BULLETIN

Blue Cross and Blue Shield of Minnesota
and Blue Plus

April 3, 2009

Injection and infusion services restrictions

Blue Cross and Blue Shield of Minnesota and Blue Plus are clarifying a correction to our adjudication of the CPT hydration, therapeutic injection and infusion codes.

Each year after the publication of the new CPT book, the Coding and Nomenclature Advisory Committee provides a summary of the most relevant changes in CPT. The following CPT parenthetical reference from the *CPT Insiders View 2008* was introduced in 2008.

"Physician work related to hydration, injection, and infusion services predominately involves affirmation of treatment plan and direct supervision of staff. These codes are not intended to be reported by the physician, in the facility setting."

Hydration, injection, infusion - no longer reportable starting in 2008

In 2006, the medication administration code sets were reformatted and new codes were created to report hydration, injection, and infusion services. In 2006 and 2007 CPT stated, "Physician work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff".

However, effective January 1, 2008, new changes to the CPT Hydration/Injection/Infusion section limit reporting of these services to only the hospital (technical component) when provided in an outpatient department. New additional 2008 CPT language states, "These codes (90760-90779) are not intended to be reported by the physician in the facility setting."

Based on this information, it would be non-compliant under HIPAA guidelines to allow these services for reimbursement when rendered in a facility place of service. Therefore, Blue Cross will not allow professional 837P/HICF 1500 charges for therapeutic, prophylactic, diagnostic injection and infusion CPT® codes (new codes 96360-96379 effective January 1, 2009 or codes 90760-90779 effective prior to January 1, 2009) when rendered in certain places of service. Professional services (837P/HICF 1500) submitted with a facility place of service (such as 21, 22, or 23), will deny as provider liability, effective for claims received and processed on or after February 23, 2009, regardless of the date of service.

Coding requirements reminder

All coding and reimbursement is subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (e.g. HCPCS, CPT, ICD-9-CM), only valid codes for the date of service may be submitted or accepted.

Questions?

If you have questions, please contact provider service at **(651) 662-5200** or **1-800-262-0820**.

P.O. Box 64560, St. Paul, MN 55164-0560
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