There continues to be some confusion in the use of CPT codes 64612-64614 for botulinum toxin injections. In recent years there have been some changes made to the Medicare Fee Schedule indicating that Medicare allows providers to bill for these procedures bilaterally.

**Can CPT codes 64612-64614 be billed more than once on a date of service?**
Only if the procedure is performed bilaterally.

**Can the codes be billed bilaterally?**
From a detailed review of the 2008 Medicare Fee Schedule, CMS allows two units of codes 64612, 64613 and 64614 to be submitted if bilateral procedures are performed. According to the 2008 Medicare Physician Fee Schedule, bilateral procedures are payable at 150% of the allowed amount for a unilateral procedure. Anecdotally, there are a variety of differing policies from other payers. We now advise our members that there is variability in how different insurance carriers handle these codes. Some may allow two units of each of the codes to be submitted if bilateral injections were done. Others may allow only one unit of each of the codes even for bilateral injections. The individual provider will need to determine what is the proper billing procedure for these codes in his or her locality. The official AMA CPT® stance is that these codes are billable once per day, so it is in your best interest to make sure you are following each individual payer’s billing guidelines when billing for these services. It is common and incorrect to assume that if you were paid, you billed the service correctly. To avoid any compliance risk, check with each payer. Getting it right will allow you to appropriately maximize reimbursement for these services.

**Can CPT code 64612-64614 be billed together?**
Yes, they can be reported together as they pertain to different anatomical regions.

**If EMG guidance is performed what is the appropriate way to code for this additional procedure?**
To account for the EMG guidance use the CPT code listed below in addition to the CPT code for the injection.

+95874 Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

**If guidance using electrical stimulation is performed what is the appropriate way to code for this additional procedure?**
To account for the guidance using electrical stimulation use the CPT code listed below in addition to the CPT code for the injection.

+95873 Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

**How do I account for the medication administered?**
In addition to coding for the procedure, physicians should also code for the drug itself. There are different Healthcare Common Procedure Coding System (HCPCS) supply codes for the two types of botulinum toxin currently in clinical use:
Botulinum toxin type A is supplied in single-dose vials of 100 units. To receive proper reimbursement, it's important to correctly code the amount used for each patient following individual payer instructions.

A typical payer procedure for billing when a single patient is injected is as follows. If less than 100 units is administered during a single session and the remainder is not used for another patient, specify 100 units in the “Days/Units” field (item 24G) on the CMS 1500 claim form. For Medicare, if you have unavoidable drug wastage, the quantity of wasted drug must be reported on a separate line with the JW modifier. So, if a patient receives 75 units of drug and the remaining 25 units are wasted, the first line will be reported as J0585 with a quantity of 75, and the second line will be J0585 with a JW modifier with a quantity of 25. It is very important that drug wastage be documented in the medical record. If wastage is not documented appropriately in the record, your practice could be subject to recoupment for the undocumented wastage.

If more than 100 units are administered and the remainder is not used for another patient, round up to the nearest 100 units (eg, 150 units would be billed as 200 units). If you are dividing a vial between patients, the correct way to do this depends on how the drug was obtained. If you have received the drug via mail order pharmacy or if the patient brought their own from a local pharmacy, the portion of drug that is not used for that patient should be wasted and documented in the note as such even if an opportunity exists for it to be used on another patient. Pre-paid drugs should never be shared between patients even if they have the same insurance plan. For patients where the practice has purchased and is billing for the drug, the actual units dispensed to each patient should be billed to each patient or their insurance and if there is some amount that is wasted it should be assigned to the patient who was last injected and again documented in the medical record as having been wasted. Not documenting wastage is a compliance risk even if the practice is not billing for the drug, and may subject a practice to recoupment for quantities of drug not accounted for in a note. For practices enrolled in the CAP (Medicare Part B Drug Competitive Acquisition Program), see the CAP guidelines on how to account for wastage that are available at: http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage.

Similar considerations apply to botulinum toxin type B, although the units differ.