Primer on Botulinum Toxin Billing and Coding: What Neurologists Need to Know For 2014

Here's an update on strategies for earning appropriate reimbursement.

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Many clinicians are adding botulinum toxin (BTX) therapy to their practice. Unfortunately, even after a clinician feels comfortable with neurotoxin injection techniques, billing and coding may still seem daunting. Correct coding using current procedural terminology (CPT) and International Classification of Diseases, ninth revision, (ICD-9) linkage is critical for successful integration of botulinum toxin therapy into clinical practice. In addition to understanding and using correct billing and coding, clinicians need to be familiar with purchasing and storage of BTX, prior authorization requirements across insurers, and correct documentation of procedures. Once a clinically appropriate patient has been identified, what needs to be done to provide timely, reimbursed treatment?

PRIOR AUTHORIZATION

Medicare, Medicaid, and private insurances cover botulinum toxin treatment for on and off-label uses that are considered medically necessary. Many off-label conditions (i.e. lower limb spasticity or limb dystonia) are still considered standard of care and will be approved. Medicare policies can vary from state to state, but private insurance policies are typically universal. Being familiar with the policies in your state can save time and frustration when submitting for authorization.

With traditional Medicare or Medicaid, no prior authorization is needed for BTX, and payment will occur if the procedure is covered on your state's policy and if the proper linkage between ICD-9 code and CPT code has been documented. All private insurances and Health Maintenance Organization (HMO) Medicare/Medicaid patients should be prior authorized for BTX even for on-label injections. Using the toxin company's prior authorization services can expedite approvals and save staff time. Patients must sign a consent document to allow the company to contact their insurance provider. An office note justifying the reasoning for BTX treatment along with a letter of medical necessity (LMN) should always be included with the prior authorization request. The LMN should include the preferred toxin, ICD-9 diagnosis, prior treatment failures, expected number of vials, CPT codes, and electromyography or other guidance technique to be used.

Verification of benefits is performed first to assure that the patient's insurance policy is current and that it covers

TIPS FOR SCHEDULING

- Patients with traditional Medicare/Medicaid can be scheduled as soon as practical because prior authorization is not required.
- Scheduling patients with private insurance or HMO Medicare/Medicaid plans in 4-6 weeks allows time to ensure authorization and prevents multiple calls from patients inquiring about status of approval.
- Request consent at time of scheduling from patients with private insurance or HMO Medicare/Medicaid if an authorization service may be utilized.

TABLE 1.

Toxin	Company	J-code	Vial Size	Price
Botox® (OnabotulinumtoxinA)	Allergan	J0585	100 unit vial	$541
			200 unit vial	$1082
Dysport® (AbobotulinumtoxinA)	Ipsen	J0586	300 unit vial	$426
			500 unit vial	$710
Xeomin® (IncobotulinumtoxinA)	Merz	J0588	50 unit vial	$212.50
			100 unit vial	$450
Myobloc® (RimabotulinumtoxinB)	US WorldMeds	J0587	2,500 unit vial	$262
			5,000 unit vial	$524
			10,000 unit vial	$1048

injectable treatments such as BTX. Benefit verification does not equal preapproval or medical necessity. Prior authorization must be performed to increase the probability of proper payment. Most insurance companies will prior authorize a patient for six to twelve months or for two to four treatments. Confirm that injections are performed within this authorization window or payment could be denied. Authorization can be submitted online or by fax depending on the toxin company. Authorization results typically include approved dates of service, approved CPT codes, and the expected deductible based on the patient's plan. The allowable number of toxin units and how to obtain the drug (i.e. buy and bill vs specialty pharmacy) are also reported.

ORDERING, STORAGE, AND BILLING THE TOXIN

Options for procurement of the drug include buy and bill by the practice or purchase from a specialty pharmacy. Medicare and most private insurance companies will require the practice to buy and bill the drug. Some companies such as United Health Care require the use of a third party specialty pharmacy. The use of a specialty pharmacy may limit risk of potential loss of funds from insurance denials; however, it also reduces total reimbursement. If the clinician obtains the drug and bills from his/her stock, a margin above the cost of the drug is obtained. For Medicare the margin is six percent above the average wholesale cost of the drug. Private insurance companies typically reimburse between six and twenty percent above wholesale cost. Botox® and Xeomin® are billed per one unit, Dysport® is billed per five units, and Myobloc® is billed per 100 units. Remember that both the amount of drug used for injection and the drug wasted should be charged. For example, if a 200 unit vial of Botox® is mixed to inject a patient for chronic migraine with 155 units, the 45 units wasted are also billed.

