Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 16: Medication Administration and Injections

Effective July 1, 2024

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

Table of Contents

Definitions

The following terms are utilized in this chapter and are defined as follows:

Bundled codes: Are procedure codes that are not separately payable because they are accounted for and included in the payment of other procedure codes and services.

Link: For the legal definition of Bundled codes, see WAC 296-20-01002.

Dry Needling: Dry needling is considered a variant of trigger point injections. It is a technique where needles are inserted directly into trigger point locations without medications injected. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(7)(d).

Modifiers

The following CPT®, HCPCS, and/or local code modifiers appear in this chapter:

Use	Payment Information
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier should only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.

Use	Payment Information
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–TC (Technical component)	
Use this modifier to indicate when only the technical component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's technical component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the technical component (**–TC**) rate for each specific radiology service performed or billed charge, whichever is less.

Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

Payment policy: Botulinum toxin (BTX)

Prior authorization

Botulinum toxins are payable when authorized.

Coverage of Onabotulinumtoxin A for treatment of chronic migraine is exempt from the 2-course limit based on an HTCC coverage determination. A maximum of 5 courses may be authorized.

Link: Prior authorization criteria and L&I's coverage decision information is available online.

Requirements for billing

Billing codes

Refer to the fee schedule for current fees.

If the **injection** is…	Then the appropriate **HCPCS billing code** is:
Onabotulinumtoxin A, 1 unit (Botox® or Botox Cosmetic®)	**J0585**
If the **injection** is…	Then the appropriate **HCPCS billing code** is:
Abobotulinumtoxin A, 5 units (Dysport®)	**J0586**
Rimabotulinumtoxin B, 100 units (Myobloc®)	**J0587**
Incobotulinumtoxin A, 1 unit (Xeomin®)	**J0588**

Services that aren't covered

The insurer won't authorize payment for BTX injections for off label indications.

Onabotulinumtoxin A for the treatment of chronic tension-type headache isn't a covered benefit.

Payment policy: Compound drugs

Prior authorization

All compounded drug products require prior authorization. Failure to seek authorization before compounding will risk nonpayment of compounded products.

Compounded drug products include, but aren't limited to:

- Antibiotics for intravenous therapy,
- Pain cocktails for opioid weaning, *and*
- Topical preparations containing multiple active ingredients or any non-commercially available preparations.

Link: For more information, see the L&I coverage decision on compound drugs.

Services that aren't covered

Compounded topical preparations containing multiple active ingredients aren't covered. There are many commercially available, FDA approved alternatives, on the Outpatient Drug Formulary such as:

- Oral generic nonsteroidal anti-inflammatory drugs,
- Muscle relaxants,
- Tricyclic antidepressants,
- Gabapentin, *and*
- Topical salicylate and capsaicin creams.

Requirements for billing

Compounded drug products must be billed by pharmacy providers on the Statement for Compound Prescription with national drug code (NDCs or UPCs if no NDC is available) for each ingredient.

Payment limits

No separate payment will be made for **99070** (Supplies and materials).

Payment policy: Hyaluronic acid for osteoarthritis of the knee

Coverage Change

Hyaluronic acid is no longer covered for osteoarthritis of the knee based on a coverage decision effective 3/1/2024. For more information on this change, see L&I's coverage decision.

Payment policy: Immunizations

Prior authorization

Immunization materials are payable when authorized.

Services that can be billed

CPT® codes **90471** and **90472** are payable, in addition to the immunization materials code(s).

For each additional immunization given, add on CPT® code **90472** may be billed.

Payment limits

E/M codes aren't payable in addition to the immunization administration service, **unless** the E/M service is:

- Performed for a separately identifiable purpose, *and*
- Billed with a modifier **–25**.

Additional information

Bloodborne pathogens and infectious diseases

Information on L&I's coverage decision for bloodborne pathogens is available online. For more information about work related exposure to an infectious disease, see WAC 296-20-03005.

Payment policy: Immunotherapy

Services that aren't covered

Complete service codes aren’t paid.

Requirements for billing

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. The provider bills:

- 1 of the injection codes, *and*
- 1 of the antigen/antigen preparation codes.

Payment policy: Infusion therapy services and supplies for RBRVS providers

Prior authorization

Regardless of who performs the service, prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home.

An exception is **outpatient services**, which are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. (See Services that can be billed below.)

With prior authorization, the insurer may cover:

- Implantable infusion pumps and supplies,
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal, *and*
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, baclofen).

Services that can be billed

Urgent and emergent outpatient services

Outpatient services are allowed when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. The following CPT® codes are payable to physicians, ARNPs, and PAs:

- **96360**,
- **96361**, *and*
- **96365-96368**.

Supplies

Implantable infusion pumps and supplies that may be covered with prior authorization include these HCPCS codes:

- **A4220**,
- **E0782-E0783**, *and*
- **E0785-E0786**.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

Services that aren't covered

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material aren't covered with the following exceptions for accepted conditions:

- To treat pain caused by cancer or other end-stage diseases, *or*
- To administer anti-spasticity drugs when spinal cord injury is an accepted condition.

Link: For more information, see WAC 296-20-03002.

