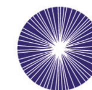
CODING ADVISOR

A Collaboration Between *Retina Today* and 

SUCCESSFULLY CODING RETINA INJECTABLE DRUGS

Follow these procedures to ensure accurate coding.

BY JOY WOODKE, COE, OCS, OCSR

Accurately coding injectable drugs in order to receive appropriate reimbursement is dependent on completing a number of specific steps. Adhering to the procedure outlined in this article will ensure that your internal process for coding for retina injectable drugs is comprehensive.

IDENTIFY THE APPROPRIATE J-CODE

Each medication has a Healthcare Common Procedure Coding System (HCPCS) code used for coding and billing. This standardized coding system is used for services not addressed by the Common Procedural Terminology (CPT) code set, including durable medical equipment, supplies, and medications. Most of the medications used for intravitreal injections are assigned an HCPCS code represented with a first character of J, and so sometimes called a *J-code*. (There are exceptions for facility claims, which begin with C.)

Each HCPCS code denotes a specific drug name, dosage, and route of administration.

For example, the aflibercept (Eylea, Regeneron) HCPCS description is: J0178 injection, aflibercept, 1 mg. This detailed description can be identified in an HCPCS coding book or in the CMS average sales price (ASP) drug pricing files for the current year, which can be found at cms.gov/Medicare/Medicare-Fee-for-Service-Part-B Drugs/McrPartBDrugAvgSalesPrice/2019ASPFiles.html, or at **bit.ly/Woodke0419**.

CONFIRM SINGLE-USE OR MULTIDOSE VIALS

All injectable drug vials are designated as either single-use or multidose. This can be identified on the package insert or the vial itself. Most important, providers should identify the injectable drug's number of units and whether billing for wastage is appropriate.

For single-use vials (eg, triamcinolone acetonide [Triesence, Alcon]), the units injected are billed with the appropriate J-code, along with any

AT A GLANCE

- Accurately coding injectable drugs in order to receive appropriate reimbursement is dependent on completing specific steps.
- One must identify the appropriate J-code, confirm single-use or multidose vials, identify the NDC code, review documentation, calculate average sales price and units, and review the medication inventory log before coding the injection.

TABLE 1. CONVERTING NDC NUMBERS TO 11-DIGIT FORMATS				
Drug	NDC Format	NDC Code	NDC Claim Format	NDC Code for Claim
Ranibizumab 0.5 mg	5-3-2	50242-080-03	5-4-2	50242-0080-03
Triamcinolone acetonide	4-4-2	0003-0293-28	5-4-2	00003-0293-28

Abbreviations: NDC, National Drug Code

TABLE 2. CMS ASP PRICING CHANGES TO TRIAMCINOLONE ACETONIDE INJECTABLE SUSPENSION (J3300) AND AFLIBERCEPT (J0178)		
Date	Triamcinolone acetonide injectable suspension (J3300) ASP per 1 unit	Aflibercept (J0178) ASP per 1 unit
Q1 2017	$3.72	$980.38
Q2 2017	$3.74	$980.14
Q3 2017	$3.89	$978.09
Q4 2017	$3.89	$978.09
Q1 2018	$3.87	$971.95
Q2 2018	$3.87	$968.79
Q3 2018	$3.86	$967.67
Q4 2018	$3.86	$967.33
Q1 2019	$3.86	$963.54

Abbreviations: ASP, average sales price; CMS, Centers for Medicare and Medicaid Services

wasted medication greater than 1 unit. Billing for wasted medication is submitted with the same J-code on a second line and with a -JW modifier. For multidose vials (eg, triamcinolone acetonide [Kenalog, Bristol-Myers Squibb]), only the units injected are billed.

COMPOUNDED DRUGS

When medication is compounded at a pharmacy into a single-dose syringe, many insurance carriers prefer the unlisted J-codes J3490 or J3590. When these are used, the description of the medication and dosage should be indicated in box 24a of the CMS-1500 form or EDI loop 2410.

Bevacizumab (Avastin, Genentech) is a compounded drug when used in ophthalmology, and each insurance carrier may have a preferred J-code to use based on its policy. Many Medicare Administrative Contractors may have a local coverage determination or local coverage article that specifies the approved J-code. Commercial, Medicare Advantage, and Medicaid plans may prefer other codes for claim submission. The options for bevacizumab coding include J9035, J3490, J3590, and J7999.

IDENTIFY THE NATIONAL DRUG CODE

The National Drug Code (NDC) is a unique 10-digit, three-segment number assigned to each medication. The NDC can be identified on the vial or confirmed in the NDC directory at accessdata.fda.gov/scripts/cder/ndc/index.cfm.

NDC numbers may originate as a 5-3-2 or 4-4-2 format. Although the NDC is a 10-digit number, most insurance carriers require a conversion to a 5-4-2 format, totaling 11 digits. To convert to the 5-4-2 format, a zero is added to the appropriate segment, as shown in red in Table 1.

REVIEW DOCUMENTATION

Chart documentation should be evaluated to confirm that all necessary requirements are completed per insurance payer guidelines. For services provided to Medicare beneficiaries, reference the current Medicare local coverage determination, which can be found at aao.org/lcds. Commercial, Medicare Advantage, and Medicaid payers may have policies on their websites or in provider manuals for reference.

The checklist on the next page can be used as a guide and can be updated based on payer guidelines.

