Eli's Rehab Report

Optimize Reimbursement by using Correct Botox Codes

"**Nugget:** Coders should bill both the CPT and HCPCS codes for Botox and should check with top carriers to see if the unused portion of the expensive drug can also be billed.

Physical medicine and rehabilitation (PM&R) offices that use botulinum toxin (botox) injections to treat spastic muscle disorders may be losing reimbursement unless they bill for both the injection and the medication being injected, says **Sheldon Schmidt, CPC**, a biller at Badger Billing Service, a medical billing firm in Mequon, Wisc.

Botox injections are used to treat focal muscle spastic disorders and contractions, such as spasms and twitches. According to the Medicare Part B Billing Manual for Physical Medicine and Rehabilitation, the injections produce temporary paralysis in individual muscles, allowing the treated areas to weaken and produce less movement.

Billing for Medication and the Injection

Billing for the botox injections has basically been a nightmare, says **Margaret Flesher**, office manager of Medical Rehabilitation Group in Grand Blanc, Mich. Weve only done three or four of these, but Medicare has delayed on paying us for the medication part of it. We billed the J code for the medication and its taken us over a year to get paid.

Schmidt says that Flesher is correct in billing both the CPT code and the HCPCS code for the botulinum toxin injections (J0585). Coders should start by determining the site of the injection, since each refers to a different anatomical location. For example, 64612 (destruction by neurolytic agent; [chemodenervation of muscle endplate]; muscles innervated by facial nerve, e.g., for blepharospasm, hemifacial spasm); 64613 (destruction by neurolytic agent; cervical spinal muscles; e.g., for spasmodic torticollis); and 67345 (chemodenervation of extraocular muscle) are the appropriate CPT codes to use for the actual injection.

Our doctors mainly use the botox injections in the face, and we bill one unit of 64612 for that, no matter how many injections he has to do along the nerve, says Schmidt. If the doctor injects into the face and spine, you can bill the two different CPT codes (64612 and 64613), and you dont need a modifier because each is specific to a different area of the body. Billers should remember to add the modifier for the left (-LT) or right
(-RT) sides of the body when appropriate.

Many readers tell us they have problems with billing for the medication injected particularly as its an expensive drug. Weve only billed for botox a few times in the past, but it was so expensive, we had to get a preapproval from the patients workers compensation carrier to bill for the medication and the procedure, says **Robin Pollard**, who bills for four providers at North Florida Physical Medicine in Jacksonville.

Get Paid for Unused Portion

In Wisconsin, says Schmidt, Medicare allows providers to bill for even the unused portion of the drug left in the vial, because once the vial is opened, the medication has a very short life, and it is expensive. We use the J0585 (botulinum toxin type A, per unit) as the HCPCS code for the actual drug itself. You would bill that per unit of the drug, so if you give 100 units, you would just enter 100 into the unit field.

Flesher has gone through many denials for the botox injections, and the problem turned out to be an electronic glitch when billing for the vial of botox medication. For the longest time, Medicare told us that the botox injections were medically unnecessary, says Flesher. Then they said, no, the problem was our diagnosis. Then we rebilled it many times and finally found out that since we were billing it electronically, the 100 units of medication we billed was electronically

being turned into one unit. So we have to either bill it non-electronically, or we have to bill two separate line items. On the first line, we bill for 99 units of the J0585, and on the second line, we bill one unit, totaling the whole 100 units.

Most state Medicare carriers will allow providers to bill for the full vial of the medication, and billers should check their carriers medical policies to determine the exact rules in their states. For example, both the Iowa and Oklahoma Medicare policy statements state: Due to the short life of the botulinum toxin, Medicare will reimburse the unused portion of this drug, only when the vial is not split between patients. However, documentation must show in the patients medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug.

The policies both encourage offices to schedule more than one botulinum toxin patient at a time to prevent wasting of the medication. If a vial is split between two patients, the billing in these instances must be for the exact amount of botulinum toxin used for each patient using J0585, they state. If there is any toxin unused after injecting multiple patients, the remainder can be appropriately billed as wastage on the claim of the last patient injected.

Billing for Botox Injections With EMG

The Medicare Part B Billing Manual for Physical Medicine and Rehabilitation also points out that electromyographic [EMG] guidance can be used to ensure the proper needle location within the treated muscles. Each state Medicare carrier provides its own listing of allowable EMG codes for botox injections, but the most common of these are 95860 (needle electromyography, one extremity with or without related paraspinal areas); 95861 (needle electromyography, two extremities with or without related paraspinal areas); 95867 (needle electromyography, cranial nerve supplied muscles, unilateral); 95868 (needle electromyography, cranial nerve supplied muscles, bilateral) and 95869 (needle electromyography; thoracic paraspinal muscles).

Coders also should check their local Medicare policy manuals to determine whether laryngoscopy services (31513, 31570, 31571) are covered for botox injections and to discern the applicable ICD-9 codes for this procedure.
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