Submitting Supplemental and Additional Diagnoses

The Centers for Medicare & Medicaid Services’ non-institutional claim form – CMS 1500 – allows 12 diagnoses per Current Procedural Terminology (CPT) line. However, some practice management systems limit the number to fewer than 12.

If your practice management system limits the number of diagnoses, here are some ways you can submit claims so all diagnoses are captured for Risk Adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®)/Stars performance measures. This process can also be used to submit supplemental diagnoses after an original claim for an evaluation and management (E&M) service is billed.

How to Capture All Diagnoses

Submit a second original claim and use procedure code 99080. We can accept either a zero charge or a penny charge on this line. (Some practice management systems don’t allow a zero-billed charge.) If the claim is electronic, use frequency code “0.” This code will deny as incidental to the procedure code submitted on the primary claim, and no payment will apply. Billing with a zero charge needs no reconciliation on the outstanding balance of a penny for providers.

Enter at least one clinical ICD-10 code from the original claim in position one and all additional ICD-10 codes in positions two through 12. Make sure to update your medical record documentation for the additional ICD-10 codes in accordance with CMS guidelines.

Do not submit a corrected claim Frequency Type 7. A corrected claim tells us the original claim was wrong; we’ll recover on the original claim with valid charges and pay the penny claim instead.

When we perform analysis for HEDIS/Stars, Risk Adjustment and other performance reports, our system uses case data and combines all the diagnoses submitted for the care event, not just diagnoses submitted on a single claim.

Important to Remember

All claim submissions, including those for supplemental claims, must be submitted within 180 days of the original E&M service.

If you have a capitated payment arrangement, do not submit date-span claims for office services (Place of Service 11). CMS requires documentation, coding and claim submissions to align to each individual date of service and face-to-face encounter.

The original date of service for which you submit supplemental information must have included an E&M management service CPT code.

¹HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA®).

Florida Blue and Florida Blue Medicare are Independent Licensees of the Blue Cross and Blue Shield Association.

101674 0620