Hydration, IV Infusions, Injections and Vaccine Charge Process

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Hydration, IV Infusions, Injections and Vaccine Charge Process

Coding for drug therapy in an outpatient/ambulatory setting can be confusing. Appropriate code selection depends on the type of medication administered, the method of administration, the time required to administer the medication, the access site, and the sequence (concurrent or sequential) of administration. This paper provides coding information, code tables, general billing guidance, references and billing scenarios to assist providers in reporting these services correctly.

The charge process is divided into four specific groups of codes and processes --

1. **Hydration and IV Therapy**

   Hydration -- time-based administration of prepackaged fluids and/or electrolytes administered without drugs to replenish body water (i.e., normal saline (NS), sodium chloride (NaCl), dextrose in ½ normal saline (D5 ½ saline), pre-packaged KCL, dextrose in ½ normal saline plus potassium (D5 ½ NS+K), dextrose 5 percent in water (D5W), etc.).

   IV Therapy

   - **IV or Intra-arterial Push (IVP) –**

     (a) delivery of a therapeutic, prophylactic, or diagnostic drug administered all at once, or

     (b) an infusion that runs for 15 minutes or less while the healthcare professional continuously observes the patient, or

     (c) any infusion provided without documentation of a stop or continuing time.

   - **Infusions --** diagnostic, prophylactic, or therapeutic introduction of (IV) fluids and/or drugs administered over time (i.e., heparin, banana bags, antibiotics, antiemetics, etc.). Infusions are administered as initial, sequential, or concurrent; an infusion may be intravenous or subcutaneous.

2. **Injections into IV lines and Intramuscular injections (nonchemotherapy) --**

   Injection -- administration of a drug using a needle and syringe. The most common types of injections are intra-arterial, intramuscular, intradermal, intravenous, and subcutaneous. Injections deliver a dosage in one "shot."

   Intramuscular (IM) Injection -- therapeutic, prophylactic, or diagnostic drug into the substance of a muscle, usually the muscle of the upper arm, thigh, or buttock. Intramuscular injections are given when the substance needs to be absorbed quickly.

3. **Vaccines --** administration of a product to stimulate the protective immunity from an infectious disease or harmful agent.

4. **Chemotherapy --** described by both CPT® and CMS as "non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers."

Hydration, IV Infusions, Injections and Vaccine Charge Process

Hydration and IV Therapy

- IV fluid and medication administration charges are reported/charged on only outpatient or ambulatory care areas of the hospital, such as an infusion center, emergency department, and patients in observation. For inpatients, IV drug administration is not separately charged, but considered included in the room rate if performed by regularly assigned unit nursing staff.
- Hydration and IV therapy are time-based charges measured by the first hour and subsequent hours.
- Hydration therapy must last longer than 30 minutes to qualify for an initial (first) hour code.
- IV therapy less than 16 minutes may be reported as an IV injection.
- Hydration less than 30 minutes is not a billable. It is inappropriate to charge for an IV start if no therapy was administered. (CPT® 36000 (introduction of needle or intracatheter, vein) is appropriate only when coding percutaneous vascular procedures.)
- Establishing a heparin or saline lock to "keep open" the IV line or a slow drip of saline for access is not billable, as it does not qualify as hydration or IV therapy.
- Hydration procedures must have a diagnosis supporting the medical necessity of the procedure.

The time-based codes used for Hydration and IV Therapy are as follows --

Hydration and IV Therapy Codes (added notes in italics)
96360 - Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361 - Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure). *[The additional time has to be greater than 30 minutes]*
96365 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour. *[16-60 minutes (less than 16 min = IVP)]*
96366 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure), *[16-60 minutes and a different drug]*
96368 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure). *[once per encounter]*
96369 - Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s). *[16-60 minutes]*
96370 - Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure). *[must be greater than 30 minutes]*
96371 - Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure.) *[once per encounter]*

Injections into IV lines and Intramuscular Injections (nonchemotherapy)

Injections into IV lines must be classed into the following codes --

1. Initial injection medication A (96374)
2. Additional subsequent injection, medications B – Z (96375)
3. Additional subsequent injections medication A (96376); more than 30 minutes must pass between injections of same drug to qualify each injection as an additional unit of 96376.

The codes used for IV injections are as follows --

IV Injection Codes
96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
96376 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure) *see time note above*

The codes used for intramuscular, subcutaneous and intra-arterial injections are as follows --

Intramuscular, Subcutaneous and Intra-arterial Injection Codes
96372 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial

Vaccines

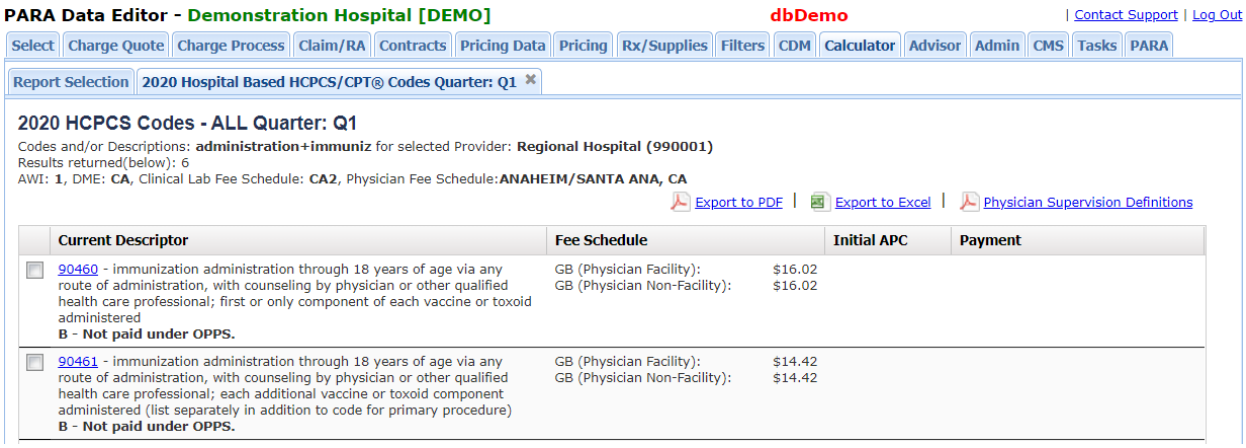
- Vaccines are based on the number of injections and, for Medicare, the type of vaccine.
- The vaccine codes below report administration by nursing services.

