AMERICAN ACADEMY OF OPHTHALMOLOGY®

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Checklist: Intravitreal Injections Documentation and Coding Guidelines

Revised September 2023

Reminder: This checklist should be updated 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 their response to the current medication and the reason for continuing it.
  - 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
- ☐ Documentation showing that the patient desires surgery
- ☐ Physician's order that 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 that includes:
  - Diagnosis
  - Route of administration (intravitreal injection) and medication name
  - Site of injection (which eye(s) treated)
  - Dosage in mg and volume in mL, (eg, Avastin 1.25 mg/0.05 mL) and lot number
  - For single-dose vials or syringes, record of wastage of 1 unit or greater (eg, Visudyne)
  - For wastage of 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 involving off-label use of a medication (eg, Avastin), a complete informed consent form with that notification
  - A completed Advanced Beneficiary Notice of Noncoverage (ABN) for Medicare Part B beneficiaries or a waiver of liability all other patients, if applicable (eg, diagnosis not indicated, exceeds frequency)
- ☐ Medical record that is legible and has patient identifiers (eg, patient's name, date of birth) on all pages
- ☐ A legible physician's signature
- ☐ Paper medical records with a signature log
- ☐ Electronic Health Record with a secure electronic physician signature and a related practice policy that is readily available for audits
- ☐ Abbreviations that are consistent with an approved list and are readily available for audits
- ☐ Well-maintained, legible inventory logs and medication administration records (MARs)

Coding Injections

- ☐ CPT 67028, eye modifier appended (-RT or -LT)
  - Bilateral injections billed with modifier -50- per payer guidelines (Medicare Part B claims billed with 67028 -50 on one line, fees doubled and 1 unit)
- ☐ A HCPCS code for the medication
  - Append JZ modifier to the HCPCS code for single-dose vials and no wastage
- ☐ Appropriate units administered (ie, EYLEA 2 units)
- ☐ A HCPCS code with modifier -JW appended on the second line for wasted medication, if appropriate
- ☐ Medically necessary ICD-10 code appropriately linked to 67028 and HCPCS code(s)
- ☐ On the CMS-1500 claim form **in** item
  - 24a or Electronic Data Interchange (EDI) loop 2410: 11-digit NDC code in 5-4-2 format, preceded by N4 qualifier followed by unit of measurement (UOM), ML and appropriate amount. (eg,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)