

Add-on Codes Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee’s benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the Same Individual Physician or Other Qualified Health Care Professional reporting the same Federal Tax Identification Number on the same date of service unless otherwise specified within the policy. Add-on codes reported as Stand-alone codes are not reimbursable services in accordance with Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services (CMS) guidelines.

For the purpose of this policy, the Same Individual Physician or Other Qualified Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

The basis for Add-on codes is to enable physicians or other qualified health care professionals to separately identify a service that is performed in certain situations as an additional service or a commonly performed supplemental service complementary to the primary service/procedure.

UnitedHealthcare follows the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) with respect to the reporting of "Add-on" CPT and HCPCS codes. Per CPT Add-on codes describe additional intra-service work associated with a primary procedure/service, are always reported in addition to the primary service/procedure, and must be performed by the Same Individual Physician or Other Qualified Health Care Professional reporting the primary service/procedure. Many Add-on codes are designated by the AMA with a "+" symbol and are also listed in Appendix D of the CPT book. CMS assigns Add-on codes a Global Days indicator of "ZZZ" on the CMS National Physician Fee Schedule (NPFSS).

In some instances, a Definitive Source specifies the primary procedure/service codes that must be reported in conjunction with a given Add-on code.

In other situations, a primary/add-on code relationship may exist but the guidance from CPT or CMS is not as well-defined. Specifically, the code description does not directly identify the Add-on code or identify any specific primary codes that correspond with that code. In those instances an interpretation is necessary utilizing CPT, CMS and/or specialty society guidelines. UnitedHealthcare will interpret these sources to identify additional primary/add-on relationships. For these code pairs, UnitedHealthcare also requires that the Add-on code must be reported with a given primary procedure/service code. In addition, add-on codes are never reimbursed unless a primary procedure code is also reimbursed. Please see the Definitions section below for further explanations of Definitive and Interpretive Sources.

Key phrases to identify Add-on codes when not specified in the code description, include, but are not limited to, the following:

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

Unless otherwise specified within this policy, add-on procedures must be reported with the primary procedure for the same date of service.

Mohs Micrographic Surgery

The Mohs micrographic surgery codes (CPT codes 17311, +17312, 17313, +17314, +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, thus there are 3 Add-on codes (+17312, +17314 and +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 same claim as the primary Mohs procedure even though the dates of service may differ.

Psychological and Neuropsychological Testing

The Psychological/Neuropsychological Testing codes (CPT codes 96136, +96137, 96138, +96139), describe procedures that involve test administration and scoring services performed together by a physician or other qualified health care professional. In some instances, the Psychological/Neuropsychological testing may extend beyond the initial date of service, thus there are two Add-on codes (+96137, and +96139) that might be performed on different dates of service than their primary procedure. The Add-on code should be reported on same claim as the primary procedure even though the dates of service may differ.

Critical Care Services (CPT Codes 99291, +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. UnitedHealthcare will reimburse for critical care add-on services (code +99292) in the following situations:

- The Same Individual Physician or Other Qualified Health Care Professional reporting provides more than 74 minutes, thus submitting Add-on code +99292 indicating each additional 30 minutes of care beyond the first 74 minutes.

- The Same Specialty Physician or Other Qualified Health Care Professionals each supplying critical care services for the same patient on the same date of service may report using one of the following methods:
 - The primary code 99291 is reported by the physician or other qualified health care professional that provides the first 30-74 minutes of critical care. The Add-on code +99292 is reported for each additional 30 minutes of care beyond the first 74 minutes of critical care when provided by the Same Specialty Physician or Other Qualified Health Care Professional.
 - A single physician may report all critical care service codes on behalf of the other members within the same group/same specialty.
- The Same Group Physician and/or Other Qualified Health Care Professionals each supplying critical care services for the same patient on the same date of service would each individually report their own critical care services. For example, two physicians within the same provider group, but of different specialties each provide critical care services for the same patient on the same date of service. Because the physicians are of different specialties, each would report their critical care services separately. Both physicians may individually report code 99291, and +99292 for each additional 30 minutes of critical care services depending of the length of services provided by each physician.

