Chemotherapy Administration, Hydration and Therapeutic, Prophylactic, and Diagnostic Injections and Infusions

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Overview

Chemotherapy administration is defined as the parenteral administration of non-radionuclide anti-neoplastic drugs for cancer diagnoses, anti-neoplastic agents provided for the treatment of non-cancer diagnoses or to substances such as monoclonal antibody agents, and other biologic response modifiers. These services can be provided by any physician and typically are highly complex services requiring direct supervision. Special consideration and training is often involved due to preparation, dosage or disposal of the substances. These services entail significant patient risk and frequent monitoring.

Therapeutic infusions are defined as parenteral administration of substances/drugs for therapeutic, prophylactic or diagnostic purposes. Fluids used to administer these substances/drugs are incidental hydration and not separately reportable. These services also typically require direct physician supervision and trained staff for patient assessment and monitoring.

Hydration is defined as an IV infusion that consists of pre-packaged fluid and electrolytes. Hydration is not used to report infusion of drugs or other services. Hydration refers strictly to replacement of fluids and should have the corresponding diagnosis of dehydration or hypovolemia. Hydration infusions generally entail less patient risk and monitoring than either chemotherapy or therapeutic infusions.

Chemotherapy, therapeutic infusions and hydration can be performed in different settings. Blue Cross Blue Shield of North Dakota (BCBSND) follows Medicare guidelines for the billing of chemotherapy and other therapeutic infusions. There are different coding and billing guidelines based on where the services are performed and the type of claim form (CMS-1500 or UB-04) used. Services provided in the clinic or office setting are billed on the CMS-1500 and are considered professional services. Services performed in the outpatient hospital setting are billed on the UB-04 and are considered institutional services. The billing guidelines are listed below based on professional or institutional services.

Professional Services

Chemotherapy, hydration and other therapeutic infusions are identified and billed using CPT® codes. These CPT® codes have Relative Value Units (RVUs) assigned to them and reimbursement is based on those RVUs.

There are three categories of drug administration services:

- Hydration
- Non-chemotherapy therapeutic/diagnostic injections and infusions other than hydration
- Chemotherapy administration (other than hydration) which includes infusions/injections

The American Medical Association (AMA) has issued the following clarifications and guidelines:

1. CPT® specifically notes that code 96376 is for use by the **facility only**. This code should not be billed by the physician on the CMS-1500.

2. Drug administration codes include an "initial" service code that best describes the key reason for the patient encounter. It does not reflect the order that the infusions or injections occur.

3. If a patient is admitted for the primary purpose of chemotherapy but receives other infusions prior to the chemotherapy, the chemotherapy "initial" code is the only "initial" code used. For example, if a patient receives Zofran and Dexamethasone prior to the chemotherapy, the "initial" service code billed would be for the chemotherapy as it is the key reason for the encounter.

4. There is only one "initial" drug administration code per encounter. The only exceptions are if the protocol requires two separate IV sites or if the patient comes back for a second encounter on the same date of service. These services are identified with modifier 59. Medical documentation is required to justify the use of the modifier.

5. Chemotherapy administration codes (96401-96549) are for use with parenteral administration of non-radionuclide anti-neoplastic drugs and anti-neoplastic agents provided for treatment of noncancer diagnoses. They may also be used for substances such as certain monoclonal antibody agents and other biologic response modifiers. These highly complex substances require additional physician and staff monitoring due to the higher incidence and severity of adverse reactions. Only certain pharmaceuticals are allowed to be used with the chemotherapy administration codes. These include J9001-J9999, J1745, J0894 or J3315.

6. Chemotherapy administration codes are not used for intravenous immunoglobulin (IVIG). IVIG is billed under therapeutic/diagnostic infusions.

7. When coding "additional hours" of infusions, a minimum of 30 minutes of additional administration time is required to use these codes. It is necessary to have at least 31 minutes of infusion time to bill an "additional hour."

8. An intravenous or intra-arterial push is defined by CPT® as:

    - An injection in which the health care professional administering the substance or drug is continuously present to administer the injection and observe the patient, **OR**

    - An infusion of 15 minutes or less. An infusion of 15 minutes or less should be reported using a "push" code.

9. An office visit (99211) should not be reported separately when drug administration services are provided. These services are incorporated into the RVUs for the administration codes. However, if a patient comes in to the office, nauseated and vomiting, and an assessment indicates the need for hydration, the infusion service can be billed in addition to the E&M.

10. An IV line that only provides hydration and is considered an integral part of chemotherapy or drug administration is not separately reportable. This service is included in chemotherapy or other therapeutic administration codes.

