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HOW TO DOCUMENT INJECTIONS WITH EASE

Focus on these five aspects to ensure you sail through a Medicare audit.

BY JOY WOODKE, COE, OCS, OCSR

Because intravitreal injections are such an integral part of every retina practice, with high utilization, they remain a common target for payer audits. Recently, Medicare has been conducting service-specific probes—Targeted Probe and Educate (TPE) and Supplemental Medical Review Contractor—and other focused reviews of intravitreal injection coding and documentation.

The published CMS reports from these audits and the lessons shared by your colleagues have brought to light five areas of your documentation that are vulnerable to deficiencies. Let's review these areas and ways to ensure your documentation is rock solid.

FIVE AREAS TO SCRUTINIZE

1 Procedure Note

Review the intravitreal injection procedure note and confirm that the required elements are included based on the AAO's intravitreal injection checklist (see *Where to Find Documentation Guidelines*). If the auditor determines that the procedure note is missing or incomplete, this will result in a failed chart audit. Deficiencies can include no description of the procedure, an incorrect diagnosis, or a missed notation of the eye injected.

Each electronic health record system may display the procedure note differently. If your printed chart note includes the data but doesn't define it as a procedure note or includes it on different pages, the auditor may not recognize that the data has been appropriately documented. If this is the case, provide an audit letter summary to guide the auditor through your note and identify the required entries.

2 Medication Dosage

Continue to take a close look at the procedure note, and focus on the documentation of the medication dosage. The auditor is looking for a complete record that includes the medication name and the dosage in mg and mL. Even if the medication is a single-use prefilled syringe and the dosage is always the same, it must be included in the chart record. For example, a syringe of aflibercept (Eylea, Regeneron) is always 2 mg/0.05 mL, and that information should still be included in the chart.

Auditors have also reported deficiencies and failed audits for medication recorded in mL only. As the Healthcare Common Procedure Coding System (HCPCS) codes for the medication used are defined by mg, the auditor will need to confirm both the mg and mL. This should be reflected in the coding and units reported based on the HCPCS descriptor.

3 Covered Diagnosis

Confirm that the indication for the intravitreal injection is documented in the procedure note. The review will include confirmation of a covered diagnosis based on the published policy or FDA label indications. If the diagnosis is included in the plan but not in the procedure note, this may be considered a failure. Make sure it appears in both places.

PREPARING FOR THE INEVITABLE AUDIT IS ESSENTIAL, AS IT IS NOT A MATTER OF IF, BUT WHEN, YOUR PRACTICE RECEIVES THE DREADED MEDICARE ADR—THE ADDITIONAL DOCUMENTATION REQUEST.

4 Wastage

Include the amount of drug injected and wasted in your chart documentation. This should mirror the coding on the claim that is submitted to the payer. For single-use vials of medication with measurable wastage of 1 unit or greater, such as for triamcinolone acetonide injectable suspension (Triesence, Alcon) and verteporfin (Visudyne, Bausch + Lomb), report the medication injected and appropriate units with the HCPCS code, and, on a second line, report the HCPCS code with a -JW modifier and the remaining units discarded. Incorrectly reporting on the claim and not documenting wastage can prompt an audit—and a failure. For more information, visit the AAO's Coding for Injectable Drugs at www.aao.org/practice-management/coding/injectable-drugs.

For single-use vials of medication without measurable wastage of 1 unit or greater (eg, aflibercept and ranibizumab [Lucentis, Genentech/Roche]), include in the procedure note "residual medication less than 1 unit was discarded." This communicates to the auditor that there was no wastage to document or report and eliminates additional requests for wastage documentation or even worse, audit failures. However, there have been reported cases of this scenario where the retina specialist had to send multiple letters stating there was no measurable wastage to report as the chart note did not clearly indicate.

5 Frequency

Remember that Medicare generally covers intravitreal injections every 28 days. For treatments sooner than 4 weeks, it will deny the claim or recoup in an audit. Additionally, Medicare policies often reference the FDA label frequency (eg, Palmetto A53387, the local coverage article for aflibercept).[1]

Recently, there have been TPE audits focused on brolucizumab-dbll (Beovu, Novartis). The recommended frequency per the FDA label for this medication is unique, which often prompts a review for treatments outside these parameters. For wet AMD, the recommendation is monthly (every 25–31 days) for the first three doses, followed by one dose every 8 to 12 weeks.[2] When treating diabetic macular edema, the recommendation is every 6 weeks for the first five doses, followed by one dose every 8 to 12 weeks. Submitting claims outside these guidelines can prompt audits and requests for medical literature supporting the treatment, along with the usual documentation.

IN THE FUTURE

Focusing on these five common deficiencies and improving documentation will contribute to a successful Medicare audit. In addition, holding frequent internal audits and using the AAO's intravitreal injection checklist and Medicare policies will ensure that you are including all of the required elements within your documentation. Preparing for the inevitable audit is essential, as it is not a matter of if, but when, your practice receives the dreaded Medicare ADR—the additional documentation request. ■

1. Billing and coding: aflibercept (Eylea). Accessed October 6, 2022. CMS.gov
2. Beovu package insert. Accessed October 6, 2022. www.novartis.com/us-en/sites/novartis_us/files/beovu.pdf

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WHERE TO FIND DOCUMENTATION GUIDELINES

Medicare published policies—local coverage determinations or articles—for intravitreal injections (found at aao.org/lcds) include documentation requirements, frequency limitations, and indications.

The AAO has also published a checklist for intravitreal injection documentation and coding (at aao.org/retinapm) that provides the key components required for documentation and outlines the correct coding.