Childhood vaccine administration codes (90460-90461) are billed according to the number of disease components of the vaccine, but unique coding rules often apply to coding state Vaccines for Children (VFC) programs in each state.

For most payors, the vaccine administration code(s) are billed along with the specific vaccine serum code.

The official CPT® code set for vaccine administration, with counseling, for patients through age 18

consists of only two codes, 90460 and 90461, regardless of the route of administration. CPT® Assistant guidelines instruct coders to use 90460 for the first component of each vaccine that is administered with counseling for patients through age 18, and 90461 for each additional component. If administering more than one vaccine on the same day, 90460 may be billed with multiple units. The administration code(s) are billed together with another CPT® indicating the vaccine serum administered.



PARA Data Editor - Demonstration Hospital [DEMO] dbDemo | Contact Support | Log Out

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx/Supplies | Filters | CDM | Calculator | Advisor | Admin | CMS | Tasks | PARA

Report Selection | 2020 Hospital Based HCPCS/CPT® Codes Quarter: Q1

2020 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **administration+immuniz** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 6
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

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Current Descriptor	Fee Schedule	Initial APC	Payment
90460 - immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered **B - Not paid under OPPS.**	GB (Physician Facility): $16.02 GB (Physician Non-Facility): $16.02		
90461 - immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (list separately in addition to code for primary procedure) **B - Not paid under OPPS.**	GB (Physician Facility): $14.42 GB (Physician Non-Facility): $14.42		

However, state VFC programs bend the coding rules to fit to the state reimbursement scheme. VFC coding and billing rules vary, and coding may differ from the CPT® instructions. Providers participating in the VFC program must carefully review the state VFC coding requirements and abide by the coding and billing requirements applicable for the state in which the VFC service is rendered.

For instance, California Medicaid (Medi-Cal) asks providers to bill vaccines supplied through VFC by reporting only the vaccine serum CPT® with the SL modifier, without a separate administration code. Non-VFC claims report both an administration code AND a serum code.

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/vaccine_m00o03o04o11.doc

CPT Codes Used To Bill VFC

The following CPT codes are used to bill the administration fee for vaccines supplied free by the VFC program. All claims for VFC vaccines require modifier SL (used for VFC program recipients younger than 19 years of age).

Bill this CPT code when administering	This VFC vaccine
90620	Meningococcal vaccine serogroup B (Bexsero)
90621	Meningococcal vaccine serogroup B (Trumenba)
90630	Influenza virus vaccine, quadrivalent, split virus, preservative free, for intradermal use
90633	Hepatitis A vaccine/pediatric/adolescent (Vaqta®, Havrix®)
90644	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type B vaccine (Hib-MenCY), 4 dose schedule, when administered to children **6 weeks** – 18 months of age, **for intramuscular use**
90647	Haemophilus influenzae b (Hib) vaccine (PedvaxHIB®)

New York's managed Medicaid payor, United Healthcare, instructs providers to bill only 90460 for VFC administration.

> https://www.uhccommunityplan.com/content/dam/uhccp/healthcareprofessionals/Bulletins/NY-Bulletins/NY-Tips-New-Billing-Requirements-Vaccines-Children-Services.pdf
>
> "The Centers for Medicare & Medicaid Services (CMS) requires state Medicaid programs to reimburse for Vaccines for Children (VFC) services on administration codes 90460, 90471, 90472, 90473, and/or 90474 rather than the serum/toxoid code. Per the Patient Protection and Affordable Care Act (PPACA), CPT code 90461 is not reimbursable for VFC services. **While some states will reimburse for all of these administration codes, NY will only reimburse for 90460**."

Vaccine Administration Codes
90471 - Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472 - Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
Vaccination Administration Codes (continued)
G0008 – ADMINISTRATION OF INFLUENZA VIRUS VACCINE
G0009 - ADMINISTRATION OF PNEUMOCOCCAL VACCINE
G0010 - ADMINISTRATION OF HEPATITIS B VACCINE – not billable hospital outpatient Part B

Drug costs are captured by reporting product codes 90476 – 90749 (sample below).

HCPCS/CPT®	Status	Weight Payment Nat. Copay Min. Copay	Accepted Revenue Codes (Medicare Outpatient)	CCI Edit	LCD	MUE
90581 - ANTHRAX VACCINE, FOR SUBCUTANEOUS OR INTRAMUSCULAR USE	E2	- 0.00 0.00	0250	NO	YES	1
90630 - INFLUENZA VIRUS VACCINE, QUADRIVALENT (IIV4), SPLIT VIRUS, PRESERVATIVE FREE, FOR INTRADERMAL USE	L	- 0.00 0.00	0636	YES	NO	1
90632 - HEPATITIS A VACCINE (HEPA), ADULT DOSAGE, FOR INTRAMUSCULAR USE	N	- 0.00 0.00	0250,0636	YES	YES	1
90633 - HEPATITIS A VACCINE (HEPA), PEDIATRIC/ADOLESCENT DOSAGE-2 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	N	- 0.00 0.00	0250,0636	YES	YES	1
90700 - DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), WHEN ADMINISTERED TO INDIVIDUALS YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	N	- 0.00 0.00	0250,0636	YES	YES	1

Chemotherapy

Direct supervision by a qualified healthcare professional and advanced practice training is typically required under state law for nursing staff who provide the administration of chemotherapy drugs. A quote from AMA CPT® --

> "Chemotherapy services are typically highly complex and require direct supervision for any anor all purposes of patient assessment, provision of consent, safety oversight and intraservice supervison of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician or other qualified healthcare professional about these issues."

