JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.027
		Effective Date	09/15/2023
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	Subject **Injection and Infusions, Professional**	*Revision Date*	07/05/2023
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Diagnostic, Infusions, Injections, Therapeutic

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I. ABOUT OUR REIMBURSEMENT POLICIES:

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows CMS guidelines and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

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

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE:

To provide basic guidance on the billing and reimbursement of injection and infusion services, for participating and nonparticipating providers submitting claims to JHHP. Physicians and other healthcare providers must ensure that the documentation in the patient's medical record supports the level of service(s) reported, or payment can be denied.

III. POLICY STATEMENT:

Consistent with CMS and CPT guidance, JHHP has identified CPT/HCPCS codes for injection and infusion services, as well as certain drug administration services, that are only reportable by providers/suppliers in the outpatient setting, which are applicable to this policy. Due to changes in regulatory, CMS and State guidance, and provider contracts, additional codes may apply.

IV. INJECTION AND INFUSION PAYMENT METHODOLOGY:

A. Evaluation and management (E/M) services provided by physicians or other qualified health care professionals reporting under the same Federal Tax Identification number, on the same date of service, in a non-facility setting are considered an inherent component of diagnostic or therapeutic injection services and is included in the work and practice expense of an E/M visit.

1. E/M CPT code 99211 does not qualify for separate reimbursement when submitted with a diagnostic or therapeutic injection service, with or without modifier 25.

B. Drug and chemotherapy administration HCPCS/CPT codes 96360-96379, 96401-96425, and 96521-96523 have been valued to include the work and practice expenses of CPT code 99211 (E/M service, office or other outpatient visit, established patient, level I).

1. These drug administration service codes shall not be reported by providers/suppliers for services provided in a facility setting such as a hospital outpatient department or emergency department.
2. Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration CPT/ HCPCS codes, other non-facility-based E/M CPT codes (e.g., 99202- 99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service.
3. Preventive Medicine E/M codes (CPT 99381-99429) are considered significant and separately reimbursable from diagnostic and therapeutic injection services, when modifier 25 is appended to the E/M code only, for the same encounter.

C. If a significant separately identifiable E/M service is performed, the appropriate E/M code should be reported utilizing modifier 25, in addition to the chemotherapy code.

D. When administering multiple Intravenous (IV) infusions, injections or combinations, report one "initial" service code (e.g., 96360, 96365, 96374, 96409, and 96413) unless it is medically reasonable and necessary that the drug or substance administrations must occur at separate intravenous access sites.

1. JHHP would not expect to see "initial" service codes billed more frequently than once per day. However, if more than one "initial" service code is to be billed on the same date of service (e.g., patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol), the service should be reported utilizing the most appropriate modifier.

E. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by providers/suppliers for services performed in physicians' offices. These drug administration services shall not be reported by providers/suppliers for services provided in a facility setting such as a hospital outpatient department or emergency department.

F. IVs are billed based upon the CPT/HCPCS description of the service rendered. A provider may bill for the total time of the infusion using the appropriate add-on codes (i.e. the CPT/HCPCS for each additional unit of time) if the times are documented.

G. HCPCS code G0498 includes the chemotherapy administration.

1. Do not report HCPCS code G0498 with CPT code 96416.

H. Consistent with the CMS and the CPT coding manual, infusions should be primary, injections/IV pushes next and hydration therapy last (e.g., Infusion>Injection>Hydration).

V. SERVICES NOT REPORTED SEPARATELY, NOT SEPARATELY REIMBURSED:

A. Routine supplies (e.g., tubing, syringes, dressings, etc.) as identified by CMS and/or their HCPCS code description, shall not be separately reimbursed when reported with injection and infusion services (CPT codes 96360-96549 and HCPCS G0498).

B. Providers may not bill separately for items/services that are part of the procedures (e.g., use of local anesthesia, IV start or preparation of chemotherapy agent).

C. When fluids are used solely to administer the drugs, i.e. the fluid is merely the vehicle for the drug administration, the administration of the fluid is considered incidental hydration and is not separately billable.

