PROVIDER REIMBURSEMENT GUIDANCE			
Add-On Codes			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
	04/01/2022	04/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

Payment Policy Summary

Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the Same Individual Physician or Other Qualified Health Care Professional reporting the same Federal Tax Identification Number 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 complementary to the primary service/procedure.

CCA 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 Individual Physician or Other Qualified Health Care Professional 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).

Key phrases to identify Add-on codes when not specified in the code description, include, but are not limited to, the following:

- list separately in addition to; and
- each additional; and
- done at time of other major procedure.

Unless otherwise specified within this policy, add-on procedures must be reported with the primary procedure for the same date of service.

Mohs Micrographic Surgery: The Mohs micrographic surgery codes (CPT codes 17311, +17312, 17313, +17314, +17315), describe procedures that involve surgery and pathology services performed together by the same individual physician. In some instances, the Mohs surgical procedure may extend beyond the initial date of service, thus there are 3 Add-on codes (+17312, +17314 and +17315) that might be performed on a different date of service than their primary procedure. Consistent with the November 2006 CPT Assistant, the Add-on code should be reported on same claim as the primary Mohs procedure even though the dates of service may differ.

Psychological and Neuropsychological Testing: The Psychological/Neuropsychological Testing codes (CPT codes 96136, +96137, 96138, +96139), describe procedures that involve test administration and scoring services performed together by a physician or other qualified health care professional. In some instances, the Psychological/Neuropsychological testing may extend beyond the initial date of service, thus there are two Add-on codes (+96137, and +96139) that might be performed on different dates of service than their primary procedure. The Add-on code should be reported on same claim as the primary procedure even though the dates of service may differ.

Critical Care Services (CPT Codes 99291, +99292): Critical care codes are time-based Evaluation and Management (E/M) services. CPT code 99291 is reported for the first 30-74 minutes of care; Add-on code +99292 is reported for each additional 30 minutes. UnitedHealthcare will reimburse for critical care add-on services (code +99292) in the following situations:

- The Same Individual Physician or Other Qualified Health Care Professional reporting provides more than 74 minutes, thus submitting Add-on code +99292 indicating each additional 30 minutes of care beyond the first 74 minutes.
- The Same Specialty Physician or Other Qualified Health Care Professionals each supplying critical care services for the same patient on the same date of service may report using one of the following methods:
    - The primary code 99291 is reported by the physician or other qualified health care professional that provides the first 30-74 minutes of critical care. The Add-on code +99292 is reported for each additional 30 minutes of care beyond the first 74 minutes of critical care when provided by the Same Specialty Physician or Other Qualified Health Care Professional.
    - A single physician may report all critical care service codes on behalf of the other members within the same group/same specialty.
- The Same Group Physician and/or Other Qualified Health Care Professionals each supplying critical care services for the same patient on the same date of service would each individually report their own critical care services. For example, two physicians within the same provider group, but of different specialties each provide critical care services for the same patient on the same date of service. Because the physicians are of different specialties, each would report their critical care services separately. Both physicians may individually report code 99291, and +99292 for each additional 30 minutes of critical care services depending on the length of services provided by each physician.

References

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

CCA Website

CMS Website

CMS Claims Processing Manual

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

Policy Timeline Details

1. Drafted: January 2022
2. Approved: February 2022
3. Implemented: April 2022