Requirements for billing

Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for home infusion services in Chapter 11: Home Health Services for more information.

Link: For information on home infusion therapy in general, see the home infusion services section of Chapter 11: Home Health Services.

Drugs

Drugs for outpatient use must be billed by pharmacy providers, either electronically through the point of service (POS) system or on appropriate pharmacy forms (Statement for Pharmacy Services, Statement for Compound Prescription or Statement for Miscellaneous Services) with national drug codes (NDCs or UPCs if no NDC is available).

Note: Total parenteral and enteral nutrition products are exceptions and may be billed by home health providers using the appropriate HCPCS codes.

Payment limits

E/M office visits

Providers will only be paid for E/M office visits in conjunction with infusion therapy if the services provided meet the code definitions.

Opiates

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) aren't covered **unless** they are:

- Part of providing anesthesia, *or*
- Short term postoperative pain management (up to 48 hours post discharge), *or*
- Medically necessary in emergency situations.

Link: For more information, see WAC 296-20-03014.

Equipment and supplies

Infusion therapy supplies and related DME, such as infusion pumps, aren't separately payable for RBRVS providers. Payment for these items is **bundled** into the fee for the professional service.

Diagnostic injections

Intravenous or intra-arterial therapeutic or diagnostic injection codes, CPT® codes **96373** and **96374**, won't be paid separately in conjunction with the IV infusion codes.

Payment policy: Injectable medications

Requirements for billing

Providers must use the HCPCS J codes for injectable drugs that are administered during an E/M office visit or other procedure. The HCPCS J codes aren't intended for self-administered medications.

When billing for a nonspecific injectable drug, the following must be noted on the bill and documented in the medical record:

- Name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity of drug administered.

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, **providers must bill their acquisition cost for the drugs**. To get the total billable units, divide the:

- Total strength of the injected drug, *by*
- The strength listed in the manual.

For example:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units.

Payment limits

Payment is made according to the published fee schedule amount, or the acquisition cost for the covered drug(s), whichever is less.

Payment policy: Medical foods and co-packs

Services that aren't covered

Medical food products and their convenience packs or "co-packs" aren't covered.

Examples of medical food products include:

- Deplin® (L-methylfolate), *and*
- Theramine® (arginine, glutamine, 5-hydroxytryptophan, and choline).

Examples of "co-packs" include:

- Theraproxen® (Theramine and naproxen), *and*
- Gaboxetine® (Gabadone and fluoxetine).

Link: For more information, see L&I's coverage decision on medical foods and co-packs.

Payment limits

Medical foods and co-packs administered or dispensed during office procedures are considered **Bundled** in the office visit.

No separate payment will be made for **99070** (Supplies and materials), which is a **bundled** code.

Payment policy: Non-injectable medications

Services that can be billed

Providers may use distinct HCPCS J codes that describe specific non-injectable medication administered during office procedures. Separate payment will be made for medications with distinct J codes. The HCPCS J codes aren't intended for self-administered medications.

Services that aren't covered

No payment will be made for pharmaceutical samples or repackaged drugs.

Requirements for billing

Providers must bill their acquisition cost for these drugs.

The name, NDC, strength, dosage, and quantity of the drug administered must be documented in the medical record and noted on the bill.

Link: For more information, see the payment policy for Acquisition cost in Chapter 28: Supplies, Materials, and Bundled Services.

Payment limits

Miscellaneous oral or non-injectable medications administered or dispensed during office procedures are considered **bundled** in the office visit. No separate payment will be made for these medications:

- **A9150** (Nonprescription drug), *or*
- **J3535** (Metered dose inhaler drug), *or*
- **J7599** (Immunosuppressive drug, NOS), *or*
- **J7699** (Noninhalation drug for DME), *or*
- **J8498** (Antiemetic drug, rectal/suppository, NOS), *or*
- **J8499** (Oral prescription drug non-chemo), *or*
- **J8597** (Antiemetic drug, oral, NOS), *or*
- **J8999** (Oral prescription drug chemo).

Payment policy: Spinal injections

Payment methods

Physician or CRNA/ARNP

The payment methods for physician or CRNA/ARNP are:

- Injection procedure: **–26** component of Professional Services Fee Schedule, *and*
- Radiology procedure: **–26** component of Professional Services Fee Schedule

A separate payment for the injection **won't be made** when computed tomography (CT) is used for imaging, unless documentation demonstrating medical necessity is provided.

Radiology facility payment methods

The payment methods for radiology facilities are:

- Injection procedure: No facility payment, *and*
- Radiology procedure: **–TC** component of Professional Services Fee Schedule.

Hospital payment methods

The payment methods for hospitals are:

- Injection procedure: APC or POAC (payment method depends on the payer and/or the hospital's classification), *and*
- Radiology procedure: APC, POAC or **–TC** component of Professional Services Fee Schedule. Radiology codes may be packaged with the injection procedure.

Payment policy: Therapeutic or diagnostic injections

Prior authorization

These services require prior authorization:

- Trigger point injections and **dry needling** (refer to guideline for limits), and
- Sympathetic nerve blocks (refer to the CRPS guideline).

