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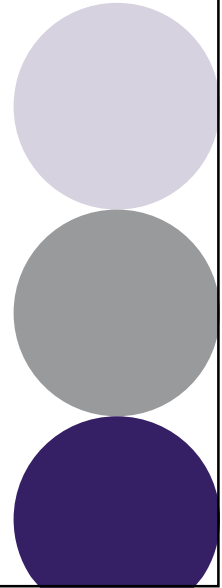
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# Intravitreal Injection Documentation Checklist

CMS Audits

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## Reality

- Third-party payer audits have returned.
- If a payer has a policy on the documentation requirements for the exam to determine the need for surgery, it is published on their website.
- For convenience, Academy staff has linked Medicare's local coverage determinations and articles to [aao.org/lcds](http://aao.org/lcds).
  - Not password protected.
  - Your staff has access.
  - Visit the site often as policies are updated frequently.



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## CMS Audits

- Service Specific Probe
  - Post-payment service specific medical record review
- Targeted Probe and Educate (TPE)
  - Up to three rounds of a prepayment or post-payment probe review with education
  - Each round examines 20-40 claims
  - Results will be mailed and may require a one-on-one educational session
  - High failure rate will initiate additional rounds, extrapolation or referral to the Recovery Auditor (RA) or Unified Program Integrity Contractor (UPIC)



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## Service Specific Probes

- Palmetto
  - Post payment service-specific probe, Lucentis
  - January – March 2021
  - Overall denied rate of 7.27%
- Novitas
  - Service-specific review, Eylea and Lucentis
  - September 2020 – February 2021
  - Overall denial rate of 2%



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## Common Reasons for Denial

Insufficient  
documentation

Does not  
support medical  
necessity

Incorrect coding

Claim billed in  
error by  
provider



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## Common Reasons for Denial

Insufficient  
documentation

- Lack of procedure note including drug, indication or wastage or 1 unit or greater

Does not support  
medical necessity

- ICD-10 codes included in Medicare LCD
- Injection sooner than 28 days

Incorrect coding

- Wrong units
- Missing modifier
- Incorrect ICD-10

Claim billed in  
error by provider

- Injection not performed
- Wrong medication



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# Intravitreal Injection Documentation Checklist

- Visual acuity, chief complaint and appropriate history of present illness (HPI)
- Treatment plan
  - For new patients, document why the specific medication was chosen.
  - For established patients, document response to current medication and why continuing.
  - When changing medications, document the reason.
- Diagnosis supporting medical necessity and appropriate indication for use per payer policy
- Any relevant diagnostic testing services, with interpretation and report
- Risks, benefits and alternatives discussed
- Document that the patient desires surgery
- Physician's order includes:
  - Date of service
  - Medication name and dosage
  - Diagnosis
  - Physician signature
- Interval of administration is appropriate such as 28-day rule



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# Intravitreal Injection Documentation Checklist

- Procedure record includes:
  - Diagnosis
  - Route of administration (intravitreal injection) and medication name
  - Site of injection - eye (s) treated
  - Dosage in mg and volume in ml, (e.g., Avastin 1.25 mg@ 0.05 ml) and lot number
  - Single-use medications record wastage greater than 1 unit (e.g., Triesence)
  - For wastage less than 1-unit document: *"any residual medication less than one unit has been discarded."* (e.g. EYLEA)
  - Consent completed for injection, medication and eye (s) on file.
  - For initial treatment using a medication with off-label use, an informed consent with that notification is completed. (e.g. Avastin)
  - Advance Beneficiary Notice (ABN) for Medicare Part B beneficiaries or waiver of liability (all other patients) is completed, if applicable (e.g. diagnosis not indicated, exceeds frequency)
- Chart record is legible and has patient identifiers (e.g. patient name, date of birth) on all pages
- Physician signature is legible
  - Paper chart records have a signature log
  - EHR, the electronic physician signature is secure
- Abbreviations are consistent with approved list and readily available for audits
- Maintain legible medication administration and inventory records



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# Intravitreal Injection Documentation Checklist

## CHECKLIST/GUIDE FOR CODING INJECTIONS

- CPT 67028, eye modifier appended (-RT or-LT)
  - Bilateral injections billed with a -50 modifier per payer guidelines. (Medicare Part B claims billed with 67028-50 on one line, fees doubled and 1 unit.)
- HCPCS J-code for medication
- Appropriate units administered (i.e., EYLEA 2 units)
- HCPCS J-code on a second line for wasted medication, if appropriate
  - -JW modifier appended
- Medically necessary ICD-10 code appropriately linked to 67028 and J-Code (s)
- On the CMS-1500 claim form in item
  - 24a or EDI loop 2410: 11-digit NDC code in 5-4-2 format, preceded by "N4" qualifier
  - 19 or EDI equivalent: Description of medication and dosage per insurance guidelines (e.g. Avastin)



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# Academy Resources

- Download the Intravitreal Injection Documentation Checklist

- [aao.org/retinapm](http://aao.org/retinapm)

- Documentation Checklists

- Intravitreal Injection & Anti-VEGF Drug Treatment
- Fluorescein Angiography and Fundus Photography
- Fluorescein Angiography and Indocyanine Green Angiography Combined Checklists
- Indocyanine Green Angiography Documentation Checklist
- Retina OCT Documentation Checklist
- Photodynamic (PDT) Laser
- Eye visit code checklist

- Proactive Audit Preparedness

- Competency Questions and Answers
- ICD-10 Linkage Documentation
- Medical Chart Review Standards
- Medical Necessity
- Reality of Third-Party Payer Audits



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# Begin Internal Audit Today! Now!



Identify areas of vulnerability.



Take immediate corrective action.



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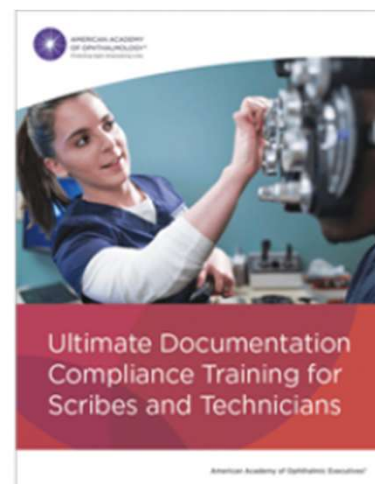
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## Coding is a Team Sport

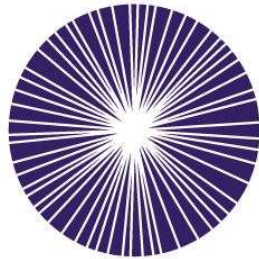
- Websites
  - [aao.org/retinapm](http://aao.org/retinapm)
  - [aao.org/lcds](http://aao.org/lcds)
  - [aao.org/em](http://aao.org/em)
- Products [aao.org/store](http://aao.org/store)
  - Retina Coding: Complete Reference Guide
- Coding Courses
  - Codequest – [aao.org/codequest](http://aao.org/codequest)
  - Fundamentals of Ophthalmic Coding
    - Virtual course, February 26



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