According to Chapter 11 of the National Correct Coding Intitiative Manual:

> https://apps.para-hcfs.com/para/documents/Chapter11_CPTCodes90000-99999_Final_11.12.19.pdf
>
> "If therapeutic fluid administration is medically necessary (e.g., correction of dehydration, prevention of nephrotoxicity) before or after transfusion or chemotherapy, it may be reported separately."

Not all drug administration performed in the chemotherapy department with or without another chemotherapy treatment is considered a chemotherapy service. The CMS Claims Processing Manual, Chapter 12, 30.5 D. Chemotherapy Administration, states --

> https -- //www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
>
> "The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration."

General principles regarding chemotherapy administration coding --

1. Report subsequent non-chemotherapy infusion of medication using HCPCS code 96367 (additional sequential infusion, up to 1 hour). This code describes the infusion of a second or subsequent non-chemotherapy drug after the initial drug infusion, regardless of whether the initial drug is chemotherapy. The infusion must be sequential, meaning one after the other, not a concurrent (given at the same time) infusion. Code 96367 is reported once per sequential infusion of the same non-chemotherapy substance.

2. When a subsequent chemotherapy infusion follows an initial chemotherapy infusion, report HCPCS 96417 (Chemotherapy administration, intravenous infusion technique; each additional

sequential infusion (different substance/drug), up to 1 hour.) List 96417 separately in addition to code for primary procedure.

3. Report concurrent non-chemotherapy infusion with add-on code HCPCS 96368 (IV infusion; for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure).) Code 96368 in addition to the code for the primary procedure.

    - A concurrent infusion is when multiple infusions are provided simultaneously through the same intravenous line.
    - Multiple substances mixed in one bag are considered one infusion.
    - The concurrent infusion code can only be billed once per day.
    - Code 96368 to report therapeutic/diagnostic infusions only. Do not code it for chemotherapy infusions.

4. Concurrent chemotherapy -- There is no concurrent chemotherapy administration code, although some chemotherapeutic agents are given concurrently. In the usual circumstance where chemotherapy agents are mixed or given concurrently, report the unlisted chemotherapy administration code 96549, unlisted chemotherapy procedure. The services described by sequential infusion codes require that the patient observations do not overlap. Multiple drugs given at the same session are considered sequential injections, rather than concurrent. Sequential injections are reported with 96411 for IV push administration of additional non-chemotherapy drugs/substances at the same session, and 96417 for IV infusion administration of additional non-chemotherapy drugs/substances at the same session.

5. Report a port flush (code 96523) when a patient comes into the office simply to have their port flushed with saline. Do not report 96523 if any other service related to the port (i.e., lab draw or another infusion) is performed that day.

6. Time units are calculated based on how long the fluid infuses into the patient. Time ends when the fluids have infused. Documentation within the medical record must substantiate start and stop times for the services billed. If the documentation does not provide a start and stop time, bill the injection code (96374 for non-chemotherapy drugs, or 96409 for chemotherapy drugs) instead.

7. Services such local anesthesia, IV start, access to indwelling IV (a subcutaneous catheter or port), a flush at the conclusion of an infusion, standard tubing, syringes and supplies are included in the payment for the drug administration service. These services and supplies are not separately billable.

8. If the same drug is given in multiple pushes, only one unit can be billed, whether or not the drug is a chemotherapy or non-chemotherapy drug.

CMS created HCPCS G0498 in 2015 to report the initiation of a chemotherapy infusion by portable pump that will continue in the private/home setting. CMS instructs that when the infusion is initiated in a provider setting and continued in the "community setting," the external infusion pump supplied for patient use is a component of the prolonged chemotherapy administration service, and the pump may not be billed as a separate DME claim to the DME MAC.

https -- //www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1609.pdf

What You Need to Know

Medicare pays for drugs and biologicals which are not usually self-administered by the patient and furnished "incident to" physicians' services rendered to patients while in the physician's office or the hospital outpatient department. In some situations, a hospital outpatient department or physician office may:

- purchase a drug for a medically reasonable and necessary prolonged drug infusion,
- begin the drug infusion in the care setting using an external pump,
- send the patient home for a portion of the infusion, and
- have the patient return at the end of the infusion period.

Medicare reimburses both the traditional prolonged chemotherapy CPT®, 96416, and G0498 the same rate under OPPS --

2020 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **96416,G0498** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 2
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

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Current Descriptor	Fee Schedule		Initial APC	Payment	
96416 - chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump **S - Paid Under OPPS; Separate APC.**	GB (Physician Facility): GB (Physician Non-Facility):	$165.20 $165.20	5694 - Level 4 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	3.832 $309.60 $0.00 $61.92
G0498 - chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion **S - Paid Under OPPS; Separate APC.** **Berenson-Eggers Type of Service:** P7B - ONCOLOGY - OTHER			5694 - Level 4 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	3.832 $309.60 $0.00 $61.92

Chemotherapy administration codes, listed below, are used for highly complex drugs and biologic agents.

Chemotherapy Administration Codes
96401 - Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
96402 - Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic
96405 - Chemotherapy administration; intralesional, up to and including 7 lesions

Chemotherapy Administration Codes (continued)
96406 - Chemotherapy administration; intralesional, more than 7 lesions
96409 - Chemotherapy administration; intravenous, push technique, single or initial substance/drug
96411 - Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)
96413 - Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
96415 - Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)
96416 - Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump [*see also G0498 below]*
96417 - Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)
96420 - Chemotherapy administration, intra-arterial; push technique
96422 - Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour
96423 - Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)
96425 - Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96440 - Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96446 - Chemotherapy administration into peritoneal cavity via indwelling port or catheter
96450 - Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture
96549 - Unlisted chemotherapy procedure
G0498 - Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion

Chemotherapy drugs typically include the J9000-J9999 code set. However, some payors (including some Medicare MACs) have given individual consideration for drugs that have increased adverse patient reactions, require advanced-trained clinical staff preparation and oversight, and/or are considered chemotherapy but are not in the J9xxx range. For those drugs, they will cover a chemotherapy administration code. Below are some examples of drugs which are eligible for reporting with chemotherapy administration codes:

