Submission of Additional Diagnoses

AvMed is striving to improve collection of critical data to ensure we have complete, valid records of our Members' care history. Using CPT and diagnosis codes for billing and reporting patient conditions for HCC capture and risk coding is industry standard. Some electronic practice management systems have limitations preventing the submission of more than 12 diagnoses codes (in most cases) on the HCFA Claim form in Box 21. Often times Medicare members have more than twelve diagnoses. In order to capture additional diagnosis for CMS, CPT II codes or CPT4 code 99080 is required. Complicating matters even further, the EDI format for clearing house data exchange limits each CPT4 code to four diagnoses. When there are more than four diagnoses, and only one billable procedure code, AvMed requires the use of a CPT II code or code 99080 to capture all critical diagnosis codes. Although there is no remuneration for the CPT II codes or code 99080, this process is considered best industry practice for HCC capture. Instructions below provide a solution to submitting multiple diagnoses codes.

Instructions

1. Use Box 21 (A-L) of the HCFA claim form to include all appropriate diagnoses codes.
2. Use Box 24 to include service lines with a diagnosis pointer referencing codes in Box 21.
   To capture more than four diagnoses, additional procedure codes can be included. Use the procedure codes listed below (see example). Repeat as necessary for additional diagnosis codes.
   - Use same date of service as entered in box 21
   - Use same place of service as entered in box 21
   - Use one of the following procedure codes
     - 1159F – Medication list documented in record
     - 1160F – Review medications by prescribing doctor in record
     - 1111F – Discharged medication/current medication merge
     - 0521F – Plan of care for pain documented
     - 1125F – Amount pain noted pain present
     - 99080 –Special reports or forms
- Point to the corresponding diagnosis in Box 21 as described above for additional diagnosis codes not captured on the original service line.
- Charges should be $0.00, however, if your software requires a dollar amount $1.00 is preferred.

See billing examples on the following page.

Example 1:

(**HCFA Box 21 A-L**) Diagnosis or Nature of Illness or Injury (This example shows 6 diagnoses and one CPT Code. The use of CPT Code 1159F allows the submission of the two additional diagnoses.)

A. 381.81 B. 381.02 C. 478.19 D. 259.4

E. 250.03 F. 719.43 G. _____ H. _____

I. _____ J. _____ K. _____ L. _____

HCFA Box 24:

Dates of Service	Place Of Service	Procedure Code	Modifier	Diagnosis Pointer (24e)	Charges
1/1/2014	11	99212		A B C D	$80.00
1/1/2014	11	1159F		E F	$0.00

Example 2:

(**HCFA Box 21 A-L**) Diagnosis or Nature of Illness or Injury (This example shows 11 diagnoses and one CPT Code. The use of CPT Codes 1159F and 1160F allows the submission of the seven additional diagnoses.)

A. 381.81 B. 381.02 C. 478.19 D. 259.4

E. 250.03 F. 719.43 G. 781.6 H. 250.00

I. 719.47 J. 719.46 K. 719.48 L._____

HCFA Box 24:

Dates Of Service	Place Of Service	Procedure Code	Modifier	Diagnosis Pointer (24e)	Charges
1/1/2014	11	99212		A B C D	$80.00
1/1/2014	11	1159F		E F G H	$0.00
1/1/2014	11	1160F		I J K	$0.00

Electronic Submissions for Previously Processed Claims

To enter additional diagnosis codes for claims previously submitted electronically, please use HCFA Claim Type Indicator on the CLM05-3 segment of loop 2300 (claim level) value 1 (regular). Do not submit the claim electronically as a corrected claim.

For questions regarding this billing initiative, please contact the Provider Service center at (800) 452-8633.

We appreciate your continued participation and the quality of care you bring to our members.