CALCULATE ASP AND UNITS

According to CMS, the allowable payment per drug is typically calculated at 106% of the ASP, based on the drug manufacturer's data. Each drug is assigned a payment limit, or *allowable*, and the HCPCS dosage is confirmed on the CMS ASP drug pricing published spreadsheet. The published data for aflibercept in the first quarter of 2019, for example, shows an HCPCS code dosage of 1 mg and a payment limit of $963.537 per unit billed.

Because the ASP is adjusted quarterly, it is crucial to monitor updates to the payment limits. Table 2 illustrates how these prices change over time. Although triamcinolone acetonide injectable suspension (J3300) has maintained a fairly consistent allowable from the first quarter of 2017 to the first quarter of 2019, aflibercept (J0178) has had a $16.84 reduction per unit over the same period.

When you review the ASP file, identify the appropriate J-code for each medication, the description and dosage,

Checklist for Chart Documentation Prior to Billing for an Injectable Drug

- ○ Diagnosis supporting medical necessity and appropriate indication for use.
- ○ Any relevant diagnostic testing services, with interpretation and report.
- ○ Risks, benefits, and alternatives discussed with patient.
- ○ Physician order including:
  - ▪ Date of service;
  - ▪ Medication name and dosage;
  - ▪ Diagnosis;
  - ▪ Physician signature.
- ○ Interval of administration 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, (ie, bevacizumab 1.25 mg @ 0.05 mL) and lot number;
  - ▪ For single-use medications (eg, triamcinolone acetonide injectable suspension), record wastage greater than 1 unit;
  - ▪ For wastage less than 1 unit, document: "Any residual medication less than 1 unit has been discarded."
  - ▪ Consent completed for injection, medication, and eye(s) on file;
  - ▪ For initial treatment using a medication with off-label use (eg, bevacizumab), an informed consent with that notification is completed;
  - ▪ Advance Beneficiary Notice 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;
  - ▪ For EHR, the electronic physician signature is secure.
- ○ Abbreviations are consistent with approved list and readily available for audits.

TABLE 3. UNDERSTANDING UNITS BILLED PER DOSAGE	
Scenario	**Example**
Dosage is the same as the HCPCS code descriptor.	HCPCS description of drug is 6 mg; 6 mg is administered; 1 unit is billed.
Dosage is more than the HCPCS code descriptor.	1. HCPCS description of drug is 50 mg; 200 mg is administered; 4 units are billed. 2. HCPCS description of drug is 1 mg; 10 mg is administered;10 units are billed.
Dosage is less than the HCPCS code descriptor for 1 unit (minimum dosage).	HCPCS description of drug is 10 mg; 1 mg is administered; 1 unit is billed.
Abbreviations: HCPCS, Healthcare Common Procedure Coding System	

and the payment limit per unit. The dosage per the HCPCS descriptor is the minimum dosage and is considered 1 unit. Then, calculate the units according to the examples provided in Table 3.

Using this method, when coding the injection of ranibizumab 0.3 mg, for example, first review the ASP description.

Ranibizumab has a minimum dosage of 0.1 mg. If 0.3 mg is injected, then submit 3 units. This dosage is a single-use vial but does not have wastage greater than 1 unit, so no wastage would be billed. The medication would be billed as: J2778 3 units x 363.979 = $1091.94 total reimbursement.

The appropriate coding for triamcinolone acetonide injectable suspension would be determined from the ASP descriptor to identify the minimum dosage and single unit, which is 1 mg. Triamcinolone acetonide injectable suspension is a single-use vial of 40 mg. If 1 mg of triamcinolone acetonide injectable suspension is injected and 39 mg is wasted, submit a total of 40 units as:

J3300 1 unit x 3.855 = $3.86
J3300-JW 39 units x 3.855 = $150.35
Total reimbursement = $154.21

Confirm that the documentation for the injection of triamcinolone acetonide injectable suspension clearly states the appropriate dosage injected and wasted and that it is accurately reflected on the claim submission.

The payment limit per the CMS ASP drug pricing is the allowable for Medicare Part B claims. For commercial, Medicare Advantage, and Medicaid payers, reimbursement may be based on your contract. Some payers may calculate it as a percentage of the CMS ASP pricing or of your usual and customary fee.

REVIEW THE MEDICATION INVENTORY LOG

A review of the current medication inventory log your office uses to track the purchase and dispensing of medications is best practice. The record should include the invoice number, date of purchase, drug name and dosage, lot number, expiration date, patient name, and date of service administered, and it should be consistent with the chart documentation as applicable.

Additionally, a periodic comparison of the inventory log and medication billing reports should be completed to identify any discrepancies. If you are using a computerized inventory system, then a report can usually be produced to confirm that the medication dispensed matches the medication billed for a specific reporting period.

CODE THE INJECTION

After you review the steps for appropriately coding injectable drugs, you can bill for the procedure. Following is an outline for coding your procedure.

- CPT 67028, eye modifier appended (-RT or -LT). Bilateral injections are billed with a -50 modifier per payer guidelines. Medicare Part B claims are billed with 67028-50 on one line, fees doubled, and 1 unit;
- HCPCS J-code for medication;
- Appropriate units administered (eg, aflibercept 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.

For example, an injection of aflibercept in the right eye with a diagnosis of active exudative age-related macular degeneration with choroidal neovascularization would be coded as 67028-RT, J0178, 2 units, H35.3211.

PUT IT INTO PRACTICE

I hope this outline of the steps involved in coding retina injectable drugs will prove helpful in your practice. ■

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