Priority Health	BILLING POLICY No. 090
ADD-ON CODES	
Date of origin: May 13, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

This policy is complementary to our General Coding Policy and simply provides more detail for add-on code billing.

Add-on codes (AOCs) are supplemental procedure codes that represent reimbursable services when reported in addition to the appropriate primary service. These are commonly performed by the same provider, and this add on service is done in addition to or in conjunction with the primary service unless otherwise specified within the guidelines or another policy.

POLICY SPECIFIC INFORMATION

Add-on codes to enable providers to separately identify a service that's performed in combination with another more comprehensive or primary service / procedure.

CPT utilizes key phrases within parenthetical statements, instructions or guidelines to assist in flagging when the add-on code requirements exist. Some examples include, but aren't limited to, the following:

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

Add-on codes are identified within the CPT manual (instructions, guidelines, parenthetical statements), CMS interpretation of HCPCS / CPT codes and CMS coding instructions. CPT identifies add on codes within the CPT manual with a "+" symbol next to the code to indicate this requires a primary service to be coded. In addition, Appendix D of the CPT manual details a summary of all add on codes. If the primary service / procedure isn't billed or is denied due to an editing or billing error, the add-on code will also be denied.

CMS also publishes a list of add-on codes and their primary codes, which can be used as a reference tool. These updates may be posted quarterly by CMS. To determine an appropriate primary procedure code for an add-on HCPCS code, check the CPT manual or use CMS Add-On Code edit tables.

Add-on codes reported without the primary procedure will result in a claim denial.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

A primary procedure code must be billed in order for add-on codes to be reimbursed.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

Resources

- AMA CPT Professional Edition (current year)
- Medicare NCCI Add-on Code Edits (CMS)

Related policies

- General Coding policy

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made