

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



REVISED products from the Medicare Learning Network® (MLN)

- [“Internet-based Provider Enrollment, Chain and Ownership System \(PECOS\) Contact Information,”](#) Fact Sheet, ICN 903766, Downloadable only.

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Note: This article was revised on August 16, 2013, to add a reference MLN Matters® article MM8271 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8271.pdf>) to alert providers that Medicare contractors will generate an Informational Unsolicited Response (IUR) or reject claims for an add-on CPT code on an outpatient claim when there is no primary procedure CPT code associated with the add-on code OR when the primary procedure CPT code associated with the add-on code associated is not covered by Medicare. All other information remains the same.

Add-on HCPCS/CPT Codes Without Primary Codes

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

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This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.

Provider Action Needed

An add-on code is a Health Care Common Procedure System (HCPCS) code or Current Procedural Terminology (CPT) code that describes a service that, with one exception (see Background Section below), is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service.

The Centers for Medicare & Medicaid Services (CMS) has learned from Recovery Auditor reports that some providers are billing only Add-on HCPCS/CPT codes without their respective primary codes resulting in overpayments.

This MLN Matters® Special Edition Article provides an overview of billing for HCPCS/CPT Add-on codes, and it is based on CMS manuals and publications including the "Medicare Claims Processing Manual," (Chapter 12, Sections 30(D) and 30.6.12(I). Change Request (CR) 7501 (Transmittal 2636 dated January 16, 2013) titled "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION."

Background

An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with the primary service. An add-on code is eligible for payment only if it is reported with the appropriate primary procedure performed by the same practitioner.

The "Medicare Claims Processing Manual," Chapter 12, Section 30.6.12(I) requires a provider to report CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)), without its primary code CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes). If two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service.

For the same date of service only one physician of the same specialty in the group practice may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292. See Change Request (CR) 7501 at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf> on the CMS website for current information regarding add-on codes in addition to the manual section mentioned above.

The following shows an example of this issue:

Example:

A provider submitted a claim with CPT Code 26863 for one unit for date of service May 5, 2010, without billing for the primary CPT Code 26862. Add-on codes billed without their primary codes are considered an overpayment. Overpayment for add-on CPT Code 26863 was retracted as a billing error.

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- Add-on CPT Code 26863 Description: Fuse/Graft added joint – Arthrodesis, interphalangeal joint with or without internal fixation; with autograft, each additional joint. List separately in addition to code for primary procedure.
- Primary CPT Code 26862 Description: Fusion/graft of finger – Arthrodesis, interphalangeal joint, without internal fixation; with autograft. This is a parent CPT Code and can be reported with add-on CPT Code 26863.

Additional Information

You can find Change Request (CR) 7501 (Transmittal 2636 dated January 16, 2013) titled "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION" at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf> on the CMS website.

You can review the "Medicare Claims Processing Manual" (Chapter 12, Section 30.6.12(l) Critical Care Services Provided by Physicians in Group Practice(s)) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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