



Rule Category:
Billing

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Injection, Infusion and Hydration codes

Adjudication Rule

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Abstract

For Members

Billing Rules are the adjudication rules, which are in compliance with official CPT, ICD-CM and HAAD/CCSC coding guidelines.

A billing rule defines the minimum requirements to be met when a service is claimed for a Daman beneficiary in terms of frequency, duration etc.

It explains the minimum required documentation to claim a service. It also defines the coverage of a service under a particular insurance plan administered by Daman.

For Medical Professionals

This adjudication rule describes the reporting requirements of Therapeutic/prophylactic/diagnostic injection(s) and infusion(s) (excluding chemotherapy) and hydration.

Therapeutic/ prophylactic/diagnostic injection(s) and infusion(s) (excluding chemotherapy) and hydration service(s) are covered for all health insurance plans administered by Daman (subject to the policy terms and conditions), if medically necessary and are clinically appropriate in terms of diagnosis, frequency and duration.

In multiple Infusion/hydration injections, only one "initial" service code should be reported that best describes the "primary or key reason for the encounter", irrespective of the order in which the infusions or injections administered (unless protocol requires use of two IV sites).

Approved by:
Daman

Responsible:
Medical Strategy &
Development Department

Related Adjudication Rules:
None

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Scope

This adjudication rule describes the reporting requirements of Therapeutic/prophylactic/diagnostic injection(s) and infusion(s) (excluding chemotherapy) and hydration.

A therapeutic injection or infusion is for the administration of substances/drugs.

Intravenous Push is IV Infusion of drug or substance of 15 minutes or less. It is mandatory that, a healthcare professional administers the substance/drug injection and is continuously present to observe the patient.

Intravenous infusion is Infusion of drug or substance for more than 15 minutes. Requires direct physician supervision and intra-service supervision of staff.

Injections codes for injections are differentiated according to the status, as subcutaneous or intramuscular injection and Intra-arterial.

- The fluid used to administer the drug (s) in therapeutic/ prophylactic/ diagnostic injections and infusions is incidental hydration and is not separately payable
- IV Hydration codes can be billed with therapeutic Infusion codes, only when the hydrations are given before or after the therapeutic infusion (if both infusions are given simultaneously, the provider should not bill for IV hydration).

In case of multiple Infusion/hydration injections, only one "initial" service code should be reported, which best describes the "primary or key reason for the encounter" irrespective of the order in which the infusions or injections are administered (unless protocol requires the use of two IV sites).

If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code should be reported.

Always report specific materials or drugs for each therapeutic, prophylactic and diagnostic injection(s) and infusion(s)

Adjudication Policy

Eligibility / Coverage Criteria

Therapeutic/ prophylactic/ diagnostic injection(s) and infusion(s) (excluding chemotherapy) and hydration services are covered for all health insurance plans administered by Daman (subject to the policy terms and conditions), if medically necessary and are clinically appropriate in terms of diagnosis, frequency and duration.

Requirements for Coverage

ICD and CPT codes must be coded to the highest level of specificity and the service(s) should be clinically appropriate in terms of diagnosis, frequency and duration.

Non-Coverage

The service(s) will not be covered if the ICD-CM codes are not reported with the highest level of specificity OR if not medically necessary OR if non-compliant with payment and coding rules.

Payment and Coding Rules

Following services are included in infusion or injection or hydration and should not be reported separately:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies

Status	IV Push	IV Infusion	Hydration
Initial	96374	96365	96360 ⁵
Subsequent		96366 ²	96361 ⁶
Sequential (New substance)	96375	96367 ³	
Sequential (Same substance)	96376 ¹		
Concurrent		96368 ⁴	

1. Do not report if performed within 30 minutes of a reported push of the same substance or drug.
2. Report the infusion code for "each additional hour" only if the infusion interval is greater than 30 minutes beyond the 1 hour increment
3. Report 96367 only once per sequential infusion of same infusate mix.
4. Report concurrent infusion only once in an encounter.
5. Do not report infusion of hydration of 30 minutes or less
6. Report 96361 "each additional hour" only if the infusion interval is greater than 30 minutes beyond the 1 hour increment

Injections: The codes are differentiated according to the status as subcutaneous or intramuscular injection and Intra-arterial

Documentation Requirements

- Outpatient facility or office records should clearly document the medically justified conditions for infusion or injection services which should be legible and to be maintained in the patient's medical record.

- The volume and route of injection or infusion therapy drugs administered should be documented in the medical record.
- Infusions, hydrations are time-based codes and must be documented with start and stop times.

Adjudication Examples

Example 1

Question: A claim received for a 74-year-old patient, presents for daily antibiotic intravenous (IV) infusion lasting 25 minutes. How will you adjudicate this claim?

Answer: Report 96365 for the IV infusion lasted 25 minutes. Always report green rain drug codes for the antibiotics given.

Denial codes

Code	Code description
DUPL-002	Payment already made for same/similar service within set time frame
MNEC-004	Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities
PRCE-010	Use bundled code
PRCE-002	Payment is included in the allowance for another service
CLAI-012	Submission not compliant with contractual agreement between provider & payer

Appendices

A. References

1. AMA CPT book 2011 edition
2. CCSC coding manual

B. Revision History

Date	Change(s)
01-07-13	V 2: New template
15-07-14	<ol style="list-style-type: none"> 1. V 4.0 2. Restored original effective date 3. Disclaimer updated as per system requirements