Add-on Codes

Last Updated: 7/8/2026 **Last Reviewed:** 7/8/2026 **Originally Effective:** 8/2/2004
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No
If yes, Texas Last Update Effective Date: n/a
Policy #: RPM025

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All)
Claim Forms: CMS1500 & CMS1450 (paper and electronic versions)
Provider Contract Status: Any
Claim Dates: All

Reimbursement Guidelines

A. Add-on Code Requirements

1. An add-on code is considered a "child" code that may not be reported on a claim alone. The add-on code must be directly accompanied by a "parent" code to which it is matched or assigned.
   a. Add-on codes must be reported in conjunction with an appropriate primary procedure code by the same physician (or qualified provider) on the same date of service.[1,3]
   b. Both the "parent"/primary procedure code and the add-on "child" code are to be submitted on the same claim (not split claims).
   c. Both the "parent"/primary procedure code and the add-on "child" code need to be performed at the same patient encounter, and thus reported with the same POS.
   d. Refer to "Special Circumstances" below for exceptions.
2. Just having any primary procedure code present on the claim is not sufficient to satisfy the requirement of an accompanying "parent code." The "parent"/primary procedure code must be related and appropriate to be billed in combination with that specific add-on code.
3. An add-on code is eligible for payment if and only if one of its primary codes is also billed and eligible to be allowed.[7] If the "parent"/primary procedure code is denied for any reason (e.g. incorrect coding, insufficient documentation, lack of required preauthorization, etc.), then the add-on code is also subject to denial.
4. Submitting an add-on code without meeting the above coding requirements for add-on codes is considered a billing error. Clinical edits are employed to identify incorrectly billed add-on codes and deny them to provider write-off. There is no modifier that will bypass a denial for an add-on code violation.
5. When an appropriate "parent"/primary procedure code has not been submitted in conjunction with the add-on code, a corrected claim will be needed to remedy the clinical edit denial. The denial may not be overturned or adjusted based upon a phone call to Customer Service. The billing error must be corrected.
6. Clinical edits for the "parent"/primary code may also affect the add-on "child" code. Per NCCI guidelines, if an edit prevents payment of the primary procedure code, the add-on code will not be paid.[4]
   a. Also, if CCI has a PTP edit for the primary code pair (e.g. 63081/63075), then there may be a PTP edit for the add-on code pair (e.g. 63082/63076), as the same coding principle for the primary PTP edit applies to the add-on code pair as well.

b. The add-on PTP edit will also require appropriate use of a modifier to bypass the edit on the add-on code pair.

B. Determining the correct primary procedure code ("parent code")

1. In general, the CPT book provides specific parenthetical instructions for an add-on code indicating which primary procedure codes should accompany the add-on code.
   a. For example, "(Use 33141 in conjunction with 33400 – 33496, 33510 – 33536, 33542)," or "(Use 22585 in conjunction with 22554, 22556, 22558)."
   b. "When the *CPT Manual* identifies specific primary codes, the add-on code should not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code." [4]
2. In addition, on April 1, 2013 CMS began publishing a list of add-on codes and their primary codes annually prior to January 1.
   a. The list is updated quarterly based on the AMA's "CPT Errata" documents or implementation of new HCPCS/CPT add-on codes.
   b. CMS identifies add-on codes and their primary codes based on *CPT Manual* instructions, CMS interpretation of HCPCS/CPT codes, and CMS coding instructions.[6]
3. To determine an appropriate primary or "parent" procedure code for an add-on HCPCS code, check the CMS Add-On Code edit tables.
4. For a few codes, the CMS add-on code edit tables list "Contractor Defined Primary Code(s)." In these cases, the coder must locate the procedure code with a matching common description (e.g., the portion of the procedure description prior to the semicolon).

C. Special Circumstances

Type of Circumstance	Policy for that Circumstance
Anesthesia for unplanned cesarean delivery or hysterectomy (01967 / 01968, 01969)	When neuraxial analgesia/anesthesia (e.g., spinal, epidural) is provided for a planned vaginal delivery which ultimately results in a cesarean delivery or an emergency cesarean hysterectomy, two anesthesia procedure codes must be reported. 01967 is the "parent"/primary code, and 01968 or 01969 are the related add-on "child" codes. When the neuraxial labor analgesia/anesthesia is initiated prior to midnight, and the cesarean delivery or cesarean hysterectomy is performed after midnight, the total anesthesia service is provided as a continuous service, but the two portions actually occur on different, sequential dates. Thus, the primary/"parent" code 01967 may legitimately be billed for a different date of service immediately preceding the date for the add-on code(s). When a cesarean delivery is performed after a lengthy vaginal labor, the vaginal neuraxial analgesia/anesthesia (01967) and the cesarean anesthesia (01968, 01969) may be performed and billed by two separate anesthesia providers. Due to these considerations, we will allow 01968 and 01969 even when 01967 has not been billed by the same provider or provider group.

