Add-on Codes

Policy REIMB-005

Origination Date: 03/01/2024

Reviewed/Revised Date: 03/08/2024

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Current Effective Date: 05/08/2024

Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Description:

Add-on codes represent codes that describe a service associated with and performed in addition to the primary service. The description of the add-on code includes the phrase "List separately in addition to code for primary procedure". By coding guidelines, add-on codes cannot be billed in isolation without an appropriate 'primary' code also provided as part of the same claim by the same provider, and on the same date of service.

When an add-on code is used, the code for the primary procedure must also be billed on the same claim by the same provider or same group practice on the same date of service to ensure correct claim adjudication. Same group practice is defined as a physician and/or other qualified health care professional of the same group and same specialty with the same Federal Tax ID number.

Policy Statement and Criteria

1. Commercial Plans

U of U Health Plans will reimburse add-on services when correct coding guidelines are followed as defined by AMA-CPT guidance.

U of U Health Plans aligns with AMA-CPT guidelines and will not reimburse add-on codes in either of the following circumstances:

A. The add-on code is submitted as a standalone code.

B. A modifier -50 is appended to the add-on code.

C. A modifier -51 is appended to an add-on code.

U of U Health Plans may make an exception in the following circumstances:

A. Same day service requirements if:

   i. The add-on code is a labor epidural code and the required primary code is present on the same day or the day prior.

   ii. The add-on code is a facility IV infusion code and the required primary code is present on the same day or within 2 days prior.

B. Billing an add-on code without a primary procedure in the following 2 circumstances *(in both circumstances, the primary procedure must be billed by a provider of the same specialty in the same group practice)*:

   i. When CPT code 99291* is billed for the same date of service as CPT code 99292*, only one physician of the same specialty in the group practice may report 99291 with or without 99292, and the other physician(s) must report their critical care services with 99292.

   ii. For Medicaid and Marketplace services, when CPT code 01967* is billed by one anesthesia provider, another anesthesia provider in the same group practice may report 01968*.

   **See descriptions of codes below (Applicable Coding)*

2. Medicaid Plans

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: https://medicaid.utah.gov/utah-medicaid-official-publications/ or the Utah Medicaid code Look-Up tool

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

Applicable Coding

CPT Codes

01967 Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)

01968 Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

99292 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

HCPCS Codes

No applicable codes

Modifiers

Modifier -50 Bilateral Procedure

Modifier -51 Multiple Procedures

Note: CPT or HCPCS codes that are bilateral in intent or have bilateral in their description should not be reported with the bilateral modifier 50 or modifiers LT and RT because the code is inclusive of the bilateral procedure.

References:

1. American Medical Association (AMA). Current Procedural Terminology (CPT®)
2. Centers for Medicare & Medicaid Services, CMS Manual System, Medicare Claims Processing Manual 100-04, and NCCI Policy Manual
3. Centers for Medicare & Medicaid Services. Medicare, Coding & Billing, National Correct Coding Initiative (NCCI) Edits."Medicare NCCI Add-on Code Edits". Accessed: February 14, 2024. Available at: https://www.cms.gov/ncci-medicare/medicare-ncci-add-code-edits#:~:text=An%20Add%2Don%20Code%20(AOC,service%20by%20the%20same%20practitioner

Disclaimer:

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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