LifeWise
Health Plan of Washington

Payment Policy

cmi_171645

Title	**Add-On Codes**		
Number	**CP.PP.408.v1.4**		
Last Approval Date	09/04/24	**Original Effective Date**	06/15/18
Replaces			
Cross Reference	• *Medicare Indicator "Status B, Status P and Status T" Services Reimbursement* • *Modifier 51 – Multiple Procedures*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose/ Application	This policy describes how the Plan will recognize and reimburse for the correct submissions of add-on codes that are submitted on a CMS 1500 paper claim or 837P electronic claim form and a UB-04 paper claim form or an 837I electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Definitions	**Add-on code** – Codes which describe an additional intra-service work that is associated with a primary or parent service **Primary/parent code**-The main CPT or HCPCS codes that denotes the majority of the services provided to a patient on a specific date of service
Policy	Add-on codes must be reported **in conjunction with** an appropriate primary/parent procedure code on the same date of service by the same provider unless instructions in either the CPT or HCPCS codebooks indicates an add-on code can be billed on same or different dates from the primary/parent code. **Both** the primary/parent code and the add-on code must be submitted on the **same claim**. Submitting an add-on code without an appropriate primary/parent code or by itself without an appropriate primary/parent code on the same claim will be denied reimbursement. Add-on codes are exempt from multiple procedure reduction concepts and therefore modifier 51-multiple procedures should not be appended to these codes. In addition, there are no modifiers that will bypass a denial of an add-on code if the primary/parent code is denied. If the primary/parent code is denied reimbursement for any reason, the add-on code will also be denied reimbursement. Add-on codes reported by a provider other than the provider who performed the primary/parent procedure code will not be reimbursed.

<table>
<tr><td>Codes/Coding Guidelines</td><td>

<u>Identification of Add-On Codes and Correct Primary/Parent Procedure Code</u>

Add-on codes, both CPT and HCPCS codes, can be identified by **key phrases** in the code description which include, but are not limited to, the following:

- List separately in addition to primary procedure
- Each additional
- Done at time of other major procedure

Add-on codes and their respective parent/primary codes are identified in the following industry sources:

<u>American Medical Association CPT Professional Codebook:</u>

- Add-on codes are identified by the plus symbol "+" notation next to the procedure code.
- Appendix D in the same codebook also lists a summary of add-on codes in the codebook.
- The primary/parent procedure code(s) associated with these add-on codes are found in the codebook in a parenthetical instruction after each add-on code indicating which primary codes should accompany the add-on code.
- When there is a specific primary/parent code listed in the codebook, the add-on code must **not** be reported with a procedure code(s) other than that which is listed as the primary/parent code(s).
- When there is not a parenthetical note after the add-on code that identifies appropriate primary/parent code(s), the code description itself will identify what kind of primary/parent code the add-on code should be billed with.
  (e.g., 58611 - Ligation or transection of fallopian tube(s) **when done at the time of cesarean delivery or intra-abdominal surgery** (not a separate procedure) (List separately in addition to code for primary procedure))

<u>CMS Add-On Code Listing:</u>

- CMS maintains a current listing of add-on CPT and HCPCS codes)
  - Medicare NCCI Add-on Code Edits | CMS
  - Scroll down to the bottom of page and look for "Related Downloads" on the left sidebar to access the most current version of the add-on code file
- Add on codes are also identified in the National Physician Fee Schedule with a "Global Days Indicator" code of "ZZZ"
- Some add-on codes with the "Global Days Indicator" code of "ZZZ" are classified as Medicare Status B codes on the CMS National Physician Fee Schedule. As such, these codes will not be reimbursed even if billed with an appropriate primary/parent code

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<tr><td>Violations of Policy</td><td>

Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined in Plan's sole discretion.

Violations of this policy may be grounds for corrective action, up to and including termination of employment.

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Exceptions	Those codes where instructions in the CPT or HCPCS codebooks indicate that the add-on code can be billed on the same or different dates of service from the primary code.
Laws, Regulations & Standards	
References and Resources	• American Medical Association, Current Procedural Terminology (CPT), Professional Edition, Introduction • CMS National Correct Coding Initiative Policy Manual, Chapter 1 "General Correct Coding Policies" • CMS National Physician Fee Schedule

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department	
Annual Review Dates	09/04/24; 12/13/23; 02/08/23; 03/04/22; 03/23/21; 04/01/20; 05/03/19; 05/07/18	
Version History	05/07/18	Creation of new policy
	05/03/19	In the Policy and Exception sections, added a phrase to accommodate those new 2019 add-on code exceptions that can be billed on different dates of service
	04/01/20	Annual review; no changes
	03/23/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms. In the Codes/Coding Guidelines section, added a fifth bullet in the sub-section American Medical Association CPT Professional Codebook on how to identify primary/parent codes when no parenthetical note is found after the add-on code
	03/04/22	Annual review; no changes
	02/08/23	Rewrote the last paragraph in the Policy statement to make it read clearer.
	12/13/23	Corrected the link to the CMS file of Add-On codes.
	09/04/24	Annual review; no changes

This policy was published on September 09, 2024