Billing and Coding Guidelines

Contractor Name
Wisconsin Physicians Service Insurance Corporation

Title
Botulinum Toxin Type A & Type B

Revision Effective Date
09/01/2012

AMA CPT/ ADA CDT Copyright Statement

CMS Regulations:
Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Coding Information

Reasons for Denial
Payment will not be made for any spastic condition not listed under "ICD-9-CM Codes That Support Medical Necessity such as:

1. Use of botulinum toxin for the treatment of anal spasm, irritable colon, biliary dyskinesia, headaches, craniofacial wrinkles or any treatment of other spastic conditions not listed as covered in this policy are considered to be experimental (including the treatment of smooth muscle spasm).
2. Use of botulinum toxin for patients receiving aminoglycosides, which may interfere with neuromuscular transmission; or
3. Use of botulinum toxin for patients with chronic paralytic strabismus, except to reduce antagonistic contractor in conjunction with surgical repair
4. Treatment exceeding accepted dosage parameters unless supported by individual medical record review as well as treatments where the goal is to improve appearance rather than function.
5. The corresponding surgery code was not billed.
6. Use of HCPCS code J0588 incobotulinumtoxinA for treatment of blepharospasm without prior history of treatment with onabotulinumtoxinA.

Coding Guidelines
1. Claim submission must include an ICD-9-CM code

2. No E&M code will be allowed in conjunction with the procedure, unless there is a clear indication that the patient was seen for an entirely different reason. Modifier 25 must be appended to the E&M code to indicate that the visit was for an unrelated condition.
3. To bill medically necessary electromyography guidance, report the appropriate following CPT code(s):

92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with Interpretation and report
95860	Needle electromyography, one extremity with or without related paraspinal areas
95861	Needle electromyography, two extremities with or without related paraspinal areas
95863	Needle electromyography, three extremities with or without related paraspinal areas
95864	Needle electromyography, four extremities with or without related paraspinal areas
95865	Needle Electromyography; larynx
95866	Needle electromyography: hemidiaphragm
95867	Needle electromyography; cranial nerve supplied muscle(s) , unilateral
95868	Needle electromyography; cranial nerve supplied muscle(s), bilateral
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)
95870	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscled (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles or sphincters
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)

4. Medicare provides payment for the discarded drug/biological remaining in a single use drug product after administering what is reasonable and necessary for a patient's condition. The rules for billing discarded portions of botulinum toxin are the same as for other drug/biologicals and can be found in the IOM 100-04 Chapter 17, section 40.

   It is acceptable for the provider to bill for the discarded drug on the last patient of the day when more than one patient is treated with one single use vial of Botulinum toxin.

CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 17: 40 - Discarded Drugs and Biologicals

(Rev. 1962, Issued: 04-30-10, Effective: 07-30-10, Implementation: 07-30-10)

The CMS encourages physicians, hospitals and other providers and suppliers to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.

When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

NOTE: *Multi-use vials are not subject to payment for discarded amounts of drug or biological.*

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Revision: 09/01/2012, Revised the instruction for billing of discarded drugs, moved the coding list to the body of the LCD, Removed instructions for billing code 64999 because spasmodic dysphonia is included in the description of code 64613.

05/01/2012, (Twelve) updated coding guideline number 4, added ICD-9 codes 438.20, 438.21, 438.22, 438.30, 438.50, 438.51-438.53
01/01/2012, (Eleven) effective dated of service 01/01/2012, added J0588 Injection, incobotulinumtoxinA, 1 unit, removed HCPCS code Q2040;

10/01/2011, (Ten) allow on same DOS either CPT code 64612 or 64613 for migraine. Added section titled "Either 64612 or 64613." ICD-9 codes for CPT procedures 64612 and 64613 are 346.70, 346.71, 346.72 and 346.73. Removed CPT code 42699 and replaced with CPT code 64611.Added for CPT code 64611, ICD-9 codes 332.0 and 527.2.

03/01/2011, (Nine) added HCPCS code Q2040 effective 4/01/2011, removed J3490 effective 03/31/2011;

02/01/2011, (Eight), corrected typo in revision history, corrected HCPCS J0583 to HCPCS J0585,

01/01/2011, (Seven), per FDA approval of HCPCS code J0585 for this service added ICD-9 code 346.70 – 346.73, not covered for HCPCS code J0585 346.01 or 346.91;

12/01/2010, (Six) added information regarding Xeomin®, added ICD-9 code 346.01, 346.11, 346.91 w/CPT code 64613 for J0585 dates of service after 10/15/10 ;

09/01/2010, (Five) added ICD-9 codes 596.54, 596.55 when billed with CPT code 53899, 64614 or 64647 with an effective date of 05/16/2009;

02/01/2010, four, added CPT code 53899, added ICD-9 596.59 and 788.41 with an effective date of 05/16/2009;

01/01/2010, three, annual HCPCS update change in description of CPT code 95860, J0585, J0587, added J0586, removed reference to brand names in text of LCD;

10/01/2009 two, annual ICD-9, 2010 code update description change 784.40, 784.49 codes 784.42,784.43,784.44 added to range, added new codes 784.51,784.59 Deleted code 784.5;

07/01/2009, one, added ICD-9 code 374.03 and 333.1 to CPT codes 64614 and 64640;

Note: