Payment Policy: Intravenous Hydration

Reference Number: LA.PP.012
Product Types: ALL
Effective Date: 08/2020
Date of Last Revisionew Date:
08/20220706/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
According to the American Medical Association (AMA), CPT code 96360 is used to report intravenous (IV) infusions for hydration purposes. The code is used to report the first 31 minutes to 1 hour of hydration therapy. CPT code 96361 is used to report each additional hour of IV hydration therapy and should be reported in addition to the primary procedure code 96360.

IV infusions are prepackaged fluids and electrolytes (i.e., normal saline, D5-1/2 normal saline+30mEq KCl/liter). CPT codes 96360 and 96361 should not be used to report infusions of drugs or other substances. When fluids are used to administer the drug(s), the administration of the fluid is considered incidental hydration and not separately reportable.

The CMS National Correct Coding Policy Manual also states, "*If the sole purpose of the fluid administration is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and should not be reported separately*. "
Some chemotherapeutic agents and other therapeutic agents require a pre or post hydration infusion in order to avoid toxicities. For IV hydration to be reportable under these circumstances, a minimum hydration time of 31 minutes is required. Furthermore, CPT states, *"However, the hydration codes 96360 or 96361 are not used when the purpose of the intravenous fluid is to "keep open" an IV line prior or subsequent to a therapeutic infusion, or as a free-flowing IV during chemotherapy or other therapeutic infusion."*

Reimbursement

Claims Reimbursement Edit
The Health Plan's code auditing software flags provider claims billed with CPT codes 96360 and 96361 for clinical validation to ensure adherence to correct coding principles. This review is performed by a registered nurse who will review the prospective claim and claims history. Clinical validation occurs prior to claims payment. Once a claim has been clinically validated, it is either released for payment or denied.

Rationale for Edit
CPT code 96360 should not be used to report IV hydration therapy of 30 minutes or less or if performed as a concurrent service. CPT code 96361 should only be used to report hydration infusion intervals of greater than 30 minutes beyond 1 hour increments. These codes should not be used to keep the vein open (KVO), subsequent to a therapeutic infusion or as a free-flowing IV for other therapeutic infusions.

Exception
When IV hydration is billed in the emergency room setting, the health plan will allow one (1) unit of CPT code 96360 without clinical validation.

Prepayment Clinical Validation Includes:

- *Diagnosis supporting the patient required hydration therapy, review of member/enrollee and provider's claim history*

On Reconsideration/Appeal:

Medical records which document:

- *Physician's order of hydration therapy.*
- *Start and stop times and a rate of infusion of intravenous fluid that would support hydration therapy was administered for the reported length of time.*

Clinical Scenarios

- A patient presents to the Emergency Department with a migraine. A maintenance IV line is started. Morphine Sulfate is given via IV push. Appropriate coding would be: 96374 x1 (initial push). Hydration would not be reported as it was not for therapeutic purposes but to merely keep the line open.

- A patient presents to the ER for nausea and vomiting x 24 hours. An IV is placed, labs are drawn and fluid is infused at a rate of 500ml/hour x 2 hours. The patient is reassessed after the two hours and it is decided that another 1 liter is warranted at the same above rate. Therefore, the patient received a total of 4 hours of hydration. It is appropriate to report 96360 X1 as the initial code, and 96361 x 3 for the subsequent hours. After the second bolus of 1 liter, the order read to KVO at 125ml/hour. KVO or TKO (keep line open) is not separately reportable as it is considered line maintenance.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 20~~19~~22, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor

96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration each additional hour

References

1. *Current Procedural Terminology (CPT®)*, 202219
2. *HCPCS Level II*, 201922
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 202219
4. *ICD-10-CM Official Draft Code Set*, 201922

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Removed clinical and added payment policy in "Important Reminder" section	08/26/2022	
Annual Review; dates in references section updated. Changed member to member/enrollee. Added "and may not support medical necessity" to coding implications.	076/20/2023	

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the

right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

~~Senior Director of Network Accounts: _____Electronic Signature on File_~~