CLAIMS SUBMISSION: PROCEDURE FOR 12+ DIAGNOSIS CODES

For Cigna Medicare Advantage Providers

Form CMS-1500 and the X12-837P transaction (electronic format) allow providers to submit a maximum of 12 diagnosis codes in a single claim to report active chronic and acute diagnoses. However, there are times when you will want to report additional codes. This document explains the procedure to follow.

We encourage providers to submit additional codes, when supported by medical record documentation, because it will give the Centers for Medicare & Medicaid Services (CMS) a more accurate picture of the breadth of services and treatments provided to patients, particularly for complex cases. In addition, it can impact quality reporting for CMS and Healthcare Effectiveness Data and Information Set (HEDIS®) metrics, as well as diagnosis coding for risk adjustment.

Procedure

For 837P submissions, file a claim as you normally would but be sure to include the following:

- Use Current Procedural Terminology (CPT®) code 99499 to populate loop 2400, sub-element SV101-2 of the X12-837P transaction. Populate additional diagnosis codes in loop 2300, HIxx-2 where HIxx-1 equals “ABK” or “ABF.”
- Bill a zero-dollar claim.
- Do not bill any other CPT codes on this supplemental diagnostic data claim.
- Be sure the CLM05-3 Claim Frequency Type Code is set to 1 (original).

Required	CLM05 - 3	1325	Claims Frequency Type Code	O	ID	1/1
			Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type **IMPLEMENTATION NAME:** Claim Frequency Code **CODE SOURCE 235:** Claim Frequency Type Code			

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