If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSNM may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

CPCP026 Therapeutic, Prophylactic and Diagnostic Injection and Infusion Coding

Policy Number: CPCP026

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: May 4, 2023

Plan Effective Date: May 15, 2023

Description

This policy serves as a reference for billing therapeutic, prophylactic, and diagnostic injection and infusion services when billing with Evaluation and Management (E/M) services. Additionally, guidance is provided for supplies and/or drug codes billed with injection and/or infusion services.

Health care providers (i.e., facilities, physicians, and other qualified health care professionals) are expected to exercise independent medical judgement in providing care to members. This policy is not intended to impact care decisions or medical practice. Providers are responsible for

accurately, completely, and legibly documenting services performed. Appropriate coding is the key to minimizing delays in claims processing.

Definitions

Injection is the introduction of a substance into the body using a syringe and an attached needle. Injections may be given under the skin (subcutaneous), via a vein (intravenous), deep into a muscle (intramuscular), or into the fluid surrounding the spinal cord (intrathecal).

Infusion is the intravenous or subcutaneous injection of one of a variety of therapeutic solutions, such as saline or glucose, in the treatment of dehydration, hypoglycemia, or other plasma electrolyte imbalance. Often referred to as a drip.

- **Initial Infusion** (a) Physician or other qualified healthcare professional, the initial infusion is the key or primary reason for the encounter. This is reported irrespective of the temporal order in which the infusion/injection are administered. (b) Facility reporting is based using the hierarchy. (c) For both, reporting should include only one initial service code unless the protocol or member's condition requires that two separate intravenous (IV) sites must be utilized.

Intravenous/Intra-arterial Push is defined as (a) an injection in which the individual who administers the drug/substance is continuously present to administer the injection and observe the member, or (b) an infusion of 15 minutes or less.

Qualified Healthcare Professional (QHP) - Is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Sequential Infusion is an infusion or IV push of a new substance or drug following a primary or initial service. All sequential services require that there be a new substance or drug, except that facilities may report a sequential intravenous push of the same drug using CPT code **96376**.

Concurrent Infusion is an infusion of a new substance or drug infused at the same time as another substance or drug. Concurrent infusion services are not time based and are only reported once per day regardless of whether an additional new drug or substance is administered concurrently. Hydration may not be reported concurrently with any other service. Also, a separate subsequent concurrent administration of another new drug or substance should not be reported.

Reimbursement Information:

The Plan reserves the right to request supporting documentation. Documentation may be used to validate services billed with care that was rendered to a member. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims are reviewed on a case-by-case basis. Submission of any code should be fully supported in the medical documentation.

Services that are considered mutually exclusive, integral to, incidental or within the global period of a primary service are not eligible for separate reimbursement.

Services, Equipment and Supplies

Routine services, equipment and supplies are included in the general charge where services are being rendered. Additional charges for equipment and supplies that are commonly furnished or are a usual part of a surgical/medical procedure, during an office visit or office procedure are ineligible for separate reimbursement and should not be billed separately. **Examples:**

- Some HCPCS supply codes are not separately reimbursable as the cost of the supplies are incorporated into the Evaluation and Management (E/M) service or procedure code. Therefore, the plan will not separately reimburse the HCPCS supply codes if those supplies are utilized on the same day as the E/M service or procedure performed in a non-facility location or place of service.
- Supplies that are used during the course of the administration of injections or intravenous infusions are considered an integral component of the services provided and therefore are not separately reimbursed.

Documentation

Documentation may be requested upon a claim review to determine that appropriate coding was billed. Providers must keep accurate documentation. When infusion time is a factor, providers should report the actual timeline over which the infusion is administered. Documentation should include but is not limited to:

- Orders from a physician or a non-physician provider (Nurse Practitioner/Physician Assistant)
- Types of infusion(s)
- Signature log or signature attestation for any missing or illegible signatures within the medical record (includes all personnel providing services)
- Documentation of the anatomic location
- Preparation of the site
- Local anesthetic administration
- Name and dosage of the drug administered
- Start time of each infusion
- Stop time of each infusion
- Rate of each infusion
- Member reaction, such as vital signs; Time of each member interaction during monitoring
- All post-procedure instructions related to the injection

Coding and Billing for Therapeutic, Prophylactic, and Diagnostic Injections and Infusions

Provider services related to hydration, injection, and infusion services involves affirmation of the treatment plan and direct supervision of staff. Coding and billing for therapeutic, prophylactic, diagnostic injections and infusions include the following categories of codes in the American Medical Association's (AMA) Current Procedural Terminology (CPT) codebook:

1. **Hydration**: Hydration codes (**96360-96361**) are used to report a hydration IV infusion which consists of pre-packaged fluid and/or electrolytes but are not used to report

infusion of drugs or other substances. Hydration IV infusions usually require direct supervision for purposes of consent, safety oversight, or intra-service supervision of staff. Note, facility basic charges include the administration of any medicine, and/or IV fluids for hydration.

