moda HEALTH	Reimbursement Policy Manual		Policy #:	RPM025
Policy Title:	**Add-on Codes**			
Section:	Administrative	**Subsection:**	None	

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:	
Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	8/2/2004	Initially Published:	6/18/2013
Last Updated:	4/8/2024	Last Reviewed:	4/10/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		4/10/2024	

Reimbursement Guidelines

A. Add-on Code Requirements

1. An add-on code is considered a "child" code that may not be reported on a claim alone. The add-on code must be directly accompanied by a "parent" code to which it is matched or assigned.

    a. Add-on codes must be reported in conjunction with an appropriate primary procedure code by the same physician (or qualified provider) on the same date of service. (AMA [1,3])

    b. Both the "parent"/primary procedure code and the add-on "child" code are to be submitted on the same claim (not split claims).

    c. Both the "parent"/primary procedure code and the add-on "child" code need to be performed at the same patient encounter, and thus reported with the same POS.

    d. Refer to "Special Circumstances" below for exceptions.

2. Just having any primary procedure code present on the claim is not sufficient to satisfy the requirement of an accompanying "parent code." The "parent"/primary procedure code must be related and appropriate to be billed in combination with that specific add-on code.

3. An add-on code is eligible for payment if and only if one of its primary codes is also billed and eligible to be allowed. (CMS[7]) If the "parent"/primary procedure code is denied for any reason (e.g. incorrect coding, insufficient documentation, lack of required preauthorization, etc.), then the add-on code is also subject to denial.

4. Submitting an add-on code without meeting the above coding requirements for add-on codes is considered a billing error. Clinical edits are employed to identify incorrectly billed add-on codes and deny them to provider write-off. There is no modifier that will bypass a denial for an add-on code violation.

5. When an appropriate "parent"/primary procedure code has not been submitted in conjunction with the add-on code, a corrected claim will be needed to remedy the clinical edit denial. The denial may not be overturned or adjusted based upon a phone call to Customer Service. The billing error must be corrected.

6. Clinical edits for the "parent"/primary code may also affect the add-on "child" code. Per NCCI guidelines, if an edit prevents payment of the primary procedure code, the add-on code will not be paid. (*CMS* [4])

    a. Also, if CCI has a PTP edit for the primary code pair (e.g. 63081/63075), then Moda Health will most likely have a PTP edit for the add-on code pair (e.g. 63082/63076), as the same coding principle for the primary PTP edit applies to the add-on code pair as well.

    b. The add-on PTP Moda Health edit will also require appropriate use of a modifier to bypass the edit on the add-on code pair.

B. Determining the correct primary procedure code ("parent code")

1. In general, the CPT book provides specific parenthetical instructions for an add-on code indicating which primary procedure codes should accompany the add-on code.

    a. For example, "(Use 33141 in conjunction with 33400 – 33496, 33510 – 33536, 33542)," or "(Use 22585 in conjunction with 22554, 22556, 22558)."

    b. "When the *CPT Manual* identifies specific primary codes, the add-on code should not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code." (*CMS* [4])

2. In addition, on April 1, 2013 CMS began publishing a list of add-on codes and their primary codes annually prior to January 1.

    a. The list is updated quarterly based on the AMA's "CPT Errata" documents or implementation of new HCPCS/CPT add-on codes.

    b. CMS identifies add-on codes and their primary codes based on *CPT Manual* instructions, CMS interpretation of HCPCS/CPT codes, and CMS coding instructions. (*CMS* [6])

3. To determine an appropriate primary or "parent" procedure code for an add-on HCPCS code, check the CMS Add-On Code edit tables.

4. For a few codes, the CMS add-on code edit tables list "Contractor Defined Primary Code(s)." In these cases, the coder must locate the procedure code with a matching common description (e.g., the portion of the procedure description prior to the semicolon).

C. Special Circumstances

Type of Circumstance	Moda Health Policy for that Circumstance
Anesthesia for unplanned cesarean delivery or hysterectomy (01967 / 01968, 01969)	When neuraxial analgesia/anesthesia (e.g., spinal, epidural) is provided for a planned vaginal delivery which ultimately results in a cesarean delivery or an emergency cesarean hysterectomy, two anesthesia procedure codes must be reported. 01967 is the "parent"/primary code, and 01968 or 01969 are the related add-on "child" codes.
	When the neuraxial labor analgesia/anesthesia is initiated prior to midnight, and the cesarean delivery or cesarean hysterectomy is performed after midnight, the total anesthesia service is provided as a continuous service, but the two portions actually occur on different, sequential dates. Thus, the primary/"parent code 01967 may legitimately be billed for a different date of service immediately preceding the date for the add-on code(s).
	When a cesarean delivery is performed after a lengthy vaginal labor, the vaginal neuraxial analgesia/anesthesia (01967) and the cesarean anesthesia (01968, 01969) may be performed and billed by two separate anesthesia providers.
	Due to these considerations, Moda Health will allow 01968 and 01969 even when 01967 has not been billed by the same provider or provider group.
Assistant Surgeon	The primary surgeon must report both the "parent"/primary procedure code and the add-on "child" code in order for the assistant surgeon to report assistant services for both the "parent"/primary procedure code and the add-on "child" code. The assistant surgeon *may not* report the add-on "child" code without an assistant surgeon modifier simply because they "did the work of the additional level/other side," etc.
Co-surgery, Reporting all codes with modifier 62	One co-surgeon may not report an "orphan" add-on code with modifier 62 appended for a "parent"/primary code that the other co-surgeon reported.
	Both surgeons must report both components of the related service (the "parent"/primary code and the add-on code) with modifier 62 appended.

