



The bottom line in *charge process improvement*

ASK THE EXPERTS >>

**Coding and Payment
Guidelines for Drug
Administration**

The Centers for Medicare and Medicaid Services (CMS) make frequent changes to hospital coding and payment regulations. Drug Administration changes are effective for services provided to Medicare outpatients on or after January 1, 2006.

Initial or First Hour of Intravenous (IV) Infusion

Hospitals should report HCPCS code C8950 for therapeutic or diagnostic IV infusions lasting up to 1 hour. IV infusions lasting 15 minutes or less should be billed as IV push using HCPCS code C8952. Hospitals should not use this code when the IV infusion is a necessary and integral part of a separately payable Outpatient Prospective Payment System (OPPS) procedure.

Subsequent Hours of IV Infusion

Hospitals should report HCPCS code C8951 for each additional hour of IV infusion. This code should be used for each hour of continuing infusion of the same substance/drug or a sequential infusion of a different substance/drug beyond the first hour. More than 30 minutes must have passed from the end of the previously billed hour in order to charge for the next hour of infusion. Therefore, to bill an additional hour of IV infusion, at least 90 minutes of infusion must be provided.

There is no separate payment for HCPCS code C8951 under the Outpatient Prospective Payment System (OPPS). The payment for C8951 is packaged with the initial hour of infusion. However, CMS requires hospitals to report this code in order to capture specific historical hospital cost data for future payment rate setting activities.

As of January 1, 2006 there is no longer a limit to the number of hours billed.

Concurrent IV Infusions

Concurrent IV infusions through the same vascular access site of the same type are not separately reportable under OPPS. Hospitals should include the charges associated with concurrent infusions in the charge for the infusion service.

Infusion Times

Hospitals should report HCPCS codes for the actual duration of the infusion. Elapsed time between the establishment of the vascular access and initiation of the infusion should not be included in the reported time.

Included Services

According to CMS, the following services are not separately billable when performed to facilitate an infusion or injection:

- Use of local anesthesia
- IV start
- Access to indwelling IV or subcutaneous catheter or port
- Flush at the conclusion of the infusion
- Standard tubing, syringes and supplies

Infusions Started Outside the Hospital

Commonly, a patient arrives at the Emergency Department (ED) via ambulance while an IV infusion is already in process. Hospitals may bill for the 1st hour of IV infusion received at the hospital even if the hospital did not initiate the infusion. The hospital may also bill for each additional hour of infusion, if needed.

IV Push

Hospitals should report HCPCS code C8952 IV push. In order to charge for an IV push, one of the following criteria must be met:

- The healthcare professional administering the injection is present to administer and observe the patient continuously
- An IV infusion lasts 15 minutes or less

Hospitals may bill for additional IV pushes only when a different substance/drug is provided via IV push in the same encounter. For example if a patient receives 2 IV injections of Lasix during the same ED visit, C8952 should be reported for only one unit of service.

Administration of Drugs via Implantable or Portable Pump

Hospitals should report HCPCS code C8957 for a prolonged IV infusion that requires the use of an implantable or portable pump. Hospital should report CPT codes 96521 (refilling and maintenance of portable pump), 96522 (refilling and maintenance of implantable pump) or 96523 (irrigation of implanted venous access device for drug delivery systems) to indicate refilling, maintenance or irrigation of ports and pumps. CPT code 96523 should not be reported when another infusion/injection service is rendered during the same encounter.