

## **Billing and Coding Guidelines**

### **LCD Title**

Botulinum Toxin Type A & Type B

### **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.

*Italicized font* -represents CMS national language/wording copied directly from CMS Manuals or CMS Transmittals. Contractors are prohibited from changing national language/wording.

### **Coding Information**

#### **Reasons for Denial**

Payment will not be made for any spastic condition not listed under Codes That Support Medical Necessity such as:

1. Use of botulinum toxin for the treatment of 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 a diagnosis 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
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.

Effective January 1, 2017 (CR 9603) JW Modifier is required to identify unused drugs or biologicals and providers must record the discarded amounts of drugs and biologicals in the patient's medical record.

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.

**Revision:**

09/01/2017 Annual review completed. No changes in coverage.

10/01/2016 annual review no change to coverage.

07/01/2016 Changed effective date to 01/01/2017 for JW modifier statement based on transmittal 3538 CR 9603.

06/01/2016 Added effective 07/01/2016 requirement for JW modifier and medical record requirements for billing of discarded drug. Removed copied portion of IOM.

11/02/2015 Annual Review, no change to coverage.

12/01/2014 Annual review updated format no change to coverage.