Eli's Rehab Report

Better Your Botulinum Coding -- 64612-64614 Is More Than Skin Deep

Discover why you may not be able to use modifier 50, even if your provider performs bilateral injections

Physical medicine and rehab coders know that botulinum toxin can do more than be a fountain of youth. Now be sure your treatments sail smoothly through the claims process.

Know Your A's From B's

Physicians in the United States have two types of botulinum accepted for patient treatment. The FDA approves type A to treat diagnoses such as strabismus, blepharospasm, cervical dystonia, severe primary hyperhidrosis, and glabellar lines (the only FDA-approved cosmetic use of botulinum). The FDA approves type B for cervical dystonia treatment.

Off-label uses for botulinum -- and many payer coverage policies -- include treatment for migraine headaches, back or myofascial pain, piriformis syndrome, spasticity, and focal hyperhidrosis.

Rely on Chemodenervation Codes for Most Procedures

When you report a botulinum procedure, you'll have four factors to consider:
• the CPT procedure code
• the appropriate add-on code for needle guidance
• the HCPCS botulinum code, such as J0585 (Botulinum toxin type A, per unit) and J0587 (Botulinum toxin type B, per 100 units)
• any ICD-9 codes supporting medical necessity.

If you frequently code for botulinum injections, you'll probably rely most often on CPT's chemodenervation codes:
• 64612 -- Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
• 64613 -- ... neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia)
• 64614 -- ... extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis).

You should look at 64612 when the physician treats patients who have frequent migraine headache episodes (346.x). The facial nerve, the seventh cranial nerve, is the nerve of facial expression. It supplies innervation to most of the facial and forehead muscles. Additionally a branch runs to the back of the scalp and provides innervation to the occipital frontalis muscle.

"Most of these patients have failed other therapies or treatments," says **Jennifer Gero**, a coder and billing specialist with TB Consulting in Myrtle Beach, S.C. "They have also had unacceptable side effects associated with other preventive or acute therapies before trying botulinum."

But that's not the only diagnosis that 64612 applies to. You can also use this code for hemifacial spasm (**351.8**) or the involuntary contractions of the muscles on the face's side. Another option is blepharospasm (333.81) or the increased blinking and involuntary closing of the eyes.

Other potential candidates for botulinum injections include patients who have chronic tension headaches (307.81) and chronic daily headaches (784.0).

Real-life scenario: A patient diagnosed with right-side Meige's syndrome (333.82) as a side effect of Bell's palsy comes to your PM&R clinic. Your physician injects botulinum A in an effort to reduce the patient's painful spasms on the right

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side of her face. In this case, you should report 64612 for the injection procedure.

Physicians also use botulinum to reduce the severity of a patient's abnormal head position and neck pain that are associated with cervical dystonia (333.6, Idiopathic torsion dystonia; and 333.7, Symptomatic torsion dystonia).

Example: Conservative treatment of spastic torticollis fails to help the patient. The physiatrist injects botulinum B to relax the patient's cervical spinal muscles and reduce muscle spasms. You submit 64613 for the chemodenervation injection.

Descriptor note: CPT 2006 revised the descriptor for 64613. The physician injects different muscle groups in the neck to treat spasmodic torticollis and spasmodic dysphonia, so the previous descriptor for "cervical spinal muscles" limited when you could compliantly report 64613. Changing the descriptor to represent chemodenervation to the "neck muscles" and adding spasmodic dysphonia as an example allow you to rely on 64613 more often.

Using 64614: The provider injects botulinum A in the dominant left arm and leg of a 12-year-old cerebral palsy patient. He administers the injection to treat spastic hemiplegia (342.11), and you report 64614 for the procedure.

Pay Attention to Needle Guidance Codes

If your provider uses needle guidance for chemodenervation, you'll also report one of these codes for the procedure:

• +95873 -- Electrical stimulation for guidance in conjunction with chemodenervation (list separately in addition to code for primary procedure)
• +95874 -- Needle electromyography for guidance in conjunction with chemodenervation (list separately in addition to code for primary procedure).

