Reimbursement Policy	
Title: Add-On Code	
Policy Number: RP-P-100X	**Application:** All Medica Members
Last Reviewed: 01/09/2024	**Effective Date:** 10/30/2006
Related Policies: Anesthesia, Global Days, Prolonged Services, Rebundling	

Disclaimer: *This reimbursement policy is intended to provide general guidance regarding Medica's policy for the services described, and does not constitute a guarantee of payment. You are responsible for submitting accurate claims. Factors affecting claims reimbursement may include, but are not limited to, state and federal laws, regulations and accreditation requirements, along with administrative services agreements, provider contracts, and benefit coverage documents. Coding methodology and industry standards are also considered in developing reimbursement policy.*

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Summary:

This policy has been established to provide reimbursement guidelines for the reporting of claims with add-on codes. Add-on codes are eligible for reimbursement when reported in addition to the appropriate primary service or procedure code and meets coding and reimbursement policy guidelines.

Policy Statement:

Medica follows the Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT®) and interpretive sources based on specialty society guidelines for the reimbursement of "add-on" codes.

Per CMS and CPT, an add-on code describes a service that is performed in conjunction with a primary service and must never be reported as a stand-alone code. Medica will only reimburse the add-on code when it is reported on the same claim with the following (unless otherwise indicated within specific sections of the policy):

- appropriate primary service or procedure *and*
- on the same date of service (as appropriate primary service or procedure) *and*
- by the Same Individual Physician or Other Qualified Health Care Professional reporting the same Federal Tax Identification number

CPT contains key phrases to identifying add-on codes which include, but are not limited to the following:

- *list separately in addition to primary procedure*
- *each additional*
- *done at time of other major procedure*

Mohs Micrographic Surgery
The Mohs micrographic surgery codes (CPT code 17311 and/or 17313 with add-on codes 17312, 17314 and/or 17315), describe procedures that involve surgery and pathology services performed together by the same individual physician. In some instances, the Mohs surgical procedure may extend beyond the initial date of service. There are 3 add-on codes (17312, 17314 and/or 17315) that might be performed on a different date of service than their primary procedure. Consistent with the November 2006 CPT Assistant, the add-on code should be reported on the same claim as the primary Mohs procedure, even though the dates of service may differ.

Critical Care Services (CPT Codes 99291 and 99292)
Critical care codes are time based Evaluation and Management (E/M) services. CPT code 99291 is reported for the first 30-74 minutes of care; Add-on code 99292 is reported for each additional 30 minutes. The following situations apply to critical care add-on service code 99292.

Same Individual Physician or Other Qualified Health Care Professional supplying critical care services for the same patient, on the same date of service, in the same group practice and provides more than 30-74 minutes may report the following:

- primary code 99291 for the first 74 minutes and
- add-on code 99292 for each additional 30 minutes of care (beyond the first 74 minutes)

Same Specialty Physicians or Other Qualified Health Care Professionals each supplying critical care services for the same patient, on the same date of service, in the same group practice and providing more than 74 minutes may report using one of the following methods:

- The *first* Physician or Other Qualified Healthcare Professional would report the primary code 99291 for the first 30-74 minutes of critical care.
- The *second* Physician or Other Qualified Healthcare Professional would report the add-on code 99292 for each additional 30 minutes of care (beyond the first 74 minutes).
  or
- A single Physician or Other Qualified Health Care Professional may report all critical care service codes on behalf of the other providers.

Different Specialty Physicians or Other Qualified Health Care Professionals in same group practice supplying critical care services for the same patient, on the same date of service and providing more than 74 minutes would each individually report their own critical care services.

- The *first* Physician or Other Qualified Healthcare Professional would report primary code 99291 for the first 74 minutes and add-on code 99292 for each additional 30 minutes of care (beyond the first 74 minutes).
- The *second* Physician or Other Qualified Healthcare Professional would *also* report primary code 99291 for the first 74 minutes and add-on code 99292 for each additional 30 minutes of care (beyond the first 74 minutes).

CPT provides coding guidelines for some add-on codes. It specifies which primary service or procedure code should be reported in conjunction with a given add-on code. Medica follows these guidelines and will only reimburse an add-on code when it is reported with the appropriate primary service/procedure code.

In other instances, CPT does not specifically identify the primary/add-on code relationships. When this occurs, interpretation may be done utilizing CMS and/or specialty society guidelines to determine additional primary and add-on code relationships.

Add-on codes are designated by CPT with a "+" symbol and/or are assigned a Global Days indicator of "ZZZ" in the CMS National Physician Fee Schedule (NPFS).

For add-on codes 01968, 01969, or 99100-99140, please refer to the *Anesthesia* reimbursement policy.

For add-on codes 99417, 99418 and 99359, please refer to the *Prolonged Services* reimbursement policy.

In addition, add-on codes may have unbundle relationships consistent with and/or independent of the corresponding primary service or procedure code(s), please refer to the *Rebundling* reimbursement policy for further information.

Code Lists:
Add-On to Primary Code Relationship Code List

Modifiers:	
59	Distinct procedural service
76	Repeat procedure or service by same physician or other qualified health care professional
91	Repeat clinical diagnostic laboratory test
XE	Separate encounter, a service that is distinct because it was performed on a separate organ/structure
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

Q & A:	
Q:	How does Medica determine which add-on code should be linked to which primary procedure code?
A:	Medica's Add-On Code policy follows CPT & National Physician Fee schedule guidance. Add-on codes are represented with a "+" symbol and CPT & CMS release guidance on which primary code should be billed with a particular add-on code.
Q:	Can the add-on code be billed on a separate claim from the primary procedure code?
A:	The only time Medica will accept an add-on code on a separate claim are for instances listed in the policy. Any add-on code submitted on a separate claim form (from the primary procedure code), outside of what is indicated within the policy will be denied.

Exclusions/Exemptions:
• Add-on codes are modifier 51 exempt. It is inappropriate to append modifier 51 to add-on codes.

Definitions:	
Add-On Code	Add-on codes describe additional intra-service work associated with the primary service/procedure.
Interpretive Source	An edit source that includes guidelines without listing specific codes. Therefore, an interpretation must be made to determine codes that correlate to the guidelines.
Same Individual Physician or Other Qualified Health Care Professional	The Same Individual Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification Number.
Same Provider Group	Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification Number.
Stand-Alone Code	A code reported without another primary service/procedure code by the Same Physician or Other Qualified Health Care Professional.

Resources:
Centers for Medicare and Medicaid Services (CMS)
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
National Physician Fee Schedule (NPFS)

Effective Date:	10/30/2006

Revision Updates:	
01/09/2024	Code List Update Updated Policy Template
08/16/2021	Annual Policy Review
08/17/2020	Annual Policy Review
05/15/2020	Code List Update
01/01/2020	Code List Update