# CHARGE PROCESS: HYDRATION, INFUSIONS, AND INJECTIONS

CorroHealth

# CONTENTS

Coding for IV 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 drug administration. This paper provides coding information, code tables, general billing guidance, references, and billing scenarios to assist providers in reporting these services correctly.

# Hydration and IV Therapy

Hydration is the administration of prepackaged IV 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.). Hydration is reported with time-based HCPCS 96360 and 96361.

IV Drug Therapy is the administration of medications into a vein (or artery) by either injection (IV push) or infusion. IV drug therapy is reported with time-based HCPCS which describe the initial, subsequent, and/or concurrent administration of each substance by push or infusion into an intravenous or intra-arterial access line or into subcutaneous tissue.

An IV or Intra-arterial Push (IVP) may be reported to describe:

> (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.

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

An Infusion describes 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.

IV Drug Therapy Charge Capture -- 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 status. For inpatients, IV drug administration is not separately charged, but considered included in the room rate if performed by regularly assigned unit nursing staff.

1. Hydration and IV therapy are time-based charges measured by the first hour and subsequent hours.
2. Hydration therapy must last 31 minutes to 1 hour to qualify for an initial (first) hour code.
3. IV infusion less than 16 minutes may be reported as an IV injection.

4. Hydration less than 30 minutes is not 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 certain percutaneous vascular procedures.
5. 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.
6. Hydration procedures must have a diagnosis supporting the medical necessity of the procedure.

| 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]* |

## Injection/Push into IV lines and Intramuscular Injections (non-chemotherapy)

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.

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

| 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* |

| 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 |

## General Principles for Coding Multiple Drug and Fluid Administration Procedures

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 Hydration Chemo Admin Codes Charge Sheet assists in assignment of administration codes.

- 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 push 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 push 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 with a thrombolytic, report 36593 (Declotting by thrombolytic agent of implanted vascular access device or catheter), along with the thrombolytic, such as Cathflo, J2997 (Injection, alteplase recombinant, 1 mg).

# Chemotherapy

Chemotherapy is 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." Chemotherapy drugs are most commonly used to treat cancer, but may also be used to treat non-oncologic conditions. 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 or all purposes of patient assessment, provision of consent, safety oversight and intraservice supervision 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 Initiative 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 –

> "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 chemotherapy drugs/substances at the same session, and 96417 for IV infusion administration of additional chemotherapy drugs/substances at the same session.
5. Report a port flush (code 96523) when a patient encounter is only a port flush 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.

9. Prolonged Chemotherapy Infusions -- 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.

   > 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.

   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.

Medicare issued MLN Matters article SE1609 to ensure providers understand the obligation to supply the portable pump when reporting G0498:

> 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.
>
> In this case, the drug or biological, the administration, and the external infusion pump is billed to your MAC. **However, because prolonged drug and biological infusions started incident to a physician's service using an external pump should be treated as an incident to service, it cannot be billed on suppliers' claims to DME MACs.**

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

**2023 HCPCS Codes - ALL Quarter: Q4**

Codes and/or Descriptions: **G0498,96416** for selected Provider: **DEMODEV (990001)**
Results returned(below): 2
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)**

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Physician Supervision Definitions

| 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<br>**S - Procedure or service, not discounted when multiple** | GB (Physician Facility): $151.71<br>GB (Physician Non-Facility): $151.71 | 5694 - Level 4 Drug Administration | Weight: 3.89<br>Payment: $ 332.62<br>National Co-pay: $0.00<br>Minimum Co-pay: $66.53 |
| 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<br>**S - Procedure or service, not discounted when multiple**<br>**Berenson-Eggers Type of Service:** P7B - ONCOLOGY - OTHER | Contractor Priced | 5694 - Level 4 Drug Administration | Weight: 3.89<br>Payment: $ 332.62<br>National Co-pay: $0.00<br>Minimum Co-pay: $66.53 |

# Vaccines

Vaccines consist of the administration of a product to stimulate the body's immunity from an infectious disease or harmful agent.

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

The vaccine product codes should be reported with the appropriate vaccine administration code (90461, 90462, 90471, 90472) based on the age of the patient and the number of vaccines administered during the encounter.