J0202 – Injection, alemtuzumab, 1 mg
J0640 – Injection, leucovorin calcium, per 50 mg
J0642 – Injection, Levoleucovorin (khapzory) 0.5 mg
J1745 – Injection, infliximab, excludes biosimilar 10 mg
J2350 – Injection, ocrelizumab, 1 mg
J2820 – Injection, sargramostim (gm-csf), 50 mcg
J9153 – Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine

Additionally, several MACs offer Local Coverage Articles which list medications deemed appropriate for reporting with a chemotherapy administration code:

ARTICLE ID#	TITLE	CONTRACTOR NAME
A56141	Billing and Coding: Chemotherapy	Palmetto GBA
A55639	Billing and Coding: Chemotherapy Agents for Non-Oncologic Conditions	Wisconsin Physicians Service Insurance Corporation
A52953	Chemotherapy Administration	Noridian Healthcare Solutions, LLC
A52991	Chemotherapy Administration	Noridian Healthcare Solutions, LLC
A52532	Off-Label Cancer Chemotherapy Use	CGS Administrators, LLC

Chapter 12 of the Medicare Claims Processing Manual offers additional chemotherapy examples:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#

30.5 - Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

…

D. Chemotherapy Administration

Chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g.,

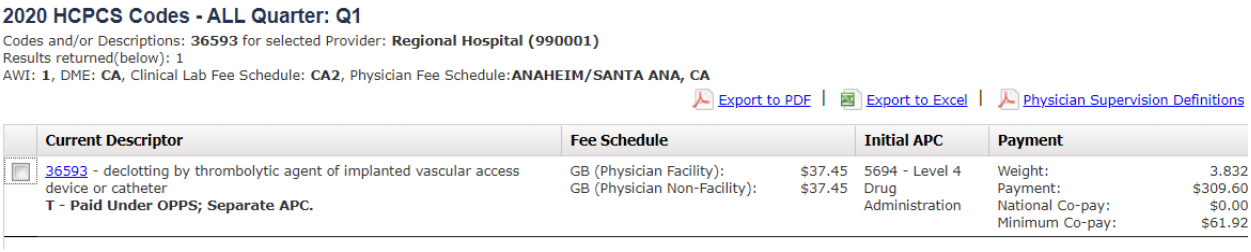
cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers. The following drugs are commonly considered to fall under the category of monoclonal antibodies: infliximab, rituximab, alemtuzumb, gemtuzumab, and trastuzumab. Drugs commonly considered to fall under the category of hormonal antineoplastics include leuprolide acetate and goserelin acetate. The drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes. A/B MACs (B) may provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare. The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration.."

General Billing/Coding Rules for Multiple Drug and Fluid Administrations

Facility coding is based on Hierarchy. There can only be one "initial" procedure for a given date unless two separate IV sites are required.

- The ranking or hierarchy provided below determines the initial procedure. The remaining procedures must be coded as additional or subsequent.
    1. **Chemotherapy services**
    2. **96365 – IV therapy 1st hour**
    3. **96374 – IV injection initial**
    4. **Any other infusion/IV therapy code precedes a hydration code**
    5. **96360 – Hydration 1st hour-this code used as "initial" only if NO OTHER drug is administered as an infusion or IV therapy**
- Establishing IV access is not hydration or IV therapy.
- Hydration procedures must have a diagnosis supporting the procedure, hydration substances include normal saline, D5W, and pre-packaged KCL.
- Initial IV therapy must last longer than 15 minutes, but if less than 16 minutes, the procedure should be charged as an IV injection.
- Drug administration charges are only reported on outpatient/ambulatory care, emergency and observation patients, the service is not charged on inpatients.
- For the charge for an "additional" hour of hydration or IV med therapy the service must last for more than 30 minutes into the additional hour.
- AMA CPT® instructs that "If performed to facilitate the infusion or injection, the following services are included and are not reported separately" --
    1. **Use of local anesthesia**
    2. **IV start**
    3. **Access to indwelling IV, subcutaneous catheter or port**
    4. **Flush at conclusion of infusion**
    5. **Standard tubing, syringes, and supplies**

- For Declotting a catheter or port, report 36593



2020 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **36593** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 1
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

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Current Descriptor	Fee Schedule		Initial APC	Payment	
36593 - declotting by thrombolytic agent of implanted vascular access device or catheter **T - Paid Under OPPS; Separate APC.**	GB (Physician Facility): GB (Physician Non-Facility):	$37.45 $37.45	5694 - Level 4 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	3.832 $309.60 $0.00 $61.92

For hospital billing, there are a number of revenue codes which can be used to report medication administration services. The basic guideline is to list the charge against the "nursing station" providing the service.

Drug Administration Revenue Codes
0260 - IV Therapy - General Classification
0450 - Emergency Room - General Classification
0456 - Emergency Room - Urgent Care
0510 - Clinic - General Classification
0516 - Clinic - Urgent Care Clinic
0761 - Treatment or Observation Room - Treatment Room
0762 - Treatment or Observation Room - Observation Room
0940 - Other Therapeutic Services - General Classification

Concise Billing Scenarios

#	Service	Billing Codes	Billing Code Description
1	Patient receives a saline/hep lock for access	None	Insertion of an access site catheter does not create a billable event
2	Patient receives infusion TKO at a rate of 100 ml/hr for a period of 2 hours	None	Infusion of a fluid for access TKO/KVO is not a billable event
3	Patient receives a hydration infusion "bolus" of less than 30 minutes	None	Hydration must last longer than 30 minutes to be billable
4	Patient receives a med infusion of less than 16 minutes	96374	Med infusions less than 16 minutes are to be billed as an IVP injection
5	Patient receives hydration of 89 minutes	96360	Patient is to be billed for 1 hour hydration, additional hours require greater than 30 minutes of additional time
6	Patient receives IV hydration and a separate injection into the tissues around the mouth.	96360 96374-59 (or XS)	The IM injection is billed in addition to the IV hydration; a modifier is required to bypass a CCI; injection was at a separate body structure/site.
7	Patient receives hydration for 45 minutes and a med injection into the IV line, there is not a medical condition to require the hydration	96374	If the hydration is only a method to admin the drug through the IV line the Patient should only be billed for the IV injection, but not the infusion
8	Patient receives hydration for 45 minutes and a med injection into the IV line, there is a medical condition to require the hydration	96361 96374	If there is a medical requirement for the hydration, then both codes are billable, bill only one initial per encounter, IVP outranks hydration

