CENTENE Corporation

Payment Policy: Duplicate Primary Code Billing

Reference Number: CC.PP.044
Product Types: All
Effective Date: 01/01/2014
Last Review Date: 12/01/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

The American Medical Association (AMA) publishes Current Procedural Terminology (CPT®) guidelines that describe procedures and their appropriate use. The description of some CPT codes limit reporting to once per day, per member, on a single date of service. Instead, the AMA has designated "add-on" codes that should be used to indicate additional units of a service.

The purpose of this policy is to define payment criteria when a primary procedure code is billed in multiple quantities instead of the more appropriate add-on code.

Application

Physician and Non-Physician Practitioner and Outpatient Institutional claims

Policy Description

Certain CPT codes are appropriately billed only once per date of service. A billing error is identified when these primary codes are billed in a quantity greater than one for the same member on a single date of service. When indicated, providers should bill the appropriate add-on code to indicate additional intra-service work associated with the procedure.

Reimbursement

The health plan's code editing software evaluates primary CPT codes and the number of units or service lines billed. If more than one unit of a primary code is billed and there is an appropriate add-on code to report the additional units, the service line is denied and a new line is added with the correct quantity of one. The remaining units are rebalanced to reflect the non-payable codes.

Example

Primary Procedure Code Billed with Multiple Units Versus Add-on Code								
Service Line	**Date**	**Procedure**	**Count**	**Explanation Code**	**Description**	**Charge**	**Allow**	**Deny**
0100	4/19/2006	99291	4	xf	Maximum Units Exceeded	$1,972	$0	$1,972
0200	**4/19/2006**	**99291**	**1**	**92**	**Paid in full**	**$493**	**$216.56**	**$0**
0300	4/19/2006	99291	3	xh	Service line represents denial of additional units billed	$1,479	$649.68	$649.68

1. Code editing software analyzed each service line, the CPT code billed and its description.
2. CPT code 99291 is defined as "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes."

3. A total of 4 units were billed on service line 0100 with a total charge amount of $1972.
4. The software determined that an add-on code should have been used to represent the time spent beyond 74 minutes (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).
5. The software denied service line 0100 with 4 units as the quantity exceeded the maximum units allowed for the procedure. The total charged amount for each unit is $493 ($493 x 4=$1972).
6. As a courtesy to the provider, the software added a new service line to reflect the total number of units allowed (1). The total charge amount for one unit is $493 and the total allowed amount for one unit is $216.56.
7. The total denied amount for the non-payable codes is $649.68.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

References

1. *Current Procedural Terminology (CPT®)*, 2022

Revision History	
11/01/2016	Initial Policy Draft Created
03/10/2018	Reviewed and revised policy; added Add-on codes 81416-0496T
03/30/2019	Conducted review, verified codes, expanded to 0523T, updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual review completed; no major updates required
12/01/2022	Annual review completed; code tables removed since this information can be found in CPT resources

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage,

certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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