Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: **All Physicians, Nurse Practitioners, Clinics, Federally-Qualified Health Clinics, and Rural Health Clinics**

Subject: **Revised Policy for Billing of Office-Administered Injectable Drugs and Infusions**

> *Note: The information in this bulletin about prior authorization, payment methodology, and maximum fees may vary for providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.*

Overview

The policy revisions outlined in this bulletin are effective for all claims with dates of service on or after February 1, 2002. Historically, the Indiana Health Coverage Programs (IHCP) has reimbursed office-administered injectable drugs based on the average wholesale price for the drug plus a $2.90 fee per dose using the Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS) J-codes or current procedural terminology (CPT) codes. To ensure greater accuracy of claims payment, the IHCP has amended billing procedures for office-administered injectables and infusions. This bulletin describes new policies and clarifies how injectable products are classified by the IHCP for billing purposes.

Billing of Injectables and Infusions

For the IHCP, office-administered drugs are categorized as either **injectables,** such as, intramuscular, intra-arterial, subcutaneous, or intradermal or **infusions,** such as intravenous (IV) administration of medication. Revised billing procedures are explained further in this bulletin.

Injectables

When administering injectables, providers should bill the appropriate HCPCS J-Code or CPT drug code with billed units corresponding to the narrative description of the code. For example, if the narrative of a billed code indicates 50mg per dose, and 100mg of the product is administered, the practitioner should bill two units.

Effective February 1, 2002, the $2.90 administration fee will no longer be added to the reimbursement of billed injectiable drug codes. Providers may separately bill an appropriate CPT drug administration code, 90782 – 90784, 90788, or 90799, in addition to the HCPCS J-code or CPT drug code. If an evaluation and management (E&M) code **is** billed with the same date of service as an office-administered drug, the provider should **not** bill a drug administration code separately. Reimbursement for administration is included in the E&M allowed amount. Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one injection is given on the same date of service and no E & M code is billed, providers may bill a separate administration fee for each injection using 90782 or 90788 as appropriate.

Exceptions to this policy are drugs administered by either intravenous or intra-arterial injections (90783 and 90784). Practitioners can bill the appropriate administration code for these routes of administration even if an E&M code is paid on the same date of service.

> *Note: Administration codes should not be billed when drugs are administered orally in a practitioner's office.*

Infusions

When administering an infusion, providers should bill the appropriate HCPCS J-code or CPT drug code. An E & M code may be billed on the same date as infusion therapy if the physician's documentation supports such a code and the E & M service is reasonable and necessary. This should be interpreted to mean that while both services may be billed, the physician is not entitled to bill an E & M code on each occasion of infusion therapy.

Billing for Vaccines and Toxoids

Reimbursement for vaccines and toxoids, procedure codes 90585 – 90749, will continue to include the $2.90 administration fee. Codes 90471 and 90472 are nonreimbursable codes, since the fee for administration of the vaccine or toxoid is included in the procedure code. **Providers should not bill any other administration code with these procedure codes. Payments made for additional administration is subject to recoupment.**

Vaccine for Children Program

There are no changes to billing procedures for the Vaccine for Children (VFC) program. Providers should continue to submit the appropriate vaccine CPT code for the immunization. The rate remains at $8.00, per vaccine CPT code, for all VFC immunizations. IHCP-enrolled children 18 years old and younger are eligible for free vaccines. The system pays the lesser of $8.00 per vaccine CPT code, or the billed amount. Providers should bill their usual and customary fee for administering immunizations when providing VFC vaccine.

For vaccine or toxoid not included in the VFC program, or for IHCP individuals over age 18 years old who receive a vaccine or toxoid included in the VFC program, IHCP continues to reimburse for the vaccine or toxoid and the $2.90 administration fee. Following is a list of immunizations currently included in the VFC program. Providers can receive up to an $8.00 administration fee, per vaccine CPT code, for these immunizations, when administered to a VFC-eligible IHCP member (those members under 19 years of age).

Table 1 – Vaccine for Children Program Codes

Procedure Codes		
90645	90702	90721
90647	90707	90744
90648	90713	90748
90669	90716	
90700	90718	

Additional Information

Questions about the information contained in this bulletin may be directed to the Health Care Excel Medical Policy department at (317) 347-4500. Questions about billing procedures should be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.