Childhood vaccine administration codes -- 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 more than one vaccine is administered 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.

| Immunization Administration (with counseling, up to age 18) |
|---|
| 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 |
| 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) |

State "Vaccines for Children" Programs may impose unique coding rules which differ from the CPT® instructions. Providers participating in the VFC program must carefully abide by the state VFC coding requirements applicable for the state in which the VFC service is rendered.

Most immunizations provided without counseling and for patients over age 18 are reported with 90471 and 90472; however, effective September all COVID vaccine and administration codes in a healthcare setting are reported with 90480; the administration of a COVID vaccine in the home setting is reported with M0201.

| Immunization Administration (without counseling) |
|---|
| 90471 - immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 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) |
| 90473 - immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) |
| 90474 - immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure) |
| 90480 - Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-cov-2) (coronavirus disease [COVID-19]) vaccine, single dose |
| M0201 - COVID-19 vaccine administration inside a patient's home; reported only once per individual home per date of service when only covid-19 vaccine administration is performed at the patient's home |

The vaccine drug is reported with product codes 90476 – 90759. CMS publishes Influenza vaccine pricing annually on the CMS Vaccine Pricing website:

## Flu Season Payment Allowances & Effective Dates

- **Payment Allowances and Effective Dates for the 2023-2024 Flu Season:**

| Code | Labeler Name | Vaccine Name | Payment Allowance | Effective Dates |
|---|---|---|---|---|
| 90662 | Sanofi Pasteur | Fluzone High-Dose Quadrivalent (2023/2024) | $73.403 | 08/01/2023 – 07/31/2024 |
| 90672 | MedImmune | FluMist Quadrivalent (2023/2024) | $27.788 | 08/01/2023 – 07/31/2024 |
| 90674 | Seqirus | Flucelvax Quadrivalent (2023/2024) (Preservative Free) | $34.172 | 08/01/2023 – 07/31/2024 |
| 90682 | Sanofi Pasteur | Flublok Quadrivalent (2023/2024) (Preservative Free) | $73.403 | 08/01/2023 – 07/31/2024 |
| 90686 | GlaxoSmithKline | Fluarix Quadrivalent (2023/2024) (Preservative | $22.350 | 08/01/2023 – 07/31/2024 |

# Facility Charge Revenue Codes

Hospital facility fees for medication administration may be reported under a number of revenue codes. The basic guideline is to use the revenue code which best represents the "nursing station" providing the service.

| Medication 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 beyond the first hour |
| 6 | Patient receives IV hydration and a separate injection into the tissues around the mouth. | 96360<br><br>96372-59 (or -XS) | In addition to the IV hydration, an IM injection is billed. 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<br><br>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<br>96366<br>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<br>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<br>96365-59 (or XS)<br>96366<br>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<br>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<br>96375<br>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<br>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<br>96375<br>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 |

(continued)

| # | Service | Billing Codes | Billing Code Description |
|---|---|---|---|
| 16 | Patient is injected a pain med IM and then also a vaccine | 96372<br>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<br>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<br>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<br>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. |
| 20 | Patient receives 142 mg of Oxaliplatin administered concurrently via same IV line, piggyback (IVPB) over the course of 2 hours and 20 minutes; patient also receives 888 mg of Leucovorin via IV infusion over 2 hrs. | 96413<br>96415<br>96368 | Report 96413 and 96415 for the oxaliplatin administration.<br>Report 96368 for the concurrent administration of Leucovorin, which is not a chemotherapeutic drug. |

# Frequently Asked Questions

## 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?

Answer – Yes, If the ordering provider has documented a specific electrolyte deficiency that is treated by an electrolyte or other additive in the IV fluid (whether pre-packaged or mixed in the pharmacy) the IV infusion or push code set (96365, 96366, or 96374) may be reported. To illustrate this concept, CGS, a Medicare Administrative Contractor in the Midwest, repeated four clinical scenarios in an article adapted from the AHA Coding Clinic, Volume 12; Number 1; First Quarter 2012:

