American Academy of Ophthalmic Executives®

Checklist: Intravitreal Injections Documentation and Coding Guidelines

Reviewed August 2022.

Reminder: Update per payer guidelines.

Chart Documentation

- ☐ 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 and/or FDA indication
- ☐ 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 in mg and mL
  - Diagnosis
  - Physician signature
- ☐ Interval of administration is appropriate per the 28-day rule
- ☐ 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, (eg, Avastin 1.25 mg/0.05 mL) and lot number
  - For Single-use vials or syringes, record wastage 1 unit or greater (eg, Triesence)
  - For wastage less than 1-unit document: *"any residual medication less than one unit has been discarded."* (eg, EYLEA)
  - Consent completed for injection, medication and eye(s) on file and updated annually
  - For initial treatment using a medication for off-label use, an informed consent with that notification is completed. (eg, Avastin)
  - Advance Beneficiary Notice (ABN) for Medicare Part B beneficiaries or waiver of liability (all other patients) is completed, if applicable (eg, diagnosis not indicated, exceeds frequency)
- ☐ Chart record is legible and has patient identifiers (eg, 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, and the related practice policy is readily available for audits
- ☐ Abbreviations are consistent with an approved list and readily available for audits
- ☐ Maintain legible inventory logs and medication administration records (MAR)

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 code for the medication
- ☐ Appropriate units administered (ie, EYLEA 2 units)
- ☐ HCPCS code on a second line for wasted medication, if appropriate
  - JW modifier appended
- ☐ Medically necessary ICD-10 code appropriately linked to 67028 and HCPCS code(s)
- ☐ On the CMS-1500 claim form **in** item
  - 24a or EDI loop 2410: 11-digit NDC code in 5-4-2 format, proceeded by “N4” qualifier followed by unit of measurement (UOM), ML and appropriate amount. (e.g., ML0.05)
    - Example, Avastin: N450242006001 ML0.05
  - 19 or EDI equivalent: Description of administration method, medication and dosage per insurance guidelines and when reporting a miscellaneous HCPCS code (eg, Avastin)

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