Eli's Rehab Report

Be Specific When Coding for Myobloc

Although the U.S. Food and Drug Administration (FDA) approved botulinum toxin, or "Botox" type B, in December 2000, PM&R coders have been unsure of how to code for injections of this antispasmodic drug. Many PM&R practices are erroneously billing for Botox type B, also known by its trade name, Myobloc, by using the "unclassified drugs" code (**HCPCS J3490**). Although this is how practices were advised to bill for the drug when it was first approved, that advice is no longer accurate. The more specific code J0587 was assigned to Botox type B effective Jan. 1, 2002, eliminating the need for practices to submit additional paperwork and backup documentation to demonstrate what was injected.

This change has elicited a domino effect in the coding scenario because coders must now face the question of how many units of the drug to bill, which ICD-9 codes have been approved, and which CPT codes to assign. The following tips will help PM&R coders to bill more accurately for Botox type B.

Only Reimbursable for Cervical Dystonia

Myobloc is payable by Medicare when administered to patients with cervical dystonia (also known as spasmodic torticollis [333.83]). This is the only diagnosis that Medicare covers on a national basis, which can frustrate physiatrists who would like to use Botox type B for patients with other conditions. For example, says **Julie Hayden,** the insurance billing specialist at Rehab Medicine Associates, a five-physiatrist practice in Eugene, Ore., "the majority of our patients who receive that type of injection have spastic hemiparesis [342.1x], which is not a covered diagnosis for Myobloc."

The good news is that some insurers are allowing reimbursement for Myobloc when other conditions are present. For instance, says **Rita Lane,** billing specialist at Upstate Medical Rehabilitation, a three-physician practice in Greenville, S.C., "the FDA approved Myobloc for cervical dystonia, and Medicare will only reimburse it for that condition. But I've seen other payers, such as CIGNA or Companion, pay for it for other spasticity disorders. You just have to call your patient's insurers beforehand to find out their conditions for reimbursing the injections."

Even the various Medicare carriers differ in their flexibility regarding the cervical dystonia guidelines. For example, the local medical review policy (LMRP) for Myobloc in Kansas states in bold letters, "At this time, BTB [Botox type B] coverage will be extended only to cervical dystonia."

However, the LMRP for Alabama Blue Shield indicates that other diagnoses may be reimbursable. The policy states, "BTB has not received approval for other conditions," but a later paragraph reads, "For BTB, other diagnoses will merit coverage only on an individual basis when additional documentation is submitted with the claim or on review of a denied claim. To support such a consideration, medical record documentation such as loss of response to BTA (Botox type A) is necessary. Other off-label uses of BTB must be accompanied by supporting medical literature."

This does not mean that practices should be injecting Myobloc for other diagnoses and assuming that the documentation will support their claims. It does show, however, that some carriers may be open to paying these claims for other conditions when no other drugs will treat the patient's illness as well as Myobloc does.

Administration Codes

As with Botox type A, the HCPCS code for the Botox type B should be reported with the CPT code for the administration, based on the site injected. The most commonly used injection code for Myobloc administration is 64613 (Chemodenervation of muscle[s]; cervical spinal muscle[s] [e.g., for spasmodic torticollis]) because this is the site code used for cervical dystonia patients. For those practices using Botox injections for other sites, the following list comprises the remaining Botox injection codes:

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1. 64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
2. 64614 ... extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
3. 67345 Chemodenervation of extraocular muscle.

   Medicare payers reimburse for these injection codes "per operative session" regardless of the number of injections performed per site. For instance, if the cervical dystonia patient received three injections of Botox type B into the cervical spinal muscles, only one unit of 64613 could be reported. If the cervical spinal muscles were injected and, the same day, the patient received a Botox type A injection into the face, the practice could bill 64612 and 64613. A modifier would not be necessary to bill both because each injection is specific to a different area. However, the backup documentation must support the medical need for Botox type A and B on the same day.

   Practices also should note that injections to the right and left sides of the spine should not be billed as "bilateral injections." According to CMS guidelines, "bilateral procedures will only be considered when both eyes or sides of the face are injected," in which case the claim would be submitted with modifier -50 (Bilateral procedure).

   Note: Injections performed on both sides of the spine are considered unilateral.

   Units to Report

   Many practices are familiar with billing for the number of units of Botox type A (J0585, Botulinum toxin type A, per unit), which requires coders to enter on the claim form the exact number of units injected into the patient. However, there is a major difference for practices billing for Myobloc. The descriptor for J0587 reads, "Botulinum toxin type B, per 100 units." Therefore, if 100 units of the drug are administered, only one unit of the drug should be listed on the claim form.

   Practices usually administer more than 100 units of Myobloc per session, and the drug should be billed in 100-unit increments. For example, if 5,000 units are injected, 50 units of the drug should be listed. Because Myobloc is available in 10,000-unit vials, some practices may be billing for 100 units. But many payers do not allow three digits listed in the "units" column of their claim forms. Therefore, PM&R practices administering 100 units of Myobloc should enter 99 units on the first line and one unit on the next line.

   E/M,EMG With Injection

   Most state carriers allow electromyographic (EMG) guidance with Botox injections to ensure the proper needle location within the treated muscles. Each state Medicare carrier provides its own listing of allowable EMG codes for Myobloc injections. The most common of these are listed below:

4. 95860 Needle electromyography, one extremity with or without related paraspinal areas
5. 95861 Needle electromyography, two extremities with or without related paraspinal areas
6. 95863 Needle electromyography, three extremities with or without related paraspinal areas
7. 95864 Needle electromyography, four extremities with or without related paraspinal areas

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8. 95867 Needle electromyography, cranial nerve supplied muscles, unilateral
9. 95868 Needle electromyography, cranial nerve supplied muscles, bilateral
10. 95869 Needle electromyography; thoracic paraspinal muscles
11. 95870 limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters).

    An E/M service can be billed on the same date as a Myobloc injection as long as a significant and separately identifiable evaluation was necessary and modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) is appended to the E/M code.

    For instance, the cervical dystonia patient arrives for her Myobloc injection complaining of pain in her neck at the previous injection site. The physiatrist suspects that an infection may be present and performs a level-two evaluation of the patient, only to find that the patient is suffering from minor bruising on the neck at the prior injection site, but no infection. He then administers the Myobloc injection for that visit. The encounter would be coded as follows:

12. 64613 (for the Myobloc injection)
13. J0587 x 25 units (for 2,500 units of the drug injected)
14. 333.83 (to denote that the patient had cervical dystonia)
15. 99212-25 (for the evaluation of the patient's neck)
16. 920 (Contusion of face, scalp, and neck [except eye(s)]).

    Review Local Carrier's Guidelines

    When performing Myobloc injections, be sure to request your insurer's requirements in writing because some carriers may have special billing requirements for the drug or the administration. For instance, Hayden says, her practice's carrier denied a Myobloc claim based on the place of service. "We performed a Myobloc injection on a cervical dystonia patient in a nursing home, but we were only paid for the injection and not the drug. Our insurer told us that they do not consider a nursing home an approved place of service for Myobloc injections. Of course, with this type of injection, the drug is more expensive than the injection procedure, so that denial was very costly."

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