11. Hydration codes are intended to report IV infusions of pre-packaged fluid and/or electrolytes. They should not to be used to report infusion of drugs or other substances.

12. Code 96367 (additional sequential infusion, up to 1 hour) is used to report the infusion of a second or subsequent drug after the initial drug infusion. This must be a sequential infusion – not a concurrent infusion. Concurrent is defined as being given at the same time. Sequential is defined as one after the other. Code 96367 is reported once per sequential infusion of the same substance.

13. Code 96368 identifies a concurrent infusion. It is an add-on code and must be listed separately 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 to be one infusion.
    - The concurrent infusion code can only be billed once per day.
    - Code 96368 is used to report therapeutic/diagnostic infusions only. It should not be used for chemotherapy infusions.

14. Code 96523 identifies a port flush and is used when a patient comes into the office simply to have their port flushed with saline. This code should not be reported if any other service related to the port (i.e. lab draw or other infusion) is performed that day.

15. Time units are calculated based on how long the fluid is actually infusing into the patient. Time ends when the fluids have infused. Documentation within the medical record should substantiate start and stop times for the services.

16. Services such as the use of 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 should not be billed separately.

17. If the same drug is given in multiple pushes, only one unit can be billed.

Institutional Services

For consistency in billing, BCBSND implemented the same billing guidelines for institutional chemotherapy, hydration and other therapeutic infusions as Medicare. The guidelines apply to all institutional providers, including critical access hospitals. Chemotherapy/therapeutic infusion and hydration services are billed using only CPT® codes, with the exception of C8957.

There are three categories of drug administration services:

- Hydration
- Non-chemotherapy therapeutic/diagnostic injections and infusions other than hydration
- Chemotherapy administration (other than hydration) which includes infusions/injections

1. CPT® specifically notes that code 96376 is for use by the **facility only**. This code should not be billed by the physician on the CMS-1500. This code may not be reported with less than a 30-minute interval for sequential intravenous push administration of the same drug.

2. Drug administration codes include an “initial” service code that best describes the key reason for the patient encounter. It does not reflect the order that the infusions or injections occur.

3. According to CPT®, when these codes are reported **by the facility**, there are certain instructions that apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections.

4. If a patient is admitted for the primary purpose of chemotherapy but receives other infusions prior to the chemotherapy, the chemotherapy “initial” code is the only “initial” code used. For example, if a patient receives Zofran and Dexamethasone prior to the chemotherapy, the “initial” service code billed would be for the chemotherapy as it is the key reason for the encounter.

5. There is only one “initial” drug administration code per encounter. The only exceptions are if the protocol requires two separate IV sites or if the patient comes back for a second encounter on the same date of service. These services are identified with modifier 59. Medical documentation is required to justify the use of the modifier.

6. Chemotherapy administration codes should not be used for intravenous immunoglobulin (IVIG). IVIG is billed under therapeutic/diagnostic infusions.

7. Chemotherapy administration codes (96401-96549) are for use with parenteral administration of non-radionuclide anti-neoplastic drugs and anti-neoplastic agents provided for treatment of noncancer diagnoses. They may also be used for substances such as certain monoclonal antibody agents and other biologic response modifiers. These highly complex substances require additional physician and staff monitoring due to the higher incidence and severity of adverse reactions. Only certain pharmaceuticals are allowed to be used with the chemotherapy administration codes. These include J9001-J9999, J1745, J0894 or J3315.

8. A separate amount will be reimbursed for “each additional hour” as services will not be reimbursed on a bundled “per encounter” rate. It is important to correctly identify the units for these services.

9. To bill “each additional hour,” a minimum of 31 additional minutes of services must be provided. Time units are calculated based on how long the fluid is actually infusing into the patient. Time ends when the fluids have infused. Documentation within the medical record should substantiate start and stop times for the services. An infusion of 15 minutes or less should be reported using a “push” code.

10. An intravenous or intra-arterial push is defined by CPT® as:

    - An injection in which the health care professional administering the substance or drug is continuously present to administer the injection and observe the patient, **OR**

    - An infusion of 15 minutes or less. An infusion of 15 minutes or less should be reported using a “push” code.

11. An IV line that only provides hydration and is considered an integral part of chemotherapy or drug administration is not separately reportable. This service is included in chemotherapy or other therapeutic administration codes.

12. Hydration codes are intended to report IV infusions of pre-packaged fluid and/or electrolytes. They should not be used to report infusion of drugs or other substances.

