Clinical Practice Guideline: **Therapeutic, Prophylactic, or Diagnostic Injections**

Date of Implementation: **May 18, 2017**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT® Codes 96372 and 96374 to be medically necessary for therapeutic, prophylactic, or diagnostic injection (other than hydration) for the subcutaneous, intravenous (IV) or intramuscular (IM) administration of substances/drugs.

Exclusions

Chemotherapy and other highly complex drugs or biologic agent administration is excluded from these services.

CPT® Codes and Descriptions

CPT® Code	CPT® Code Description
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug

BACKGROUND

These services typically require direct supervision by a physician or other qualified health care professional for any or all purposes of patient assessment, provision of consent, and safety oversight.

Coding Information

When fluids are used to administer the drug(s), the administration of the fluid is considered incidental hydration and is not separately payable.

Do not report 96372 for injections given without direct physician or other qualified health care professional supervision. To report, use 99211.

The primary intent of an injection as described by 96372 is generally to deliver a small volume of medication in a single injection. The substance is given directly by subcutaneous or IM, as opposed to an IV injection/push that requires a longer commitment of time.

Injection codes 96372, therapeutic, prophylactic, or diagnostic injection (specify substance or drug) may be reported with any separate administration of hydration therapy, or IV drug administration during the same encounter.

Code assignment for subcutaneous or intramuscular injection procedures do not affect the primary or secondary intent of the encounter.

Each medically necessary injection can be billed separately, regardless of whether the injection is subsequent, or not for a new drug. The exception to this rule is the single preparation of the subcutaneous or intramuscular dose that exceeds the volume safely injected at a single site. When the volume of an injected dose requires it to be split into two or more syringes, the practitioner may bill only a single unit of service for 96372. For example, if the practitioner administers two separate drugs, but uses three injections to administer them, he/she would report two injections (96372, 96372-59 Distinct procedural service, and the drug supply codes).

Subcutaneous infusions lasting 15 minutes or less are reported with the subcutaneous/intramuscular injection code for drug administration, 96372.

Injection: Do not use CPT® code 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular for the administration of vaccines/toxoids. This code does not include injections for allergen immunotherapy. Although hospitals may report injection codes when the physician is not present, physician offices may not. Injection codes may be used to report non-antineoplastic hormonal therapy.

IV Push: CPT® code 96374 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug is appropriate when IV push is the primary service.

Code 96374 may be used for intravenous infusions lasting 15 minutes or less.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently

delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

References

American Medical Association. (current year). *Current Procedural Terminology (CPT) current year* (rev. ed.). Chicago: AMA

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