Clinical Scenarios

1. A patient is seen in a facility because of dehydration due to continuous nausea with vomiting. She is given a prepackaged solution of 1,000 cc's of D5 ½ NS with 20 mEq KCL added to the bag (prepared by the pharmacy). The hydration is administered for an hour and 15 minutes. CPT code 96360, Intravenous infusion, hydration; initial, 31 minutes to 1 hour, would be reported for this encounter because there was no other intravenous infusion service performed during this encounter and the primary reason for the encounter was to administer the fluids and electrolyte(s) due to fluid loss from the patient's continuous nausea with vomiting. The additional 15 minutes would not be reported due to the hydration services not being greater than 30 minutes past the initial hour.
2. A patient arrived in the emergency department febrile, and dehydrated with a suspicious chest x-ray indicating possible pneumonia. The patient received an intravenous hydration infusion over six hours of Lactated Ringers as well as an infusion of Vancomycin over 1 hour. How would the hydration and administration of Vancomycin be reported? The medically necessary hydration would be reported with six units of 96361 and the infusion of antibiotics would be reported as the primary infusion with one unit of 96365.
3. A 55 year-old diabetic female is brought to the emergency department due to acute altered level of consciousness. Blood glucose level initially is 42 mg1dL. The patient is promptly administered dextrose 50% (D50) 25g IV push for the altered level of consciousness at 08:29 am. Her blood glucose at 08:37 is 219 mgl dL. What is the correct CPT code for the D50? An IV push code would be used for the D50 since length of infusion time is not documented and the D50 is of a therapeutic (not hydration) nature.
4. A patient was seen for low potassium level. He received a one hour bolus of intravenous fluid mixed with potassium for treatment of his low potassium level. What would the correct CPT code be for this encounter? 96365, *infusion, for therapeutic, prophylactic or diagnostic purposes*; *initial; up to one hour*. Since the potassium bolus is targeted at the treatment of the patient's low blood levels, the infusion becomes therapeutic as opposed to hydration.

***Reviewed: 12.15.22***

Prior to assigning the infusion code set 96365-96366 or 96374, the decision to report an infusion rather than hydration should take into consideration the following points.

- Does the ordering practitioner's documentation indicate the primary intent of IV therapy is to correct an imbalance of electrolytes (or glucose etc.) rather than to deliver ordinary hydration?
- 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 saline+30mEq KCl/liter), but are not used to report infusion of drugs or other substances."

- A "banana bag" typically includes thiamine, folic acid, magnesium, and multivitamins. Since these ingredients constitute more than electrolytes, a banana bag infusion meets the definition of a medication infusion per CPT®.

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

Answer -- While there is no CPT® or CMS guidance on the rate of flow that qualifies for hydration, 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), we do not recommend billing either hydration; the service should be considered a component of the outpatient room rate or visit charge.

Medicare's 2023 Medically Unlikely Edit (MUE) for CPT® 96361 (additional hour of hydration therapy) is 24.

The references supporting this guidance are provided below.

1. CPT® 2023 Professional Edition 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. …"

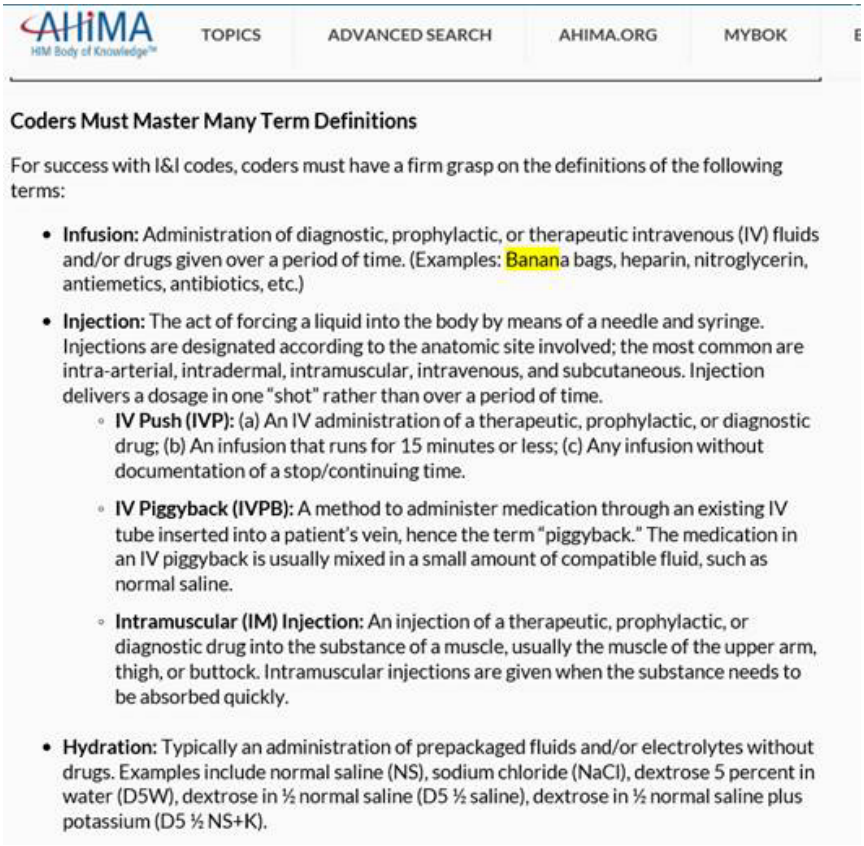
2. The Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners repeats the CPT® instructions –

