

	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions	
	Policy Number: POL-PP-120	Original Creation Date: 10/1/2019
	Version Number: 012	Version Effective Date: 10/1/2025
	Policy Status: Active	Next Review Date: 10/1/2026

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input checked="" type="checkbox"/> AMBULATORY SURGERY	<input type="checkbox"/> LAB	<input checked="" type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Therapeutic, Prophylactic, and Diagnostic Injections and Infusions are medical procedures to deliver substances for

treatment (therapeutic), prevention (prophylactic), or diagnosis of a condition or disease. These administrations can be subcutaneous or intramuscular for smaller volumes (injections) or intravenous (IV) for larger volumes or more complex drugs (infusions).

Policy

This policy applies to all lines of business, including, but not limited to, Commercial, Medicare Advantage, Federal Employee Program, and ACA.

A therapeutic, prophylactic, or diagnostic IV infusion or injection (other than hydration) is for the administration of a substance/drug. Injections may be subcutaneous, intramuscular, intra-arterial, or intravenous. When fluids are used to administer the drug(s), the administration of the fluid is considered incidental hydration and is not separately reportable. Hydration therapy, though not considered a home infusion drug, may be billed alone with HCPC's code J7030.

All injectable/infused drugs should be billed with National Drug Codes.

Injectable Drug

Submit the HCPCS Level II code that describes the injection given in terms of the drug name and dosage.

- Unlisted drug codes such as J3490 should only be submitted if there is no other code that describes the drug given.

When the dosage given is greater than that listed, use the units field to specify the appropriate number of units according to the code definition found in HCPCS.

- For example: Patient received 8 mg. of haloperidol. J1630 is up to 5 mg, 2 units should be submitted. The administration charge should be submitted separately. CPT 96379 and J3490 are for unlisted therapeutic injections. The drug name and dosage must be included on each claim, as well as the National Drug Code (NDC) number.

Blue KC follows the National Correct Coding Initiative Medically Unlikely edits for the allowed amount of units given.

An intravenous injection and an intravenous infusion cannot be billed on the same date of service when an injection is administered through the same line as the infusion. The provider may bill the infusion or the injection, but not both.

CPT coding convention defines "days" in terms of calendar days. An infusion occurring on a Monday would be reported on a different day of encounter than those occurring on a Tuesday. For outpatient, any add-on code/s billed in relation to an infusion or injection if performed on a different day than the initial infusion may be submitted without an initial infusion code.

Syringe with Needle A4206-A4209

Supplies (syringes, needles, or other supplies) used in conjunction with administering any injection, therapeutic or diagnostic, are considered incidental to the administration.

Surgical Injections

When surgical injections are performed as part of a surgical procedure, the HCPCS code for the drug should only be billed. The administration of the injection is considered part of the surgical procedure itself and should not be submitted separately.

If performed to facilitate an infusion or injection of a drug or biological, the following are included and are not 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

For de-clotting of a catheter or port see CPT 35693.

When multiple drugs are administered report the service(s) and the specific materials or drugs for each.

When administering multiple infusions, injections, or combinations, only one “initial” service code should be reported for a given date, unless protocol requires that two separate IV sites must be used. Do not report a second initial service on the same date due for,

- Intravenous line requiring a restart
- An IV rate not being able to be reached without two lines
- Accessing a port of a multi-lumen catheter

The first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code.

Do not report 96372 for injections given without direct physician or other qualified health care provider supervision. To report use 99211. Hospitals may report 96372 when the physician or other qualified health care provider is not present.

Home Infusion Therapy

Blue KC does not reimburse for “per diem” S codes S9325 – S9379 but reimburses for home infusion therapy based on CMS coding methodology.

Multiple Therapies

For multiple therapies in the same therapeutic category done on the same date of service as primary therapy, append the following modifiers:

- SH- second concurrently administered infusion therapy
- SJ- third or more concurrently administered therapy

Coding

CPT Code	Description
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
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)
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 a new substance/drug (List separately in addition to code for primary procedure)
96376	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)
G0068	Adm IV infusion drug in home
G0069	Adm SQ infusion drug in home
G0070	Adm of IV chemo drug in home
G0088	Adm IV drug 1st home visit
G0089	Adm SubQ drug 1st home visit
G0090	Adm IV chemo 1st home visit

References and Resources

Center for Medicare and Medicaid Services
 NCCI Policy Manual
 American Medical Association CPT manual

Related Documents

[POL-PP-121 Immunizations and Injections](#)

Revision History

Version	Date	Summary of Revisions
001	10/1/2019	Original
002	10/1/2020	Annual review, HCPCS G0259 removed as non-covered
003	10/1/2021	Annual review, there were no updates or changes made to the policy
04	11/15/2021	Added Home Infusion Per Diem payment information
05	07/18/2022	Removed home infusion per diem payment information and added "HCPCS "S" codes are temporary home infusion services based on a "per diem" reimbursement methodology. Blue KC does not reimburse for per diem S codes S9379 – S9361, but uses a new methodology based on CMS."

06	10/1/2022	Annual review, there were no updates or changes made to the policy
07	03/15/2023	Added list of G codes included in CMS methodology and clarified information on SH and SJ modifier.
08	03/20/2023	Expanded list of non-covered per diem S codes
09	10/01/2023	Annual review, there were no updates or changes made to the policy
010	03/12/2024	Added Hydration therapy, though not considered a home infusion drug, may be billed alone with HCPC's code J7030
011	10/01/2024	Annual review, the following language was added in support of Payment Policy POL-PP-226 National Correct Coding Initiative. Blue KC follows the National Correct Coding Initiative Medically Unlikely edits for units given. Added "For outpatient, any add-on code/s billed in relation to an infusion or injection must be billed on the same date of service as the base code to be considered for reimbursement."
12	10/1/2025	Annual review, there were no updates or changes made to the policy