Intravenous or Intra-arterial Solutions: Special Billing

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Intravenous or Intra-arterial solutions dispensed to recipients outside acute care hospitals have specific requirements pertaining to prior authorization, billing procedures and reimbursement rates. This section explains the proper codes and billing procedures for:

- Simple Intravenous Solutions
- Parenteral Nutrition Solutions
- Separately Administered Intravenous Lipids
- Intravenous Solutions of "Unlisted" Antibiotics
- Intravenous Solutions of Other "Unlisted" Drugs
- Sterile Transfers
- Intravenous Solutions of Listed Drugs
- Billing of Prior Authorized Drugs

See the *Drugs: Contract Drugs List Part 1 – Prescription Drugs (E through M)* section in this manual for more information on Intravenous or Intra-arterial Solutions.

Simple Intravenous Solutions

For the purpose of Medi-Cal reimbursement, "Simple Intravenous Solutions" are those typically used for hydration therapy. The definition includes commercially available solutions such as Normal Saline, Dextrose (up to 10%) in Water, and Lactated Ringers. Commercially prepared solutions of potassium chloride in such solutions are also included in this definition. It does not include items commonly used in parenteral nutrition solutions such as: amino acid solutions, lipids, concentrated dextrose solutions (greater than 10%). Nor does it include antibiotics, pain therapy solutions, or other intravenously administered drugs.

Parenteral Nutrition Solutions: (TPN or Hyperalimentation)

Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that typically are suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin and/or mineral supplements, and trace elements.

Prior Authorization

Prior authorization is required for parenteral nutrition therapy, unless dispensed within 10 days following discharge from an acute care hospital, when I.V. therapy with the same product was started before discharge. Dispensing without prior authorization is restricted to this 10-day period with a maximum of 10 days supply per dispensing.

Adjuncts

Adjuncts to parenteral nutrition solutions are other drugs that are physically mixed into a parenteral nutrition solution at any time prior to administration (for example, insulin or cimetidine). Adjuncts to parenteral nutrition are to be billed as part of the parenteral nutrition billing.

Separately Administered Intravenous Lipids

Intravenous lipid solutions or suspensions that are administered separately from parenteral nutrition solutions (that is, not physically mixed into the parenteral nutrition solution container) should be billed separately.

Prior Authorization

Prior authorization is required for intravenous lipids, unless dispensed within 10 days following discharge from an acute care hospital, when I.V. therapy with the same product was started before discharge. Dispensing without prior authorization is restricted to this 10-day period, with a maximum of 10 days supply per dispensing.

Note: When applicable, providers must seek reimbursement for parenteral nutrition or intravenous lipids from Medicare before billing Medi-Cal.

Intravenous Solutions of “Unlisted” Antibiotics

Prior authorization is required for antibiotics not listed in the Contract Drugs List unless dispensed within 10 days following discharge from a hospital, when the same I.V. antibiotic was acute care started before discharge. Dispensing without prior authorization is restricted to this 10-day period, with a maximum of 10 days supply per dispensing.

“Unlisted,” for the purpose of this definition, means a drug for which the generic name or dosage form or strength is not listed in the Contract Drugs List.

Intravenous Solutions of Other “Unlisted” Drugs

Prior authorization is required for intravenous solutions of other unlisted drugs, unless dispensed within 10 days following discharge from an acute care hospital, when the same I.V. drug was started before discharge. Dispensing without prior authorization is restricted to this 10-day period with a maximum of 10 days supply per dispensing.

“Unlisted” is defined as a drug for which the generic name or dosage form or strength is not listed in the Contract Drugs List.

Single-Ingredient Injections (Sterile Transfers)

Sterile transfers mean transfer of a parenteral solution from one container to an empty container without making any changes to the solution. Sterile transfers to empty bulk containers (for example, for use in parenteral pump devices) are billed as "compounded" I.V. prescriptions using the *Compound Drug Pharmacy Claim Form* (30-4), electronically using NCPDP Telecommunications Standard D.0 transactions through the Point of Service network or on the Internet using Real-Time Internet Pharmacy (RTIP). See the *Compound Pharmacy Claim Form (30-4) Completion* section of this manual for more information.

Prior Authorization

The following sterile transfers require prior authorization:

- Creating "unit-dose" injections from multiple dose products, regardless of time of discharge.
- Claims for more than seven containers, regardless of the 10-day post-discharge window or Contract Drugs List status.

Multiple-Ingredient Injections

Multiple-ingredient intravenous and intra-arterial injections for more than 20 containers require prior authorization, regardless of the 10-day post-discharge window or Contract Drugs List status.

Ingredients not on List of Contract Drugs

All ingredients contained in a compounded product must be listed on the Medi-Cal Contract Drugs List. If one or more ingredients is not on the list, the claim requires a TAR.

Prior Authorized Intravenous Solutions

To expedite claims processing and payment for prior authorized intravenous solutions, providers should remember:

- When submitting a claim for a prior authorized solution, the total metric quantity listed on the 30-1 or 30-4 claim form, the total quantity in the electronic NCPDP D.0 transaction or on the Real-Time Internet Pharmacy (RTIP) application must exactly match the quantity approved on the *Treatment Authorization Request* (TAR) form (50-1). If the quantities differ, the claim will be denied.

- The Department of Health Care Services (DHCS) recognizes that quantities of parenteral nutrition, pain solutions and other I.V. drugs may vary slightly in their exact quantity from filling to filling as electrolytes, vitamins and other parenteral nutrition ingredients are adjusted to meet the patient's needs. To avoid claim denial due to minor quantity variations, enter the quantities of I.V. solutions in figures rounded to the nearest 500 ml. For example, enter "3000" ml rather than "3152" ml or "2500" ml instead of "2456" ml.
- Non-compounded products must be billed using the product's NDC number.
- For compounded products, the service code on the TAR 50-1 form must be 99999999996. Do not request authorization for the ingredients on separate TAR 50-1 forms.

See the *TAR Submission: Drug TARs* section of this manual for more information.

Code I Documentation Requirements

Providers must maintain readily retrievable documentation for fulfilling all aspects of Code I restrictions. For I.V. solutions that are exempt from TAR requirements because of recent hospitalization, the document must also include the date of hospital discharge and whether the same I.V. drug was started before discharge. When billing for compound claims on the 30-4 form, enter the discharge date in the *Hosp Discharge Date* field (Box 40). Please refer to the POS Network Specifications, Prior Authorization Segment when billing compound claims through the POS network. When billing for compound claims using RTIP, enter the patient's hospital discharge date in the *TCN/Discharge Date* field.

Claims Submission for Intravenous Solutions

Complete the 30-1 for non-compounded I.V. solutions, or the 30-4 for compounded I.V. solutions or sterile transfers, paying particular attention to the following:

- *Date of Service*. This is the date that the completed prescription leaves the pharmacy.
- *Quantity*. Enter the TOTAL number of cc's being billed on this claim.

  Note: Quantity billed must not include future dispensings.
- *Charge*. The total charge for the quantity dispensed.

If the solution is compounded or sterile transfer, use the *Pharmacy Claim Form* (30-4). For more information, refer to the *Compound Pharmacy Claim Form (30-4) Completion* section in this manual.

Non-compounded and compounded I.V. claims also may be submitted electronically through the POS network or RTIP application using the same rules specified above.

For additional information on completing the 30-1, refer to the *Pharmacy Claim Form (30-1) Completion* section of this manual. For reimbursement information, see the *Reimbursement* section of this manual.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.