Payment Policy: Add-On Code Billed Without Primary Code

Reference Number: LA.PP.030
Product Types: All
Effective Date: 08/2020
Last Review Date: 08/2022

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

Louisiana Healthcare Connections 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.

Louisiana Healthcare Connections code editing software evaluates 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®)*, 2019
2. *HCPCS Level II*, 2019
3. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*

Revision History	
08/15/2020	Converted corporate to local policy.
08/29/2022	Annual Review; Removed clinical and added payment policy in "Important Reminder" section

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.

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

This payment policy is the property of LHCC. 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.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File______