5101:3-4-13 **Therapeutic injections (including trigger point injections) and prescribed drugs.**

(A) Therapeutic injections or other pharmaceuticals administered during an office visit.

(1) Therapeutic injection services include the provision of the injectable.

(2) A physician may not be reimbursed for injections/drugs provided in an inpatient hospital, an outpatient hospital or a hospital emergency room department setting.

(3) A physician may be reimbursed, in addition to the office visit, for covered injections/drugs provided by and administered in the physician's office, clinic, in a patient's home, or in a long-term care facility (LTCF) when the physician purchased the injectable.

(a) Conditions for reimbursement.

(i) Reimbursement will be limited to only those injections/drugs:

(a) That have an FDA approved indication; or,

(b) Considered by accepted standards of medical practice as specific or effective treatment for the particular condition for which they are given.

(ii) Reimbursement will not be made for injections/drugs administered beyond the frequency or duration indicated by accepted standards of medical practice as an appropriate level of care for that condition.

(iii) Reimbursement will not be made for injections/drugs for or associated with noncovered medicaid services (e.g., cosmetic, fertility, or infertility).

(b) Reimbursement for therapeutic injections or other pharmaceuticals administered during an office visit.

(i) For the reimbursement of therapeutic injections/drugs, bill one of the codes listed in appendix DD to rule 5101:3-1-60 of the Administrative Code. Code numbers for injectable drugs are listed only under the generic drug name.

(ii) If there is a code available for the injectable but not for the correct dosage, to add up to the correct dosage, either bill the code (or codes) repeatedly or enter the appropriate number of units in the unit space on the invoice. The provider must use the fewest number of codes and/or unit values to obtain the correct dosage for the injection administered.

(iii) Epoetin-alfa (EPO) for the treatment of anemia associated with chronic renal failure and for the treatment of anemia not related to chronic renal failure is covered as a physician service when the physician, group practice, or clinic incurs the cost of the drug and the service is provided in a clinic (e.g., renal dialysis) or physician's office as defined in rule 5101:3-4-02.2 of the Administrative Code.

(a) For EPO administered for the treatment of anemia associated with chronic renal failure providers must bill the appropriate code listed in appendix DD to rule 5101:3-1-60 of the Administrative Code, for each one thousand units of EPO injected in accordance with paragraph (A)(3)(b)(iii)(c) of this rule.

(b) For EPO administered for anemia not associated with chronic renal failure providers must bill the appropriate code listed in appendix DD to rule 5101:3-1-60 of the Administrative Code. One unit must be billed for each one thousand units of EPO.

(c) The unit field on the claim form must indicate one unit for each one thousand units of EPO. When the dosage of EPO does not equal a multiple of one thousand units, the number of units must be rounded down if the excess is between zero and four hundred ninety-nine units or rounded up if the excess is between five hundred and nine hundred ninety-nine units. For example, when four thousand four hundred units are given, four units of service would be billed. When four thousand nine hundred units are given, five units of service would be billed.

(iv) If there is no code available for the generic drug name or the dosage is lower than the code available, use the most appropriate miscellaneous code listed in paragraph (A)(3)(b)(v) of this rule. When billing a code listed in paragraph (A)(3)(b)(v) of this rule

the national drug code (NDC) number, name of the drug/injectable, and the dosage must be provided in the remarks column of the billing invoice; all three items must be included in the remarks column for payment determination. The unit field on the claim form must indicate a unit of one. Under no circumstances should more than one miscellaneous code, as listed in paragraph (A)(3)(b)(v) of this rule, be used for the same drug on the same date of service.

(v) The following are miscellaneous codes that should only be used if there is not a specific code available, in accordance with paragraph (A)(3)(b)(iv) of this rule: J3490, J3535, J3590, J7599, J7699, J7799, J8499, J8999, J9999, ~~90779~~96379.