(continued next page)

#	Service	Billing Codes	Billing Code Description
9	Patient receives IV infusion for 91 minutes, on the 45th minute the Patient receives a 2nd med same site / line infusion for 45 minutes	96365 96366 96368	Patient is to be billed for 1st hour med infusion, additional hour infusion (greater than 30 minutes), and 1 hour concurrent med infusion
10	Patient receives IV infusion for 90 minutes, on the 91st minute the Patient receives a 2nd med same site for 45 minutes	96365 96367	Patient is to be billed for 1st hour med infusion, and 1 hour sequential med infusion, 2nd hour infusion requires greater than 30 minutes
11	Patient receives IV infusion for 91 minutes, the Patient then receives a 2nd med at a new site (if medically necessary) and pump for 45 minutes	96365 96365-59 (or XS) 96366 96367	Patient is to be billed for 1st hour med infusion, add hour infusion, and a 2nd 96365 with a -59 modifier for the initial med infusion at a new site. *
12	Patient receives med infusion for 45 minutes, and a 2nd drug is injected into the IV line	96365 96375	Patient is to be billed for an IV med infusion, plus an IV injection, only one initial code per encounter
13	Patient receives med infusion for 45 minutes, and a 2nd drug is injection into the IV line, and then 31 minutes later the same drug is injected into the IV line	96365 96375 96376	Patient is to be billed for IV med infusion, injection of a drug into IV line, and then the same drug injected into an IV line, outside the 30 minute inclusion limit
14	Patient receives med infusion for 45 minutes, and a 2nd drug is injection into the IV line, and then 20 minutes later the same drug is injected into the IV line	96365 96375	Patient is to be billed for IV med infusion, injection of a drug into IV line, because the same drug was injected within 30 minutes no additional code(s)
15	Patient receives med infusion for 45 minutes, and a 2nd drug is injected into the IV line, and then a 3rd drug is injected into the IV line	96365 96375 x 2	Patient is to be billed for an IV med infusion, injection into an IV line, and sequential drug injection into an IV line

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#	Service	Billing Codes	Billing Code Description
16	Patient is injected a pain med IM and then also a vaccine	96372 90471	Patient is to be billed IM injection and a vaccine admin injection
17	Patient is injected the same drug twice IM 15 minutes apart	96372 x 2	Patient is to be billed the IM injection twice
18	Patient receives an infusion of 2 different chemotherapy meds, first one infused for 1 hour, 2nd infusion for 30 minutes	96413 96411	Patient to be billed for 1st hour of chemotherapy as infusion and 2nd chemotherapy medication as intravenous push, since the 2nd medication was infused less than 31 minutes.
19	Patient receives 2 chemo medications administered by infusion, first one for 60 minutes, and the second for an additional 60 minutes sequentially.	96413 96415	Patient is to be billed for 1st hour infusion for the first chemotherapy medication, and the add-on code 96415 for the 2nd chemo medication. Medications were administered sequentially.

Frequently Asked Questions --

Question #1 -- Regarding hydration vs. an infusion of medication -- does an infusion of potassium qualify as a medication if the medical necessity of potassium is documented?

2020 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **96360,96365** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 2
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule		Initial APC	Payment	
96360 - intravenous infusion, hydration; initial, 31 minutes to 1 hour **S - Paid Under OPPS; Separate APC.**	GB (Physician Facility): GB (Physician Non-Facility):	$39.63 $39.63	5693 - Level 3 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	2.2742 $183.74 $0.00 $36.75
96365 - intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour **S - Paid Under OPPS; Separate APC.**	GB (Physician Facility): GB (Physician Non-Facility):	$83.09 $83.09	5693 - Level 3 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	2.2742 $183.74 $0.00 $36.75

Answer -- Having researched this in numerous authoritative reference publications, we find --

- No instruction defines a point when the vitamin and mineral additives in a pre-packaged IV solution bag might constitute a medication.
- The CPT® manual states -- "Codes 96360-96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal salien+30mEq KCl/liter), but are not used to report infusion of drugs or other substances."
- Both CPT and CMS indicate that fluid with electrolytes does not constitute medication infusion, but hydration. Potassium is an electrolyte; therefore we find that an infusion of IV fluid with potassium qualifies as hydration.
- A "banana bag" typically includes thiamine, folic acid, magnesium, and multivitamins. Since this is more than electrolytes, a banana bag infusion meets the definition of a medication infusion per CPT®.

Question #2 -- What constitutes a minimum flow rate for hydration therapy?

- There is no CPT® or CMS guidance on the rate of flow that qualifies for hydration; however, we found one Medicare Administrative Contractor statement that providers should not bill hydration for an infusion which addresses an imbalance of less than 500 ml of volume.
- If the hydration flow rate is 100 ml per hour or less (for an adult patient), PARA does not recommend billing either hydration or medication infusion charges; the service should be considered a component of the outpatient room rate or visit charge.
- Medicare's 2020 Medically Unlikely Edit (MUE) for CPT® 96361 (additional hour of hydration therapy) is 24.

The references supporting these findings is provided below.

1. The 2019 CPT® code book, guideline for Hydration offers the following instruction --

   "Codes 96360-96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal saline+30mEq KCL/liter) but are not used to report infusion of drugs or other substances. …"

2. The Medicare Claims Processing Manual -- Chapter 12 - Physicians/Nonphysician Practitioners repeats the CPT® instructions --

   https -- //www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

   Hydration - The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and/or electrolytes (e.g. normal saline, D5-1/2 normal saline +30 mg EqKC1/liter) but are not used to report infusion of drugs or other substances.

