Subject: Injection and Infusion Administration and Bundled Services and Supplies

NY Policy: 0015 Effective: 10/01/2013 – 03/31/2014

Coverage is subject to the terms, conditions, and limitations of an individual member’s programs or products and policy criteria listed below.

DESCRIPTION

This policy addresses reimbursement and reporting requirements for injection/infusion administration services and supplies submitted by a provider on a Form CMS-1500 claim form; and applies to procedures included in the code ranges of 96360-96361 for hydration; 96365-96371 for therapeutic, prophylactic, or diagnostic infusion; 96372-96379 for injection; and 96401-96549 for chemotherapy and other highly complex drug or biological agent codes.

POLICY

1. Place of Service:
The Health Plan follows Current Procedural Terminology (CPT®) coding guidelines for the appropriate place of service reporting of hydration, injection and infusion codes. Per CPT, “These codes are not intended to be reported by the physician in the facility setting.” Therefore, the Health Plan’s claims editing system will deny reimbursement for procedures in the code ranges stated above (excluding 96405-96406, 96440, 96446, 96450, and 96542) if reported as performed by a physician in a facility setting. Some examples of facility settings include but are not limited to: hospital inpatient/outpatient and emergency departments, ambulatory surgery centers, surgical suites, birthing centers, skilled nursing facilities, and residential treatment facilities.

2. Reporting Multiple Infusions:
The Health Plan requires that correct coding be followed when reporting the administration of multiple infusions, injections, or a combination of both, whether performed concurrently or sequentially. The following examples are some, but not all, CPT coding guidelines that should be followed:

- Only one initial service code should be reported unless two separate IV sites are used.
- The initial code is one that best describes the primary reason for the encounter even if performed subsequent to another infusion.
- If an injection or infusion is of a secondary nature (e.g. not the primary reason for the encounter), but was administered first, the appropriate subsequent or concurrent code should be reported.*

*Example: If hydration is administered prior to the chemotherapy infusion, chemotherapy is the primary reason for the patient encounter and is reported as the initial service (96413). The hydration
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Infusion is reported as 96361 (each additional hour listed separately in addition to the primary procedure) even though chronologically it was administered first.

In addition, the Health Plan has implemented frequency restrictions for certain infusion procedures when the description of the code may be reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service. For example:
- 96416 which describes prolonged (more than eight hours) IV Chemotherapy administration has a frequency restriction of one time per date of service
- 96367 which describes additional sequential IV infusion up to one hour (in addition to the code for the primary procedure) has a frequency restriction of six times per date of service

For comprehensive guidelines on the reporting of initial and sequential injection and infusion codes, please refer to the guidelines outlined in the Current Procedural Terminology Manual in the section for Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and other Highly Complex Drug or Highly Complex Biologic Agent Administration

3. Reporting an E/M Service in addition to infusion administration
The Health Plan also requires that correct coding be followed when reporting an E/M service provided on the same day as injection and infusion administration services. When a substantial diagnostic or therapeutic procedure is performed, or a major or even minor surgical/therapeutic procedure is rendered, there is an inherent evaluation and management service component included in the reimbursement for these procedures; therefore, the E/M service is not separately reimbursed.
- If however, the patient’s presenting condition or symptoms required a significant, separately identifiable E/M service above and beyond the other service provided; then modifier 25 should be appended to the E/M service code to be eligible for separate reimbursement.

4. Reporting Injections and Infusions with Nuclear Medicine Studies
The February 2012 publication of cpt Assistant states the injection or administration of a radiopharmaceutical or nuclear medicine related drug is considered part of patient management in the course of providing nuclear medicine studies and considered inherent to the studies. Therefore, the Health Plan considers CPT codes 96365, 96369, 96372, 96373, 96374, and 96379 to be incidental to nuclear medicine studies, CPT codes 78000 – 79999, and not be eligible for separate reimbursement.

The Health Plan’s allowance for nuclear medicine studies does not include the cost of radiopharmaceuticals or nuclear medicine related drugs. The provider may report these drugs separately with the proper Healthcare Common Procedure Coding System Level II (HCPCS) J, Q, or S codes which are eligible for separate reimbursement.

5. Reporting an Agent for Infusion:
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CPT advises that both the specific substance(s) and/or drug(s) provided be reported along with the administration service rendered. Therefore, therapeutic fluids and medications administered by the physician are reported separately using the appropriate CPT/HCPCS code(s) and if covered, are eligible for separate reimbursement.

- The diagnosis for the infused/injected drug must be reported at the claim line level.
- If fluids are used to administer the therapeutic agent or drug, this administration is an integral component of the drug administration; it is not reported separately, and is not eligible for separate reimbursement.
- However, therapeutic IV hydration infusion administered separately over a prescribed time and rate, is separately reported and is eligible for separate reimbursement. Please refer to the multiple reporting methodologies described in #2.

6. **Inclusive Services and Supplies:**
Services related to intravenous infusion such as local anesthesia, IV start or access to a catheter or port, and flushing procedures should not be reported separately, and are not eligible for separate reimbursement.

In addition, The Health Plan follows CPT coding guidelines for CPT 96523 (irrigation of implanted venous access device for drug delivery systems) which state that the code “….should not be reported in conjunction with any other service.” Therefore, CPT 96523 is not eligible for separate reimbursement when billed with any other service.

Materials and supplies used during the course of the administration of intravenous infusion, or for injections, are considered to be an integral component of the reimbursement for the services provided and are not eligible for separate reimbursement. Specific HCPCS codes can be found in the coding section. These supplies include but are not limited to:

- needles and syringes
- needle free injection devices
- sterile water, saline, heparin, and/or dextrose diluent/flush
- refill kits
- disinfectant wipes and agents such as alcohol, peroxide, iodine, Betadine, and pHisoHex,
- tape, gauze, gloves, trays, etc., and/or any other miscellaneous supplies or items related to the administration of an injection or IV infusion
- ambulatory infusion pumps, IV poles

**CODING**
The following table identifies by code some of the materials and supplies that are described in the policy section. The inclusion or exclusion of a specific code does not indicate eligibility for
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coverage under all circumstances. This table is provided as an informational tool only, to help identify some of the procedures described above.

The Health Plan has implemented a customized edit, if none already existed, in the standard ClaimsXten® editing software package that denies reimbursement for the codes found in this table when billed with the associated injection/infusion administration codes described in the “Description” section of this policy. Modifier 59 will not override the incidental edit.

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POLICY HISTORY

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Use of Reimbursement Policy:
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