"These are add-on codes specifically for use with 64612-64614," says **Marvel J. Hammer, RN, CPC, CCS-P, CHCO**, owner of MJH Consulting in Denver. The parenthetical note specifically states that 95873 and 95874 are either/or codes, Hammer says. That means you can report either 95873 or 95874 if your physician provides and documents services, but you cannot report both.

CMS Guidelines Dictate Modifier Use

Physicians often administer multiple injections when treating patients with botulinum. One of the biggest challenges with using chemodenervation codes can be when your provider injects botulinum in multiple body sites or bilaterally, Hammer says.

Frequently, physicians do not administer chemodenervation injections to mirror-image sites, so modifier 50 (Bilateral procedure) frequently may not apply to the documentation. Even if the physician does administer bilateral injections, some coding guidelines recommend you only report one unit of service for the chemodenervation injections.

Example: The AMA's CPT Assistant states, "CPT codes 64612-64614 should be reported only one time per procedure, even if multiple injections are performed in sites along a single muscle or if several muscles are injected."

Opposite view: Many Medicare carriers' local coverage determinations (LCDs), such as Empire Medicare in New York and Cigna Medicare in Tennessee, will allow payment for one injection per site regardless of the number of injections made into the site. A "site" means the muscles of a single contiguous body part, such as a single limb, each eye including the extraocular muscles and eyelids, face, and neck. Therefore, you can submit multiple units of 64614 when appropriate.

Medicare and many commercial and workers' compensation carriers also allow modifier 50 when the physician injects both of the patient's eyes or both sides of his face (64613).

Checkpoint: Don't automatically append modifier 50 to every case involving multiple injections. "If the physician injects

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botulinum toxin in the upper and lower
lid of the same eye or adjacent facial muscles or brow, the procedure is considered to be unilateral," Gero says.

Watch the Timing for Multiple Injections

Most carriers do not consider botulinum A or B injections for spasticity or excess muscular contraction conditions to be medically necessary more often than every 90 days, Gero says.

The big issue to remember is that one unit of botulinum A does not equate to one unit of botulinum B.

Botulinum A has a therapeutic dose range of 20-300 units at a treatment session, with treatment sessions spaced at a minimum of three months apart. Botulinum B has a therapeutic range of 2,500-10,000 units per three-month treatment session. "The key is to remember that the units of each serotype are not interchangeable," Hammer says.

Providers must document the results of and the patient's response to any botulinum injections after each session. Carriers should cover treatments unless any two consecutive treatments fail to produce a satisfactory clinical response. The patient's medical record must be available to the carrier upon request.

Close Out the Claim With Correct Diagnoses

The final coding factor you must consider is medical necessity. Diagnoses supporting botulinum injections will vary according to the reason for treatment -- and according to the carrier's policy -- but some common options include:

- 333.81 -- Blepharospasm
- 333.82 -- Orofacial dyskinesia
- 333.83 -- Spasmodic torticollis
- 342.1x -- Spastic hemiplegia
- 350.9 -- Trigeminal nerve disorder, unspecified
- 351.8 -- Other facial nerve disorders
- 351.9 -- Facial nerve disorder, unspecified
- 378.5x -- Paralytic strabismus (nerve palsy)
- 728.85 -- Spasm of muscle.

Medicare carriers are converting their local medical review policies (LMRPs) to LCDs. During this process, carriers update many of the diagnosis codes that support medical necessity for the covered services, including botulinum and chemodenervation. Some carriers, such as Noridian with a new policy effective May 1, have changed to an equal coverage policy for both botulinum toxins, Hammer says.

"One thing I cannot express enough is that it is very important to always read your LCDs carefully," Gero says. "We bill for physicians all over the country and have found that the diagnoses covering botulinum vary from state to state and payer to payer."

Keeping an eye on your carriers' policies is always a good idea, but remember to code based on the patient's diagnosis and medical record, not the carrier's policy. Learning the complete picture will keep your botulinum coding -- and your claims -- accurate.

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