PAYMENT POLICY ID NUMBER: 10-033

Original Effective Date: 06/29/2010

Revised: 09/12/2024

Administration of Injections and Infusions in Facility Settings

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

Physicians and providers perform intravenous infusions and injections to patients for hydration (e.g., fluids, electrolytes, etc.), as well as diagnostic, preventative, and therapeutic purposes (e.g., chemotherapy). In facility settings, hospital employees typically perform infusions and injections under the supervision of staff physicians. The degree of physician supervision is contingent upon the level of complexity of the injection or infusion.

Hospitals submit the injection/infusion administration codes on the institutional claim along with the applicable revenue codes. In some cases, the attending physician also submits a professional claim for the supervision component.

This policy applies to billing for services on a CMS-1500 or equivalent claim form. Same provider for the purposes of this policy includes all physicians and/or other health care professionals reporting under the same Federal Tax Identification number.

REIMBURSEMENT INFORMATION:

Consistent with Centers for Medicare and Medicaid Services (CMS) guidelines, Florida Blue will not allow reimbursement to physicians and other healthcare professionals for codes identified with a CMS PC/TC indicator 5 when reported in a facility place of service (19, 21, 22, 23, 24, 26, 34, 51, 52, 56, and 61). In addition, Current Procedural Terminology (CPT®) coding guidelines for many of the PC/TC indicator 5 codes specify that these codes are not intended to be reported by a physician in a facility setting.

PC/TC indicator 5 is defined as "Incident-to Codes" and is described as "codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the

physician and working under his or her direct supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes".

To identify those procedures which have a CMS PC/TC indicator 5, please refer to the Medicare Physician Fee Schedule Database (MPFSDB).

BILLING/CODING INFORMATION:

CPT® Coding

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)
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
+ 96361	Intravenous infusion, hydration; each additional hour
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour
+ 96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis; each additional hour
+ 96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis; additional sequential infusion of a new drug/substance, up to 1 hour
+ 96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion
96369	Subcutaneous infusion for therapy or prophylaxis; initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion sites
+ 96370	Subcutaneous infusion for therapy or prophylaxis; initial, including pump set-up and establishment of subcutaneous infusion sites; each additional hour
+ 96371	Subcutaneous infusion for therapy or prophylaxis; initial, including pump set-up and establishment of subcutaneous infusion sites; Additional pump set-up with establishment of new subcutaneous infusion sites
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular
96373	Therapeutic, prophylactic, or diagnostic injection; Intra-arterial
96374	Therapeutic, prophylactic, or diagnostic injection; Intravenous push, single or initial substance/drug
+ 96375	Each additional sequential intravenous push of a new substance/drug
+ 96376	Each additional sequential intravenous push of the same substance/drug provided in a facility
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
96402	Chemotherapy administration, subcutaneous or intramuscular; Hormonal anti-neoplastic

96409	Chemotherapy administration; Intravenous, push technique, single or initial substance/drug
+ 96411	Chemotherapy administration; Intravenous, push technique, each additional substance/drug
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
+ 96415	Chemotherapy administration, intravenous infusion technique; Each additional hour
96416	Chemotherapy administration, intravenous infusion technique; Initiation of prolonged chemotherapy infusion, requiring use of a portable or implantable pump
+ 96417	Chemotherapy administration, intravenous infusion technique; Each additional sequential infusion, up to 1 hour
96420	Chemotherapy administration, intra-arterial; push technique
96422	Chemotherapy administration intra-arterial; Infusion technique, up to 1 hour
+ 96423	Chemotherapy administration intra-arterial; Infusion technique, each additional hour
96425	Chemotherapy administration intra-arterial; Infusion technique, initiation of prolonged infusion, requiring the use of a portable or implantable pump
96446	Chemotherapy administration into the peritoneal cavity via implanted port or catheter.
96521	Refilling and maintenance of portable pump
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)
96523	Irrigation of implanted venous access device for drug delivery systems

+ List separately in addition to a code for the primary procedure.

HCPCS Coding

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

REFERENCES:

1. Centers for Medicare and Medicaid Services: Medicare Physician Fee Schedule Database (MFSDB): https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
2. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition
3. Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS); HCPCS Release and Code Sets https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update
4. Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf

GUIDELINE UPDATE INFORMATION:

06/29/2010	New policy
05/31/2012	Revised – Changed name from BCBSF to Florida Blue
06/16/2016	Annual Review; update reimbursement information and code list
06/15/2017	Annual Review; Codes 90471, 90472, 96377 and G0498 and places of service 19, 24, 26, 34, 51, 52, 56, & 61 added.
06/14/2018	Annual Review – no changes
06/20/2019	Annual Review – no changes
06/11/2020	Annual Review – descriptors revised
06/10/2021	Annual Review – no changes
09/15/2022	Annual Review – no changes
09/14/2023	Annual Review – Reference reviewed and updated.
09/12/2024	Annual Review – Clarifying language added to indicate this policy applies to billing for services on a CMS-1500 or equivalent claim form. CPT® 96446 descriptor revised. References reviewed and updated.