Eli's Rehab Report

CPT 2006 Update: Get Ready to Change the Way You Report Chemodenervation and Orthotic Services

Chin up: Add-on codes 95873-95874 will reimburse the same amount as 95870

You've got only a short time before you'll have to implement CPT's 2006 changes on Jan. 1--especially since there's no grace period--so here are the chemodenervation and needle guidance changes likely to affect your rehabilitation practice that you should learn now.

Classify 2 New Chemodenervation Codes

Two new codes will debut in January for chemodenervation of the eccrine glands. One covers "both axillae" (64650, Chemodenervation of eccrine glands; both axillae), and the second covers other areas, such as the scalp, face or neck, per day (64653, ... other area[s] [e.g., scalp, face, neck], per day). And next year the definition for **CPT 64613** (Chemodenervation of muscle[s]; cervical spinal muscle[s] [e.g., for spasmodic torticollis]) will change from "cervical spinal muscles" to "neck muscles" and will add "spasmodic dysphonia."

These chemodenervation injections will treat hyperhidrosis (705.21, Disorders of sweat glands; primary focal hyperhidrosis; 705.22, ... secondary focal hyperhidrosis; and 780.8, Generalized hyperhidrosis). Look for these diagnoses to support 64650 and 64653.

Heads up: Although some experts expected that CPT 2006 would introduce new codes for chemodenervation of eccrine glands in the extremities, you still won't find a specific CPT code for Botox injections to the hands and feet. However, a note under the two new codes reads, "For chemodenervation of extremities (e.g., hands or feet), use 64999." So if the physiatrist injects two hands or two feet, you would only be able to report 64999 once, says **Pamela J. Biffle, CPC, CCS-P**, president of PB Healthcare Consulting and Education in Fort Worth, Texas. You would not be able to append modifier 50 (Bilateral procedure) to the code to report two injections, she says.

Don't forget: Another note directs coders to "report the specific service in conjunction with code(s) for the specific substance(s) or drug(s) provided." To report Botox supplies, you should use HCPCS supply code J0585 (Botulinum toxin type A, per unit) and record the number of units the physician injects in box 24G of the CMS-1500 claim form.

But how insurers will view these codes remains to be seen. "The most common definition of medical necessity applies to services provided to improve, restore or maintain the function of a malformed, diseased or injured body part," says **Eric Sandhusen, CHC, CPC,** director of compliance for the Columbia University department of surgery. "Excessive sweating may be an annoyance, but I don't know if insurers will classify it as malformation, disease or injury."

Sandhusen expects that insurers will stipulate coverage guidelines that require--at least--that the physician attempt to treat the condition nonsurgically, to quantify the extent to which the condition impairs the patient's activities of daily living, and to show that alternatives to Botox injection have been tried and failed, before they will cover 64650-64653.

Add These Needle Guidance Add-On Codes

In January, CPT will include two add-on codes to report needle guidance along with chemodenervation:

• +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).

In the past: Most local coverage determinations had instructed you to use 95870 (Needle electromyography; 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) for needle guidance, which is for a limited study. Code 95870 was also the only code that the National Correct Coding Initiative didn't bundle with chemodenervation codes, says **Marvel Hammer, RN, CPC, CHCO**, president of MJH Consulting in Denver. At least one carrier preferred for you to use the unlisted-procedure code (95999, Unlisted neurological or neuromuscular diagnostic procedure), she adds.

But 95870 never really accurately reflected the service your physiatrist performed because the physician used EMG or electrical stimulation to find the best place to put the needle for chemodenervation. Because chemodenervation can last 90 to 120 days, you can't repeat the procedure, so it's important to hit the right spot the first time, Hammer says.

Good news: You may worry that you will lose out on electromyography for needle-placement. Add-on codes 95873 and 95874, however, will reimburse the same amount as 95870, about 0.78 nonfacility relative value units (RVUs).

This is good news, although the RVUs for a new code frequently change after the first year or two, Hammer says. "I'm surprised to see that the reimbursement levels for E-stim and needle EMG are nearly identical, given the expense of an EMG machine," Hammer adds.

Open Up Your Orthotic Coding Options

If your physiatrist performs orthotic and/or prosthetic management, you'll have three new codes. Prior to this, you had no way of reporting the assessment and management of a patient using a prefabricated or custom-made orthotic.

Code 97760 (Orthotic[s] management and training [including assessment and fitting when not otherwise reported], upper extremity[s], lower extremity[s] and/or trunk, each 15 minutes) covers orthotic management and training. This means that you'll report this when your physiatrist assesses the patient, determines the most appropriate orthotic (such as static or dynamic), and designs, selects or fabricates the orthotic.

Code 97761 (Prosthetic training, upper and/or lower extremity[s], each 15 minutes) covers prosthetic training. You'll use this code when the provider sees the patient for follow-up visits that include exercises, skin care advice and orthotic wearing time.

You'll use 97762 (Checkout for orthotic/prosthetic use, established patient, each 15 minutes) for checkout for orthotic/prosthetic use. In other words, your physiatrist judges the patient's response to the orthotic use (including redness, pressure areas and any adjustments).

Note: Each of these codes counts in 15-minute units. This means you'll be using the eight-minute rule (for a free PDF chart of the eight-minute rule, e-mail the editor at suzannel@eliresearch.com).

Highlight These 2 Additions

You've got new codes in two other areas likely to affect your rehabilitation practice as well. Here's what to keep in mind this January:

1. As of Jan. 1, you'll have two new codes in the electomyography and nerve conduction tests section. Codes 95865 (Needle electromyography; larynx) and 95866 (... hemidiaphragm) will cover needle electromyography in the larynx and hemidiaphragm respectively.

2. If your physiatrist covers an inpatient type of practice (such as SNF) instead of an outpatient injury practice, then you should definitely circle this change. CPT adds codes for initial nursing facility care (99304-99306) and a miscellaneous code for "other nursing facility services" (99318). And you'll have new codes for care plan oversight in home care,

assisted living facilities and rest homes: 99339-99340.