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

   …

   B. Hydration The hydration codes are used to report a hydration IV infusion which consists of a prepackaged 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. AHIMA article "Injection and Infusion Coding Offers High Stakes: Outpatient Coders Must Play Their Cards Right" –



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**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).

4. Novitas LCD L34960 – Hydration Therapy is instructive –

   History/Background and/or General Information

   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 milliliters (mL). In general, an imbalance of less than 500 mL of volume is not likely to require intravenous rehydration.

   Hydration therapy services require the direct supervision of the physician. Refer to CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 60.1 for additional information regarding direct supervision.

   Covered Indications

   When performed in conjunction with chemotherapy, hydration therapy services are considered medically reasonable and necessary:

   1. When infusion is prolonged and done sequentially (done hour[s] before or after administration of chemotherapy; and
   2. When the volume status of a beneficiary is compromised or will be compromised by side effects of chemotherapy or an illness.

Limitations

The following are considered not medically reasonable and necessary:

1. Rehydration with the administration of an amount of fluid equal to or less than 500 mL is considered not reasonable and necessary.
2. Hydration therapy services are not to be used for intradermal, subcutaneous or intramuscular or routine IV drug injections.
3. Hanging of Dextrose 5% in Water (D5W) or other fluid just prior to administration of chemotherapy (minutes) is not hydration therapy.
4. Hydration therapy services may not be used in addition to prolonged infusion services.
5. 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 services are not hydration therapy.
6. Administration of fluid in the course of transfusions to maintain line patency or between units of blood product is, likewise, not hydration therapy.
7. Administration of fluid to maintain line patency or flush lines between different agents given at the same chemotherapy session is not hydration therapy.
8. Infusion of saline, an antiemetic, or any other non-chemotherapy when these drugs are administered at the same time as chemotherapy (within minutes) is not hydration therapy.
9. Fluid used to administer drug(s) is incidental hydration and not hydration therapy.

## 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, which require a minimum of 15 minutes.

Hospital reimbursement under Medicare OPPS 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.

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

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Report Selection | 2022 Hospital Based HCPCS/CPT® Codes Quarter: Q2

2022 HCPCS Codes - ALL Quarter: Q2

Codes and/or Descriptions: 37195,92977,J3101 for selected Provider: DEMODEV (990001)
Results returned(below): 3
AWI: 1, DME: CA, Clinical Lab Fee Schedule: CA2, Physician Fee Schedule:LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)

