Florida Blue
Your local Blue Cross Blue Shield

June 2023

Submitting Claims that Capture All Diagnoses

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

If your practice management system limits the number of diagnoses, you can submit a supplemental claim to capture all diagnoses for Risk Adjustment and Healthcare Effectiveness Data and Information Set (HEDIS®[1])/Stars performance measures. You can also use this process 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 claim and use procedure code 99080. We will also accept procedure code 99499 for practice management systems that are unable to submit 99080. We can accept a zero-dollar charge ($0.00), or a penny charge ($0.01) if your system does not allow zero-dollar charges.

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 penny charge needs no reconciliation on the outstanding balance for providers.

Enter at least one clinical ICD-10 code from the original claim in position 1 and all additional ICD-10 codes in positions 2 through 12. Be sure to update your medical record documentation for the additional ICD-10 codes in accordance with CMS guidelines.

All diagnosis codes must have been documented in a face-to-face encounter and be supported in the patient's medical record.

Please do not submit a corrected claim Frequency Type 7 or Type 8. A corrected claim Type 7 tells Florida Blue the original claim was wrong, and a Type 8 claim will void or cancel the original claim.

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, diagnosis coding, and claims 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 include an E&M management service CPT code.

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

Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.
101674 0623R