Supplemental diagnosis code submission process for submitting chart reviews

The Centers for Medicare & Medicaid Services (CMS) requires all health plans to submit Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 claims transactions to CMS for Medicare risk adjustment. However, a healthcare provider may be unable to submit all relevant patient diagnosis codes by limitations or other submission issues.

As a result, CarePlus has established the 99499 submission process to assist the healthcare provider in the submission of additional diagnoses.

This process, and the instructions on the back of this flyer, allow for the inclusion of codes via a single transaction to capture codes from multiple sources. Please see the list below to identify which instructions should be used for each source.

Instructions for submitting chart reviews

Electronic transactions related to chart reviews (i.e., resulting from the review of a medical chart) must be submitted using the industry-standard HIPAA X12 837 Health Care Claim format.

Please see the following page for details regarding encounters generated from a chart review with a face-to-face visit and the information needed for submission.

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On encounters generated from a chart review with a face-to-face visit, please submit the following:

Professional Claim				
HIPAA Implementation Guide Reference	**Loop**	**Segment**	**Description**	**Value**
CLM – CLAIM INFORMATION	2300	CLM02	Monetary Amount	0
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK01	Report Type Code – 09 = Progress Notes	09
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK02	Report Transmission Code – AA = Available on Request at Provider Site	AA
HI – HEALTH CARE DIAGNOSIS CODE	2300	HI01 – HI12 (as needed)	Diagnosis Code Information – Most current ICD version of code	
HI – HEALTH CARE DIAGNOSIS CODE	2300	HI01-1 – HI12-1 (as needed)	Code List Qualifier Code – Most current ICD qualifier	
SV1 – PROFESSIONAL SERVICE	2400	SV101-2	Product/Service ID (Procedure Code)	99499
SV1 – PROFESSIONAL SERVICE	2400	SV101-7	Description	Chart Review
SV1 – PROFESSIONAL SERVICE	2400	SV102	Monetary Amount	0
Institutional Claim				
CLM – CLAIM INFORMATION	2300	CLM02	Monetary Amount	0
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK01	Report Type Code – 09 = Progress Notes	09
PWK – CLAIM SUPPLEMENTAL INFORMATION	2300	PWK02	Report Transmission Code – AA = Available on Request at Provider Site	AA
HI – PRINCIPAL DIAGNOSIS CODE	2300	HI01 – HI12 (as needed)	Diagnosis Code Information – Most current ICD version of code	
HI – PRINCIPAL DIAGNOSIS CODE	2300	HI01-1 – HI12-1 (as needed)	Code List Qualifier Code – Most current ICD qualifier	
HI – OTHER DIAGNOSIS CODE	2300	HI01 – HI12 (as needed)	Diagnosis Code Information – Most current ICD version of code	
HI – OTHER DIAGNOSIS CODE	2300	HI01-1 – HI12-1 (as needed)	Code List Qualifier Code – Most current ICD qualifier	
SV2 – INSTITUTIONAL SERVICE LINE	2400	SV202-1	Product/Service ID (Procedure Code)	99499
SV2 – INSTITUTIONAL SERVICE LINE	2400	SV202-7	Description	Chart Review
SV2 – INSTITUTIONAL SERVICE LINE	2400	SV203	Monetary Amount	0

- Chart review records must be tied to the same member and same dates of service (DOS) as the initial submitted transaction.
- Submit up to 12 diagnosis codes on a professional transaction or 24 diagnosis codes on an institutional transaction.
- Usage of the 99499 for the same member and same DOS can only be used once; otherwise, it will cause a duplicate reject from CMS.

For more information on HIPAA X12 837 Health Care Claim transactions, please visit the Washington Publishing Company (WPC) site at **http://wpc-edi.com/**.

If you have additional questions, please contact your market representative.