13. Code 96367 (additional sequential infusion, up to 1 hour) is used to report the infusion of a second or subsequent drug after the initial drug infusion. This must be a sequential infusion – not a concurrent infusion. Code 96367 is reported once per sequential infusion of the same substance.

14. Code 96368 identifies a concurrent infusion. It is an add-on code and must be listed separately 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 to be one infusion.

    - The concurrent infusion code can only be billed once per day.

    - Code 96368 is used to report therapeutic/diagnostic infusions only. It should not be used for chemotherapy infusions.

    - The concurrent infusion code will not be reimbursed separately. It will be bundled into other services.

15. Code 96523 identifies a port flush and is used when a patient comes into the office simply to have their port flushed with saline. This code should not be reported if any other service related to the port (i.e. lab draw or other infusion) is performed that day. It will be reimbursed when it is the only service provided.

16. Services such as the use of 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 should not be billed separately.

17. All providers, including Critical Access Hospitals, will use these codes to identify infusion services.

18. If the same drug is given in multiple pushes, only one unit can be billed. An additional IV push can be billed **for each new substance/drug**.

19. These codes should not be submitted for any infusions given during the course of an outpatient surgical procedure. IV infusions during surgery and recovery are considered part of the surgery and are included in the outpatient surgical roll-up.

20. If a patient is hospitalized during the course of outpatient chemotherapy, separate the outpatient claims so they do not overlap the inpatient stay.

21. Due to the number of services provided during outpatient chemotherapy administration or other therapeutic infusions, claims tend to be lengthy. The adjudication process will improve if shorter date spans are used when submitting these claims.

22. Line item services are required on these types of claims.

The following chart shows the CPT® codes available for services in the outpatient hospital setting. Codes that identify initial services are in bold.

Hydration Administration Codes		
CPT® Code	**Description**	**Institutional Units**
96360	Intravenous infusion, hydration; **initial**, 31 minutes to 1 hour	1
+96361	each additional hour (List separately in addition to code for primary procedure)	Multiple
Therapeutic, Prophylactic, and Diagnostic Injections and Infusions		
CPT® Code	**Description**	**Institutional Units**
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis; **initial**, up to 1 hour	1
+96366	each additional hour (List separately in addition to code for primary procedure)	Multiple
+96367	additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)	Multiple
+96368	concurrent infusion (List separately in addition to code for primary procedure)	Bundled into other payment
96369	Subcutaneous infusion for therapy or prophylaxis; **initial**; up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	1
+96370	each additional hour (List separately in addition to code for primary procedure)	Multiple
+96371	additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	Multiple

CPT® Code	Description	Institutional Units
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	Multiple
96373	intra-arterial	Multiple
96374	intravenous push, single or **initial** substance/drug	1
+96375	each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	Multiple
+96376	each additional sequential intravenous push of the same substance/drug provided **in a facility** (List separately in addition to code for primary procedure) **Cannot be billed on the CMS-1500.**	Bundled into other payment
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	Multiple
Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration		
CPT® Code	**Description**	**Institutional Units**
96401	Chemo administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	Multiple
96402	hormonal anti-neoplastic	Multiple
96405	Chemo administration; intralesional, up to and including 7 lesions	Multiple
96406	intralesional, more than 7 lesions	Multiple
96409	IV, push technique, single or **initial** substance/drug	1
+96411	IV, push technique, each additional substance/drug	Multiple
96413	Chemo administration, IV infusion technique; up to 1 hour, single or **initial** substance/drug	1
+96415	each additional hour	Multiple
96416	initiation of prolonged chemo infusion (more than 8 hrs), requiring use of a portable or implantable pump	1
+96417	each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)	Multiple
96420	Chemo administration, intra-arterial; push technique	Multiple
96422	infusion technique, up to 1 hour	1

CPT® Code	Description	Institutional Units
+96423	infusion technique, each additional hour (List separately in addition to code for primary procedure)	Multiple
96425	infusion technique, initiation of prolonged infusion (more than 8 hrs), requiring the use of a portable or implantable pump	1
96440	Chemo administration into pleural cavity, requiring and including thoracentesis	Multiple
96445	Chemo administration into peritoneal cavity, requiring and including peritoneocentesis	Multiple
96450	Chemo administration into CNS (eg, intrathecal), requiring and including spinal puncture	Multiple
93521	Refilling and maintenance of portable pump	1
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	1
96523	Irrigation of implanted venous access device for drug delivery systems	1
96542	Chemo injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	Multiple
96549	Unlisted chemotherapy procedure	Multiple
C8957	IV infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hrs), requiring the use of portable or implantable pump. **This code is for institutional use only.**	1