5101:3-4-12 **Immunizations, injections and infusions (including trigger-point injections), and provider-administered pharmaceuticals.**

(A) General provisions.

(1) "Current procedural terminology (CPT)" is a comprehensive listing of medical terms and codes published by the American medical association, www.ama-assn.org, for the uniform designation of diagnostic and therapeutic procedures in surgery, medicine, and the medical specialties. "Healthcare common procedure coding system (HCPCS)" is a numeric and alphanumeric code set maintained and distributed by the Centers for Medicare & Medicaid Services (CMS), www.cms.gov, for the uniform designation of certain medical procedures and services.

(2) A "not otherwise specified," "unlisted," or "miscellaneous" procedure code should be reported on a claim only if no procedure code is available that identifies the particular service or item provided.

(3) An immunization, injection, infusion, vaccine, toxoid, or provider-administered pharmaceutical is not separately reimbursable as a physician service or a clinic service if it is provided in a hospital setting (inpatient hospital, outpatient hospital, or hospital emergency department).

(4) A provider-administered pharmaceutical reported on a claim submitted in accordance with Chapter 5101:3-9 of the Administrative Code is regarded as a pharmacy service rather than a physician service, and reimbursement of the claim is governed by the provisions of that chapter. For example, a vaccine, toxoid, or other provider-administered pharmaceutical prescribed for a resident of a long-term care facility (LTCF) and subsequently administered by a LTCF staff member is a pharmacy service.

(5) Reimbursement for an immunization, injection, or infusion includes payment for related supplies (e.g., alcohol wipes, needles, syringes, and tubing).

(B) Coverage of immunizations.

(1) An immunization has two components: the administration of the vaccine or toxoid (represented by a CPT code in the range from 90460 to 90474) and the vaccine or toxoid itself (represented by a CPT code in the range from 90476 to 90749). In general, medicaid does not allow reimbursement for the administration of a vaccine or toxoid; instead, separate reimbursement may be made either for the least complex evaluation and management service (represented by CPT code 99211) or for another medical service that includes an evaluation and management element. An eligible provider specified in rule 5101:3-1-60.3, however, may receive separate reimbursement for covered immunization administration performed on a date specified in that rule.

(2) Providers participating in the federal vaccines for children (VFC) program, which is administered by the Ohio department of health (ODH), may obtain selected vaccines at no cost; reimbursement is therefore not allowed for the cost of VFC-designated vaccines obtained from a source other than ODH. In addition to reimbursement for an evaluation and management service, described in paragraph (B)(1) of this rule, participating VFC providers may receive a supplemental fee for each VFC-designated vaccine they administer.

(3) Limitations based on age or gender apply to certain vaccines.

(a) Regardless of the formulation, hepatitis B vaccine (HBV) administered to individuals younger than nineteen years of age is reimbursable only under the VFC program. Different procedure codes must be reported on claims to distinguish HBV administered to individuals younger than nineteen from HBV administered to individuals nineteen or older.

(b) The quadrivalent vaccine for the human papilloma virus (HPV) is covered for both males and females from nine through twenty-one years of age. For both males and females who are eligible for medicaid only through the family planning services benefit, coverage extends through twenty-six years of age.

(c) The bivalent vaccine for HPV is covered for females from nine through twenty-one years of age. For females who are eligible for medicaid only through the family planning services benefit, coverage extends through twenty-six years of age. This vaccine is not covered for males.

(C) Coverage of therapeutic, prophylactic, or diagnostic injections or infusions (excluding chemotherapy and other complex procedures).

(1) An injection or infusion has two components: the administration of a fluid medium (represented by a CPT code in the range from 96360 to 96379) and, except in the case of hydration, the pharmaceutical itself (represented by an appropriate procedure code, such as a CPT code in the range from 90281 to 90399 or a HCPCS code beginning with the letter J). No separate reimbursement is made for the administration service if an injection or infusion is given during the course of an office visit or in conjunction with another medical service that includes an evaluation and management element.

(2) Reimbursement may be made for an injection or infusion or a provider-administered pharmaceutical only if the following criteria are met:

(a) Its use for a particular indication has been approved by the U.S. food and drug administration; or

(b) According to accepted standards of medical practice, it is a specific or

effective treatment for the particular condition for which it is given.

(3) No separate reimbursement is made for an injection or infusion or a provider-administered pharmaceutical that meets either of the following criteria:

(a) The frequency or duration of its administration exceeds accepted standards of medical practice for the particular condition; or

(b) It is provided for or in association with noncovered medicaid services, which are defined in rule 5101:3-4-28 of the Administrative Code.

