Add-on Codes Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the UB-04 Health Insurance Claim Form or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network facilities and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract facilities.

Policy

Overview

Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the Same Facility reporting the same Federal Tax Identification Number 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.

For the purpose of this policy, the Same Facility is the same facility rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

The basis for Add-on codes is to enable providers 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.

UnitedHealthcare Community Plan follows the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (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 Facility 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.

In some instances, a Definitive Source specifies the primary procedure/service codes that must be reported in conjunction 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. Specifically, the code description does not directly identify the Add-on code or identify any specific primary codes that correspond with that code. In those instances, an interpretation is necessary utilizing CPT, CMS and/or specialty society guidelines. UnitedHealthcare Community Plan will interpret these sources to identify additional primary/add-on relationships. For these code pairs, UnitedHealthcare Community Plan also requires that the Add-on code must be reported with a given primary procedure/service code. Please see the Definitions section below for further explanations of Definitive and Interpretive Sources.

Key phrases to identify Add-on codes when not specified in the code description, include, but are not limited to, the following:

- list separately in addition to; *and*
- each additional*; and*
- done at time of other major procedure.

Unless otherwise specified within this policy, add-on procedures must be reported with the primary procedure for the same date of service.

Mohs Micrographic Surgery

The Mohs micrographic surgery codes (CPT codes 17311, +17312, 17313, +17314, +17315), describe procedures that involve surgery and pathology services performed together by the same provider. In some instances, the Mohs surgical procedure may extend beyond the initial date of service, thus there are 3 Add-on codes (+17312, +17314 and +17315) that might be performed on a different date of service than their primary procedure. The Add-on code should be reported on same claim as the primary Mohs procedure even though the dates of service may differ.

Infusion Services

Hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with 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 service. However, both the initial drug service and the corresponding add-on code must be reported on the same claim.

Note: All services described in this policy may be subject to other UnitedHealthcare Community Plan reimbursement policies.

State Exceptions	
Florida	C&S Medicaid facility claims are paid under Ambulatory Patient Groups, or APG payment methodology, and are excluded from this policy.
Kansas	Per state guidance, CPT code 99494 is reimbursable when billed with HCPCS code G2214 as primary.
Nebraska	C&S Medicaid facility claims are paid under Ambulatory Patient Groups, or APG payment methodology, and are excluded from this policy.
New York	C&S Medicaid facility claims are paid under Ambulatory Patient Groups, or APG payment methodology, and are excluded from this policy.
Ohio	C&S Medicaid facility claims are paid under Ambulatory Patient Groups, or APG payment methodology, and are excluded from this policy.

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Virginia	C&S Medicaid facility claims are paid under Ambulatory Patient Groups, or APG payment methodology, and are excluded from this policy.
Texas	Per State Regulations, the following codes are informational only: G2211, G2212, G2213, G2215, and G2216
Washington	C&S Medicaid facility claims are paid under Ambulatory Patient Groups, or APG payment methodology, and are excluded from this policy.
Wisconsin	C&S Medicaid facility claims are paid under Ambulatory Patient Groups, or APG payment methodology, and are excluded from this policy.

Definitions	
Add-on code	Add-on codes describe additional intra-service work associated with the primary service/procedure.
Same Facility	The same Facility rendering health care services 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 Health Care Professional.
Definitive Source	Definitive Sources contain the exact codes, modifiers, or very specific instructions from the given source.
Interpretive Source	An edit source that includes guidelines; however, no exact or specific code or modifier information is listed. Therefore, an interpretation must be made as to what codes correlate to the guidelines. Additionally, an interpretation may be applied to surrounding or similar codes based on related definitively sourced edits.

Questions and Answers	
1	**Q:** How has UnitedHealthcare Community Plan determined which codes are “Add-on” codes that must be reported with a primary service? **A:** The policy follows CPT guidelines for those codes designated with a “+” symbol. These codes are considered to be Add-on codes by UnitedHealthcare Community Plan.
2	**Q:** Does UnitedHealthcare Community Plan require the Add-on code be submitted on the same claim as the primary code? **A:** No. The Add-on code may be reported on a separate claim submission from the primary code; however, it is recommended the Add-on and primary procedure codes be reported on the same claim form.
3	**Q:** Why does UnitedHealthcare Community Plan have some Add-on codes listed as primary in the Add-On to Primary Code Relationship List? **A:** CPT® indicates in the parentheticals of some Add-on codes, that those codes must be reported in conjunction with other codes that can include Add-on codes. UnitedHealthcare Community Plan will indicate an Add-on code that must be reported as primary to another by adding it to the primary column. An appropriate primary code would still be required when reporting both Add-on codes.

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Attachments	
Add On to Primary Code Relationship List	This table includes Add-on codes which will only be reimbursed when reported with the appropriate primary code.
Infusion Add On to Primary Code Relationship List	This table includes Infusion Add-on codes which will only be reimbursed when reported with the appropriate primary code on the same claim.

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files Global Surgery Indicator: ZZZ=The code is related to another service and is always included in the global period of the other service.

History

4/12/2026	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 4/12/2024 archived
1/18/2026	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 1/18/2024 archived
11/09/2025	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 11/09/2023 archived
8/22/2025	Policy Version Change State Exceptions Section: Added Kansas and Texas
7/20/2025	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 7/20/2023 archived
4/27/2025	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 4/27/2023 archived
1/26/2025	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list
1/12/2025	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 1/12/2023 archived
10/13/2024	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 10/13/2022 archived
8/18/2024	Policy Version Change Attachments Section: Updated Add On to Primary Code Relationship list History Section: Entries prior to 8/18/2022 archived

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2/1/2018	Policy implemented by UnitedHealthcare Community & State

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