## Part B Insider (Multispecialty) Coding Alert

## Reader Question: Modifier 50 Doesn't Always Apply

Question: When our physicians administer Botox for chronic migraines, we bill the HCPCS J code for the drug with procedure code 64613 and modifier 50. Payers are sending multiple denials, stating that the procedure/modifier combination is invalid. What's our best coding strategy?

Answer: When billing injections of Botulinum toxins, aka chemodenervation, the key is to review the CPT® code terminology. The procedure code you'll turn to is 64613 (Chemodenervation of muscle[s]; neck muscle[s] [e.g., for spasmodic torticollis, spasmodic dysphonia]).

Note that the descriptor states, "muscle(s)." Regardless of the number of injections your provider administers to the same muscle area, you should only report the applicable chemodenervation code once.

Report J0585 (Injection, onabotulinumtoxina, 1 unit) for the medication. Remember most payers allow coverage for unavoidable wastage of single dose medications, including Botulinum toxins. It is important that your provider clearly documents both the amount injected and wasted. Some payers require the wastage to be reported on a separate line item with modifier JW (Medication discarded as waste). It is best to check your payer's policy before filing the claim.

Change: In the past, Medicare allowed you to report bilateral instances of 64613 or 64614 (...; extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis) on the same claim by appending modifier 50 (Bilateral procedure). Effective April 1, 2011, Medicare changed the billing rules, however. The Physician Fee Schedule currently shows a modifier indicator of " 0, " meaning you cannot bill these codes bilaterally. The exception to the rule is 64612 (Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm); if the physician injects the muscles around both eyes, you can append modifier 50 to 64612 and be paid accordingly.

