers LT (Left side) and RT (Right side) appended.

"This helps immensely in clarifying the 'discrepancy' between Medicare's stance that 64612 could be reported as bilateral, and the AMA's stance that it would be reported only once for all injections," says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** owner of MJH Consulting in Denver, Co.

Plus: In a similar revision, when CPT® 2013 goes into effect, 64614 will specifically represent chemodenervation to a single extremity. The new descriptor reads as follows: Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis).

Add 64615 for Chronic Migraine Treatment

A new addition to your chemodenervation options in 2013 will be 64615 (Chemodenervation of muscle[s]; muscle[s] innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral [e.g., for chronic migraine]).

Currently: Until 64615 goes into effect, providers potentially report both 64612 and 64613 if they inject the muscles in the forehead area as well as muscles in the back of the head or upper neck area during the same encounter to treat chronic migraine. In those situations, a question arose regarding whether the provider could report both codes bilaterally, which could lead to potentially high reimbursement when compared to multiple Botulinum injections of an extremity. Introducing 64615 answers the question by offering a single code for the multiple-injection scenario.

Take Advantage of Expanded Provider Inclusions

If your provider reports E/M services or certain fluoroscopy codes, check the updated descriptors in 2013. Many now include services by "other qualified health care provider" instead of only a physician.

For example, the explanation with many E/M office visit codes now reads, "Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, XX minutes are spent face-to-face with the patient and/or family."

Differences: Previous descriptors stated that the counseling and/or coordination of care took place with "other providers or agencies." The face-to-face time associated with each code also was attributed to the physician instead of being open to physicians or other qualified providers.

Clarification: The updated code descriptors coincide with CPT®'s 2012 Instructions for Use that defined "other health care provider" as an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileges (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff" who work under the supervision of a physician or other qualified health care professional.

Pump refill change: Code 62370 also will apply to other qualified health care professionals instead of only physicians. The revised descriptor is as follows:

- 62370 -- Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)

"Many mid-level providers already successfully manage implanted intrathecal pumps," says **Anne M. Dunne, RN-BC, MSCN, MBA,** director of healthcare consulting for Grassi and Co. in Jericho, N.Y. In that instance, providers report 62369 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion [includes evaluation of reservoir status, alarm status, drug prescription status]; with reprogramming and refill).

"In New York State, there's a minor $5 difference in the Medicare fee schedule between codes 62369 and 62370," Dunne adds. "I suspect this new change will have little to no impact on how neurology practices manage this clinical service or the associated reimbursement they would budget."