

ILUVIEN CODING: PHYSICIAN OFFICE (POS 11)

The following table provides an overview of potential codes that may be used when billing for ILUVIEN in the physician office setting.

ILUVIEN Coding – Physician Office (POS 11 – Office)				
	Type of Code	Code + Laterality (1 - right, 2 - left, 3 - bilateral)	Descriptor	Notes
Patient Diagnosis	ICD-10-CM <i>Effective January 1, 2017</i>	E08.311_, E08.321_, E08.331_, E08.341_, E08.351_ E09.311_, E09.321_, E09.331_, E09.341_, E09.351_ E10.311_, E10.321_, E10.331_, E10.341_, E10.351_ E11.311_, E11.321_, E11.331_, E11.341_, E11.351_ E13.311_, E13.321_, E13.331_, E13.341_, E13.351_	Diabetes mellitus + ophthalmic complications + diabetic retinopathy + diabetic macular edema	In ICD-10-CM, a single code describes diabetic macular edema
Injection Procedure	CPT	67028	Intravitreal injection of pharmacologic agent, separate procedure	Use modifiers -RT and -LT to indicate which eye was injected
ILUVIEN	HCPCS	J7313	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	Each ILUVIEN implant contains a fixed dose of 0.19 mg and should be billed as 19 units using J7313 (the HCPCS billing unit for J7313 is 0.01 mg) See payer-specific guidelines to determine drug code requirements
	NDC	68611-190-02 (10 - digit) 68611-0190-02 (11 - digit)	Fluocinolone acetonide intravitreal implant, 0.19 mg	See payer-specific guidelines for submitting 11 - digit NDC

Note: Providers should use clinical judgment when selecting codes and should use the codes that most accurately represent the services delivered. The coding information presented here should not be construed as legal advice or a guarantee of payment.

HCPCS Coding in the Physician Office – Additional Considerations

Effective January 1, 2016, ILUVIEN was assigned a unique HCPCS J-code, J7313. The descriptor of J7313 is “Injection, fluocinolone acetonide intravitreal implant, 0.01 mg.”

It is important to note that the HCPCS billing unit for J7313 is 0.01 mg. Each ILUVIEN implant contains a fixed dose of 0.19 mg and should be billed as 19 units using J7313 for appropriate reimbursement.

While it is not required to include additional information in Box 19, it is recommended that you include the product NDC which is 68611-0190-02. You may also include the product description as a source of additional information for the payer: “Injection, fluocinolone acetonide intravitreal implant, 0.01 mg”.

See payer-specific guidelines or consult the ILUVIEN AccessPlus Program for additional billing and coding information.

Commonly requested information includes:

- Drug name: ILUVIEN
- National Drug Code (NDC):
 - 10-digit format: 68611-190-02
 - 11-digit format: 68611-0190-02
- Route of administration: Intravitreal injection (IVT)

Please note: Providers who acquire drugs through a specialty pharmacy provider will bill only for the drug administration on the claim form. However, some payers may require the provider to include the HCPCS drug code on the claim form. To do so, enter “0” in box 24G, “Days or Units” (or electronic equivalent, Loop 2400), and “\$0.00” in box 24F, “\$ Charges” (or electronic equivalent, Loop 2400). The SPP will need to confirm with the payer to ensure the appropriate information is included in the claim form.

Check with the patient’s payer (or the **ILUVIEN AccessPlus Program**) to determine billing procedures for drugs obtained from the specialty pharmacy provider.

SAMPLE CMS-1500 CLAIM FORM (PHYSICIAN OFFICE BILLING)

HEALTH INSURANCE CLAIM FORM										CARRIER	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
PICA											
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John D			3. PATIENT'S BIRTH DATE MM DD YY XX XX XX M F			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John D					
5. PATIENT'S ADDRESS (No., Street) 1234 Anystreet				6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street)					
CITY Anytown		STATE AS		8. RESERVED FOR NUCC USE		CITY		STATE			
ZIP CODE 12345		TELEPHONE (Include Area Code) (xxx) xxx-xxxx				ZIP CODE		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. INSURED'S DATE OF BIRTH MM DD YY		SEX M F			
PRODUCT INFORMATION (Box 19) Include product NDC for ILUVIEN: 68611-0190-02 Additional Information (Optional): ILUVIEN, Injection, fluocinolone acetonide intravitreal implant, 0.01 mg, one implant				DIAGNOSIS CODE (Box 21) Enter appropriate ICD-10-CM diabetic macular edema code. Right eye example: E11.3411		b. OTHER CLAIM ID (Designated by NUCC)					
c. INSURANCE PLAN NAME OR PROGRAM NAME				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
						SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. XX XX XX				15. OTHER DATE QUAL. MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY RELATED TO CURRENT SERVICES TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				7a. NPI		7b. NPI					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ILUVIEN (fluocinolone acetonide) 0.19 mg, NDC 68611-0190-02, IVT, one implant				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. E11.3411		ICD INDICATOR (Box 21) "0" is used for ICD-10-CM codes					
23. PRIOR AUTHORIZATION NUMBER XXXXXXXXXXXX						SERVICE UNITS (Box 24G) Report number of units used. (One implant = 19 units for J7313) Enter 0 if acquired through Specialty Pharmacy Provider.					
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS H. EPSDT Family Plan	
1 XX XX XX XX XX XX 11		J7313		A		XXX XX 19					
2 XX XX XX XX XX XX 11		67028 RT		A		XXX XX 1					
PRODUCT CODE (Box 24D) Document use of product with J7313 or other payer-specified code, as required by the payer.				MODIFIERS (Box 24D) Document eye that was treated using modifiers (-RT) right side or (-LT) left side, as required by payer.		DIAGNOSIS CODE (Box 24E) Specify diagnosis, from Box 21, relating to each CPT/HCPCS code listed.					
25. FEDERAL TAX I.D. NUMBER				30. AMOUNT PAID		30. BALANCE DUE					
31. SIGNATURE OF PHYSICIAN INCLUDING DEGREES OF (I certify that the statements apply to this bill and are me				33. BILLING PROVIDER INFO & PH # ()							
SIGNED				b.		a.		b.			

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Note: This is a sample only and is being provided for illustrative purposes only. Providers should use clinical judgment when selecting codes and should use the codes that most accurately represent the services delivered. The coding information presented here should not be construed as legal advice or a guarantee of payment.

Please see enclosed full Prescribing Information.