Injections: An Overview

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This section is an overview for policy related to billing for injection services. The information in this section applies to services listed in the following manual sections:

- ‹‹*Injections: Drugs A Policy*
- *Injections: Drugs B Policy*
- *Injections: Drugs C Policy*
- *Injections: Drugs D Policy*
- *Injections: Drugs E Policy*
- *Injections: Drugs F Policy*
- *Injections: Drugs G Policy*
- *Injections: Drugs H Policy*
- *Injections: Drugs I Policy*
- *Injections: Drugs J-L Policy*
- *Injections: Drugs M Policy*
- *Injections: Drugs N-O Policy*
- *Injections: Drugs P-Q Policy*
- *Injections: Drugs R Policy*
- *Injections: Drugs S Policy*
- *Injections: Drugs T Policy*
- *Injections: Drugs U-Z Policy*››››
- *Injections: Hydration*

Important Notice and TAR Requirement

All listed medications may be approved for FDA-labelled indications, dosages and usages. An approved *Treatment Authorization Request* (TAR) is required for off-label use to justify medical necessity. It must meet current standards of practice, current medical literature or treatment guidelines, in accordance with statutory requirements (22 CCR § 51313(4)). Billing codes and utilization management criteria are listed with each code. Experimental Services are not a benefit. Investigational Services are covered in accordance with statutory requirements (22 CCR § 51303(g)). Authorization is required for dosages exceeding the maximum recommended dosages as approved by the FDA.

Providers submitting electronic TARs (eTARs) must select the Special Handling description “Cannot Bill Direct, TAR is Required,” which is found in the *Patient Information* section of the eTAR application.

Reimbursement Methodology

Physician-administered drugs are reimbursed at the Medicare rate of reimbursement when established and published by the Centers for Medicare & Medicaid Services (CMS) or the pharmacy rate of reimbursement when the Medicare rate is not available. The Medicare rate is currently defined as the average sales price (ASP) plus six percent. The pharmacy rate is currently defined as the lower of (1) the National Average Drug Acquisition Cost (NADAC) or, when the NADAC is not available, the wholesaler acquisition cost (WAC) plus 0 percent; (2) the federal upper limit (FUL); or (3) the maximum allowable ingredient cost (MAIC). For more information on the pharmacy rate of reimbursement please refer to the Pharmacy provider manual section titled *Reimbursement*.

Reimbursement is determined by the cost of the injection, plus the physician's injection administration fee for the first billed unit of drug. The price listed on the Medi-Cal Rates page of the Medi-Cal website for each physician-administered drug includes the one-time injection administration fee of $4.46. Since the injection administration fee is applied only once for each drug administered, subsequent units claimed will have the administration fee subtracted from the published rate.

Billing Guidelines

Providers must bill according to the physician-administered drug policy, which may be found in the *Physician-Administered Drugs – NDC* section in this manual. For physician claim form completion instructions, refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions*, or *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* sections in the appropriate Part 2 manual. Non-pharmacy providers must use the appropriate HCPCS injection codes and modifiers (when required) to bill for all injections listed in the *Injections: Code* List section in this manual.

Reimbursement is determined by the cost of the injection, plus the physician's administration fee. The price listed on the Medi-Cal Rates page of the Medi-Cal website for each Physician Administered Drug includes the one-time administration fee. Since the administration fee is paid only once for each drug administered, subsequent units claimed must have the administration fee subtracted from the published rate.

Weekly Injections

Billing weekly injections on the CMS-1500 claim

Providers should enter the date the injection is administered as the “From” date of service and enter the date prior to the day the next injection is administered as the “To” date of service in the *Date(s) of Service* field (Box 24A).

Refer to the *Injections: Billing Example for CMS-1500* section in the appropriate Part 2 manual.

Billing weekly injections on the UB-04 claim

Enter the date the injection is administered and enter the date prior to the day the next injection is administered in the *Serv. Date* field (Box 45).

Refer to the *Injections: Billing Example for UB-04* section in the appropriate Part 2 manual.

Injection Administered More Than Once in the Same Day

When the same injection is administered more than once in the same day, each injection must be listed on a separate claim line. The time of day the multiple injections are given must be included in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim to avoid a denial as a duplicate claim.

Unclassified injections: J3490 and J3590

HCPCS code J3490 unclassified drugs

Providers may submit claims for J3490 only when a specific code for the drug is not available or does not exist. The claim form must include the following:

- ICD-10-CM diagnosis code
- National Drug Code (NDC)
- Name and strength of drug administered, and amount given in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on a separate attachment.

One billed unit equals the total dose provided to the patient.

HCPCS code J3590 unclassified biologics

Providers may submit claims for J3590 only when a specific code for the drug is not available or does not exist. The claim form must include the following:

- ICD-10-CM diagnosis code
- National Drug Code (NDC)
- Name and strength of drug administered, and amount given in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on a separate attachment.

HCPCS code J3590 requires an approved *Treatment Authorization Request* (TAR) for reimbursement. Providers must document the following on the TAR:

- Medical necessity for using the drug
- Name, strength and dosage of the drug
- ICD-10-CM diagnosis code
- National Drug Code (NDC)

One billed unit equals the total dose administered to the patient.

Unlisted Supplies/Drugs

Do not use HCPCS code Z7610 or CPT® code 99070 when billing for unlisted injections. CPT code 99070 is reserved for physicians billing unlisted supplies and non-injectable drugs for a non-surgical procedure on the *CMS-1500* claim.

Note: Important additional instructions for billing code 99070 appear in the *Supplies and Drugs for Medical Services* section of the appropriate Part 2 manual.

HCPCS code Z7610 is used by providers billing for unlisted supplies and non-injectable drugs for a non-surgical procedure on the *UB-04* claim. Refer to the *Supplies and Drugs for Outpatient Services* section in the appropriate Part 2 manual.

Items Not Separately Billable

Incidental items (adhesive bandages, tissues, swabs, cotton balls, etc.) are included in the rate for the office visit or other listed services. These incidental items must not be billed separately.

Established Patient/Level One Services: CPT Codes

Do not use established patient, Level One, Evaluation and Management codes (99211, 99281 and 99347) to bill Medi-Cal for injections. Use the appropriate injection code.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.