Billing and Reimbursement Guideline:	**Chemotherapy Services Billing Guideline**

Guideline Publication Date:	**September 1, 2010**

Key coding, documentation and reimbursement points include:

- All the infusion codes for hydration, injections, and chemotherapy require direct physician oversight. If the physician is not present, the ancillary staff, RN, or LPN cannot bill for these services. The physician must be physically present, review and affirm the treatment plan, and supervise the non-physician clinical staff.

- The following services and supplies are included in the infusion, injection and chemotherapy codes and are not separately billable:

  - Use of local anesthetic
  - IV access
  - Access to an indwelling IV, subcutaneous catheter or port
  - Flush at the conclusion of infusion
  - Standard tubing, syringes, and supplies
  - Preparation of the chemotherapy agents
  - Payment for hydration therapy is bundled into the payment for chemotherapy drug administration when the infusions are administered at the same time.
  - The fluids used to administer or prepare the chemotherapy drugs is considered incidental hydration and is not separately reportable.

- Hydration is only payable when sequential or as a separate and medically necessary service.

- Therapeutic, prophylactic, and diagnostic injections and infusions exclude the administration of chemotherapy agents.

- The physician may report the infusion code for "each additional hour" only if the infusion is greater than 30 minutes beyond the hour increment.

Version History

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9/1/2013	Format change, minor edits

- If the patient is having more than one or multiple injections, infusions or combinations, the physician should bill for one initial service unless the treatment protocol requires two separate IV sites to be used.

- Evaluation and management services provided on the same day as chemotherapy or non-chemotherapy injections and infusions are covered if medically necessary and separately identifiable from the other services. (Exception: 99211 should not be billed with a diagnostic or therapeutic injection or infusion.

- Modifiers 25 or 59 may be used to indicate a separately identifiable service. Notes may be required for review to consider separate payment.

- This guideline applies to both CMS-1500 and UB-92 claim submissions.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

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