The availability of toxin samples, discounts, and patient assistant programs vary between companies. Check with your local pharmaceutical representative for individual company services. Each toxin can be obtained directly from the manufacture with expected next day arrival. Avoid placing orders that could arrive on the weekend for toxins that require refrigeration. It is recommended that all the toxins are stored together in a locked refrigerator between 2-8°C with a temperature alarm. When using a specialty pharmacy, have the drug sent directly to your office instead of to the patient's home to assure proper storage. A separate log for drug obtained by the practice and another for drug obtained from specialty pharmacies is recommended with documentation of lot numbers. Regular reconciliation of inventory on a weekly or monthly basis is also suggested. Table 1 reviews the pricing of each toxin, vial size, and J-Code used for billing.

PROCEDURE CODING, DOCUMENTATION, AND BILLING

Proper documentation is essential for correct payments. A dictated note is suggested with details including site and location of the injections, dilution, electrophysiologic/ultrasound guidance, provider of medication, and insurance approved dates of service and prior authorization number. Although not essential, insurance companies like to see a written procedure note with a diagram of the areas injected and an outline of the specific dosages injected at each site. From a clinical perspective, this makes reproduction of injections in the future easier. Medicaid also requires documentation of the toxin's national drug code which can be found on the vial or packaging.

The use of an evaluation and management (E/M) code along with the BTX procedure is discouraged. This coding is only appropriate if a separate identifiable medical service is provided for a different diagnosis than the one used for BTX. For example, if a patient with Parkinson's Disease (PD) was seen for both medical management of PD and BTX for sialorrhea, an E/M could be used with a -25 modifier. It is imperative that the medical diagnosis is linked to the E/M and that the other diagnosis (in this case sialorrhea) is linked to the CPT code to ensure proper reimbursement.

Chemodenervation CPT Codes. Specific chemodenervation codes for BTX are based on the appropriate anatomic location "site" injected. See table 2 for a complete list of chemodenervation codes and corresponding anatomic sites. Centers for Medicare and Medicaid Services will allow payment for one injection per site regardless of the number

of injections made into the site. For injection into both parotid and/or submandibular glands for sialorrhea use CPT 64611. Use only once with no modifier. Any injection in the cranium (64612) including corregator, frontalis, temporalis, occipitalis, facial muscles, and masseter are considered head/face. This code can be used bilaterally using RT and LT or the 50 modifier. All injections within the chronic migraine paradigm are considered one site (64515) even though injections are performed in the cervical paraspinals and trapezii. No modifiers are permitted. Both 64613 (neck injection) and 64614 (limb/trunk injection) have been eliminated and can NOT be used in 2014. Both axilla are considered one site (64640 chemodenervaton of eccrine glands) and can only be used once per session. Use 64643, chemodenervaton of eccrine glands; other area(s), when injecting for hyperhidrosis in other areas such as the scalp, face, or extremities.

New Codes for 2014. When injecting neck muscle for conditions such as cervical dystonia, use the new code 64616 (chemodenervation of neck muscle(s) excluding muscles of the larynx). This code can be billed bilaterally with a 50 modifier. Chemodenervation of one or more extremity involves using a somewhat confusing combination of codes, but for the first time, allows for all four limbs to be reimbursed. The first code is known as the base code and should represent the limb with the most muscles injected. Pick code 64642 chemodernervation of one extremity; 1 to 4 muscle(s) or 64644 chemodenervation of one extremity; 5 or more muscle(s). Further limb injections can be billed using add on codes that depend on the numbers of muscles injected in each limb. No modifiers are necessary. For each additional extremity 1 to 4 muscle(s) injected, use +64643 and for each additional limb injected 5 or more muscles use +64645.

Prior to 2014, trunk muscles were considered to be part of a limb injection, but now trunk muscles are an independent region that includes the erector spinae/paraspinal muscles and rectus abdominis/obliques. Use CPT code 64646 when injecting 1 to 5 muscles and 64647 when injecting 6 or more muscles. Each code can only be used once per session. Based on the site definition above, muscles such as the trapezius, rhomboid, gluteus, and piriformis would be considered limb muscles.

