Add-On Codes

Reimbursement Policy ID: RPC.0007.72AC

Recent review date: 08/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

The basis for add-on codes is to enable physicians or other health care professionals to separately identify a service that is performed in certain situations as an additional service or typically performed in addition to the primary service or procedure. Add-on codes describe a service that is performed in conjunction with the primary service by the same provider.

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. 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 and Pennsylvania Department of Human Services.

Exceptions

N/A

Reimbursement Guidelines

The health plan follows guidelines of the American Medical Association (AMA) CPT code set, CMS, and Pennsylvania Department of Human Services with respect to the reporting of add-on CPT and HCPCS codes. Under CPT rules, add-on codes describe additional intra-service work associated with a primary procedure/service and are always reported in addition to the primary service or procedure and must be performed by the same individual physician or other health care professional reporting the primary service/procedure.

In addition, add-on codes are never reimbursed unless a primary procedure code is also reimbursed. Add-on CPT codes are designated with a "+" symbol and are also listed in Appendix D of the CPT manual. Add-on codes can also be noted at times as: “list separately in addition to”, and/or “each additional”, and/or “done at the time of another procedure”.

Add-on codes are identified in the CMS National Physician Fee Schedule (NPFS) as ZZZ global day indicator.

This policy does not address multiple procedure payment reduction. The Pennsylvania Medicaid regulations state when two or more surgical procedures are performed by the same practitioner during the same period of hospitalization, the practitioner will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures. See Multiple Procedure Payment Reduction policy RPC.0033.05xx

Definitions

Add-on codes
Add-on codes describe additional intra-service work associated with the primary service or procedure.

Same individual physician or other qualified health care professional
A physician or other health care professional from the same group practice with the exact same specialty and subspecialty reporting under the same federal tax identification number (TIN).

Edit Sources

I. Current Procedural Terminology (CPT)
II. Healthcare Common Procedure Coding System (HCPCS)
III. International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)
IV. Centers for Medicare and Medicaid Services (CMS)- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf
V. Centers for Medicare and Medicaid Services (CMS), Physician Fee Schedule- https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=0&CT=3&H1=22852&M=5
VI. Pennsylvania Department of Human Services Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0033.72AC Multiple Procedure Payment Reduction

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval
07/2026	Biennial review • No major changes
08/2025	Reimbursement Policy Committee Approval
07/2025	Annual Review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval