Submitting Claims With More Than 12 Diagnosis Codes

For HealthSpring℠ providers

Form CMS-1500 and the X12-837P transaction (electronic format) allow you to submit up to 12 diagnosis codes in a single claim to report active chronic and acute diagnoses. If you need to report additional codes, follow the procedure outlined below.

When supported by medical record documentation, additional codes give the Centers for Medicare & Medicaid Services a more accurate picture of the breadth of services and treatments provided to a patient, particularly for complex cases. They can also impact quality reporting for CMS and Healthcare Effectiveness Data and Information Set (HEDIS®) metrics, as well as diagnosis coding for risk adjustment.

For X12-837P submissions, file a claim as you normally would but take the following steps:

- Use Current Procedural Terminology (CPT®) code 99499 to populate Loop 2400, sub-element SV101-02 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.
- Check that the CLM05-3 (Claim Frequency Type Code) is set to 1 (original):

Required	**CLM05-3**	**1325**	**Claims Frequency Type Code** 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	**O**	**ID**	**1/1**

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