CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2137	**Date: September 6, 2018**
	Change Request 10504

Transmittal 2044, dated March 16, 2018, is being rescinded and replaced by Transmittal 2137, dated, September 6, 2018 to change "date of service" to "encounter" in the background section and BR 10504.1.1. All other information remains the same.

SUBJECT: National Correct Coding Initiative (NCCI) Add-on Codes for Non-Outpatient Prospective Payment System (OPPS) Institutional Providers Implementation

I. SUMMARY OF CHANGES: An add-on code is a HCPCS/CPT code that describes a service that 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. An add-on code is never eligible for payment if it is the only procedure reported by a practitioner. This CR implements these edits for non-Outpatient Prospective Payment System (OPPS) Institutional Providers.

EFFECTIVE DATE: April 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2137	Date: September 6, 2018	Change Request: 10504

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SUBJECT: National Correct Coding Initiative (NCCI) Add-on Codes for Non-Outpatient Prospective Payment System (OPPS) Institutional Providers Implementation

EFFECTIVE DATE: April 1, 2018
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IMPLEMENTATION DATE: April 2, 2018

I. GENERAL INFORMATION

A. Background: An add-on code is a HCPCS/CPT code that describes a service that, with one exception (see next paragraph), is always performed in conjunction with another primary service. An add-on code with one exception is eligible for payment only if it is reported with an appropriate primary procedure performed by the same provider. An add-on code with one exception is never eligible for payment if it is the only procedure reported by a provider.

The *Internet Only Manual, Claims Processing Manual*, Publication 100-04, 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 provides 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.

Add-on codes may be identified in three ways:

(1) The code is listed in this CR or subsequent ones as a Type I, Type II, or Type III, add-on code.

(2) On the Medicare Physician Fee Schedule Database an add-on code generally has a global surgery period of "ZZZ".

(3) In the *CPT Manual*, an add-on code is designated by the symbol "+". The code descriptor of an add-on code generally includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

CMS has divided the add-on codes into three Groups 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 provider for the same patient on the same encounter. 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. Pursuant to *Internet Only Manual, Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12(I) described in the “Background” section of this CR, CPT code 99292 may be paid to a physician who does not report CPT code 99291 if another physician of the same specialty in his group practice is paid

for CPT code 99291 on the same date of service.

(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 codes. 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 provider for the same patient on the same encounter.

(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 provider for the same patient on the same encounter.

Rarely contractors may allow with appropriate submitted documentation, either pre-pay or on appeal, payment for a primary code and add-on code on two consecutive dates of service if the services are appropriately related.

CMS will update the list of add-on codes with their primary procedure codes on an annual basis before January 1 every year based on changes to the *CPT Manual*. Quarterly updates will be issued, as necessary, via a Change Request.

B. Policy: Medicare Administrative Contractors (MACs) shall use add-on codes where appropriate. Use of add-on codes as part of NCCI is discussed in the Medicare Claims Processing Manual, Publication 100-04, Chapter 12 Physicians/Non-physician Practitioners, Section 30 Correct Coding Policy, Section D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10504.1	Medicare claims processing contractors shall use add-on codes as required below.	X								IOCE
10504.1.1	Medicare claims processing contractors shall adopt edits to assure that Type I add-on codes, except CPT code 99292, are paid only if a listed primary procedure code is also paid to the same provider for the same patient on the same encounter. Pursuant to *Internet Only Manual, Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.12(I) described in the “Background” section of this CR, CPT code 99292 may be paid to a physician who does not report CPT	X								IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	code 99291 if another physician of the same specialty in his group practice is paid for CPT code 99291 on the same date of service. The IOCE will set Reason Code W7106 for Type I add-on codes as a line item denial.									
10504.1.2	The IOCE will set Reason Code W7107 for Type II add-on codes as a line item denial. Contractors shall develop their own list of primary procedure codes for this type of add-on codes and bypass the IOCE edit with an Expert Claims Processing System (ECPS) event. If a contractor does not develop their own list of primary procedure codes for this type of add-on code, the contractor shall bypass the IOCE edit with an ECPS event.	X								IOCE
10504.1.3	The IOCE will set Reason Code W7108 for Type III add-on codes as a line item denial. Contractors may develop their own lists of additional primary procedure codes for this type of add-on code and bypass the IOCE edit with an ECPS event.	X								IOCE
10504.2	Medicare claims processing contractors shall rarely allow, with appropriate submitted documentation, either pre-pay or on appeal, payment for a primary code and add-on code on two consecutive dates of service if the services are appropriately related.	X								IOCE
10504.3	Medicare claims processing contractors shall implement and update the “Add-on Code” edit list on an annual and quarterly basis, as necessary, with new add-on codes and modifications of primary procedure codes for existing add-on codes, within their claims processing systems.	X								IOCE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10504.1	A current listing of Add-on Code tables can be found on the CMS website at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov ((for institutional claims processing questions))

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0