Additionally, some types of chemotherapeutic agents and other therapeutic agents require pre- and/or post-hydration to be given in order to avoid specific toxicities. AMA instructs, there is a minimum time duration of thirty-one (31) minutes of hydration infusion that is required to report the service. Providers must be aware the hydration CPT codes **96360** or **96361** are not used when the purpose of the intravenous fluid is to keep open an IV line prior to or after a therapeutic infusion, or as a free flowing IV during chemotherapy or other therapeutic infusions.

2. **Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy)**: Therapeutic, prophylactic, or diagnostic IV infusions or injections, other than hydration, (**96365-96377** and **96379**) are for the administration of substances/drugs. The fluid used to administer the drug is incidental to hydration and is not separately reimbursed. These services usually require direct supervision for any and all purposes of member assessment, provision of consent, safety oversight, and intra-service supervision of staff. The following services and items are included and are not separately reimbursed if performed to facilitate infusion, injection, or hydration:
    - **a.** Use of local anesthesia
    - **b.** IV start
    - **c.** Access to indwelling IV, subcutaneous catheter or port
    - **d.** Flush at conclusion of infusion
    - **e.** Standard tubing, syringes, and supplies

Note, if multiple drugs are administered, providers must report the service(s) and the specific materials or drugs for each injection type. If multiple infusions, injections, or a combination is administered, providers should report only one initial service code for a given date, unless protocol requires two separate IV sites to be used. If an injection or infusion is due to a subsequent and/or concurrent situation, even if it is the first service within the group of services, providers should report a subsequent and/or concurrent code from the appropriate section of codes.

Example: CPT code **96372** may be billed when a therapeutic, prophylactic, or diagnostic substance is administered by subcutaneous or intramuscular injection by a physician or an assistant under direct physician supervision. If given without direct supervision, qualified health care professionals should use CPT code **99211**. Only facilities may bill **96372** when the physician or other qualified health care professional is not present. CPT code **96372** is not eligible for separate reimbursement when billed in conjunction with an Evaluation and Management (E/M) service by the same rendering provider on the same date of service. Eligible reimbursement for **96372** is based on the injection performed alone or in conjunction with other procedures/services allowed by procedure-to-procedure editing.

The following codes are not intended to be reported by the physician in the facility setting:

CPT Code	Injection/Infusion Type	Description
96360	Hydration	HYDRATION IV INFUSION INIT

+96361	Hydration	HYDRATE IV INFUSION ADD-ON
96365	Therapeutic, Prophylactic or Diagnostic Infusion	THER/PROPH/DIAG IV INF INIT
+96366	Therapeutic, Prophylactic or Diagnostic Infusion	THER/PROPH/DIAG IV INF ADDON
+96367	Therapeutic, Prophylactic or Diagnostic Infusion	TX/PROPH/DG ADDL SEQ IV INF
+96368	Therapeutic, Prophylactic or Diagnostic Infusion	THER/DIAG CONCURRENT INF
96369	Therapeutic, Prophylactic or Diagnostic Infusion	SC THER INFUSION UP TO 1 HR
+96370	Therapeutic, Prophylactic or Diagnostic Infusion	SC THER INFUSION ADDL HR
+96371	Therapeutic, Prophylactic or Diagnostic Infusion	SC THER INFUSION RESET PUMP
96372	Injection	THER/PROPH/DIAG INJ SC/IM
96373	Injection	THER/PROPH/DIAG INJ IA
96374	Injection	THER/PROPH/DIAG INJ IV PUSH
+96375	Injection	TX/PRO/DX INJ NEW DRUG ADDON
96377	Injection	APPLICATON ON-BODY INJECTOR
96379	Injection	THER/PROP/DIAG INJ/INF PROC

The following code may only be reported by facilities

CPT Code	Injection/Infusion Type	Description
+96376	Injection	TX/PRO/DX INJ SAME DRUG ADON

For information related to home infusions, refer to **CPCP019 Home Infusion** on the Plan's website.

