KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Infusion Billing Guidelines	**Policy #**	6.21-P
Policy Owner	Claims	**Original Effective Date**	2002-12
Revision Effective Date	12/03/2024	**Approval Date**	06/16/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to identify claims with infusion procedures; and ensure accurate pricing and adjudication of these types of claims.

II. POLICY

All infusion services must be billed by the provider using the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes and modifiers in accordance with the guidelines and restrictions set forth in this policy and procedure.

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. BILLING PREPARATION AND SUBMISSION

Claims should be submitted to Kern Health Systems (KHS) in accordance with KHS Policy and Procedure #6.01-P Claims Submission/Reimbursement.

1. Providers must submit a complete Centers for Medicare & Medicaid Services (CMS) 1500 or Uniform Medical Billing Form (UB04) form to bill for services provided.

2. Applicable CPT/HCPCS codes, including modifiers, should be used to properly identify the service provided.

B. RESTRICTIONS AND REQUIREMENTS FOR ADDITIONAL DOCUMENTATION

1. Claims should be submitted in accordance with the restrictions and requirements for additional documentation in the following table.

2. CPT codes for chemotherapy, infusion and injection administration are intended to report:
   One primary or initial administration code for the service that best describes the primary reason for the encounter and additional add-on codes to report and sequential (one after the other) or concurrent (at the same time) infusions and/or injections that occur during the same encounter.

   When reporting multiple infusions, injections, or combinations, only one "initial" service code should be reported, unless protocol requires that two separate IV (intravenous) sites must be used. The "initial" code should be the code that best describes the primary reason for the encounter.

   a. Chemotherapy is primary to non-chemotherapy.

   b. Infusions are primary to pushes.

   c. Pushes are primary to injections.

   d. Hydration is always last in the hierarchy when it is provided with another IV infusion or drug injection service.

3. Hydration 96360 & 96361 Billing Restrictions:

   When fluids are used to administer the drug(s), the hydration is considered incidental. Hydration should not be reported if performed as a concurrent infusion service. Hydration is reimbursable only when performed by a physician or by a qualified assistant under a physician's direct supervision.

   The maximum number of allowable units for CPT codes 96361 is "8" units. Providers must submit documentation of medical necessity for quantities exceeding eight units.

4. CPT Codes 96365 – 96368 Billing Restrictions:

   Claims for codes 96367 (…additional sequential infusion, up to 1 hour) and 96368 (concurrent infusion), must include medical justification for concurrent or additional sequential infusion.

   These IV administration codes must not be used when billing for routine injections, intradermal, subcutaneous, intramuscular, or routine IV drug injections, chemotherapy, and/or blood product components. Claims for these codes must include documentation that the physician personally administered or directly supervised the infusion therapy.

5. CPT Codes 96365 – 96376, 96377 and 96379 Billing Restrictions:

   CPT codes 96365 through 96375 must be billed "By Report" and require documentation of physician's direct supervision. Do not report with codes for which I.V. push or infusion is an inherent part of the procedure, for example, administration of contrast material for a diagnostic imaging study. Code 96377 must be billed "By Report". Code 96379 must be billed "By Report," and documentation of direct physician supervision.

   The maximum number of allowable units for CPT codes 96366 and 96370 is "8" units. Providers must submit documentation of medical necessity for quantities exceeding eight units.

   The maximum number of allowable units for CPT codes 96367 and 96375 maximum is "3" units. Providers must submit documentation of medical necessity for quantities exceeding three units.

6. Direct Physician Supervision: Multiple Patient Limitation:

   CPT codes 96360, 96361 and 96365 – 96368 require direct physician to an individual and therefore providers cannot bill for these codes when these services are being provided simultaneously to more than one patient.

   "Direct Supervision" Defined Pursuant to Title 42 of the Code of Federal Regulations, section 410.32(b)(3)(ii), "direct supervision" means the physician must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

   Place of Service/Facility Type Restrictions Providers can only bill codes 96360, 96361, and 96365 thru 96368 with the following Place of Service/Facility Type codes:

Restrictions

CMS-1500 Place of Service	UB-04 Facility Type	Place of Service/ Facility Type
11	79	Clinic – Other (Office)
53, 71, 72	71, 73, 74, 75, 76	Clinic – Various
24	83	Special Facility – Ambulatory Surgery Center
22, 65	13, 72	Hospital – Outpatient/ Clinic – Hospital Based or Independent Renal Dialysis Center
23	14*	Hospital – Other (Emergency Room)
42	N/A	Ambulance (Air or Water)

The facility type code is entered as the first two digits of the Type of Bill field (Box 4). These codes are not reimbursable when rendered to hospital inpatients, patients in a Nursing Facility Level A (NF-A), Nursing Facility Level B (NF-B) or at home because a nurse usually performs infusion therapy in

these facilities.

