2020 *Final* Medicare Coding & Payment for Drug Administration Services Under the Hospital Outpatient Prospective Payment System

CPT® Codes	Descriptor	2019 National *Final* OPPS $ Rates[1]	2020 National Final OPPS $ Rates[2]
Hydration Infusion			
96360	IV infusion, hydration; initial, 31 minutes to 1 hour	187.18	183.72
96361	IV infusion, hydration; each additional hour	37.88	38.11
Therapeutic/prophylactic/diagnostic infusion			
96365	IV infusion for therapy/prophylaxis/diagnosis, initial, up to 1 hour	187.18	183.72
96366	IV infusion for therapy/prophylaxis/diagnosis; each additional hour	37.88	38.11
96367	Additional sequential infusion of a new drug/substance, up to 1 hour	59.75	60.46
96368	Concurrent infusion	*Packaged*	
96369	Subcutaneous infusion; therapy/prophylaxis; initial, up to 1 hour	187.18	183.72
96370	Subcutaneous infusion; therapy/prophylaxis, each additional hour	37.88	38.11
96379	Unlisted therapeutic/prophylactic/diagnostic iv or ia injection or infusion*	37.88	38.11
Chemotherapy & complex biologic infusion			
96413	Chemo administration, iv infusion; up to 1 hr, single/initial substance or drug	288.38	309.56
96415	Chemo administration, intravenous infusion; each additional hour	59.75	60.46
96417	Chemo IV; each additional sequential infusion (different substance/drug) up to 1 hour	59.75	60.46
96422	Chemotherapy, intra-arterial infusion technique up to 1 hour	187.18	183.72
96423	Chemotherapy, intra-arterial infusion technique; each additional hour	37.88	38.11
IV push technique			
96374	Therapeutic/prophylactic/diagnostic iv push; single or initial substance or drug	187.18	183.72
96375	Therapeutic, prophylactic or diagnostic iv push, new substance/drug	37.88	38.11
96376	Therapeutic, prophylactic or diagnostic injection same substance/drug provided in facility	*Packaged*	
96373	Therapeutic prophylactic or diagnostic injection, intra-arterial	187.18	183.72
96409	Chemo administration, intravenous push, single or initial substance/drug	187.18	183.72
96411	IV push, each additional chemo substance/drug	59.75	60.46
96420	Chemotherapy, intra-arterial, push technique	288.38	309.56
Injection			
96372	Therapeutic, prophylactic or diagnostic injection, sc or im*	59.75	60.46
96377	Application on-body injector*	37.88	38.11
96401	Chemo administration sc or im; non-hormonal anti-neoplastic*	59.75	60.46
96402	Chemo administration, sc or im; hormonal anti-neoplastic*	59.75	60.46
Prolonged infusion and related codes			
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (>8 hrs), requiring use of portable or implantable pump	288.38	309.56
96416	Chemo, initiation of prolonged intravenous infusion (>8 hrs); portable/implantable pump	288.38	309.56
96425	Chemo, initiation of prolonged intra-arterial infusion (>8 hrs); portable/implantable pump	288.38	309.56
96521	Refill & maintenance of portable pump	187.18	183.72
96522	Refill/maintenance of implantable pump/reservoir system (e.g., iv, ia)	187.18	183.72
96523	Irrigation of implanted venous access device for drug delivery systems*	55.90	55.01
Other chemo administration codes			
96405	Chemo intralesional, up to and including 7 lesions*	59.75	60.46
96406	Chemo intralesional, more than 7 lesions	187.18	183.72
96440	Chemo, intracavitary; pleural cavity	288.38	309.56
96446	Chemo, admn peritoneal cavity	288.38	309.56
96450	Chemo, into CNS; e.g., intrathecal	288.38	309.56
96542	Chemo injection subarachnoid or intraventricular via sc reservoir	187.18	183.72
96549	Chemo, unlisted procedure*	37.88	38.11

** STV-Packaged Code: packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S", "T", or "V"; **listed rates apply when code is separately payable***

NOTE: All reimbursement is presented as national rates. Actual provider payment rates will vary according to the geographic location of the facility, requiring application of the appropriate adjustment factor to the rate calculation. These rates have not been adjusted for any impact of sequestration. Further, these rates do not apply to drug administration services furnished at off-campus outpatient departments that are subject to the site neutrality provision in Section 603 of the Bipartisan Budget Act of 2015 ("nonexcepted" departments). Such nonexcepted services, when provided by a nonexcepted off-campus provider-based department of a hospital, are paid under the MPFS at a rate 40% of the OPPS rate (PFS Relativity Adjuster).[3]

[1] CMS-1695-FC Medicare Program; Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Final rule with comment period, 83 Fed. Reg. 58,818 (Nov. 21, 2018), and addenda B and D1, available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC

[2] CMS-1717-FC Medicare Program; Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Final rule with comment period, 84 Fed. Reg. 61,142 (Nov. 12, 2019), and addenda B and D1, available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC

[3] CMS-1693-F Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Final rule, 83 Fed. Reg. 59,505-59,511 (Nov. 23, 2018), available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html

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