(4) Immune globulin is covered when it is medically necessary to provide passive immunity to an individual who is immunosuppressed; has an acquired or congenital immunodeficiency; is at risk of Rho(D) isoimmunization; or is in immediate danger of contracting hepatitis B, tetanus, or rabies through direct contact with blood, saliva, or other body fluids through an open wound, bite, puncture, or mucous membrane. Immune globulins include nonspecific human serum globulin and specific hyperimmune globulins such as hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, and varicella-zoster. "Not otherwise specified" or "unlisted" immune globulin is not reimbursable.

(5) Epoetin alfa (EPO) for the treatment of anemia, either associated with or not related to chronic renal failure, is covered as a physician service when a provider of physician services incurs the cost of the drug and the service is provided in a clinic (e.g., a renal dialysis facility) or office setting.

(a) The appropriate procedure code must be reported on a claim.

(b) For each one thousand units of EPO administered (rounded to the nearest thousand), one unit of service must be reported on a claim.

(6) Certain procedure codes represent a specific number of dosage units. On a claim, the fewest number of procedure codes must be reported together to represent the administered dosage.

(D) Coverage of trigger-point injections.

(1) A trigger point is a hyperexcitable area of the body, where the application of a stimulus will provoke pain to a greater degree than in the surrounding area. The purpose of a trigger-point injection is to treat not only the symptom but also the cause through the injection of a single substance (e.g., a local anesthetic) or a mixture of substances (e.g., a corticosteroid with a local anesthetic) directly into the affected body part in order to alleviate inflammation and pain. Reimbursement may be made for a trigger-point injection only if the following criteria are met:

(a) The patient must have a diagnosis for which the trigger-point injection is an appropriate treatment; and

(b) The following information must be documented in the patient's medical record:

(i) A proper evaluation including a patient history and physical examination leading to diagnosis of the trigger point;

(ii) The reason or reasons for selecting this therapeutic option;

(iii) The affected muscle or muscles;

(iv) The muscle or muscles injected and the number of injections;

(v) The frequency of injections required;

(vi) The name of the medication used in the injection;

(vii) The results of any prior treatment; and

(viii) Corroborating evidence that the injection is medically necessary.

(2) A trigger-point injection is normally considered to be a stand-alone service. No additional reimbursement will be made for an office visit on the same date of service unless there is an indication on the claim (e.g., in the form of a modifier appended to the evaluation and management procedure code) that a separate evaluation and management service was performed.

(3) Certain trigger-point injection procedure codes (e.g., CPT codes 20552 and 20553) specify the number of injection sites. For these codes, the unit of service is different from the number of injections given. Reimbursement may be made for one unit of service of the appropriate procedure code reported on a claim for service rendered to a particular patient on a particular date.

(4) Trigger-point injections should be repeated only if doing so is reasonable and medically necessary. For trigger-point injections of a local anesthetic or a steroid, reimbursement will be made for no more than eight dates of service per patient per calendar year.

(E) Reimbursement.

(1) On the Fee Schedules and Rates page of the medicaid web site (http://jfs.ohio.gov/ohp/bhpp/FeeSchdRates.stm) is a link to a list of vaccines, toxoids, and other provider-administered pharmaceuticals each of which is reimbursable by medicaid either as a physician service or as a

VFC-designated vaccine. The reimbursement amount for a covered non-VFC vaccine, toxoid, or other provider-administered pharmaceutical is the lesser of the submitted charge or the maximum allowable fee. The maximum allowable fee is the first applicable item from the following ordered list:

(a) An amount specified in or determined in accordance with the Administrative Code (e.g., the fee for a "by report" procedure);

(b) The payment limit shown in the current average sales price (ASP) medicare part B drug pricing file or the current not otherwise classified (NOC) pricing file;

(c) One hundred seven per cent of the wholesale acquisition cost (WAC); or

(d) Eighty-five and six-tenths per cent of the average wholesale price (AWP).

(2) The reimbursement amount for a covered administration service or evaluation and management service is the lesser of the submitted charge or the maximum allowable fee listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(3) The supplemental fee for each immunization provided under the VFC program is ten dollars.

(4) For dates of service January 1, 2013, and after, the reimbursement amount for medroxyprogesterone acetate reported with HCPCS procedure code J1050 is the lesser of the submitted charge or twenty-eight cents per milliliter.

Replaces: 5101:3-4-12, 5101:3-4-13

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