ADD-ON POLICY

Policy Number: ADMINISTRATIVE 185.17 T0 **Effective Date**: October 1, 2018

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Related Policies

- Refer to the Reimbursement Guidelines section of the policy

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

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 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.

OVERVIEW

Add-On Codes are reimbursable services when reported in addition to the appropriate primary service by the Same Individual Physician or Other Health Care Professional reporting the same Federal Tax Identification Number 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 Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

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REIMBURSEMENT GUIDELINES

The basis for Add-On Codes is to enable physicians or other 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.

Oxford 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 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 (NPFS).

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. Oxford will interpret these sources to identify additional primary/add-on relationships. For these code pairs, Oxford also requires that the Add-On Code must be reported with a given primary procedure/service code. See the Definitions section below for further explanations of Definitive and Interpretative 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 the same claim as the primary Mohs 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. Oxford will reimburse for critical care add-on services (code +99292) in the following situations:

- The Same Individual Physician or Other 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 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 physician or other healthcare 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 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 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.

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Note: All services described in this policy may be subject to other Oxford reimbursement policies including but not limited to the policy titled *B Bundle Codes*. For reimbursement policies regarding Add-On CPT code 69990, refer to the policy titled *Microsurgery*.

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 Health Care Professional: All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.

Same Individual Physician or Other Health Care Professional: The same individual rendering health care services reporting the same Federal Tax Identification number.

Same Specialty Physician or Other Health Care Professional: Physicians and/or other 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 Health Care Professional.

QUESTIONS AND ANSWERS

1	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?
	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.
2	Q:	How has Oxford determined which codes are "add-on" codes that must be reported with a primary service?
	A:	The policy follows CPT guidelines for those codes designated with a "+" symbol. These codes are considered to be an Add-On Code by Oxford.
3	Q:	Does Oxford require the Add-On Code be submitted on the same claim as the primary code?
	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.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Payment Policy Oversight Committee. [*2018R0071C*]

American Dental Association, CDT Dental Procedure Codes

American Medical Association. Current Procedural Terminology (CPT®) and associated publications and services.

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System (HCPCS ®) Level II Manual

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files. Global Surgery Indicator: ZZZ = The code is related to another service and is always included in the global period of the other service.

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2018	• Updated and reformatted references to related Reimbursement Policies; added reference to the policy titled *B Bundle Codes* • Updated policy application guidelines; added language to clarify this 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 • Updated reimbursement guidelines; modified notation to clarify all services described in this policy may be subject to other reimbursement policies including but not limited to the policy titled *B Bundle Codes* • Updated supporting information to reflect the most current references • Archived previous policy version ADMINISTRATIVE 185.16 T0

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