OUTPATIENT HOSPITAL ADD-ON CODES POLICY (CES)

Policy Number: ADMINISTRATIVE 274.1 T0 **Effective Date**: October 1, 2020

Table of Contents **Page**

INSTRUCTIONS FOR USE 1
APPLICABLE LINES OF BUSINESS/PRODUCTS 1
APPLICATION 1
OVERVIEW 1
REIMBURSEMENT GUIDELINES 1
DEFINITIONS 2
APPLICABLE CODES 2
QUESTIONS AND ANSWERS 3
REFERENCES 3
POLICY HISTORY/REVISION INFORMATION 3

Related Policies
None

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 UB-04 claim form or its electronic equivalent or its successor form. This policy applies to all network and non-network outpatient hospital claims.

OVERVIEW

Add-On Codes are reimbursable services when reported in addition to the appropriate primary service by the same outpatient hospital 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 complimentary to the primary service/procedure.

©1996-2020, Oxford Health Plans, LLC

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 outpatient hospital 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).

CMS further defines the code pair relationships in the CMS National Correct Coding Initiative (NCCI) package. CMS NCCI designates Add-On Code relationships as Type I, II, or III. Type I Add-On Codes have a limited number of identifiable primary procedures that they must be reported with and Type II and III do not have an all-inclusive list of primary procedures.

Oxford follows the CMS 'Integrated' Outpatient Code Editor (I/OCE) specific edits for Type I Add-On Code and primary code relationships. If the Add-on code is not submitted on the claim as the same day of service or the day before, the Add-On Code will not be reimbursed. In addition, Add-On Codes are never reimbursed unless a primary procedure codes is also reimbursed.

Infusion Services

Hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Therefore, for infusion services, the Add-On Code is not required to be billed for the same date of service as the initial drug service. However, both the initial drug service and the corresponding Add-On Code must be reported on the same claim.

DEFINITIONS

Add-On Code: Add-On Codes describe additional intra-service work associated with the primary service/procedure.

Stand-Alone Code: A code reported without another primary service/procedure code by the same outpatient hospital.

APPLICABLE CODES

This list of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. The listing of a code does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

Add-On to Primary Code Relationship List
The Add-On to Primary Code Relationship List includes Add-On Codes which will only be reimbursed when reported with the appropriate primary code.

Infusion Add-On to Primary Code Relationship List							
Infusion Add-On	**Primary Code**	**Infusion Add-On**	**Primary Code**	**Infusion Add-On**	**Primary Code**	**Infusion Add-On**	**Primary Code**
96361	96360	96361	96365	96361	96374	96361	96409
96361	96413	96366	96360	96366	96365	96366	96367
96366	96413	96367	96360	96367	96365	96367	96374
96367	96409	96367	96413	96368	96360	96368	96365
96368	96366	96368	96413	96368	96415	96368	96416
96368	C8957	96370	96369	96371	96369	96375	96360
96375	96365	96375	96374	96375	96409	96375	96413
96376	96365	96376	96374	96376	96409	96376	96413
96411	96409	96411	96413	96415	96413	96417	96413
96423	96422						

CPT® is a registered trademark of the American Medical Association

©1996-2020, Oxford Health Plans, LLC

QUESTIONS AND ANSWERS

1	**Q:**	Does Oxford require the Add-On Code be submitted on the same claim as the primary code?
	A:	No, with the exception of infusion services, which must be submitted on the same claim but can have different dates of service.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2020R5012B*]

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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2020	• New Reimbursement Policy

©1996-2020, Oxford Health Plans, LLC