Modifiers. Some insurance companies allow the addition of modifiers for right and left-sided injections. Check with your local carriers to determine when to bill with a modifier. Typically, if a code is listed a second time on the billing sheet without a modifier, it is automatically kicked out as a duplicate. Some codes such as 64611 and 64615 can be used once per injection session and, therefore, modifiers will not apply. See table 3 for a list of modifiers.

Anatomic Guidance. To ensure efficacy and safety, electrophysiologic or visual guidance is suggested for many injection locations. Electromyography, muscle stimulation, and ultrasound can be used independently or together based on clinical necessity. Medicare, for instance, allows for electromyography or electrical stimulation to be performed with ultrasound guidance. Use of these techniques maximizes clinical efficacy and, as such, is reimbursable. Table 4 reviews the CPT codes for BTX injections under anatomic guidance. Each code can be used once per injection session.

TABLE 2. BOTULINUM TOXIN CHEMODENERVATION CPT CODES

64611	Parotid/Submandibular Glands (Sialorrhea)
64612	Head/Face
64613	Neck (Deleted after 12/31/13)
64614	Limb/Trunk (Deleted after 12/31/13)
64615	Chronic Migraine Paradigm
64616	Neck, excluding muscles of the larynx
64642	One extremity; 1 to 4 muscle(s)
64643	Each additional limb; 1 to 4 muscle(s)
64644	One extremity; 5 or more muscle(s)
64645	Each additional limb; 5 or more muscle(s)
64650	Axillary (hyperhidrosis)
64646	Trunk; 1 to 5 muscles
64647	Trunk; 6 or more muscles
64653	Other area (hyperhidrosis)

TABLE 3. MODIFIERS

Right	-RT
Left	-LT
Bilateral	-50
Other procedure	-59
Procedure with E/M	-25

TABLE 4

Anatomic Guidance	CPT
Electromyographic guidance for chemodeneravation	95874
Muscle stimulation guidance for chemodenervation	95873
Ultrasound guidance for musculoskeletal injection	76942
Procedure with E/M	-25

BILLING AND CODING PEARLS

- Be aware of which insurance carriers in your area allow for injections to be performed every twelve weeks (84 days) vs. every 90 days or 13 weeks (such as Medicare) to ensure payment.
- Medicaid will not pay for an E/M and a procedure on the same day.
- Medicare requires the proper CPT procedure code linked with the approved ICD-9 code for reimbursement.
- Medicare may not pay for buy and bill of the toxin if the patient is in a nursing home. Check with your local carrier as the nursing home may need to provide the drug.
- Store all toxins in a locked refrigerator. Record daily temperatures and link the thermostat to your alarm system to prevent losing drug in an event such as a faulty refrigerator or power outage.
- Keep separate inventory logs of stock drug that is used for buy and bill and drug received from specialty pharmacy complete with date received/injected and lot number.

REIMBURSEMENT AND EXPECTED COLLECTIONS

Be familiar with your major regional insurance policies for botulinum toxin. This will help to reduce delays in payment and even denials. Review each claim before the patient's next injection cycle to ensure that the procedure, anatomic guidance, and drug have all been paid in accordance with your payer contract. Commonly, the carrier may only pay for the procedures that are considered medically necessary. If a particular code is paid bilateral by a payer, reimbursement for the second side is typically reduced by half. Each of the toxin companies have reimbursement specialists that can assist in billing and coding, insurance verification, local coverage policy support, and claims denials and appeals.

This article is intended as guidance only. Please refer to current policies for carriers in your area and/or CMS to ensure compliance with current policies and regulations. Any specific inquiries should be directed to the relevant carrier. ■

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1. American Medical Association Current Procedural Terminology; CPT 2014; Standard Edition.
2. Botox® (onabotulinumtoxinA) Full Prescribing Information. Irvine, CA: Allergan, Inc; 2013.
3. Dysport® (abobotulinumtoxinA) Full Prescribing Information, Wrexham, UK: Ipsen Biopharm Ltd., 2012.
4. Myobloc® (rimabotulinumtoxinB) Full Prescribing Information Louisville, KY: Solstice Neurosciences, LLC; 2010.
5. Xeomin® (incobotulinumtoxinA) Full Prescribing Information. Greensboro, NC : Merz Pharmaceuticals, LLC.; August 2011.