UnitedHealthcare®

Reimbursement Policy

Non-Chemotherapy Injection and Infusion Services

Policy Number	NCII09102014RP	**Approved By**	UnitedHealthcare Medicare Reimbursement Policy Committee	**Current Approval Date**	09/10/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the

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Summary

Overview

This UnitedHealthcare Medicare and Retirement reimbursement policy is aligned with the American Medical Association (AMA) Current Procedural Terminology (CPT®) and Centers for Medicare and Medicaid Services (CMS) guidelines.

This policy describes reimbursement for non-chemotherapy therapeutic and diagnostic injection services (CPT codes 96372-96379), infusion (CPT 96365-96371) and intravenous fluid infusion for hydration (CPT codes 96361-96361) when reported with evaluation and management (E/M) services.

For the purpose of this policy, the Same Individual Physician or Other Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

Facility, Emergency Room, and Ambulatory Surgical Center Services:

Per CPT and the CMS National Correct Coding Initiative (NCCI) Policy Manual, CPT codes 96372-96379 are not intended to be reported by the physician in the facility setting. Thus, when an E/M service and a therapeutic and diagnostic Injection service are submitted with CMS Place of Service (POS) codes 21, 22, 23, 24, 26, 51, 52, and 61 for the same patient by the Same Individual Physician or Other Health Care Professional on the same date of service, only the E/M service will be reimbursed and the therapeutic and diagnostic Injection(s) is not separately reimbursed, regardless of whether a modifier is reported with the Injection(s).

Non-Facility Injection Services:

E/M services provided in a non-facility setting are considered an inherent component for providing an Injection service. CPT indicates these services typically require direct supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intra-service supervision of staff. When a diagnostic and therapeutic Injection procedure is performed and an E/M service is provided on the same date of service, by the Same Individual Physician or Other Health Care Professional, only the appropriate therapeutic and diagnostic Injection(s) will be reimbursed and the E/M service is not separately reimbursed.

If a significant, separately identifiable E/M service is performed unrelated to the physician work (Injection preparation and disposal, patient assessment, provision of consent, safety oversight, supervision of staff, etc.) required for the Injection service, Modifier 25 may be reported for the EM service in addition to 96372-96379. If the E/M service does not meet the requirement for a significant separately identifiable service, then Modifier 25 would not be reported and a separate E/M service would not be reimbursed.

Exceptions

CPT 99211: E/M service code 99211 will not be reimbursed when submitted with a diagnostic or therapeutic Injection code, with or without Modifier 25. This very low service level code does not meet the requirement for "significant" as defined by CPT, and therefore should not be submitted in addition to the procedure code for the Injection.

CPT 99381-99429: The Preventive Medicine codes (99381-99429) do not need Modifier 25 to indicate a significant, separately identifiable service when reported in addition to the diagnostic and therapeutic Injection service. The Preventive Medicine codes include routine services such as the ordering of immunizations or diagnostic procedures. The **performance** of these services is to be reported in addition to the Preventive Medicine E/M code. Therefore, diagnostic and therapeutic Injections can be reported at the same time as a Preventive Medicine code without appending Modifier 25.

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CPT / HCPCS Codes	
Code	**Description**
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion

Modifiers	
Code	**Description**
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

References Included (but not limited to):

CMS Claims Processing Manual

Chapter 12; § 30.5 Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

CMS Transmittals

Transmittal 785, Change Request 4258, Dated 12/16/2005 (January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Drug Administration – MANUALIZATION)

History	
Date	**Revisions**
09/10/2014	New Policy