3. Novitas LCD L34960 – Hydration Therapy – is instructive --

   https -- //www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34960&ver=21&name=331*1&UpdatePeriod=696&bc=AQAAEAAAAAAAAA%3d%3d&

   …**Indications --**

   The clinical manifestations of dehydration or volume depletion are related to the volume and rate of fluid loss, the nature of the fluid that is lost, and the responsiveness of the vasculature to volume reduction. Rehydration with fluids containing sodium as the principal solute, preferentially expand the extracellular fluid volume; a 1-liter infusion of normal saline may expand blood volume by about 300 ml. In general, an imbalance of less than 500 ml of volume is not likely to require intravenous rehydration.

   - These CPT codes require the direct supervision of the physician. Under levels of supervision (see 42 CFR 410.32 (b)(3)(ii)), direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room during the entire time the procedure is performed.
   - When performed in conjunction with chemotherapy, these CPT codes are covered only when infusion is prolonged and done sequentially (done hour(s) before or after administration of chemotherapy), and when the volume status of a beneficiary is compromised or will be compromised by side effects of chemotherapy or an illness.

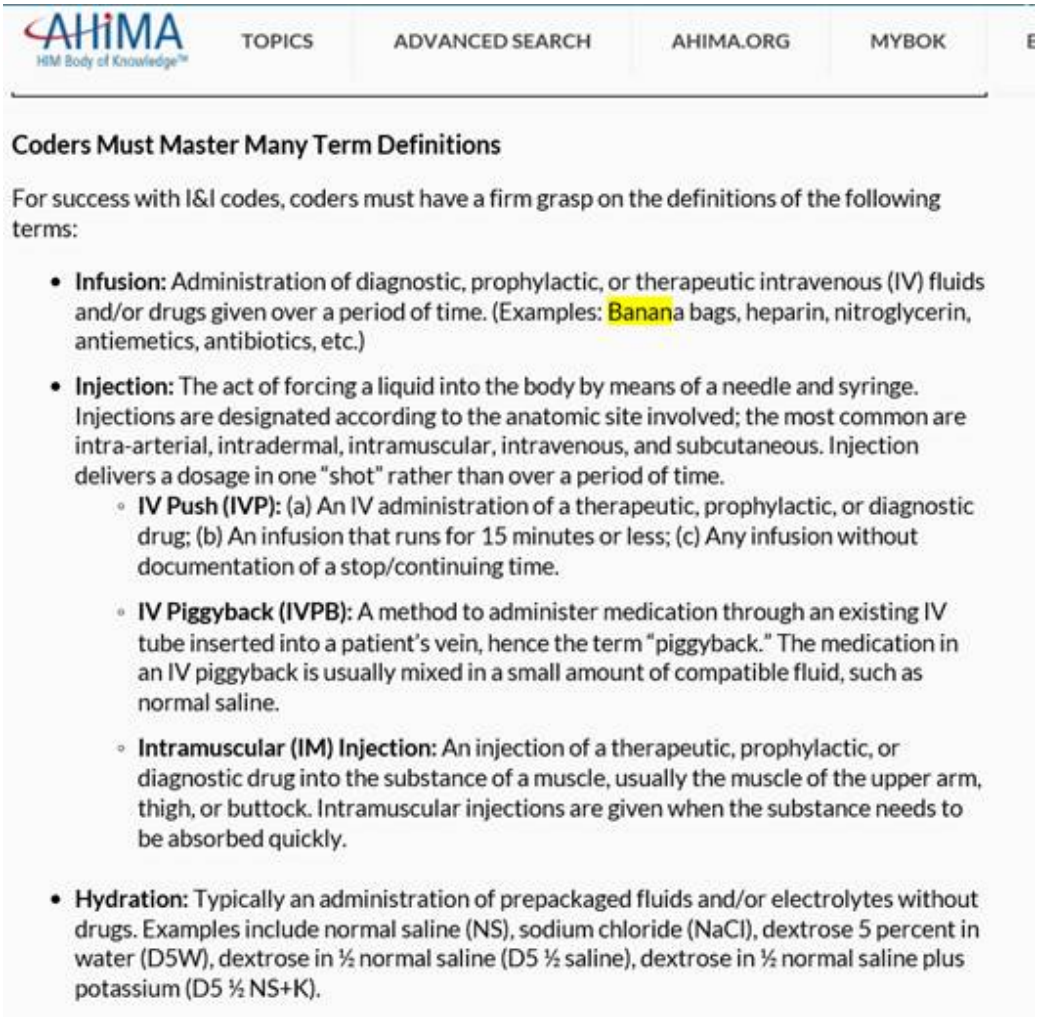
   Limitations --

   - Rehydration with the administration of an amount of fluid equal to or less than 500 ml is not reasonable and necessary.

- These CPT codes are not to be used for intradermal, subcutaneous or intramuscular or routine IV drug injections.
- Hanging of D5W or other fluid just prior to administration of chemotherapy (minutes) is not hydration therapy and should not be billed with these codes.
- When the sole purpose of fluid administration (e.g. saline, D5W) is to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic; therefore, these infusion CPT codes should not be billed as hydration therapy.
- Administration of fluid in the course of transfusions to maintain line patency or between units of blood product is, likewise, not to be separately billed as hydration therapy.

