Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Keystone First

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

Add-On Codes

Reimbursement Policy ID: RPC.0007.01CH

Recent review date: 07/2026

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.

Exceptions

N/A

Reimbursement Guidelines

The health plan follows the American Medical Association (AMA) Current Procedural Terminology (CPT) code set, Centers for Medicare and Medicaid Services (CMS) guidance, and applicable state plan requirements for

reporting add-on CPT and HCPCS codes. Under CPT guidelines, add-on codes describe additional intra-service work associated with a primary procedure or service. Add-on codes must be reported in conjunction with the applicable primary procedure or service and must be performed by the same individual physician or other qualified health care professional reporting the primary service or procedure on the same date of service.

Add-on codes are not eligible for reimbursement unless the related primary procedure code is also reimbursed. CPT add-on codes are identified by a "+" symbol and are listed in Appendix D of the CPT manual. These codes may also be described by terms such as "list separately in addition to," "each additional," or "performed at the time of another procedure."

Add-on codes are reimbursable when reported with the appropriate primary service by the same individual physician or other qualified health care professional under the same Federal Tax Identification Number on the same date of service. Add-on codes submitted without the required primary procedure or service are not reimbursable in accordance with CPT and CMS guidelines.

Add-on codes are identified in the CMS Physician Fee Schedule (PFS) with a ZZZ global period indicator.

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) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. The National Correct Coding Initiative (NCCI)
V. https://www.cgsmedicare.com/medicare_dynamic/j15/partb/ptpb/ptp.aspx
VI. https://www.cms.gov/medicare/payment/fee-schedules/physician
VII. Applicable health plans manual reference.
VIII. Commonwealth of Pennsylvania Children's Health Insurance Program guidance.
IX. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date • Replaced the plan name with "the health plan"
07/2026	Reimbursement Policy Committee Approval
06/2026	Biennial review

	• No major changes
08/2025	Reimbursement Policy Committee Approval
08/2025	Annual review • No major changes
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval