# Add-On Codes

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**Last Review: 02/27/2025**
**Next Review: 02/2026**

## Description

Add-on codes describe additional intra-service work carried out in addition to the primary procedure/service. 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). Add-on codes 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 same Federal Tax Identification Number on the same date of service unless otherwise specified within the policy.

In some instances, a Definitive Source specifies the exact primary procedure/service codes that must be reported with a given Add-on code.

In other situations, a primary/add-on code relationship may exist but the guidance from CPT or CMS is not as well-defined since the code description does not directly identify the Add-on code or the specific primary codes that correspond with that Add-on code. In those instances, an interpretation is necessary utilizing CPT, CMS and/or specialty society guidelines. Oscar will interpret these sources to identify additional primary/Add-on relationships and will require the Add-on code to be reported with the given primary code.

CPT contains key phrases to identify add-on codes with include, but are not limited to, the following:

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

Oscar follows the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) with respect to the reporting of "Add-on" and the primary CPT and HCPCS code pairings. Oscar will not reimburse the Add-on codes unless a primary procedure code is also reimbursed. There is no modifier that can bypass a denial for an add-on code violation. Unless otherwise specified within this policy, Add-on procedures must be reported with the primary procedure for the same date of service.

## Policy

Oscar will reimburse add-on services according to criteria outlined in this policy.

## Reimbursement Guidelines

When submitting an add-on code, a primary code must also be submitted. Add-on codes submitted as standalone procedures are not eligible for reimbursement.

Add-on codes are not eligible for reimbursement unless the primary procedure submitted by the same provider or same group practice is reimbursable on the same date of service, unless otherwise specified in this policy.

Add-on codes appended with Modifier 51 are not eligible for reimbursement.

Clinical edits for the primary code can also affect the add-on codes. Per NCCI guidelines, if a clinical edit is applied to a primary code and prevents it from being paid, the add-on code will not be paid

The following are specific guidelines for certain procedures:

**Mohs Micrographic Surgery**

The Mohs micrographic surgery codes (CPT primary codes 17311, 17313, and Add-on codes +17312, +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, +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 the 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 primary codes 96136, 96138, and Add-on codes +96137, +96139), describe procedures that involve test administration and scoring services performed together by the **same** individual physician or other qualified healthcare professional. In some instances, the Psychological/Neuropsychological testing may extend beyond the initial date of service, thus there are 2 Add-on codes (+96137, +96139) that might be performed on different dates of service than their primary procedure. The Add-on code should be reported on the same claim as the primary procedure even though the dates of service may differ.

**Obstetric Anesthesia**

Obstetric Anesthesia codes (CPT primary code 01967, and Add-on codes +01968, +01969), describe the service that involve anesthesia services performed together by the **same or different** individual physician or other qualified healthcare professional. In some instances, Obstetric Anesthesia involves extensive hours and the transfer of anesthesia to a second physician, thus there are 2 Add-on codes (+01968, +01969) that might be performed on different dates of service than their primary procedure. The Add-on code should be reported on the same claim as the primary procedure even though the dates of service may differ.

**Critical Care Services**

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

- The same individual physician or other qualified healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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

**Infusion Services**

Infusion service codes (CPT primary codes 96360, 96365, 96374 and Add-on codes +96361, +96366, +96367, +96368, +96375, +96376) are considered initial drug administration services which should only be reported once per encounter for each distinct vascular access site. Other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Therefore, for infusion services, the Add-on code is not required to be billed for the same date of service as the initial drug administration service. The Add-on code should be reported on the same claim as the primary procedure even though the dates of service may differ.

## Rationale

Oscar will reimburse add-on services when correct coding guidelines are followed as defined by the AMA, and CMS.

In alignment with AMA, Modifier 51 (multiple procedures) should not be appended to any add-on code as the intent behind an add-on code already encompasses the reduced service.

## Billing and Coding

Categories identified above include, but are not limited to, the below codes.

| Code | Description |
|---|---|
| 17311, 17313<br>+17312, +17314, +17315 | Mohs Micrographic Surgery |
| 96136, 96138<br>+96137, +96139 | Psychological and Neuropsychological Testing |
| 99291<br>+99292 | Critical Care |
| 96360<br>+96361, +96366, +96367,<br>+96368, +96375 | Intravenous (IV) infusions for hydration purposes |
| 96365<br>+96361, +96366, +96367,<br>+96368, +96375, +96376 | Intravenous infusion, for therapy, prophylaxis, or diagnosis |
| 96374<br>+96361, +96366, +96367,<br>+96368, +96375 | Therapeutic, Prophylactic, and Diagnostic Injections and Infusions |

## Related Policy

Modifier Guidelines

## References


1. American Medical Association, Current Procedural Terminology (CPT® )
2. Centers for Medicare & Medicaid Services, CMS Manual System, Medicare Claims Processing Manual 100-04, and NCCI Policy Manual
3. Healthcare Common Procedure Coding System


## Publication History

| Date | Action/Description |
|---|---|
| 09/2021 | Original Documentation |
| 02/27/2024 | Annual Review; Added Date Section for quick reference, Added Description Section, Added to Reimbursement Guidelines Section, Added Rationale Section, Added Related Policy Section, Added References Section. RP Governance Committee Approved. |
| 02/27/2025 | Annual Review |
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