ACTION: REVISED	DATE: 08/19/2002 11:46 AM

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: ~~considered by accepted standards of medical practice as specific or effective treatment for the particular condition for which they are given.~~

(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).

~~(iv) Reimbursement for the injection of vitamin B-12 is limited to the following conditions:~~

~~*(a)* Certain anemias, such as pernicious anemia, megaloblastic anemia, macrocytic anemia, fish tapeworm anemia.~~

~~*(b)* Certain gastrointestinal disorders, such as gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, structures, anastomoses, and blind loop syndrome.~~

~~*(c)* Certain neuropathies, such as posterolateral sclerosis, other neuropathies associated with pernicious anemia, the acute phase or acute exacerbation of a neuropathy due to malnutrition or alcoholism.~~

(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 ~~HCPCS~~ codes listed in appendix DD of rule 5101:3-1-60 of the Administrative Code. ~~HCPCS code~~Code numbers for injectable drugs are listed only under the generic drug name.

(ii) If there is a ~~HCPCS~~ code available for the injectable but not for the correct dosage, to add up to the correct dosage, either bill the ~~HCPCS~~ 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 ~~5101:3-4-022~~5101:3-4-02.2 of the Administrative Code.

~~*(a)* Providers must bill "by report" using the HCPCS code X0799. The patient's diagnosis, HCT and the total number of units administered must be submitted on or with the claim form. Providers must enter a unit of one in the unit field on the claim form.~~

~~(b)~~*(a)* For EPO administered for the treatment of anemia associated with chronic renal failure providers must bill the appropriate code, Q9920 to Q9940, for each 1,000 units of EPO injected in accordance with paragraph (A)(3)(b)(iii)(c) of this rule.

~~(c)~~*(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 units of EPO.

~~(d)~~*(c)* The unit field on the claim form must indicate one unit for each 1,000 units of EPO. When the dosage of EPO does not equal a multiple of 1,000 units, the number of units must be rounded down if the excess is between 0 to 499 units or rounded up if the excess is between 500 and 999 units. For example, when 4,400 units are given, four units of service would be billed. When 4,900 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.

~~(iv) Interferon provided in an office or clinic setting.~~

~~*(a)* Interferon is covered for the treatment of the following conditions if given as approved by the FDA: hairy cell leukemia, refractory or recurring external condylomata acuminata, AIDS-related Kaposi's sarcoma, chronic hepatitis and chronic granulomatous disease, chronic myelogenous leukemia, malignant melanoma, multiple sclerosis.~~

~~(v) Lupron depot.~~

~~*(a)* Lupron depot for the treament of endometriosis or other FDA approved indications is covered as a therapeutic injection.~~

~~*(b)* For reimbursement, the provider must bill the appropriate~~

~~HCPCS code.~~

~~(vi) Depo-provera.~~

~~*(a)* Depo-provera given in appropriate doses for contraceptive management is covered.~~

~~*(b)* For reimbursement for injections the provider must bill HCPCS code J1055 for each 150mg.~~

~~(vii) If there is no HCPCS 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.~~

(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. ~~The listing of those drugs covered as reimbursable is contained in the "Ohio Medicaid Drug Formulary," appendix A of rule 5101:3-9-12 of the Administrative Code.~~

(b) Reimbursement may be made for pharmacy products not contained in ~~the "Ohio Medicaid Drug Formulary"~~ 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.

~~(c) Drugs not contained in the "Ohio Medicaid Drug Formulary" can be~~

~~requested through the prior or post-authorization process described in Chapter 5101:3-9 of the Administrative Code.~~

(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.

~~(c) Pharmaceutical services will be covered as detailed above under paragraph (B)(1) of this rule. Drugs not contained in the "Ohio Medicaid Drug Formulary" can be requested through the prior or post-authorization process described in Chapter 5101:3-9 of the Administrative Code.~~

(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 estimated acquisition cost of the drug listed for the standard package size available (sixteen ounce packages or quantities of one hundred) as contained in the "Ohio Medicaid Drug Formulary."~~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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Certification

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