

## Coding Corner

*By: Michael Ferragamo, MD, FACS*

With the increased use of botox bladder wall injections for the treatment of the over active bladder syndrome, Oab, come new coding and reimbursement questions. Botox, botulinum toxin type a, has been approved by the fda for treatment of the oab.

Icd-9 596.51, and the neurogenic bladder, icd-9 596.54, in dosages of 100 to 360 units.

The new 2013 CPT code for this treatment is 52287, cystourethroscopy with injection(s) for chemodenervation of the bladder. This new CPT code will be for one or multiple bladder wall injections and will have a zero (0) day global allowing for repeat treatments without concern of performance within a global time period. This procedure may be performed in the office or in an outpatient facility such as a hospital or ambulatory surgical center, ASC. If the Botox is supplied by the office and injected in the office setting, bill for the Botox drug with HCPCS code J0585 per one unit. As reported in the publication, CPT Changes for 2013, a surgical assistant at the time of injections is not a payable service although one is frequently needed to inject the Botox while the surgeon endoscopically secures the multiple injection sites within the bladder.

Physicians contemplating use of Botox, should check with the specific insurance carriers as to what diagnoses they accept as indicating medical necessity.

Payable diagnoses have included ICD-9 codes 596.51, 596.52, 596.54, 596.55, 599.82, 788.31, 788.33, and 788.34 with the most commonly paid being 596.54, neurogenic bladder, and 596.55, detrusor sphincter dyssynergia. Coverage and reimbursements do not apply (payment) for Botox administered more often than every 90 days.

Bundling edits, eg. particular CPT codes, never paid when billed with 52287 include the catheterization CPT codes, 51701, 51702, 51703, as well as cystoscopy, 52000, urethral dilations, 53600 to 53665, meatotomy or urethrostomy, 53000 to 53025, and cystoscopic removal of bladder calculi or foreign bodies, 52310 and 52315. However, bladder biopsy, 52204, or bladder wall fulguration, 52214, are payable when performed with 52287 at the same encounter. Therefore, one may bill during one encounter for both a bladder wall injection, 52287, and bladder wall biopsy(s), 52204, as well as a bladder wall injection and fulguration of a bleeding Botox injection site, 52214.

The CPT code for the injection of Botox, 52287, has a work relative value, RVU, of 3.20 and total RVUs of 9.16 in the office and 4.90 in hospital or ASC. The unadjusted 2013 Medicare fees for 52287 is \$311.66 in office and \$166,71 in a facility. When the Botox is supplied and administered in an office setting, for drug payment, code J0585 on one line with the number of total units given in box 24G, units or days column, of the 1500 form or the equivalent box for an EMR submission. 2013 fourth quarter payments for Botox have ranged around \$545.30 for 100 units. Purchase price is about \$525.00 per 100 units.

Starting in 2012 and continuing for 2013, specific drug administration information must be provided for drugs administered in the office to each carrier and placed in Box # 19 of the 1500 form or the equivalent space for EMR billing.

The following information must be included for each billing and forwarded to the insurance carrier as indicated above:

1. name of drug administered      Botulinum Toxin type A
2. Total dosage given
3. Method of administration "intramuscular injection into bladder detrusor muscle"
4. National Drug Code Number, NDC#  
100 units....00023-1145-01  
200 units....00023-3921-02

One should retain all drug cost invoices and be prepared to supply this to a carrier if requested.

If you require further information or have difficulties with submission or claim denials with Botox coding and reimbursements, for assistance call Michael A. Ferragamo MD, FACS at 516-741-0118 or fax to 516-294-4736 or e-mail to [liqgold2@aol.com](mailto:liqgold2@aol.com).