Export to PDF | Physician Supervision Definitions | Export to Excel

| Current Descriptor | Fee Schedule | Initial APC | Payment |
|---|---|---|---|
| 37195 - thrombolysis, cerebral, by intravenous infusion<br>**T - Procedure or service, multiple reduction applies** | Contractor Priced | 5694 - Level 4 Drug Administration | Weight: 3.8685<br>Payment: $ 325.64<br>National Co-pay: $0.00<br>Minimum Co-pay: $65.13 |
| 92977 - thrombolysis, coronary; by intravenous infusion<br>**T - Procedure or service, multiple reduction applies** | GB (Physician Facility): $60.62<br>GB (Physician Non-Facility): $60.62 | 5694 - Level 4 Drug Administration | Weight: 3.8685<br>Payment: $ 325.64<br>National Co-pay: $0.00<br>Minimum Co-pay: $65.13 |
| J3101 - injection, tenecteplase, 1 mg<br>**K - Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals**<br>**Berenson-Eggers Type of Service:** O1E - OTHER DRUGS | | 9002 - Tenecteplase injection | Weight: -<br>Payment: $ 134.76<br>National Co-pay: $0.00<br>Minimum Co-pay: $26.96 |

4. **There is some debate as to when you can charge IV medication administration solely by the start and stop times of the physician's order, regardless of the frequency/duration specified in the order. For example, the provider placed an order "Joe Smith IVPB antibiotic 4/22/22 duration of 1 hour." If the start time was 12:00, and the stop time was 14:00, can we charge for only the one hour because the provider's original order stated one hour?**

Answer – We recently heard from a Critical Access Hospital about a deficiency that was identified in their IV therapy documentation by a Medicare MAC auditor performing a "Probe and Educate" review of their infusion coding. That auditor asserted that an infusion with a duration of two hours was not supported by the physician order, which specified an infusion of one hour. We surmise the auditor's concern was the higher charges for a longer period of infusion, which period was not specifically supported by the physician order, nor justified by nursing notes which would explain the slower rate of infusion.

If the physician order stipulates an infusion of one hour, and the difference between the time stipulated in the order and time taken for the infusion is significantly different, an auditor may find that the medical record does not support the additional time spent in administering the medication. At minimum, there should be nursing documentation which explains why the infusion took more time to carry out than stipulated in the provider order.

The Medicare Conditions of Participation regulations offers only general guidance. The CMS State Operations Manual, which provides instructions to surveyors to evaluate whether hospitals meet Medicare's Conditions of Participation, simply refers to "accepted standards of practice."

An excerpt from Medicare's State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals is provided on the following page:

CMS State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

"Accepted Standards of Practice

Hospital policies and procedures for the preparation and administration of all drugs and biologicals must not only comply with all applicable Federal and State laws, but also must be consistent with accepted standards of practice based on guidelines or recommendations issued by nationally recognized organizations with expertise in medication preparation and administration. Examples of such organizations include, but are not limited to:

- American Society of Health-System Pharmacists (http://www.ashp.org/default.aspx)
- Infusion Nurses Society (http://www.ins1.org)
- Institute for Safe Medication Practices (www.ismp.org)
- National Coordinating Council for Medication Error Reporting and Prevention (www.nccmerp.org)
- U.S Pharmacopeia (www.usp.org)

..."

The Infusion Nurses Society therefore serves as a recognized source for accepted standards of practice based on guidelines. That organization publishes "Infusion Nursing Standards of Practice," which contains "Standard 10 – Orders for the Initiation and Management of Infusion Therapy. That standard states that "Infusion therapy shall be initiated, changed, or discontinued upon the order of a licensed independent practitioner."

http://www.incativ.es/documentos/guias/INS_Standards_of_Practice_2011%5B1%5D.pdf

## 10. ORDERS FOR THE INITIATION AND MANAGEMENT OF INFUSION THERAPY

**Standard**

10.1 Infusion therapy shall be initiated, changed, or discontinued upon the order of a licensed independent practitioner (LIP).
10.2 The nurse shall verify that the LIP's order is complete by inclusion of patient identification; fluid type, volume, and a specific infusion rate; specific medication(s), dosage(s), route, and frequency of administration; and any special considerations.
10.3 The nurse shall verify that the LIP's order is clear, concise, legible, and complete prior to initiation, change, or discontinuation of infusion therapy.
10.4 Use of verbal and telephone orders shall be established in organizational policies, procedures, and/or practice guidelines.
10.5 The nurse shall accept only those abbreviations approved by the organization.
10.6 Appropriateness and accuracy of the prescribed therapy shall be assessed and documented using the nursing process.
10.7 All patient medications shall be reconciled at the time of admission, transfer within or between health care systems, and discharge.

