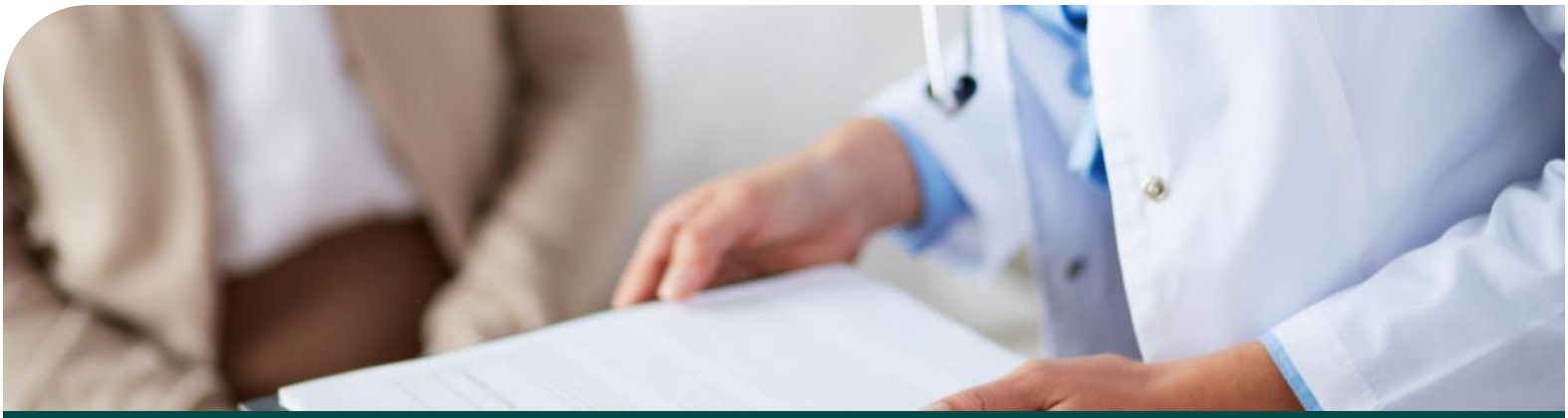

Avoiding Truncation

Report additional diagnoses on claims using CPT code 99499

What's truncation?

Truncation happens when not all diagnosis codes a provider addresses during a patient encounter can be included on a single claim. If all appropriate codes aren't submitted, the claim won't fully show a patient's acute and chronic conditions, leading to an incomplete picture of their burden of illness.

When you need to submit more than 12 diagnosis codes for an encounter, you can submit additional diagnoses using a supplemental claim and billing the **CPT code 99499.**

How to bill CPT code 99499

1. Complete and submit your first claim with the maximum 12 diagnosis codes for your patient. Be sure to bill with an acceptable office visit code (see page 2) and include any necessary supporting documentation
2. Complete and submit a supplemental claim with additional diagnosis codes and bill with CPT code 99499
3. Bill a zero-dollar or penny charge on the claim line
4. Use frequency code "0"
5. Bill with modifier 25
6. To help ensure timely claims processing, add a note to the claim indicating it's a supplemental claim for submitting additional diagnoses

Note: The secondary claim is informational only and can't be used for reimbursement.

Examples of truncation

- Electronic Health Records (EHR) limiting diagnosis submissions
- A limit of 12 diagnoses on the 1500 claim form
- Clearinghouse code cut-off on professional claims

Why submitting accurate documentation matters

- Provides a full understanding of the patient's health
- Ensures accurate reimbursement for providers
- Informs how we coordinate care, including care management and additional resources and supplemental benefits

Approved CPT codes for risk adjustable visits

99202	**99212**	**99381**	**99391**	**99495**
99203	**99213**	**99382**	**99392**	**99496**
99204	**99214**	**99383**	**99393**	**99502***
99205	**99215**	**99384**	**99394**	**G0402**
		99385	**99395**	**G0438**
		99386	**99396**	**G0439**
		99387	**99397**	**99499**

*99502 only applies to ACA individual members. This code links to a home visit for a newborn care assessment.

Note: 99499 can only be used if the primary claim includes one of the above risk adjustable CPT codes.

Best practices for submitting CPT code 99499

- ✓ Ensure the first claim submitted uses one of the above approved CPT codes for disease burden management (DBM) visits
- ✓ When submitting the supplemental claim, 99499 must be the only code billed
- ✓ Ensure the supplemental claim includes the same patient name, provider and date of service as the primary claim
- ✓ All diagnosis codes submitted on provider claims must have documentation for that date of service reflecting the condition was managed, monitored, evaluated, assessed, treated or affected patient care for that visit
- ✓ Bill with modifier 25 to avoid denials related to clinical edits
- ✓ Providers may submit a third claim using the 99499 code, if needed

If you're interested in more education/training on truncation or documenting and coding for risk adjustment, contact your Provider Programs Specialist.