Priority Health	BILLING POLICY No. 159
Chelation Therapy	
Date of origin: Sept 2025	**Review dates: None yet recorded**

MEDICAL POLICY

Chelation Therapy - 91077

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider.

In addition, the medical record must include:

- Patient's diagnosis and clinical indication
    - Laboratory confirmation of heavy metal toxicity or iron overload
    - Dosing schedule and medication administered
    - Patient response and follow-up plan

Reimbursement specifics

The following CPT/HCPCS Codes codes are used for Chelation therapy:

- 96365 – IV infusion, initial, up to 1 hour
- 96366 – IV infusion, each additional hour
- J0600 – Injection, edetate calcium disodium, up to 1,000 mg
- J8499 – Prescription drug, oral, non-specified (if applicable)
- J0899 – Prescription drug, non-chemotherapy, non-specified
- S9355 Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem – requires prior auth
- J0470 Injection, dimercaprol, per 100 mg
- J0600 Injection, edetate calcium disodium, up to 1000 mg
- J0895 Injection, deferoxamine mesylate, 500 mg J3520 Edetate disodium, per 150 mg

CPT 96365 and 96366 are subject to CCI edits—cannot be billed together with injection codes unless properly documented. The use of a modifier such as -59 (Distinct Procedural Service) or the more specific X{EPSU} modifiers may be required to indicate that the injection was a separate and distinct service from the infusion.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to

document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Sept 2025	New policy – effective Oct 16, 2025