5101:3-4-13 **Therapeutic 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 of 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 of rule 5101:3-1-60 of the Administrative Code, for each ~~1,000~~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 on dates of service on and after January 1, 1999, providers must bill code Q0136. One unit must be billed for each ~~1,000~~one thousand units of EPO.

(c) The unit field on the claim form must indicate one unit for each ~~1,000~~one thousand units of EPO. When the dosage of EPO does not equal a multiple of ~~1,000~~one thousand units, the number of units must be rounded down if the excess is between ~~0 to 499~~zero and four hundred ninety-nine units or rounded up if the excess is between ~~500 and 999~~five hundred and nine hundred ninety-nine units. For example, when ~~4,400~~four thousand four hundred units are given, four units of service would be billed. When ~~4,900~~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 ~~unlisted therapeutic injection code 90799 for nonantineoplastic drugs and J9999 for antineoplastic drugs and the unit field on the claim form~~

~~must indicate a unit of one. When billing 90799 or J9999, you must provide the name of the drug/injectable and the dosage in the remarks column of the billing invoice.~~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, 90799.

(4) Reimbursement for therapeutic, prophylactic, or diagnostic injections ranging from code 90782 to 90788 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 in the range of 90782 to 90788 are not valid for place of service inpatient hospital, outpatient hospital, or emergency room.

(B) 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 of 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 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.

Effective:

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Certification

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Date

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