If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy 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. Blue Cross and Blue Shield of TX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. Blue Cross and Blue Shield of TX 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 approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative 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.

Therapeutic, Prophylactic, Diagnostic, Injection and Infusion Administration Coding

Policy Number: CPCP026

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date:

July 30, 2024

Plan Effective Date: November 21, 2024
(Blue Cross and Blue Shield of Texas Only)

Description

This policy provides coding and billing information for therapeutic, prophylactic, diagnostic, injection and 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** 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.

- **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 (a third substance or drug) should not be reported.

- **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**.

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

Reimbursement Information

The Plan reserves the right to request supporting documentation to determine eligible reimbursement. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. 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. Equipment and supplies that are commonly furnished or are a usual part of the injection and/or infusion procedure, during an office visit or office procedure are ineligible for separate reimbursement and should not be billed separately.

Examples:

The following services and items are included and are not separately reimbursed if performed to facilitate an infusion, injection, or hydration:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes, and supplies
    - Some HCPCS supply codes are not separately reimbursable as the cost of the supplies are incorporated into the Evaluation and Management 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 an 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 appropriate billing. 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
- Route of administration, e.g., intradermal, intramuscular, intravenous, subcutaneous
- Preparation of the site
- Technique, e.g., push or drip
- 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

Hydration, injection, and infusion services involve 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 Current Procedural Terminology codebook:

- **Hydration**: Hydration codes (**96360-96361**) are used to report a hydration IV infusion which consists of pre-packaged fluids 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 in order to avoid specific toxicities. AMA instructs a minimum time duration of thirty-one (31) minutes of hydration infusion that is required to report the service. Hydration codes (**96360**-**96361)** are not used when the purpose of the intravenous fluid is to keep an IV line open prior to or after a therapeutic infusion, or as a free flowing IV during chemotherapy or other therapeutic infusions.

- **Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy and other highly complex drug or highly complex biologic agent administration)**: CPT codes **96365-96377,** and **96379** are for the administration of substances/drugs. Fluids that are solely used to administer the drug(s) are considered incidental hydration and are not separately reimbursed. These services usually require direct supervision for all purposes of member assessment, provision of consent, safety oversight, and intra-service supervision of staff.

- **Chemotherapy and 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 the administration of 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.
For additional information on submitting appropriate coding, providers should review the most current CPT codebook.

Injection and infusion billing is determined based on the provider/location.

- For *physician or other QHP reporting*, the initial infusion service is reported as the primary reason for the encounter.
- For *facility reporting*, utilize the established hierarchy (Chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration. Infusions are primary to pushes, which are primary to injections).

Both physician/other QHP and facilities, may only report one initial service code per member encounter per day, unless the protocol or members condition requires two separate IV sites be utilized. The difference in time and effort in providing the second IV access site may be reported using the initial service code and appending an appropriate modifier.

If the member returns for a separate visit/encounter on the same day, and requires an infusion or injection, another initial infusion or injection code may be billed with **modifier -59** for that service.

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 the subsequent and/or concurrent code. After completion of the first infusion, a sequential infusion may be billed for the administration of a different drug or service through the same IV site. Documentation must support the reason why the sequential infusion was administered rather than administering a concurrent infusion. Sequential infusions may also be billed only once per sequential infusion of the same fluid mix.

Examples:

- CPT code **96372** may be billed when a therapeutic, prophylactic, or diagnostic substance/drug, such as HCPCS code J2357, 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 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 a physician or other QHP in an inpatient or outpatient facility setting as the services are included in the E/M service:

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	SC THER INFUSION RESET PUMP

	Diagnostic Infusion	
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 a facility:

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

The administration time of an infusion/injection is a separate service from an E/M, therefore, the time spent on an injection/infusion should not be factored into total time for selecting an E/M level of service.

For information on the appropriate billing for E/M services rendered in the Emergency Department, or the key components in determining the appropriate E/M level of care codes rendered to a member, refer to Plan documents and/or industry standard coding guidelines.

Modifiers

Modifier 25

If a significant, separately identifiable office or other outpatient E/M service is performed on the same day as an administration of an injection/infusion, the appropriate E/M CPT code may be reported separately appending modifier -25.

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 drug administration services.

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.

Modifier 59

In addition to the scenario above in the policy regarding the use of modifier -59, other circumstances 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 and providers may append modifier -59. Documentation may be requested and 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 Plan documents and/or industry standard coding guidelines.

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.

Modifiers JW and JZ

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's description. 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. Additionally, the **JZ** modifier may be appended to reflect there were no discarded amounts from a single use vial or single use package. Documentation must identify and describe the drug, dosage, and reason. Providers are encouraged to administer and care for members in a way that drugs and biologicals are used most efficiently to prevent waste. For additional information for wasted and or discarded drugs, providers may refer to Plan documents and/or industry standard coding guidelines.

Example:

- HCPCS code **J2357** should be reported with CPT code **96372** for therapeutic, prophylactic, or diagnostic injection, by subcutaneous or intramuscular route and modifier **JW** would be appended for the discarded/not administered amount or **JZ** would be appended if there was zero drug amount discarded/not administered to a member.

Unlisted/Not Otherwise Classified Codes

Providers should select 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 code. When submitting an unlisted code, a description and/or supporting documentation should be submitted. For additional information, refer to Plan documents.

Members Who Supply Their Own Drugs or No Cost to the Provider, for Provider Administration

If no E/M service is provided and 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, providers should report the appropriate CPT code.

Example:

- If no E/M service has been provided, CPT code 96372 should be reported with a separate line that includes a code for the drug and drug dosage with a zero-dollar ($0.00) charge.

For information related to home infusions, refer to Plan documents and/or industry standard coding guidelines.

Additional Resources

Clinical Payment and Coding Policy

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 Services

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, Medicare Claims Processing Manual, Chapter 12-Physicians/Nonphysician Practitioners, Section 30.5 Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions. Accessed March 28, 2024. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

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Healthcare Common Procedure Coding System (HCPCS)

Genentech. for Xolair®, Omalizumab for subcutaneous use, Sample coding. Accessed May 10, 2024. https://www.genentech-access.com/content/dam/gene/accesssolutions/pdfs/coding/XOLAIR-Billing-Coding-for-Moderate-to-Severe-Presistent-Allergic-Asthma.pdf

Policy Update History

9/7/2021	New policy
12/20/2022	Annual Review
5/4/2023	Ad-hoc Review
7/30/2024	Annual Review