REIMBURSEMENT POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Infusion & Injection Administration-WI MP-PY-1771	06/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Injection & Infusion Administration

B. Background
All health care providers are expected to utilize the same standard coding sets and rules to codify the services provided during encounters with patients. This ensures appropriate reimbursement is made for the services rendered.

C. Definitions
- **Administration Fee** – A fee charged for the professional services related to the administration of infusion or injection therapies, which may include preparation, monitoring, and follow-up care.
- **Current Procedural Terminology (CPT)** – Codes that are issued, updated and maintained by the American Medical Association (AMA) that provide a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** – Codes that are issued, updated and maintained by the AMA that provide a standard language for coding and billing of products, supplies, and services not included in the CPT codes.
- **Infusion Injection** – The administration of medication through a needle or catheter into the bloodstream, typically requiring specialized equipment and monitoring.
- **Modifier** – Two-character codes used along with a CPT or HCPCS code to provide additional information about the service or supply rendered.

D. Policy
I. Providers must utilize the appropriate CPT codes to describe the specific infusion and injection services performed. Codes must align with (1) the substance administered, (2) the route of administration, and (3) the total duration of the procedure. It is the responsibility of the submitting provider to submit accurate documentation of services performed. Providers are expected to use the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided according to the following industry standard guidelines (may not be all-inclusive):
A. National Correct Coding Initiative (NCCI) editing guidelines
B. AMA guidelines
C. American Hospital Association (AHA) billing rules
D. HCPCS
E. ICD-10 CM and PCS
F. National Drug Codes (NDC)
G. Diagnosis Related Group (DRG) guidelines
H. CCI table edits

NOTE: The inclusion of a code in a policy does not imply any right to reimbursement or guarantee claims payment.

II. Administration Service
CareSource covers administration fees for infusions and injections, provided the services are medically necessary.
A. An injection or infusion has 2 components: the administration of a fluid medium and, except in the case of hydration, the pharmaceutical itself. No separate payment is made for the administration service if an injection or infusion is given during the course of an office visit or in conjunction with another medical service that includes an evaluation and management element.
B. Administration services associated with an infusion or injection are separately reimbursed when the infusion/injection is the primary reason or service performed during the facility visit.
C. Certain high-cost medications and complex infusion therapies may require prior authorization (PA). Please use Procedure Code Lookup Tool on CareSource website to verify if prior authorization is needed.

III. Exclusions
A. Chemotherapy and hydration
B. Home health visits

E. Conditions of Coverage

Reimbursement policies are designed to assist providers when submitting claims to CareSource. These are routinely updated to promote accurate coding and policy clarification and are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member eligibility. It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. CareSource will reimburse participating providers for medically necessary services.

Although CareSource accepts the use of modifiers, use does not guarantee reimbursement. Some modifiers increase or decrease the reimbursement rate, while others do not affect the reimbursement rate. CareSource may verify the use of any modifier through post-payment audit. Inappropriate use of a modifier can result in a claim denial or incorrect reimbursement for a product or service. All information regarding the use of these modifiers must be made available upon CareSource's request.

F. Related Policies/Rules

Modifiers, CareSource Reimbursement policy

G. Review/Revision History

	DATE	ACTION
Date Issued	03/11/2026	Approved at Committee
Date Revised		
Date Effective	06/01/2026	

Date Archived		

H. References

N/A