To minimize the risk that the infusion time is not supported by documentation, hospitals should establish a nursing procedure to be followed when the physician order for administration of medication includes a specified duration. If the actual administration time materially deviates from the physician order, documentation should indicate the ordering provider was notified and amended the order to permit the additional time required.

The nursing procedure should include instructions that cover:

1) prescriber notification when an adverse outcome is anticipated or has occurred,

2) documentation in the patient's chart and/or MAR regarding the reason the time required to administer the dose was early or delayed, and

3) evaluation of the need to ask the physician to change the timeframe of future orders.

Alternatively, or perhaps in addition, the hospital may wish to encourage ordering providers to be less restrictive in stipulating the duration of a given infusion as appropriate to the therapeutic objective. For instance, an order for hydration therapy might stipulate the duration of the order as "one to two hours as tolerated."

The physician's order should include:

- Date and time of the order to start an infusion;
- Drug name/solution to be infused
- Dose, frequency, and route;
- Quantity and/or duration, when applicable;
- Name and signature of the prescriber (electronic signatures may be acceptable.)

# References


- Excerpts from the CMS 2023 National Correct Coding Initiative Policy Manual For Medicare Services, Chapter XI – Medicine Evaluation and Management Codes

  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 2 different "initial" service codes, use National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP)-associated modifiers.


(continued)

## NCCI Chapter XI – Medicine Evaluation and Management Codes - Continued

3. If both lumina of a double lumen catheter are used for infusions of different substances or drugs, only one "initial" infusion CPT code may be reported. The double lumen catheter permits intravenous access through a single vascular site. Thus, it

would not be correct to report 2 "initial" infusion CPT codes, 1 for each lumen of the catheter.

4. Because the placement of peripheral vascular access devices is integral to intravenous infusions and injections, the CPT codes for placement of these devices are not separately reportable. Thus, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection, or chemotherapy administration (e.g., CPT codes 96360- 96368, 96374-96379, 96409-96417) shall not be reported separately. Because insertion of central venous access is not routinely necessary to perform infusions/injections, this service may be reported separately. Since intra-arterial infusion often involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions. Selective arterial catheterization codes may be reported separately.

5. The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately. Similarly, the fluid used to administer drug(s)/substance(s) is incidental hydration and shall not be reported separately.

Transfusion of blood or blood products includes the insertion of a peripheral intravenous line (e.g., CPT codes 36000, 36410), which is not separately reportable. Administration of fluid during a transfusion or between units of blood products to maintain intravenous line patency is incidental hydration and is not separately reportable.

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.

6. Hydration concurrent with other drug administration services is not separately reportable.

7. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by providers/suppliers for services performed in physicians' offices. These drug administration services shall not be reported by providers/suppliers for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical

(continued)

## NCCI Chapter XI – Medicine Evaluation and Management Codes - Continued

Center (ASC) related to a Medicare- approved ASC payable procedure are not separately reportable by providers/suppliers. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term "physician" refers to M.D.s, D.O.s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule."

8. The drug and chemotherapy administration CPT codes 96360-96375 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (Evaluation and Management (E&M) service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility-based E&M CPT codes (e.g., 99202-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since providers/suppliers shall not report drug administration services in a facility setting, a facility-based E&M CPT code (e.g., 99281-99285) shall not be reported by a provider/supplier with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non- facility setting on the same date of service. In such situations, the E&M code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.s, D.O.s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule."

Under the OPPS, hospitals may report drug administration services (CPT codes 96360-96377) and chemotherapy administration services (CPT codes 96401-96425) with facility-based E&M codes (e.g., 99281-99285, G0463) if the E&M service is significant and separately identifiable. In these situations, modifier 25 should be appended to the E&M code.

9. Flushing or irrigation of an implanted vascular access port or device of a drug delivery system prior to or subsequent to the administration of chemotherapeutic or non- chemotherapeutic drugs is integral to the drug administration service and is not separately reportable. Do not report CPT code 96523.

10. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 shall not be reported for accessing a non- programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration.