Note: The Add-on Code to Primary Code Relationship Table does not include Add-on CPT code 69990. For reimbursement regarding 69990, refer to the "Microsurgery Policy." Additionally, Add-on codes may have unbundle relationships consistent with and/or independent of the corresponding primary service/procedure code(s).

Definitions	
Add-on code	Add-on codes describe additional intra-service work associated with the primary service/procedure
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number
Same Specialty Physician or Other Qualified Health Care Professional	Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number
Stand-alone code	A code reported without another primary service/procedure code by the Same Individual Physician or Other Qualified Health Care Professional
Definitive Source	Definitive Sources contain the exact codes, modifiers or very specific instructions from the given source
Interpretive Source	An edit source that includes guidelines; however, no exact or specific code or modifier information is listed. Therefore, an interpretation must be made as to what codes correlate to the guidelines. Additionally, an interpretation may be applied to surrounding or similar codes based on related definitively sourced edits.

Questions and Answers	
1	<p>Q: How would the policy handle the billing of codes 13102 (Repair) and 13100 (Repair) on the same date of service, by the same physician?</p> <p>A: In accordance with CPT guidelines, Add-on code 13102 is to be used in conjunction with code 13101 only. Therefore, code 13102 reported without the appropriate primary code, 13101 will not be separately reimbursed.</p>

2	<p>Q: How has UnitedHealthcare determined which codes are "Add-on" codes that must be reported with a primary service?</p> <p>A: The policy follows CPT guidelines for those codes designated with a "+" symbol. These codes are considered to be Add-on codes by UnitedHealthcare.</p>
3	<p>Q: Does UnitedHealthcare require the Add-on code be submitted on the same claim as the primary code?</p> <p>A: No. The Add-on code may be reported on a separate claim submission from the primary code; however it is recommended the Add-on and primary procedure codes be reported on the same claim form.</p>

Resources
<p>American Dental Association, CDT Dental Procedure Codes</p> <p>American Medical Association, <i>Current Procedural Terminology (CPT®)</i> and associated publications and services</p> <p>Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services</p> <p>Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System (HCPCS ®) Level II Manual</p> <p>Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files</p> <p>Global Surgery Indicator: ZZZ=The code is related to another service and is always included in the global period of the other service</p>

History	
5/17/2020	Policy Version Change Updated Q&A: Removed CPT code descriptions
5/1/2020	Annual Anniversary Date and Version Change Header: Added "Commercial" History Section: Entries prior to 1/1/2018 archived
5/18/2019	Annual Anniversary Date and Version Change Title section: Removed Annual Approval information & moved policy # to the header Application: Removed pathway to policies for other lines of business History Section: Entries prior to 1/1/2017 archived
9/30/2018	Policy Version Change Policy Verbiage Change: Removed reference to other UnitedHealthcare policies in the Reimbursement Guidelines.
8/19/2018 – 9/29/2018	Policy Version Change Revision to Title
7/11/2018	Policy Approval Date Change (No New Version) Definitions: Revised
3/17/2018 – 8/18/2018	Attachments: Add-on to Primary Code Policy List removed Reimbursement Guidelines Section: Verbiage removed from Note Resources Section: Resources added
2/11/2018 – 3/16/2018	Policy List Change: Add-on to Primary Code Relationship List updated
1/1/2018 - 2/10/2018	Annual Policy Version Change Policy List Change: Add-on to Primary Code Relationship List updated Reimbursement Guidelines Section: Additional verbiage added. History Section: Entries prior to 1/1/2016 archived
10/1/2006	Policy implemented by UnitedHealthcare Employer & Individual
5/10/2006	Policy approved by the Payment Policy Oversight Committee