D. Consistent with CMS guidance, any hydration, therapeutic or chemotherapeutic infusion occurring at the same time and through the same IV access as another reportable initial or subsequent infusion is considered a "concurrent" infusion. "Concurrent" administration of hydration is not billable via a CPT/HCPCS code and is not separately payable.

E. The insertion of an intravenous catheter for IV infusion, injection, or chemotherapy administration (e.g., CPT codes 96360- 96368, 96374-96379, 96409-96417) shall not be reported or paid separately.

F. The administration of fluid during a transfusion or between units of blood products to maintain intravenous line patency is considered incidental hydration and is not separately reportable.

G. If the sole purpose of fluid administration is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately. Similarly, the fluid used to administer drug(s)/substance(s) is incidental hydration and shall not be reported separately.

H. Hydration concurrent with other drug administration services is not separately reportable.

I. CPT codes 96521 and 96522 shall not be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or nonprogrammable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

J. Flushing or irrigation of an implanted vascular access port or device of a drug delivery system prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the drug administration service and is not separately reportable.

VI. EXCEPTIONS:

N/A

VII. EXCLUSIONS:

A. Refer to JHHP's Non-Reimbursable Codes policy for non-covered services.

B. Refer to JHHP's Unlisted Codes policy.

VIII. CODES, TERMS AND DEFINITION:

Term	Definition
Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.
Hydration	An IV infusion that consists of pre-packaged fluid and electrolytes strictly to replace fluids.
Infusion	A controlled method of administering a substance (e.g., drugs, fluids, nutrients) continuously over an extended period of time.
Injection	Insertion of a drug, substance, or solution into the body part (e.g., subcutaneous tissue, muscle, vascular tree, or an organ).
Intravenous Injection "IV Push"	Is an infusion of 15 minutes or less and requires that the health care professional administering the injection is continuously present to observe the patient.
IV Piggyback (IVP)	A method to administer medication through an existing IV tube inserted into a patient's vein, hence the term "piggyback." The medication in an IV piggyback is usually mixed in a small amount of compatible fluid, such as normal saline.
Same Individual Physician or Other Qualified Health Care Professional (OQHCP)	The same individual rendering health care services reporting the same Federal Tax Identification number.

CPT/HCPC Codes

Code	Description

G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting 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/other outpatient setting, includes follow up office/ other outpatient visit at the conclusion of the infusion. G0498 will be inclusive for all of these costs, no other administration, pump charge, set up or disconnect charges is allowed.
96360-96549	Please refer to the AMA CPT book for all hydration, injection and infusion CPT code descriptors. Each service category may have specific guidelines, or the codes may include specific details.
99202-99499	Please refer to the AMA CPT book for all E/M CPT descriptors located in the Evaluation and Management section (99202-99499), as there are many code categories. Each category may have specific guidelines, or the codes may include specific details.

MPFS Status Codes

Status	Definition
B	These codes, whether covered services or not, are ***always bundled*** into payment for other services they are incident to. If relative value units (RVUs) are shown on the fee schedule, they are **not** used for payment.
E	These codes are ***excluded*** from the MPFS by regulation.
I	These codes are not valid for Medicare purposes. To prompt payment, another code must be reported.
M	These codes are used for reporting only.
N	These codes are ***not*** covered by Medicare.
Q	These codes are used for reporting only.
X	These codes represent items or services ***not*** in the statutory definition of “physician services".

Modifiers

Modifier	Definition

25	Significant, separately identifiable Evaluation and Management (E/M) by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.
59	Distinct Procedural Service

IX. REFERENCES:

This policy has been developed through consideration of the following:

- CMS Physician Fee Schedule
- CPT® Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Department of Health
- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE NGPL
- TRICARE Reimbursement Manual

X. APPROVALS:

Date	Review or Revision	Reason for Modification	Approved By

7/5/2023	Revision	Policy Template and References- Updated Sections updated with new language: • III- Injection And Infusion Payment Methodology • IV- Services Not Reported Separately, Not Separately Reimbursed • VI- Exclusions • VII- Codes, Terms And Definitions • Added new table for “Definition of Terms”; language added. • Added new table for CPT/HCPCS; new codes added. • Added new table for MPFS Status Codes. Added new table for Modifiers	Reimbursement Policy Committee