(4) Reimbursement for therapeutic, prophylactic, or diagnostic injections includes codes 96360 and 96361 and those ranging from code ~~90765 to 90779~~96365 to 96379 will be made only when billed with an injection code (J code) and no other service is rendered by the same provider on that day. Reimbursement is considered bundled into the payment made for an evaluation and management service (visit) or other physician service billed on the same date by the same provider. Codes 96360 and 96361 and those ranging from ~~in the range of 90765 to 90779~~96365 to 96379 are not valid for place of service inpatient hospital, outpatient hospital, or emergency room.

(B) Trigger point injections

A trigger point injection is one of the many modalities utilized in the management of chronic pain. A trigger point is an area of hyperexcitability where the application of stimulus will provoke pain to a greater degree than in the surrounding area. Injection of a corticosteroid mixed with a local anesthetic or a local anesthetic by itself, directly into the affected body part may alleviate or treat inflammation and pain. The treatment goal should be to treat not just the symptom of pain but also the cause of the pain.

(1) Criteria for reimbursement

All of the following coverage criteria must be met before this service can be reimbursed by the department:

(a) The services must be considered medically necessary;

(b) The conditions for reimbursement for therapeutic injections listed in paragraphs (A)(3)(a) to (A)(3)(a)(iii) of this rule must be met;

(c) The patient's diagnosis must support the need for the service; and,

(d) There must be documentation in the patient's medical record to confirm that a trigger point injection was provided. The following items must be documented in the patient's medical record:

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

(ii) Identification of the affected muscle(s);

(iii) Reasons for selecting this therapeutic option;

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

(v) Frequency of injections required;

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

(vii) For a follow up visit, the results of the initial treatment; and

(viii) Documentation that supports the medical necessity of the service.

(2) Limitations

(a) In accordance with CPT as defined in rule 5101:3-1-19.3 of the Administrative Code, only one unit of service will be reimbursed for codes 20552 and 20553 per patient, per date of service, per provider regardless of the number of sites or regions injected. Units of service are not determined by the number of injections given.

(b) A physician visit for a patient will not be separately reimbursed when trigger point injection procedures and a physician visit are performed on the same date of service in accordance with rule 5101:3-4-06 of the Administrative Code.

(c) Codes 20552 and 20553 are not to be billed collectively for the same patient on the same date of service. In accordance with CPT as defined in rule 5101:3-1-19.3 of the Administrative Code, only one of these codes will be reimbursed per date of service, per provider, per patient.

(d) Trigger point injections should be repeated only if reasonable and medically necessary. For dates of service on or after July 1, 2006, trigger point injections of local anesthetic and/or steroids will be limited to a maximum of eight dates of service per patient per calendar year. Injections exceeding this limit in a calendar year period will be denied.

(C) Prescribed drugs for take-home use.

(1) Scope and extent of coverage.

(a) The scope and extent of reimbursable pharmaceutical services are covered in detail in Chapter 5101:3-9 of the Administrative Code.

(b) Reimbursement may be made for pharmacy products not contained in appendix A to rule 5101:3-9-12 of the Administrative Code if prior-authorized or post-authorized by the department or its designee. Refills, within the limits set forth in Chapter 5101:3-9 of the Administrative Code, may also be approved at the time of the original authorization.

(2) Dispensing physicians.

(a) A physician may be reimbursed for drugs prescribed and dispensed by a physician in the office, clinic or patient's home for administration in the patient's home, or an LTCF, if the physician has a "prescribed drugs" category of service (30).

(b) All practitioners, as defined in section 4729.02 of the Revised Code, who are authorized to dispense drugs under Chapter 4729. of the Revised Code, and who have a valid medicaid provider agreement (nonpharmacy), are eligible to apply for and receive a "prescribed drugs" category of service which permits medicaid reimbursement for only the invoice cost of drugs dispensed.

(3) Reimbursement for dispensing self-administered drugs.

(a) Payment to physicians for dispensing self-administered drugs covered under the medicaid program is the lower of the billed charge (invoice cost) or the medicaid maximum allowable.

(b) No payment can be made for a professional dispensing fee, percentage

markup, or processing fee.

(c) No payment can be made for drug samples which are, in turn, dispensed to medicaid recipients.

(d) All claims for prescribed drugs must be billed following the billing instructions for suppliers of pharmacy services described in Chapter 5101: 3-9 of the Administrative Code.

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