Clover

Clover Health Add on Codes Reimbursement Policy Policy # RP-034

Policy Title	Add on Codes Reimbursement Policy
Policy Department	Payment Strategy & Optimization
Effective Date	4/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies The Center for Medicare and Medicaid Services (CMS) criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

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 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.

Definitions:

- **Add-on code**- Add-on codes describe additional intra-service work associated with the primary service/procedure.
- **Same Group Physician and/or Other Qualified Health Care Professional** All physicians and/or other qualified health care professionals of the same group reporting the same Federal Tax Identification number.

- **Same Individual Physician or Other Qualified Health Care Professional-** The same individual rendering health care services reporting the same Federal Tax Identification number.

- **Same Specialty Physician or Other Qualified Health Care Professional-** Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

- **Stand-alone code-** A code reported without another primary service/procedure code by the Same Individual Physician or Other Qualified Healthcare Professional.

Policy:

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.

Clover Health follows the American Medical Association (AMA) and 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).

CMS has divided the Add-on codes into three groups, Type I, Type II, and Type III to distinguish the payment policy for each group.

1. Type I - A Type I add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code***, with one exception,*** is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid.

2. Type II - A Type II add-on code does not have a specific list of primary procedure codes. The CR lists the Type II add-on codes without any primary procedure codes. Claims processing contractors are encouraged to develop their own lists of primary procedure codes for this type of add-on code. Like the Type I add-on codes, a Type II add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.
3. Type III - A Type III add-on code has some, but not all, specific primary procedure codes identified in the *CPT Manual*. The CR lists the Type III add-on codes with the primary procedure codes that are specifically identifiable. However, claims processing contractors are advised that these lists are not exclusive and there are other acceptable primary procedure codes for add-on codes in this Type. Claims processing contractors are encouraged to develop their own lists of additional primary procedure codes for this group of add-on codes. Like the Type I add-on codes, a Type III add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

CMS will update the list of add-on codes with their primary procedure codes on an annual basis on or by January 1 every year based on changes to the *CPT Manual or HCPCS Level II Manual*. Quarterly updates will be posted as necessary on April 1, July 1, and October 1 each year. If no changes occur in the add-on code edits for one quarter, no quarterly update will be posted.

References
Add on code edits