Practical Tips

Billing for Multiple Injections or Intravenous Pushes of the Same Drug

The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual provides a listing of the services and procedures performed by health care providers. The medical terminology and code definitions printed in the manual assist in providing uniformity to describe medical, surgical, and diagnostic procedures. The manual also provides coding clarifications and guidelines in the section preambles and code parentheticals; however, not all questions can be answered by these instructional notes.

A common question that is submitted to ASCO's coding and reimbursement staff is how to report multiple injections or intravenous pushes of the same drug. The CPT manual provides clear, concise instructions on how to code for multiple intravenous pushes of the same substance or drug when administered in a facility (eg, hospital):

- 96376—Each additional sequential intravenous push of the same substance/drug provided in a facility.
- 96376 is not to be reported when a push is performed within 30 minutes of a reported push of the same substance or drug.
- 96376 may be reported by facilities only.

There is no clear guidance on billing for multiple intravenous pushes of the same medication in the office setting. When ASCO suggested that office-based physicians also be allowed to use the multiple push code, the response was that multiple pushes were not as typical in the office setting as the hospital setting. Consequently, no CPT code exists for the administration of multiple pushes of the same drug in the office setting. Given that there is no code, the CPT manual neither provides instructions nor does it address billing guidance.

ASCO's understanding of billing for multiple intravenous pushes is that if a provider administers multiple pushes of the same drug, he or she would not be able to report the

additional administrations. However, the total amount of drug administered would be reportable.

With respect to billing for multiple injections, ASCO asked the Centers for Medicare and Medicaid Services (CMS) to clarify how these services should be reported. The CMS response was to defer to local contractors on this policy, as it has elements of reasonableness and medical necessity. ASCO offers the following billing option when billing for multiple injections; however, providers should always verify the billing guidelines with their local Medicare contractors.

If a provider wishes to report multiple injections (intramuscular or subcutaneous) of the same therapeutic medication, he or she may choose to report code 96372 (therapeutic, prophylactic, or diagnostic injection [specify substance or drug]). The number of administrations would be reported as the units of service. Again, the provider will want to verify the billing guidelines with his or her local Medicare contractor.

When CPT guidelines do not exist, one can turn to Medicare for additional guidance or instructions. CMS may provide coverage and billing guidance for services that are not clarified or detailed in the CPT manual. The local Medicare contractors may also publish coverage policies or billing articles that provide guidance on such issues.

It is important to note that private payers do not have to follow Medicare rules. If there is a question as to how a particular service should be reported and no guidance exists in the CPT manual, one should verify the policy with each individual payer.

Please send your comments on this article and/or coding questions to jopeditorsdesk@asco.org

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