

Add-on Codes Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies 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 (CMS 1450). 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

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 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.

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 Medicare Advantage follows the American Medical Association (AMA) and 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).

CMS has divided the add-on codes into three groups, Type I, Type II, and Type III to distinguish the payment policy for each group.

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 Interpretive Source is necessary utilizing CPT, CMS and/or specialty society guidelines. UnitedHealthcare Medicare Advantage will interpret these sources to identify additional primary/add-on relationships. For these code pairs, UnitedHealthcare Medicare Advantage 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.

CMS will update the list of add-on codes with the primary procedure codes on an annual basis and the changes will be based on the changes made to the CPT Manual or HCPCS Level II Manual. Quarterly changes may also be posted as appropriate.

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 Medicare Advantage 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 Professional 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.

Definitions

Add-on code	Add-on codes describe additional intra-service work associated with the primary service/procedure.
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.
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.
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.
Stand-alone code	A code reported without another primary service/procedure code by the Same Individual Physician or other qualified health care professional.

Questions and Answers

1	<p>Q: How would the policy handle the billing of codes 13102 (Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure) and 13100 (Repair, complex, trunk; 1.1 cm to 2.5 cm) 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 (Repair, complex, trunk; 2.6 cm to 7.5 cm) only. Therefore, code 13102 reported without the appropriate primary code, 13101 will not be separately reimbursed.</p>
2	<p>Q: How has UnitedHealthcare Medicare Advantage 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 an Add-on code by UnitedHealthcare Medicare Advantage.</p>
3	<p>Q: Does UnitedHealthcare Medicare Advantage 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>

4	<p>Q: On the Medicare Physician Fee Schedule Status Indicator Policy there are codes marked with a global indicator of ZZZ. Does this mean that it is an add-on code?</p> <p>A: Yes, ZZZ is an indicator that it is an add-on code. Example: Code 13102 has a ZZZ listed for global days.</p>
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Attachments	

Resources
<p>www.cms.gov</p> <p>CMS NCCI Add-On Code Edits</p> <p>CMS Claims Processing Manual and other CMS publications and resources</p> <p>AMA Current Procedural Terminology (CPT®) manual</p>

History	
06/20/20	Policy Version Change Add-on to Primary Code Relationship list removal
10/20/2019	Policy Version Change <ul style="list-style-type: none"> • Add-on to Primary Code Relationship list update • Archived history prior to 10/1/17
7/1/2019	Policy Version Change <ul style="list-style-type: none"> • Add-on to Primary Code Relationship list update
6/5/2019	Policy Version Change <ul style="list-style-type: none"> • Add-on to Primary Code Relationship list update
5/3/2019	Annual Anniversary Date (no new version)
4/1/2019	Policy Version Change <ul style="list-style-type: none"> • Add-on to Primary Code Relationship list update • Template change • Archived history prior to 4/1/17
1/17/2019	Policy Version Change <ul style="list-style-type: none"> • Add-on to Primary Code Relationship list update
1/1/2019	Policy Version Change <ul style="list-style-type: none"> • Add-on to Primary Code Relationship List update
9/7/2018	Policy Version Change <ul style="list-style-type: none"> • Policy number changed to 2018R9007A • Title change to add Professional • Archive history prior to 9/1/2016
7/11/2018	Annual Review (no new version) <ul style="list-style-type: none"> • Archive history prior to 1/1/2016
5/8/2018	Policy Version Change <ul style="list-style-type: none"> • Preamble updated • Verbiage change • Critical Care language added • Add-on to Primary Code Relationship list added • Definitions updated • Q&A updated • Resource section updated
7/9/2014	New Policy



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