CHAPTER 8
INJECTIONS AND DRUGS

CODING CORRECTLY FOR INJECTIONS AND DRUGS

Injection CPT Code Options

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
<th>GLOBAL PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>66020</td>
<td>Injection, anterior chamber of eye (separate procedure); air or liquid</td>
<td>10 days</td>
</tr>
<tr>
<td>66030</td>
<td>Injection, anterior chamber of eye (separate procedure); medication</td>
<td>10 days</td>
</tr>
<tr>
<td>67028</td>
<td>Intravitreal injection of a pharmacologic agent (separate procedure)</td>
<td>0 days</td>
</tr>
<tr>
<td>67500</td>
<td>Retrobulbar injection; medication (separate procedure, does not include supply of medication)</td>
<td>0 days</td>
</tr>
<tr>
<td>67505</td>
<td>Alcohol</td>
<td>0 days</td>
</tr>
<tr>
<td>67515</td>
<td>Injection of medication or other substance into Tenon’s capsule</td>
<td>0 days</td>
</tr>
<tr>
<td>68200</td>
<td>Subconjunctival injection</td>
<td>0 days</td>
</tr>
</tbody>
</table>

CODING GUIDELINES FOR INJECTIONS

Use the appropriate Healthcare Common Procedure Coding System (HCPCS) based on code descriptor.

- Not Otherwise Classified (NOC) codes should only be reported for those drugs that do not have a valid HCPCS code which describes the drug being administered.
- Remarks are required in box 19 to include dosage, name of drug, and route of administration and possibly the National Drug Code (NDC) number.
- Many NDC numbers listed on drug packaging has a 10-digit format. This number is needed for claims to be processed correctly when submitting for drugs used. However to be recognized by payers, it must be formatted into an 11-digit 5-4-2 sequence. This requires a zero to be placed in a specific position to meet the 5-4-2 format requirement. Most systems automatically remove the dashes.

<table>
<thead>
<tr>
<th>10-DIGIT CODE</th>
<th>DRUG</th>
<th>NDC CODE</th>
<th>NEW FORMAT</th>
<th>NDC CODE FOR PAYER</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-3-2</td>
<td>Avastin 100 mg vial</td>
<td>50242-060-01</td>
<td>5-4-2</td>
<td>50242-0060-01</td>
</tr>
<tr>
<td>5-3-2</td>
<td>Eylea 2mg/0.05mL vial</td>
<td>67555-005-02</td>
<td>5-4-2</td>
<td>67555-0005-02</td>
</tr>
</tbody>
</table>

- You cannot bill for drugs that can be self-administered. The injection must be administered by a physician.
- If there is no expense to the physician for the drug, don't bill for it.
- Units of drugs must be accurately reported in terms of dosage specified in the HCPCS descriptor.
- Do not bill units based on the way the drug is packaged, stored, or stocked.
- Do not bill for the full amount of a drug when it has been split between two or more patients. Bill only for the amount given to each patient.
- When combining drugs for a single injection, practices must bill each drug individually on separate claim lines.

To order a HCPCS book visit aao.org/store.

Single Use Vials

Whether there is wastage or not, submit the number of units assigned to the drug. See Figure 22 For example:

- Avastin 1 unit or 5 units
- EYLEA 2 units
- JE TREA 3 units
- Lucentis 3 units or 5 units
- Ozurdex 7 units
Chapter 8: Injections and Drugs

Multiple Use Vials

Insurance companies will only pay for the amount administered to the patient and will not pay for any discarded amounts of the drug. See Figure 23

Calculate Average Sales Price (ASP) and Units

Quarterly, CMS publishes the Medicare Part B Drug Average Sales Price (ASP) on their website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2019ASPFiles.html

The CMS allowable per drug is calculated at 106 percent of the ASP based on the drug manufacturer data. Each drug is assigned a payment limit and the HCPCS dosage and description can be confirmed on their published spreadsheet. When reviewing the ASP file, identify for each drug the following:

• Appropriate J-Code for the medication;
• Description and dosage;
• Payment limit (allowable) per unit.

The dosage per the HCPCS descriptor would be the minimum dosage and would be considered one unit. From the indicator, calculate the units per the following:

<table>
<thead>
<tr>
<th>If dosage administered is...</th>
<th>and HCPCS description of drug is...</th>
<th>Your units billed is...</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mg</td>
<td>6 mg</td>
<td>1 unit</td>
</tr>
<tr>
<td>200 mg</td>
<td>50 mg</td>
<td>4 units</td>
</tr>
<tr>
<td>10 mg</td>
<td>1 mg</td>
<td>10 units</td>
</tr>
<tr>
<td>1 mg</td>
<td>10 mg</td>
<td>1 unit</td>
</tr>
</tbody>
</table>

Example:
Lucentis per the CMS ASP pricing for the fourth quarter of 2019 shows a payment limit of 352.174 per unit. For an injection of 0.5 mg of Lucentis the total allowable would be 1760.87.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>HCPCS Code Dosage</th>
<th>Payment Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2778</td>
<td>Ranibizumab injection</td>
<td>0.1 mg</td>
<td>352.174</td>
</tr>
</tbody>
</table>

Reporting Units of Drugs—Examples

Reminder: Documentation in the patient’s medical record must reflect the drug and dosage.