Coding and Billing for Other Highly Complex Drug or Highly Complex Biologic Agent Administration

The term "chemotherapy" used in the descriptions for CPT codes 96401-96549 includes other highly complex drugs or highly complex biologic agents. These codes may also be billed for anti-neoplastic agents provided for treatment of non-cancer diagnoses. Highly complex infusions of other drug or biologic agents requires a physician or other qualified health care professional

and/or clinical staff monitoring beyond that of therapeutic drug agents due to the incidence of severe adverse reactions being typically greater. These drugs and biological agents require direct supervision for any or all purposes of member assessment, provision of consent, safety oversight, and intra-service supervision of staff. Administration of these types of drugs or biological agents typically require advanced practice training and competency for staff to provide these services, special consideration for preparation, dosage and disposal and entail significant member risk and frequent monitoring.

Modifiers

If a significant, separately identifiable office or other outpatient E/M service is performed, the appropriate E/M service should be reported using modifier -25 in addition to 96360-96549. For same day E/M service(s), a different diagnosis is not required. Appending modifier -25 to an E/M service(s) where a therapeutic, prophylactic, and diagnostic injection or infusion was administered must meet the pre-service evaluation time intensity requirements.

Hospitals should bill a separate E/M code, appending modifier -25, only if significant, separately identifiable E/M service(s) are performed in the same encounter with Outpatient Prospective Payment System (OPPS) drug administration services.

For additional information on the key components in determining the appropriate E/M level of care codes for services rendered refer to **CPCP024 Evaluation and Management (E/M) Coding-Professional Providers** on the Plan's website.

For additional information on the appropriate billing for E/M services rendered in the Emergency Department (ED), refer to the **CPCP003 Emergency Department Evaluation and Management (E/M) Services Coding- Facility Services** on the Plan's website.

In other circumstances it may be necessary to indicate a procedure or service was distinct or independent from other non-E/M services that were performed on the same day. In this instance, providers may append modifier -59 to that procedure/service. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual. If another already established modifier is appropriate, it should be used instead of modifier -59. For additional information on appropriate modifier usage, refer to **CPCP023 Modifier Reference Guideline** on the Plan's website.

Example: If a member receives two or three intramuscular or subcutaneous injections, CPT code 96372 would be submitted for each injection performed and modifier -59 would be appended to the second and any subsequent injection codes listed on the claim form. The provider would update the members medical records to support the use of the modifier.

Injectable Drugs

HCPCS Level II code(s) should be submitted that best describe the drug and dosage administered. If a dosage administered is greater than what is listed, the unit's field should be completed to specify the appropriate number of units per the code definition. The JW modifier may be appended to claims to report the amount of drug or biological that is discarded. The discarded amount must be billed on a separate line with the JW modifier for all non-inpatient places of service. Documentation must identify and describe the drug, dosage, and reason for

administration. Providers are encouraged to administer and care for members in a way that drugs and biologicals are used most efficiently to prevent waste. Additional information for wasted and/or discarded drugs can be found on the Plan's website in **CPCP017 Wasted/Discarded Drugs and Biologicals Guideline**.

Unlisted/Not Otherwise Classified Codes

Providers should select CPT or HCPCS codes that accurately describe the administered drug(s), service(s) or procedure(s) performed. If and only if no code exists, providers should report the drug, service or procedure code using the appropriate unlisted procedure code. When submitting an unlisted procedure code, supporting documentation must be submitted. For additional information, refer to the Plan's website for CPCP035 Unlisted/Not Otherwise Classified (NOC) Coding Policy.

Vaccination (Immunization)

Vaccinations for immunizations should be billed using the appropriate administration and vaccine codes. E/M services should not be billed with immunizations unless the E/M represents a separately identifiable service. Modifier -25 should be appended to the E/M code to indicate this separate service. Documentation may be required to allow separate reimbursement.

Members who Supply their own Drugs or No Cost to the Provider, for Provider Administration

If a member supplies their own drug to a provider for administration of the drug, and the drug is administered to the member under direct supervision, documentation should include CPT code 96372 (if no E/M service has been provided) and the drug name, drug code and drug dosage with a zero-dollar ($0.00) charge.

Additional Resources:

Clinical Payment and Coding Policies

CPCP002 Inpatient/Outpatient Unbundling Policy-Facility

CPCP017 Wasted/Discarded Drugs and Biologicals Policy

CPCP019 Home Infusion

CPCP023 Modifier Reference Policy

CPCP024 Evaluation and Management (E/M) Coding-Professional Provider

CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services (EIU)

CPCP034 Unbundling Policy-Professional Providers

CPCP035 Unlisted/Not Otherwise Classified (NOC) Coding Policy

References:

Black's Medical Dictionary, 43rd Edition

Centers for Medicare and Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 12-Physicians/Nonphysician Practitioners, Section 30.5 Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions. Accessed September 28, 2022. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Policy Update History:

9/7/2021	New policy
12/20/2022	Annual Review
5/4/2023	Ad-hoc Review