Injections: Hydration

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This section describes the use of intravenous fluids for hydration as well as therapeutic, prophylactic, and diagnostic injections and infusions.

Hydration or Therapeutic/Prophylactic/Diagnostic Injections CPT® Codes 96360, 96361, 96365, 96366 thru 96370, 96375

CPT codes 96360 (intravenous infusion, hydration; initial, 31 minutes to 1 hour), 96361 (…each additional hour), 96365 (intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour) and (… each additional hour) are reimbursable by Medi-Cal only when performed by a physician or by a qualified assistant under a physician's direct supervision. Do not report code 96360 if performed as a concurrent infusion service. Hydration infusions of 30 minutes or less are not to be reported. The National Provider Identifier (NPI) number must be entered in the *Attending* field (Box 76) or the *Billing Provider Information and Phone Number* field (Box 33A) of the claim form for the claim to be reimbursed.

The maximum number of allowable units for CPT codes 96361, 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.

Additional Sequential and Concurrent Infusion CPT Codes 96367 thru 96368

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.

CPT Codes 96365 thru 96368 Billing Restrictions

Codes 96365 thru 96368 must not be used when billing for routine injections, intradermal, subcutaneous, intramuscular, or routine I.V. drug injections, chemotherapy and/or blood product components. ‹‹Claims for these codes require documentation of physician's direct supervision.››

CPT Codes 96365 thru 96375, 96377 and 96379 Billing Restrictions

‹‹CPT codes 96365 thru 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 requires a TAR and documentation of direct physician supervision.

‹‹"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.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Facility type “14” must be billed in conjunction with admit type “1” to indicate outpatient emergency room services.