Type of Circumstance	Policy for that Circumstance
Assistant Surgeon	The primary surgeon must report both the "parent"/primary procedure code and the add-on "child" code in order for the assistant surgeon to report assistant services for both the "parent"/primary procedure code and the add-on "child" code. The assistant surgeon *may not* report the add-on "child" code without an assistant surgeon modifier simply because they "did the work of the additional level/other side," etc.
Co-surgery, Reporting all codes with modifier 62	One co-surgeon may not report an "orphan" add-on code with modifier 62 appended for a "parent"/primary code that the other co-surgeon reported. Both surgeons must report both components of the related service (the "parent"/primary code and the add-on code) with modifier 62 appended.
Co-surgery, Acting as assistant surgeon for each other's portion of the case (e.g. dividing up which codes are reported as primary surgeon and as assistant surgeon)	The primary surgeon and the assistant surgeon must be consistent for both components of the related service (the "parent"/primary code and the add-on "child" code).
Mid-level providers (PA, NP, CRNA) working under a supervising physician	A mid-level provider may not report an add-on code procedure for a primary service which was provided and billed by the supervising physician. Both services must be provided by the same person, and the "parent"/primary code and add-on "child" code must both be billed by the same provider for the same date of service on the same claim.
Critical care, evaluation and management services (99291, 99292)	We follow CMS guidelines as follows: When 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, only one physician in the specialty group 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.[5] Primary service 99291 should be submitted by the first physician in the group to provide critical care services after midnight on that date of service. The remaining physicians will submit 99292 for critical care services rendered up through 23:59 on that date. 99292 will be denied when billed on a claim without 99291 and no other physician in the same specialty group has submitted 99291 for that date of service.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
NCCI	National Correct Coding Initiative (aka "CCI")
PTP	Procedure-To-Procedure (a type of CCI edit)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
TAC	Texas Administrative Code

Definition of Terms

Term	Definition
"Child" code or Add-on procedure code	A service that must never be reported as a stand-alone code. They describe additional intra-service work associated with another procedure and can only be reported in addition to the primary procedure. In many cases, the code listing includes a parenthetical list of specific primary procedure codes; the "child"/add-on code may not be reported as an additional service to other procedure codes.
"Parent" code or Primary procedure code	The qualifying primary service with which the add-on procedure code or "child" code is associated.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifier 51 - Multiple Procedure Fee Reductions." Moda Health Reimbursement Policy Manual, RPM022.
C. "Critical Care, Evaluation and Management Services (99291, 99292)." Moda Health Reimbursement Policy Manual, RPM041.

Resources

1. American Medical Association. "Introduction - Instructions for Use of the CPT Codebook, Add-on Codes." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. American Medical Association. "Add-on (Attached) Procedures vs. Multiple Procedures" *CPT Assistant,* Fall 1991: 6.
3. American Medical Association. "Add-on Codes" CPT Assistant, April 2000: 6.
4. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § R, "Add-on Codes", pp I-34 – I-35.
5. CMS. *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12.
6. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § W, "Add-on Code Edit Tables", pp I-42 – I-44.
7. CMS. *National Correct Coding Initiative Policy Manual*. Introduction, pg. 4.

8. CMS. *Add-on Code Edits.* cms.gov. https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-add-code-edits .

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
7/8/2026	Acronyms updated. Minor rewording. No policy changes.
4/9/2025	Acronyms & Related Policies updated. Formatting updates. No policy changes.
4/10/2024	Clarified parent and add-on codes need to be billed with same POS code. Formatting updates. No policy changes.
11/09/2022	Idaho added to Scope. Acronyms & Definition of Terms added. Policy History section added; entries prior to 2022 omitted (in archive storage). Formatting updates. No policy changes.
6/18/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
8/2/2004	Original Effective Date (with or without formal documentation). Policy based on CPT and CMS guidelines.