Payment Policy: Intravenous Hydration

Reference Number: CC.PP.012
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 11/22/2024

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 reported for the initial intravenous (IV) infusion lasting more than 30 minutes and up to one hour. CPT code 96361 is reported for each additional hour beyond the initial hour, provided the additional time exceeds 30 minutes, and must be billed in addition to CPT 96360.

IV infusions involve prepackaged fluids and electrolytes (i.e., normal saline). CPT 96360 and 96361 should not be used to report infusions of drugs or other substances. When fluids are used to administer drugs, the fluid is considered incidental and not separately reportable.

The CMS National Correct Coding Policy Manual 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*."

Certain chemotherapeutic and other therapeutic agents may require a pre- or post-hydration to reduce toxicity risks. For IV hydration to be reportable under these circumstances, a minimum time of 31 minutes is required.

Reimbursement

Claims Reimbursement Edit

Claims billed with CPT codes 96360 and 96361 are flagged by code auditing software for clinical validation. A clinician reviews the member and provider's current and historical claims and any supporting diagnoses. Clinical validation occurs prior to claims payment. Once a claim has been validated, it is either released for payment or denied.

Rationale for Edit

CPT 96360 should not be used to report IV hydration therapy of 30 minutes or less or if performed as a concurrent service. CPT 96361 should only be reported for each additional hour of hydration beyond 1-hour increments. These codes must not be used for fluids administered solely to maintain venous access (KVO/TKO), following a therapeutic infusion, or as a free flowing IV for purposes other than therapeutic hydration.

Exception

When IV hydration is billed in the emergency room setting, one (1) unit of CPT 96360 is allowable without clinical validation.

Reconsideration/Appeal

Providers may submit medical records for reconsideration or appeal. Documentation must include a physician's order for IV hydration, the start and stop times of the infusion, and the infusion rate to support the reported duration of administration.

Clinical Scenarios

- Patient presents to the ER with pain. A maintenance IV line is started, and morphine is given via IV push. Correct coding would be 96374 x1; hydration would not be reported as it was not for therapeutic purposes but merely to keep the IV patent.

- Patient presents to the ER for nausea and vomiting x24 hours. An IV is placed, labs are drawn, and fluid is infused at a rate of 500ml/hour x2 hours. The patient is reassessed after two hours, and it is decided that another 1 liter is warranted at the same rate. The patient received a total of 4 hours of hydration. Correct coding is 96360 x1, and 96361 x3 for the subsequent hours. After the second liter, fluid was used to KVO at 125ml/hr. KVO or TKO 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 2025, 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. 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. **American Medical Association (AMA),** *Current Procedural Terminology (CPT®) Professional Edition, 2025*
2. **HCPCS Level II, 2025,** *Centers for Medicare & Medicaid Services*
3. **Centers for Medicare & Medicaid Services**, *CMS Medicare National Correct Coding Initiative (NCCI) Edits, https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits*
4. **Centers for Medicare & Medicaid Services**, *CMS Medicaid National Correct Coding Initiative (NCCI) Edits, https://www.cms.gov/medicare/coding-billing/ncci-medicaid*
5. **Centers for Medicare & Medicaid Services,** *CMS Medicare Claims Processing Manual, Chapter 11 and Chapter 12 https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912*

Revision History	
02/7/2017	Converted to corporate template and conducted annual review
2/25/2018	Updated policy, updated resources, conducted review and verified codes.
03/30/2019	Conducted Review, verified codes, Updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual Review completed; no major updates required
12/01/2022	Annual Review completed; no major updates required
11/07/2023	Annual Review completed; updated dates, reviewed policy, removed CPT manual quote
02/27/2024	Annual Review completed
11/22/2024	Annual Review completed; no major updates required
11/14/2025	Annual Review completed; Validated policy content, references and links; Added revision date.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations 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 plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. 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. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment 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. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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