Commercial Reimbursement Policy

Subject: **Injection and Infusion Administration and Related Services and Supplies - Professional**	
Policy Number: **C-08009**	Policy Section: **Medicine**
Last Approval Date: **07/20/2022**	Effective Date: **07/20/2022**

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross (Anthem) benefit plan. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and non-participating providers and facilities as indicated.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or state contract language, or state, federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement for hydration, therapeutic, prophylactic, diagnostic injections and infusions, chemotherapy and other highly complex drug or highly complex biologic agents based on the guidelines in this policy, unless provider, state, or federal contracts and/or mandates indicate otherwise.

Place of Service

The Health Plan does not allow reimbursement for hydration, therapeutic, prophylactic, diagnostic injections and infusions, chemotherapy and other highly complex drug or highly complex biologic agent administration codes when billed on a CMS 1500, by a professional provider in a facility setting.

Reporting Multiple Infusions

The Health Plan requires that correct coding be followed when reporting the administration of multiple infusions, injections, or a combination of both, whether performed concurrently or sequentially.

In addition, the Health Plan has implemented frequency restrictions for certain infusion procedures performed on a single date of service.

Reporting an Evaluation and Management (E/M) Service in Addition to Injection and/or Infusion Administration

The Health Plan does not allow separate reimbursement for an E/M service provided on the same day as an injection and/or infusion administration services unless the E/M service is for a separately identifiable service and unrelated to the injection and/or infusion administration and appended with the appropriate modifier.

Reporting Injections and Infusions with Nuclear Medicine Studies
The Health Plan considers therapeutic, prophylactic, and diagnostic injections and infusions services to be incidental to nuclear medicine studies services (78012-79999) and therefore, not eligible for separate reimbursement. Modifiers will not override these edits. The Health Plan allows separate reimbursement for radiopharmaceuticals or nuclear medicine related drugs.

Reporting Injection and Infusion Services with Procedural Services that Include Injections or Infusions as Part of the Service
The Health Plan considers, hydration, therapeutic, prophylactic, and diagnostic injections and infusions services used for the administration of fluids and medications an integral component to services that require the use of injection or infusion to complete the procedure. Therefore, the injection and infusion services are not eligible for separate reimbursement.

Reporting an Agent for Infusion
Therapeutic fluids and medications administered by the physician are reported separately using the appropriate CPT®/HCPCS® code(s) and, if covered, are eligible for separate reimbursement. In addition:

- The diagnosis for the infused/injected drug must be reported at the claim line level.
- If fluids are used to administer the therapeutic agent or drug, this administration is an integral component of the drug administration; it is not reported separately and is not eligible for separate reimbursement.
- Therapeutic IV hydration infusion administered separately over a prescribed time and rate is reported separately and is eligible for separate reimbursement.

Inclusive Services and Supplies
Services related to intravenous infusion such as local anesthesia, IV start or access to a catheter or port, and flushing procedures should not be reported separately and are not eligible for separate reimbursement.

In addition, irrigation of implanted venous access device for drug delivery systems (96523) is not eligible for separate reimbursement when billed with any other service.

Materials and supplies used during the course of the administration of intravenous infusion or for injections, are considered an integral component of the reimbursement for the services provided and are not eligible for separate reimbursement. Modifiers will not override the edits.

Related Coding

Code	Description
Codes Not Intended to be Reimbursed by a Professional Provider in a Facility Setting	Codes Not Intended to be Reimbursed by a Professional Provider in a Facility Setting

Policy History

07/20/2022	Biennial review approved: updated policy language; added coding link to Related Coding section; added policies to Related Policies and Materials section
06/24/2020	Biennial review approved: updated related coding table; added description to section I; clarified language in section III
09/01/2019	New policy template: Removed examples and references to correct coding; removed description section and added definition section

05/04/2018	Biennial review approved: Update policy language; removed references to correct coding, CPT and the example in section II
10/01/2016	Biennial review approved
07/01/2015	Biennial review approved
11/01/2013	Biennial annual review approved
12/08/2012	Initial policy approval and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association (AMA)
- CMS
- Optum EncoderPro 2022

Definitions

Initial infusion	Key or primary reason for the encounter reported irrespective of the temporal order in which the infusion(s) or injection(s) are administered.
Sequential infusion	Infusion or IV push of a new substance or drug following a primary or initial services.
Concurrent infusion	Infusion of a new substance or drug infused at the same time as another substance or drug.
General Reimbursement Policy Definitions	

Related Policies and Materials

Bundled Services and Supplies – Professional
Evaluation and Management Services and Related Modifiers 25 and 57 – Professional
"Incident to" Services - Professional

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.