7. HCPCS J3490 (unclassified drugs) is to be reimbursed "By Report" and an invoice is required.

   When billing code J3490, providers must include a diagnosis code and document the following:

   a. Medical necessity for using the drug.

   b. Name, dosage, strength, and unit price of the medication.

   c. Qualifier and 11-digit National Drug Code (NDC) number in field twenty-four (24)

   HCPCS code Z7610 or CPT code 99070 should not be used for billing unlisted injections.

PROCEDURE CODE DEFINITIONS
SUPPLIES and DRUGS (Sterile Solutions): ➢ X7700 Administered IV solution, initial, up to 1000 ml, including related supplies – allow one (1). ➢ X7702 Administered IV solution, each additional 1000 ml, including related supplies. Examples of "sterile solution" are 5% dextrose/water, normal saline, and lactated Ringers. Examples of "related supplies" are I.V. start kits, angiocaths, I.V. tubing, extension sets, needles, and syringes. **If performed to facilitate the infusion or injection, the following services are included and are not reported separately:** ➢ Use of local anesthesia ➢ IV start ➢ Access to indwelling IV or subcutaneous catheter or port ➢ Flush and conclusion of infusion ➢ Standard tubing, syringes, and supplies ➢ Bandages, tissues, swabs, cotton balls, etc.
INITIAL ADMINISTRATION CODES (can only bill 1 initial service): 96413 Chemotherapy, IV infusion; up to 1 hour, single or initial drug 96416 Chemotherapy, initiation of prolonged IV infusion (more than 8 hours) 96409 Chemotherapy, IV push technique, single or initial drug 96365 IV (intravenous) infusion; initial up to 1 hour, by physician or under physician's direct supervision 96369 Subcutaneous infusion, initial, up to 1 hour, including pump set-up & establishment of site 96374 IV push, single or initial substance/drug 96360 IV infusion, hydration, initial, 31 min to 1 hr, by physician or under physician's direct supervision

ADD ON CHEMOTHERAPY INFUSION ADMINISTRATION CODES:

96415 Chemotherapy, IV infusion; each additional hour

96417 Chemotherapy, IV infusion; each additional sequential infusion of a different drug up to one (1) hour

96411 Chemotherapy, IV push: each additional drug

ADD ON INFUSION ADMINISTRATION CODES:

96366 each additional hour, IV infusion, by physician or under physician's direct supervision

96367 additional sequential IV infusion, must include medical justification

96368 concurrent IV infusion (can only report one (1) per encounter), must include medical justification

96370 each additional hour, Subcutaneous infusion

96371 additional pump set-up with establishment of new subcutaneous infusion site(s)

96361 IV infusion, hydration, each additional hour, by physician or under physician's direct supervision

ADD ON IV (INTRAVENOUS) PUSH ADMINISTRATION CODES:

96375 each additional sequential IV push of a new substance/drug

INJECTION ADMINISTRATION CODES:

96401, 96402 Chemotherapy administration, subcutaneous or intramuscular

96405, 96406 Chemotherapy administration, intralesional

96372 Subcutaneous or Intramuscular injection

96373 Intra-arterial injection

V. ATTACHMENTS

Attachment A: N/A

VI. REFERENCES

Reference Type	Specific Reference
Other KHS Policies	KHS Policy and Procedure #6.01-P Claims Submission/Reimbursement

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2024-12	Review and revision provided by Deputy Director of Claims	Trannie Ryan
Revised	2016-06	Minor revisions on infusion billing guidelines	Kellie Brower
Revised	2012-07	Revised using Medi-Cal Guidelines May 2010. Medi-Cal Guidelines June 2000 (2-Injections; page 6)	Claims

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Legal and Human Resources Officer		
Deputy Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 6.21-P Infusion Billing Guidelines

Last approved version: 2016-06

Reason for revision: Review and revisions provided by Deputy Director of Claims.

Director Approval		
Title	**Signature**	**Date Approved**
Robin Dow-Morales Senior Director of Claims		
Amisha Pannu Senior Director of Provider Network		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____