Payment Policy: Add-On Code Billed Without Primary Code

Reference Number: CC.PP.030
Product Types: All
Effective Date: 01/01/2013
Last Review Date: 04/01/2019

Coding Implications
Revision Log

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

Policy Overview
The purpose of this policy is to explain the parameters for add-on codes submitted on physician claims. The American Medical Association (AMA) defines add-on procedures as those procedures "always performed in addition to the primary service or procedure and must never be reported as a stand-alone code.

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.

Add-on codes are identified in the CPT manual with the "+" symbol. Per the AMA, "The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

Application
This policy applies to outpatient professional claims (rule looks within same claim and across claims history, claims with the same date of service, same provider).

Policy Description

Reimbursement
The Health Plan follows the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) with respect to reporting of "Add-On' CPT and HCPCS codes.

The health plan's code editing software will evaluate claim lines on the current claim and in claims history for the presence of an add-on code billed with the primary procedure code.

If procedure code is found billed with an add-on code and the primary code is not present on the current claim or a claim in history, that service line will be denied.

Furthermore, if a procedure code is billed with an add-on code and the primary procedure code is present, but has been denied by another claims payment rule; the add-on code will also be denied.

References

1. *Current Procedural Terminology (CPT®)*, 2018
2. *HCPCS Level II*, 2018
3. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*

Revision History	
02/24/2018	Converted to revised template and conducted review.
04/01/2019	Conducted review and updated policy

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations 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 plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. 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. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment 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.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.