Supplemental diagnosis code submission process

The Centers for Medicare & Medicaid Services (CMS) requires all health plans to submit Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 claims transactions to CMS for Medicare risk adjustment (MRA).

CarePlus has established the supplemental diagnosis code submission process, which uses Current Procedural Terminology (CPT®) code 99499, for healthcare providers who need to submit additional diagnosis codes because of a chart review, system limitation or other submission issues. Please note it is only appropriate to use this process if the patient encounter satisfies the face-to-face requirement, as defined by CMS, for purposes of MRA submission.

Supplemental diagnosis code submission process instructions

Electronic transactions must be submitted using the industry-standard HIPAA X12 837 Health Care Claim format.

Please refer to the following table for specific requirements related to the supplemental diagnosis code submission process.

Professional claim				
HIPAA implementation guide reference	**Loop**	**Segment**	**Description**	**Value**
CLM – CLAIM INFORMATION	2300	CLM02	Monetary amount	0
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK01	Report type code – 09 = progress notes	09
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK02	Report transmission code – AA = available on request at provider site	AA
HI – HEALTH CARE DIAGNOSIS CODE	2300	HI01 – HI12 (as needed)	Diagnosis code information – most current ICD[1] version of code	
HI – HEALTH CARE DIAGNOSIS CODE	2300	HI01-1 – HI12-1 (as needed)	Code list qualifier code – most current ICD qualifier	
SV1 – PROFESSIONAL SERVICE	2400	SV101-2	Product/Service ID (Procedure Code)	99499
SV1 – PROFESSIONAL SERVICE	2400	SV101-7	Description	Supplemental diagnosis (DX) codes
SV1 – PROFESSIONAL SERVICE	2400	SV102	Monetary amount	0
Institutional claim				
CLM – CLAIM INFORMATION	2300	CLM02	Monetary amount	0
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK01	Report type code – 09 = progress notes	09
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK02	Report transmission code – AA = available on request at provider site	AA
HI – PRINCIPAL DIAGNOSIS CODE	2300	HI01 – HI12 (as needed)	Diagnosis code information – most current ICD version of code	

Institutional claim				
HI – PRINCIPAL DIAGNOSIS CODE	2300	HI01-1 – HI12-1 (as needed)	Code list qualifier code – most current ICD qualifier	
HI – OTHER DIAGNOSIS CODE	2300	HI01 – HI12 (as needed)	Diagnosis code information – most current ICD version of code	
HI – OTHER DIAGNOSIS CODE	2300	HI01-1 – HI12-1 (as needed)	Code list qualifier code – most current ICD qualifier	
SV2 – INSTITUTIONAL SERVICE LINE	2400	SV202-1	Product/Service ID (Procedure code)	99499
SV2 – INSTITUTIONAL SERVICE LINE	2400	SV202-7	Description	Supplemental DX codes
SV2 – INSTITUTIONAL SERVICE LINE	2400	SV203	Monetary amount	0
[1]ICD = International Classification of Diseases				

- All diagnosis codes must have been diagnosed in a face-to-face encounter and be supported by the patient's medical record. It is important to note that CPT code 99499 should not be used for additional diagnoses where the original encounter was billed with telephonic E&M codes 99341-99343 or similar audio-only procedure codes.
- The CarePlus member ID, patient name and date(s) of service (DOS) on the supplemental submission must match the CarePlus member ID, patient name and DOS that appeared on the original submission.
- Please do not submit a claim with multiple CPT codes of 99499 in the service lines of the same claim; only one CPT code 99499 is appropriate per claim.

You may submit up to 12 diagnosis codes on a professional transaction or 25 diagnosis codes on an institutional transaction. For more information on HIPAA X12 837 Health Care Claim transactions, please visit the Washington Publishing Company (WPC) site at **http://wpc-edi.com**.

If you have additional questions, please contact your market representative at <insert phone number, hours and days of operation and time zone>.