Links: See L&I's coverage decision for more information on trigger point and dry needling injections and L&I's CRPS guidelines for more information on sympathetic nerve blocks.

Required along with utilization review

These services require both prior authorization and utilization review:

- Therapeutic epidural and spinal injections for chronic pain,
- Therapeutic sacroiliac joint injections for chronic pain, *and*
- Diagnostic facet and medial branch block injections (refer to neurotomy guideline).

Links: See L&I's coverage decision and guidelines on spinal injections, L&I's neurotomy guidelines, and L&I's coverage decision on discography.

Services that can be billed

These services can be billed without prior authorization:

- E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable,
- Professional services associated with therapeutic or diagnostic injections (CPT® code **96372**) are payable along with the appropriate HCPCS J code for the drug,
- Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes **96373** and **96374**) may be billed separately and are payable if they aren't provided in conjunction with IV infusion therapy services (CPT® codes **96360**, **96361**, **96365**-**96368**), *and*
- Spinal injections that don't require fluoroscopy or CT guidance:
  - CPT® code **62270** – diagnostic lumbar puncture,
  - CPT® code **62272** – therapeutic spinal puncture for drainage of CSF, and
  - CPT® code **62273** – epidural injection of blood or clot patch.

Services that aren't covered

CPT® code **99211** won't be paid separately.

If billed with the injection code, providers will be paid only the E/M service and the appropriate HCPCS J code for the drug.

Perineural Injection Therapy (PIT), also known as sclerotherapy, neurofascial, subcutaneous or neural prolotherapy, are considered forms of prolotherapy. L&I does not cover any form of prolotherapy per WAC 296-20-03002. Providers may not bill or be paid for PIT. These procedures should not be confused with peripheral nerve blocks (CPT® code **64450**), which are allowed for regional anesthesia and acute pain management.

Link: See L&I's coverage decision on perineural injection therapy.

The insurer doesn't cover:

- Therapeutic medial branch nerve block injections, *or*
- Therapeutic or diagnostic intradiscal injections, *or*
- Therapeutic facet injections, *or*
- Diagnostic sacroiliac joint injections, *or*
- Therapeutic genicular nerve blocks for chronic knee pain, *or*
- Perineural injection therapy.

Links: For more information, see L&I's coverage decision on these injections and L&I's coverage decision on therapeutic genicular blocks for chronic knee pain.

Requirements for billing

Dry needling

Dry needling of trigger points must be billed using CPT® codes **20560** and **20561**.

Spinal injections that require fluoroscopy

For spinal injection procedures that require fluoroscopy:

- 1 fluoroscopy code must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied, *and*
- Only 1 fluoroscopy code may be billed for each injection (see table below).

Only 1 of these **CPT® fluoroscopy codes** may be billed for each injection…	…and it must be billed along with this underlying **CPT® code**:
77002, **77012**, **76942**	**62268**
77002, **77012**, **76942**	**62269**
77003, **72275**	**62281**
77003, **72275**	**62282**
77003, **77012**, **76942**, **72240**, **72255**, **72265**, **72270**	**62284**
72295	**62290**
72285	**62291**
72295	**62292**
77002, **77003**, **77012**, **75705**	**62294**
77003, **72275**	**62320**
77003, **72275**	**62322**
77003, **72275**	**62324**
77003, 72275	**62326**

Spinal injection procedures that include fluoroscopy, ultrasound, or CT in the code description

Paravertebral facet joint injections now include fluoroscopic, ultrasound, or CT guidance as part of the description. This includes these CPT® codes:

- **64479-64480**, *and*
- **64483-64484**, *and*
- **64490-64495**, *and*
- **0213T-0218T**, *and*
- **0228T-0231T**.

Fluoroscopic, ultrasound, or CT guidance can't be billed separately.

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for drug limitations (such as opiates)	Washington Administrative Code (WAC) 296-20-03014
Administrative rules for treatment authorization (including prolotherapy)	WAC 296-20-03002
Administrative rules for work related exposure to an infectious disease	WAC 296-20-03005
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Bloodborne pathogens	Bloodborne pathogens guidelines
Botulinum toxin (BTX) injections	Botulinum toxin coverage decision
Complex Regional Pain Syndrome (CRPS) guidelines	Complex Regional Pain Syndrome guidelines
Compound drugs coverage decision	Compound drugs coverage decision
Discography guidelines	Discography guidelines
Dry needling and trigger point injections coverage decision	Dry needling and trigger point injections coverage decision
Fee schedules for all healthcare professional services (including medication administration)	Fee schedules on L&I's website
Hyaluronic acid injections	Hyaluronic acid injections coverage decision

If you're looking for more information about…	Then see…
Medical coverage decision for **acupuncture**	WAC 296-20-03002(2) Acupuncture guidelines on L&I's website
Medical foods and co-packs coverage decision	Medical foods and co-packs coverage decision
Neurotomy guidelines	Neurotomy guidelines
Payment policies for **acquisition cost policy**	Chapter 28: Supplies, Materials, and Bundled Services
Payment policies for **home infusion therapy**	Chapter 11: Home Health Services
Spinal injections coverage decision and guidelines	Spinal injections coverage decision

Need more help?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

