Laboratory

Claims Submitted with Add-on codes without Primary Procedure may Deny

Contact Details:
1-800-343-9000
emednyalert@csc.com

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Beginning in December, claims submitted with add-on procedure codes without a primary procedure code may be denied for edit 02134 - Procedure not Substantiated by Previous Service (Deny). You may receive Claim Adjustment Reason Code: B15:

THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.

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.

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)."

More information regarding edits, including possible causes and solutions, can be found at the Edit / Error Knowledge Base Search Tool:
https://www.emedny.org/HIPAA/5010/edit_error/index.aspx

For billing questions, call CSC at 1-800-343-9000.

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