Coding Guidelines

Botulinum Toxin Types A and B - J3 CB2006.20 R7

1. Chemodenervation codes 64612, 64613, and 64614 are identified in the Medicare Physician Fee Schedule (MPFS) database as codes, which will allow 150% of the unilateral service fee schedule amount when performed bilaterally. Bilateral procedures are to be reported on a single line using modifier -50 and reporting 1 unit of service. The basis for this coding instruction is found in the Internet Only Manual (IOM)100-04, Chapter 12, Section 40.7 which states, "If a procedure is not identified by its terminology as a bilateral procedure (or "unilateral or bilateral"), physicians must report the procedure with modifier "-50." They report such procedure as a single line item. (NOTE: This Centers for Medicare and Medicaid Services (CMS) policy differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two line items.)" (Emphasis added) To illustrate, bilateral neck injections, and bilateral upper extremity injections performed at one setting would be coded as 64613-50 and 64614-50 for one service each. In the case of spastic hemiplegia, where injections are given in the upper extremity and the lower extremity on the same side, code only 64614 for one service.

(Note that bilateral indicators have changed for the following CPT codes included in this LCD, as compared to the previous version of the policy: 64612, 64613, 64614, and 67345. Use bilateral modifier as appropriate and consistent with CPT code descriptions.)

Please note that in a CPT Assistant newsletter in 2001, the American Medical Association's CPT Information Services indicated, "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." (CPT Assistant. April 2001;11(4). The NAS policy is consistent with this directive.

2. NAS understands that vocal cord injections for dysphonia may be performed either percutaneously or by direct injection via a laryngoscope. CPT 31513 describes indirect laryngoscopy with vocal cord injection and CPT 31570 describes direct laryngoscopy with injection into vocal cord(s). As noted in #1 above, these procedures should not be billed bilaterally.

When performing this procedure percutaneously, NAS requires the use of CPT code 31599, unlisted procedure, larynx. When using this code, it is necessary to place a description of the procedure in Item 19 on the CMS-1500 claim form or the electronic equivalent. However, the provider should not bill CPT 31599 with either of the laryngoscopy codes (CPT 31513, 31570) since they are mutually exclusive. These procedures, as well as 64613 chemodenervation of neck muscles, should not be billed bilaterally.

3. When billing for injections of the bladder sphincter or detrusor muscle due to covered conditions, use CPT 53899, unlisted procedure, urinary system. It is necessary to place a

description of the procedure in Item 19 on the CMS-1500 claim form or the electronic equivalent. This code may not be billed bilaterally.

4. When billing for injections of the esophagus for covered conditions achalasia or cardiospasm, use 43499, unlisted procedure, esophagus. It is necessary to place a description of the procedure in Item 19 on the CMS-1500 claim form or the electronic equivalent. This code may not be billed bilaterally.

5. When billing for muscle spasticity due to covered conditions causing spasticity, including multiple sclerosis, spinal cord injury, stroke, traumatic brain injury, and cerebral palsy, the ICD-9-CM code for the causative condition **and** the ICD-9-CM code for muscle spasticity (728.5) must both be billed in order to obtain payment.

6. CPT 92265 needle oculoelectromyography, is appropriate for use for EMG guidance for chemodenervation in the closed treatment of strabismus.

7. Unavoidably non-used and discarded toxin will be paid for when an entire single-dose vial is billed. Documentation must show in the patient's medical record the exact dosage of the drug given and the exact amount of the discarded portion of the drug. Medicare does not pay for discarded portions of multi-dose packaging.

8. ICD-9 378.71, Duane’s syndrome, is to be used only for medial rectus weakness, as it is the only manifestation of the syndrome with clear literature support for use of botulinum treatment.