Payment Policy: Duplicate Primary Code Billing

Reference Number: LA.PP.044
Product Types: All
Effective Date: 08/2020
Last Review Date: 08/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

The American Medical Association (AMA) publishes Current Procedural Terminology (CPT®) guidelines that describe procedures and their appropriate use. The description of some CPT codes limit reporting of that procedure to once per day, per member, on a single date of service. Instead, the AMA has designated "add-on" codes that should be billed to indicate that additional quantities of a procedure have been performed.

The purpose of this policy is to define payment criteria when a primary procedure code is billed in multiple quantities instead of the more appropriate "add-on" code.

Application

1. Physician and Non-Physician Practitioner claims
2. Outpatient Institutional claims

Policy Description

By definition, certain Current Procedural Terminology (CPT®) procedure codes are appropriately billed only once per date of service. A billing error is identified when these primary codes are billed in a quantity greater than one, for the same member on a single date of service. When indicated, providers should bill the appropriate add-on code to indicate additional intra-service work associated with the procedure.

Reimbursement

Louisiana Healthcare Connects code editing software will evaluate primary procedure codes, their descriptions and the number of units or service lines billed. If a primary procedure code is billed in a quantity greater than one and there is an appropriate "add-on" code to report the additional quantities, the service line is denied and a new line is added with the correct quantity of one. The remaining units are rebalanced to reflect the non-payable codes.

Example

Primary Procedure Code Billed with Multiple Units Versus Add-on Code								
Service Line	Date	Procedure	Count	Explanation Code	Description	Charge	Allow	Deny
0100	4/19/2006	99291	4	xf	Maximum Units Exceeded	$1,972	$0	$1,972
0200	4/19/2006	99291	1	92	Paid in full	$493	$216.56	$0
0300	4/19/2006	99291	3	xh	Service line represents denial of additional units billed	$1,479	$649.68	$649.68

1. The health plan's automated code editing software analyzed each service line, the CPT code billed and its description.
2. CPT code 99291 is defined as "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes."
3. A total of 4 units were billed on service line 0100 with a total charge amount of $1972.
4. The software analyzed the procedure code definition and the quantity billed and determined that an "add-on" code should have been submitted to represent the time spent beyond 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).
5. The software denied service line 0100 with a unit count of 4 as the quantity exceeded the maximum units allowed for the procedure. The total charged amount for each unit is $493 ($493 x 4=$1972).
6. As a service to the provider, the software added a new service line to reflect the total number of units allowed (1). The total charge amount for one unit is $493 and the total allowed amount for one unit is $216.56.
7. The total denied amount for the non-payable codes is $649.68.

Documentation Requirements
Not applicable

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

ICD-10 Codes	Descriptor
NA	NA

Definitions

1. Add-on Code: Procedures performed in addition to the primary procedure. Add on codes are identified by the + symbol *Appendix D of the AMA's CPT® code book*. Add on codes contain phrases such as "each additional" or "list separately in addition to the primary procedures." Add-on procedure billing applies only to services rendered by the same physician. These codes are used to describe additional intra-service work associated with the primary procedure (i.e., additional digits, lesions, vertebral segment and etc.) Add-on codes should never be reported as a stand-alone code. Add-on codes are exempt from the multiple procedure code concept (see Modifier 51 guidelines).

Additional Information
NA

Related Documents or Resources
NA

References
1. *Current Procedural Terminology (CPT®)*, 2022

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Updated dates in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section	08/30/2022	
Annual review; code tables removed since this information can be found in CPT resources.	08/01/2023	12/15/2023

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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