CPT code 96522 (Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)) and CPT code 96521 (Refilling and

(continued)

## NCCI Chapter XI – Medicine Evaluation and Management Codes - Continued

maintenance of portable pump) shall not be reported with CPT code 96416 (Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump) or CPT code 96425 (Chemotherapy administration, intra-arterial;

infusion technique, initiation of prolonged infusion (more than 8 hours), requiring use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump. Similarly, under the OPPS, CPT codes 96521 (Refilling and maintenance of portable pump) and 96522 (Refilling and maintenance of implantable pump or reservoir for systemic drug delivery (e.g., intravenous, intra-arterial)) shall not be reported with HCPCS/CPT code C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours) requiring use of portable or implantable pump).

CPT codes 96521 and 96522 shall not be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non- programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

11. Medicare Anesthesia Rules prevent separate payment for anesthesia services for a medical or surgical service when provided by the physician performing the service. Drug administration services (CPT codes 96360-96377) shall not be reported for anesthesia provided by the physician performing a medical or surgical service.

12. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96377) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS, drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers/suppliers shall not report CPT codes 96360-96377 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 62320-62327, 64400-64489 and 96360-96377 describe some services that may be used for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

(continued)

## NCCI Chapter XI – Medicine Evaluation and Management Codes - Continued

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI PTP-associated modifier if performed in a non-facility site of service.

13. Administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine is reported with HCPCS codes G0008, G0009, or G0010 respectively. Administration of other immunization(s) not excluded by law is reported with CPT codes 90460-90461 or 90471- 90474, depending upon the patient's age and physician counseling of the patient/family. Based on CPT instructions, a provider/supplier shall report administration of all immunizations other than influenza, pneumococcal, or hepatitis B vaccines on a single date of service from either of these 2 code ranges and shall not report a combination of CPT codes from the 2 code ranges.

14. If one or more immunizations and a significant, separately identifiable E&M service are rendered by a physician on the same date of service, both the immunization administration code (e.g., CPT codes 90460–90474) and the E&M code with modifier 25 appended may be reported. If the patient returns on another day solely to receive another immunization, only the immunization administration code shall be reported.

15. Similar to drug and chemotherapy administration CPT codes, CPT code 99211 (Evaluation and management service, office or other outpatient visit, established patient, level I) is not separately reportable with vaccine administration HCPCS/CPT codes 90460-90474, G0008-G0010. Other E&M CPT codes are separately reportable with a vaccine administration code if the E&M service is significant and separately identifiable, in which case the E&M CPT code may be reported with modifier 25.

16. CPT codes 96361 and 96366 are used to report each additional hour of intravenous hydration and intravenous infusion for therapy, prophylaxis, or diagnosis respectively. These codes may be reported only if the infusion is medically reasonable and necessary for the patient's treatment or diagnosis. They shall not be reported for "keep open" infusions as often occur in the emergency department or observation unit.

- Excerpts from the CMS Medicare Claims Processing Manual, Chapter 12

### 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.

A. 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.

B. 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 incidentalhydration and is not separately payable.

If performed to facilitate the infusion or injection or hydration, the following services anditems 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 ornonchemotherapy injection and infusion service.

If a significant separately identifiable evaluation and management service is performed, theappropriate 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.

(continued)

CMS Medicare Claims Processing Manual, Chapter 12 - Continued

The CPT 2006 includes a parenthetical remark immediately following CPT code 90772 (Therapeutic, prophylactic or diagnostic injection; (specify substance or drug); subcutaneous orintramuscular.) 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 incidentto service, then the injection is not covered. The physician would also not report 99211 as thiswould not be covered as an incident to service.

**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 towhich drugs may be considered to be chemotherapy drugs under Medicare.

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

If performed to facilitate the chemotherapy infusion or injection, the following services anditems 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.

(continued)

## CMS Medicare Claims Processing Manual, Chapter 12 - Continued

### 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.

When administering multiple infusions, injections or combinations, the physician should reportonly 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.

If more than one "initial" service code is billed per day, the A/B MAC (B) shall deny the second initial service code unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. For these separately identifiable services, instruct the physician to report with modifier 59.

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.

(continued)

## CMS Medicare Claims Processing Manual, Chapter 12 - Continued

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.

### 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.