Example 1: HCPCS description of drug is 6 mg
• 6 mg are administered—1 unit is billed

Example 2: HCPCS description of drug is 50 mg
• 200 mg are administered—4 units are billed

Example 3: HCPCS description of drug is 1 mg
• 10 mg vial of drug is administered—10 units are billed

Example 4: When billing a NOC drug
• Submit 1 for the units. In Box 19 of the CMS 1500 form or electronic equivalent indicate the exact name of the drug and the dosage. For example, Part B Avastin claims, enter “Intravitreal bevacizumab, [dose] mg” in Item 19 of CMS-1500 claim form or in Loop 2300 or 2400, NTE, 02 for electronic claims.

Drug Wastage

• If the remainder of a single use vial must be discarded after being administered, insurance will cover the amount discarded as well as the amount administered.
• The amount ordered, administered, and the amount discarded must be documented in the medical record.
• Reminder: payment for discarded drugs only applies to single use vials.
• Modifier -JW identifies unused/wasted drug. The medical record must document the amount administered and the amount wasted however.
• Effective January 1, 2017 the OIG requires reporting measurable drug wastage greater than one unit.
• If the remainder of a vial must be discarded after being administered, insurance will cover the amount discarded as well as the amount administered.
• The amount ordered, administered and the amount discarded must be documented in the medical record.
• Modifier –JW identifies unused/wasted drug for single dose vials.

Example:
– Trience 40 units
– J3300 1 unit injected
– J3300 -JW 39 units wasted
• Other drugs document “any residual medication less than 1 unit has been discarded”

COMPOUNDED DRUGS

• Compounded drugs do not have a National Drug Code number (NDC).
CHECKLIST/GUIDE FOR CHART DOCUMENTATION
(Update per payer guidelines)

- Diagnosis supporting medical necessity and appropriate indication for use
- Any relevant diagnostic testing services, with interpretation and report
- Risks, benefits and alternative discussed
- Physician's order includes:
  - Date of service
  - Medication name and dosage
  - Diagnosis
  - Physician signature
- Interval of administration is appropriate such as 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, (i.e., Avastin 1.25 mg@ 0.05 ml) and lot number
  - Single-use medications record wastage greater than 1 unit (i.e., Triesence)
  - For wastage less than 1 unit document: “any residual medication less than one unit has been discarded.”
  - 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. (ie Avastin)
  - Advance Beneficiary Notice (ABN) for Medicare Part B beneficiaries or waiver of liability (all other patients) is completed if applicable
- Chart record is legible and has correct patient name and date of birth
- 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

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 insurance claim in box 24a or EDI loop 2410
  - 11 digit NDC code in 5-4-2 format
  - Description of dosage per insurance guidelines

Figure 28 Checklist for Chart Documentation
## COMMON SURGICAL CASES (continued from previous page)

<table>
<thead>
<tr>
<th>CASE #</th>
<th>SURGERY</th>
<th>DIAGNOSIS</th>
<th>HPC RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Pars plana vitrectomy, preretinal membrane peel, fluid/gas exchange, laser or cryo</td>
<td>Sterile endophthalmitis</td>
<td>67041</td>
</tr>
<tr>
<td>53</td>
<td>Pars plana vitrectomy, fluid/gas exchange, laser or cryo</td>
<td>Sterile endophthalmitis</td>
<td>67039 or 67040 depending on laser type</td>
</tr>
<tr>
<td>54</td>
<td>Pars plana vitrectomy, laser or cryo</td>
<td>Sterile endophthalmitis</td>
<td>67039 or 67040 depending on laser type</td>
</tr>
<tr>
<td>55</td>
<td>Subretinal tPA and bss, with air/fluid exchange</td>
<td>Exudative macular degeneration, subretinal hemorrhage</td>
<td>67036</td>
</tr>
<tr>
<td>56</td>
<td>Pneumatic displacement</td>
<td>Submacular hemorrhage, Vitreo-macular traction (VMT)</td>
<td>67025 and 65800</td>
</tr>
</tbody>
</table>

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### Coding for Pneumatic Cases

**What is the Diagnosis?**

- Retinal detachment
- Subretinal hemorrhage
- Vitreomacular traction (VMT)

**67110**

Pneumatic retinopexy

**67025**

Injection of vitreous substitute and

**65800**

Paracentesis of anterior chamber

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Figure 30  Coding for Pneumatic Cases
Figure 32 Diagnosis Flow Chart (continued)

- **What is the Diagnosis?**
  - Retinal detachment (RD)
  - Diabetic: retinopathy, edema, hemorrhage
  - Type of RD?
    - A. Partial, total, or subtotal (See Legend on page 434)
    - B. Traction detachment
    - C. Non-diabetic
    - D. Non-diabetic

- **Diagnosis of RD?**
  - Internal limiting membrane (ILM) peel?
    - Yes
    - NO
    - w/ vitrectomy AND membrane peel?
      - Yes
      - NO
      - Laser?
        - Yes
        - NO
        - 67040 Complex RD
          - 67041 PPV with membrane peel
          - 67042 PPV with removal of ILM
    - 67113 Complex RD
      - 67107 Scleral buckle (SB)
      - 67108 Pneumatic retinopexy; air or gas

- **Coding Tip:**
  - It is common practice to stage (-58 mod) the repair of RD codes (lesser to greater):
    - 67107-67110-67108

- **Membrane peel?**
  - NO
  - Yes
    - Diabetic: retinopathy, edema, hemorrhage
    - NO
    - Yes
      - Laser?
        - Yes
        - NO
        - 67040 Complex RD
          - 67041 PPV with membrane peel
          - 67042 PPV with removal of ILM