Type of Circumstance	Moda Health Policy for that Circumstance
Co-surgery, Acting as assistant surgeon for each other's portion of the case (e.g. dividing up which codes are reported as primary surgeon and as assistant surgeon)	The primary surgeon and the assistant surgeon must be consistent for both components of the related service (the "parent"/primary code and the add-on "child" code).
Mid-level providers (PA, NP, CRNA) working under a supervising physician	A mid-level provider may not report an add-on code procedure for a primary service which was provided and billed by the supervising physician. Both services must be provided by the same person, and the "parent"/primary code and add-on "child" code must both be billed by the same provider for the same date of service on the same claim.
Critical care, evaluation and management services (99291, 99292)	Moda Health follows CMS guidelines as follows: When two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service, only one physician in the specialty group may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292. (CMS[5]) Primary service 99291 should be submitted by the first physician in the group to provide critical care services after midnight on that date of service. The remaining physicians will submit 99292 for critical care services rendered up through 23:59 on that date. 99292 will be denied when billed on a claim without 99291 and no other physician in the same specialty group has submitted 99291 for that date of service.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")

Acronym or Abbreviation		Definition
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
PTP	=	Procedure To Procedure
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Definition of Terms

Term	Definition
"Child" code or Add-on procedure code	A service that must never be reported as a stand-alone code. They describe additional intra-service work associated with another procedure and can only be reported in addition to the primary procedure. In many cases, the code listing includes a parenthetical list of specific primary procedure codes; the "child"/add-on code may not be reported as an additional service to other procedure codes.
"Parent" code or Primary procedure code	The qualifying primary service with which the add-on procedure code or "child" code is associated.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Add-on codes are always performed in addition to the primary service or procedure and **must never be reported as a stand-alone code**." (*AMA* [1]) (Bold added for emphasis.)

"The [add-on] service/procedure can never serve as a stand-alone code and must be reported in conjunction with another primary service/procedure." (*AMA* [3])

"The add-on code concept…applies only to add-on procedures or services performed by the same physician." (*AMA*[1]) Therefore, add-on codes may not be reported by a different physician or provider from the provider reporting the associated primary service or procedure code for that add-on code.

"Add-on codes are exempt from the multiple procedure concept, and therefore, modifier '-51' cannot be appended to these codes." (*AMA* [3])

"Add-on codes can be found in many sections of CPT, other than the surgery section. For example, code 99292 is found in the evaluation and management section of CPT and is used to report each additional 30 minutes of critical care time." (*AMA* [3])

"Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment." (CMS[7])

Cross References

A. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.

B. "Critical Care, Evaluation and Management Services (99291, 99292)." Moda Health Reimbursement Policy Manual, RPM041.

References & Resources

1. American Medical Association. "Introduction - Instructions for Use of the CPT Codebook, Add-on Codes." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

2. American Medical Association. "Add-on (Attached) Procedures vs. Multiple Procedures" *CPT Assistant,* Fall 1991: 6.

3. American Medical Association. "Add-on Codes" CPT Assistant, April 2000: 6.

4. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § R, "Add-on Codes", pp I-34 – I-35.

5. CMS. *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12.

6. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § W, "Add-on Code Edit Tables", pp I-42 – I-44.

7. CMS. *National Correct Coding Initiative Policy Manual*. Introduction, pg. 4.

8. CMS. *Add-on Code Edits.* cms.gov. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html .

Background Information

Add-on codes are a specific type of supplemental procedure code describing additional intra-service work associated with the primary procedure performed, e.g., additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s), vaccine(s), minute(s), hour(s), etc. Add-on procedures or services are performed by the same physician performing the primary service at the same surgical session or patient encounter. Add-on codes can be found in both CPT codes (Level I HCPCS codes) and HCPCS codes (Level II HCPCS codes).

The primary procedure code and the add-on code form a pair of connected services on the claim. The primary procedure code or service may also sometimes be referred to as the "parent code" for the add-on procedure code. Add-on codes may not be billed without an accompanying primary procedure code; when this occurs, the add-on code is considered an "orphan code" which has been incorrectly billed.

Add-on codes can be readily identified by specific phrases in the code description such as "each additional," or "(List separately in addition to primary procedure)." The CPT book also indicates add-on codes with a "+" symbol to the left of the procedure code listing and includes a comprehensive list of all add-on CPT codes in Appendix D of the CPT book. Add-on HCPCS codes are not indicated in a similar manner with a "+" symbol but must be identified entirely on the basis of the specific phrases included in the code description nomenclature.

In addition, CMS produces a list of add-on code edits to indicate appropriate primary codes for specific add-on codes. The add-on code edits are one portion of the NCCI edits and are available for public download on the CMS website. (CMS[8])

It is important to note that the primary procedure code for a specific add-on code *is not the same as* identifying which procedure code is primary or secondary for multiple procedure fee reductions, nor is it the same as identifying the allowable procedure code ("primary code") for a clinical edit (CCI or other source). While the term "primary procedure" may be used in all three situations, the context must be considered to determine which reimbursement guideline and type of "primary procedure" is being discussed.

Examples of "parent"/primary code and add-on "child" code combinations:

	Code	**Description**
Primary code:	22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
Add-on code:	22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
Primary code:	82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)
Add-on code:	82952	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)

	Code	Description
Primary code:	G0246	Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (3) patient education
Add-on code:	G0247	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
4/10/2024	Clarification/Update: Section A.1.c: clarify that parent and add-on codes need to be same POS code. Cross References: Hyperlink updated.
11/09/2022	Formatting/Update: Change to new header. Acronym table added. Definition of Terms table added. Cross References: Hyperlinks added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
6/18/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
8/2/2004	Original Effective Date (with or without formal documentation). Policy based on CPT and CMS guidelines.