4. The AHIMA article "Injection and Infusion Coding Offers High Stakes -- Outpatient Coders Must Play Their Cards Right" --

https -- //bok.ahima.org/doc?oid=107707#.XdwvIl3sZ9A



AHIMA HIM Body of Knowledge™ TOPICS ADVANCED SEARCH AHIMA.ORG MYBOK

Coders Must Master Many Term Definitions

For success with I&I codes, coders must have a firm grasp on the definitions of the following terms:

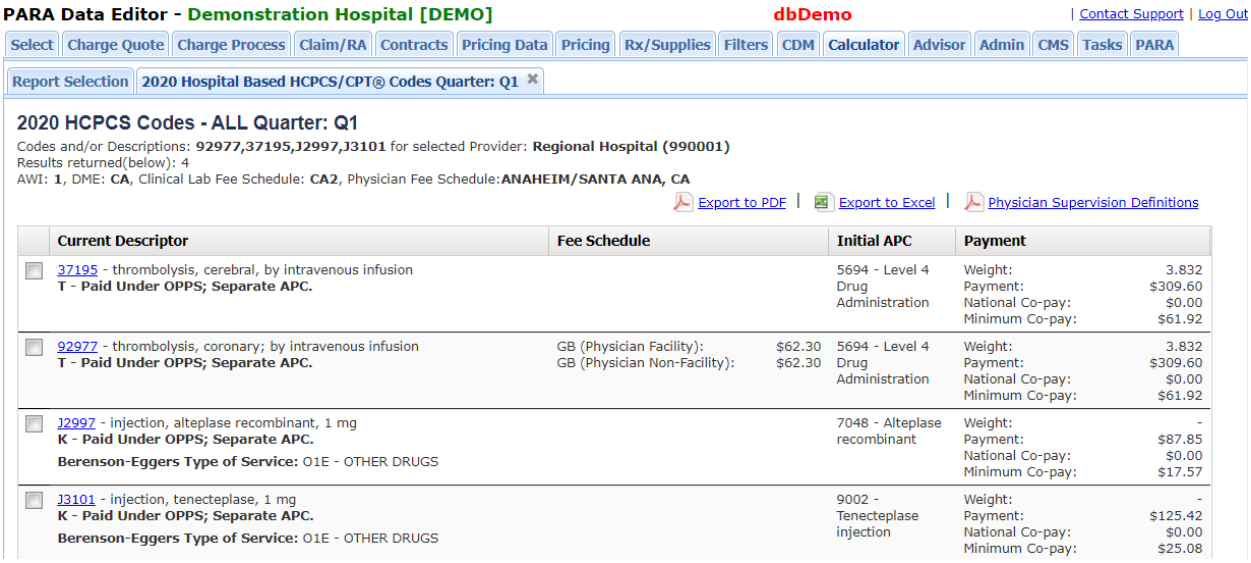
- **Infusion:** Administration of diagnostic, prophylactic, or therapeutic intravenous (IV) fluids and/or drugs given over a period of time. (Examples: Banana bags, heparin, nitroglycerin, antiemetics, antibiotics, etc.)
- **Injection:** The act of forcing a liquid into the body by means of a needle and syringe. Injections are designated according to the anatomic site involved; the most common are intra-arterial, intradermal, intramuscular, intravenous, and subcutaneous. Injection delivers a dosage in one "shot" rather than over a period of time.
  - **IV Push (IVP):** (a) An IV administration of a therapeutic, prophylactic, or diagnostic drug; (b) An infusion that runs for 15 minutes or less; (c) Any infusion without documentation of a stop/continuing time.
  - **IV Piggyback (IVPB):** A method to administer medication through an existing IV tube inserted into a patient's vein, hence the term "piggyback." The medication in an IV piggyback is usually mixed in a small amount of compatible fluid, such as normal saline.
  - **Intramuscular (IM) Injection:** An injection of a therapeutic, prophylactic, or diagnostic drug into the substance of a muscle, usually the muscle of the upper arm, thigh, or buttock. Intramuscular injections are given when the substance needs to be absorbed quickly.
- **Hydration:** Typically an administration of prepackaged fluids and/or electrolytes without drugs. Examples include normal saline (NS), sodium chloride (NaCl), dextrose 5 percent in water (D5W), dextrose in ½ normal saline (D5 ½ saline), dextrose in ½ normal saline plus potassium (D5 ½ NS+K).

Question #3 -- When the ER gives tenecteplase (TNKase), a tissue plasminogen activator, to a heart attack patient prior to transfer to the tertiary center for a heart cath procedure, is there a code other than the regular injection codes to report?

Answer -- There are two special codes for the administration of thrombolytics like Tenecteplase and Activase. 37195 is used to report thrombolysis, *Cerebral*, by IV Infusion, and 92977 reports Thrombolysis, *Coronary*, by IV Infusion. However, some thrombolytics are injected, not infused – the codes for infusions are appropriate only for infusions over time – a minimum of 15 minutes.

Hospital reimbursement for these administration procedures is higher than the usual IV administration codes such as 96374.

Be sure the claim for thrombolytic therapy includes the pharmaceutical J-Code, with the appropriate units, for the drug administered. Claims for either 37195 or 92977 may be denied as "Not Medically Necessary" if the J-Code for a thrombolytic agent is missing on the claim. Both Activase and Tenecteplase are Status K Drugs paid separately under Medicare OPPS.



CMS 2020 OPPS CCI Manual excerpt regarding separate IV sites --

www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/

B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

1. CPT codes 96360-96379 and C8957 describe hydration and therapeutic or diagnostic injections and infusions of non-chemotherapeutic drugs. CPT codes 96401-96549 describe administration of chemotherapy or other highly complex drug or biologic agents. Issues related to chemotherapy administration are discussed in this section as well as Section N (Chemotherapy Administration).

2. CPT codes 96360, 96365, 96374, 96409, and 96413 describe "initial" service codes. For a patient encounter, only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To report two different "initial" service codes, use NCCI PTP-associated modifiers.

Revision Date (Medicare): 1/1/2020
XI-3

Excerpts from the CMS Claims Processing Manual, Chapter 12

https -- //www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#

30.5 - Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

(Rev. 968. Issued -- 05-26-06; Effective/Implementation Dates -- 06-26-06)

A. General

Codes for Chemotherapy administration and nonchemotherapy injections and infusions include the following three categories of codes in the American Medical Association's Current Procedural Terminology (CPT) --

1. Hydration;

2. Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy); and

3. Chemotherapy administration.

Physician work related to hydration, injection, and infusion services involves the affirmation of the treatment plan and the supervision (pursuant to incident to requirements) of nonphysician clinical staff.

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(CMS Claims Processing Manual – continued)

B. Hydration

The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and /or electrolytes (e.g. normal saline, D5-1/2 normal saline +30 mg EqKC1/liter) but are not used to report infusion of drugs or other substances.

C. Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy)

A therapeutic, prophylactic, or diagnostic IV infusion or injection, other than hydration, is for the administration of substances/drugs. The fluid used to administer the drug (s) is incidental hydration and is not separately payable.

If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable --

1. Use of local anesthesia;

2. IV start;

3. Access to indwelling IV, subcutaneous catheter or port;

4. Flush at conclusion of infusion; and

5. Standard tubing, syringes and supplies.

Payment for the above is included in the payment for the chemotherapy administration or nonchemotherapy injection and infusion service.

If a significant separately identifiable evaluation and management service is performed, the appropriate E & M code should be reported utilizing modifier 25 in addition to the chemotherapy administration or nonchemotherapy injection and infusion service. For an evaluation and management service provided on the same day, a different diagnosis is not required.
The CPT 2006 includes a parenthetical remark immediately following CPT code 90772 (Therapeutic, prophylactic or diagnostic injection; (specify substance or drug); subcutaneous or intramuscular.) It states, “Do not report 90772 for injections given without direct supervision. To report, use 99211.” This coding guideline does not apply to Medicare patients. If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is one of the requirements for coverage of an incident to service, then the injection is not covered. The physician would also not report 99211 as this would not be covered as an incident to service.

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(CMS Claims Processing Manual – continued)

D. Chemotherapy Administration

Chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers. The following drugs are commonly considered to fall under the category of monoclonal antibodies -- infliximab, rituximab, alemtuzumb, gemtuzumab, and trastuzumab. Drugs commonly considered to fall under the category of hormonal antineoplastics include leuprolide acetate and goserelin acetate. The drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes. A/B MACs (B) may provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare.

The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration.

If performed to facilitate the chemotherapy infusion or injection, the following services and items are included and are not separately billable --

1. Use of local anesthesia;

2. IV access;

3. Access to indwelling IV, subcutaneous catheter or port;

4. Flush at conclusion of infusion;

5. Standard tubing, syringes and supplies; and

6. Preparation of chemotherapy agent(s).

Payment for the above is included in the payment for the chemotherapy administration service.

If a significant separately identifiable evaluation and management service is performed, the appropriate E & M code should be reported utilizing modifier 25 in addition to the chemotherapy code. For an evaluation and management service provided on the same day, a different diagnosis is not required.

E. Coding Rules for Chemotherapy Administration and Nonchemotherapy Injections and Infusion Services

Instruct physicians to follow the CPT coding instructions to report chemotherapy administration and nonchemotherapy injections and infusion services with the exception listed in subsection C for CPT code 90772. The physician should be aware of the following specific rules.

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(CMS Claims Processing Manual – continued)

When administering multiple infusions, injections or combinations, the physician should report only one "initial" service code unless protocol requires that two separate IV sites must be used. The initial code is the code that best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code should be reported. For example, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code.

The CPT includes a code for a concurrent infusion in addition to an intravenous infusion for therapy, prophylaxis or diagnosis. Allow only one concurrent infusion per patient per encounter. Do not allow payment for the concurrent infusion billed with modifier 59 unless it is provided during a second encounter on the same day with the patient and is documented in the medical record.

For chemotherapy administration and therapeutic, prophylactic and diagnostic injections and infusions, an intravenous or intra-arterial push is defined as -- 1.) an injection in which the healthcare professional is continuously present to administer the substance/drug and observe the patient; or 2.) an infusion of 15 minutes or less.

The physician may report the infusion code for "each additional hour" only if the infusion interval is greater than 30 minutes beyond the 1 hour increment. For example, if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the physician would report the "initial" code up to 1 hour and the add-on code for the additional 45 minutes.

Several chemotherapy administration and nonchemotherapy injection and infusion service codes have the following parenthetical descriptor included as a part of the CPT code, "List separately in addition to code for primary procedure." Each of these codes has a physician fee schedule indicator of "ZZZ" meaning this service is allowed if billed with another chemotherapy administration or nonchemotherapy injection and infusion service code.

Do not interpret this parenthetical descriptor to mean that the add-on code can be billed only if it is listed with another drug administration primary code. For example, code 90761 will be ordinarily billed with code 90760. However, there may be instances when only the add-on code, 90761, is billed because an "initial" code from another section in the drug administration codes, instead of 90760, is billed as the primary code.

Pay for code 96523, "Irrigation of implanted venous access device for drug delivery systems," if it is the only service provided that day. If there is a visit or other chemotherapy administration or nonchemotherapy injection or infusion service provided on the same day, payment for 96523 is included in the payment for the other service.

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F. Chemotherapy Administration (or Nonchemotherapy Injection and Infusion) and Evaluation and Management Services Furnished on the Same Day

For services furnished on or after January 1, 2004, do not allow payment for CPT code 99211, with or without modifier 25, if it is billed with a nonchemotherapy drug infusion code or a chemotherapy administration code. Apply this policy to code 99211 when it is billed with a diagnostic or therapeutic injection code on or after January 1, 2005.

Physicians providing a chemotherapy administration service or a nonchemotherapy drug infusion service and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with §30.6.6 using modifier 25. The A/B MACs (B) pay for evaluation and management services provided on the same day as the chemotherapy administration services or a nonchemotherapy injection or infusion service if the evaluation and management service meets the requirements of section §30.6.6 even though the underlying codes do not have global periods. If a chemotherapy service and a significant separately identifiable evaluation and management service are provided on the same day, a different diagnosis is not required.

In 2005, the Medicare physician fee schedule status database indicators for therapeutic and diagnostic injections were changed from T to A. Thus, beginning in 2005, the policy on evaluation and management services, other than 99211, that is applicable to a chemotherapy or a nonchemotherapy injection or infusion service applies equally to these codes.