Submission of All Pertinent 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. Complicating matters even further, In some cases, EDI format for clearing house data exchange limits each CPT code to four diagnoses. When there are more than four diagnoses (for those with this limitation), as well as, more than 12 diagnoses and only one billable procedure code, AvMed requires the use of an additional CPT code to capture all critical diagnosis codes. Although there is no remuneration for the CPT code, 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 or 12 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 the following procedure code:
     99487

- 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 $0.01, however, if your software requires a dollar amount $1.00 is preferred.

See billing examples on the following page and attached sample claims.

Example 1:

(**HCFA Box 21 A-L**) Diagnosis or Nature of Illness or Injury when unable to bill more than four diagnoses at a time.

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
09/01/17	11	99212		A B C D	$150.00
09/01/17	11	99487		E F	$0.01

Example 2:

(**HCFA Box 21 A-L**) Diagnosis or Nature of Illness or Injury (This example demonstrates billing more than 12 diagnoses at a time)

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. F1010
M. F19.280 N. F19.931

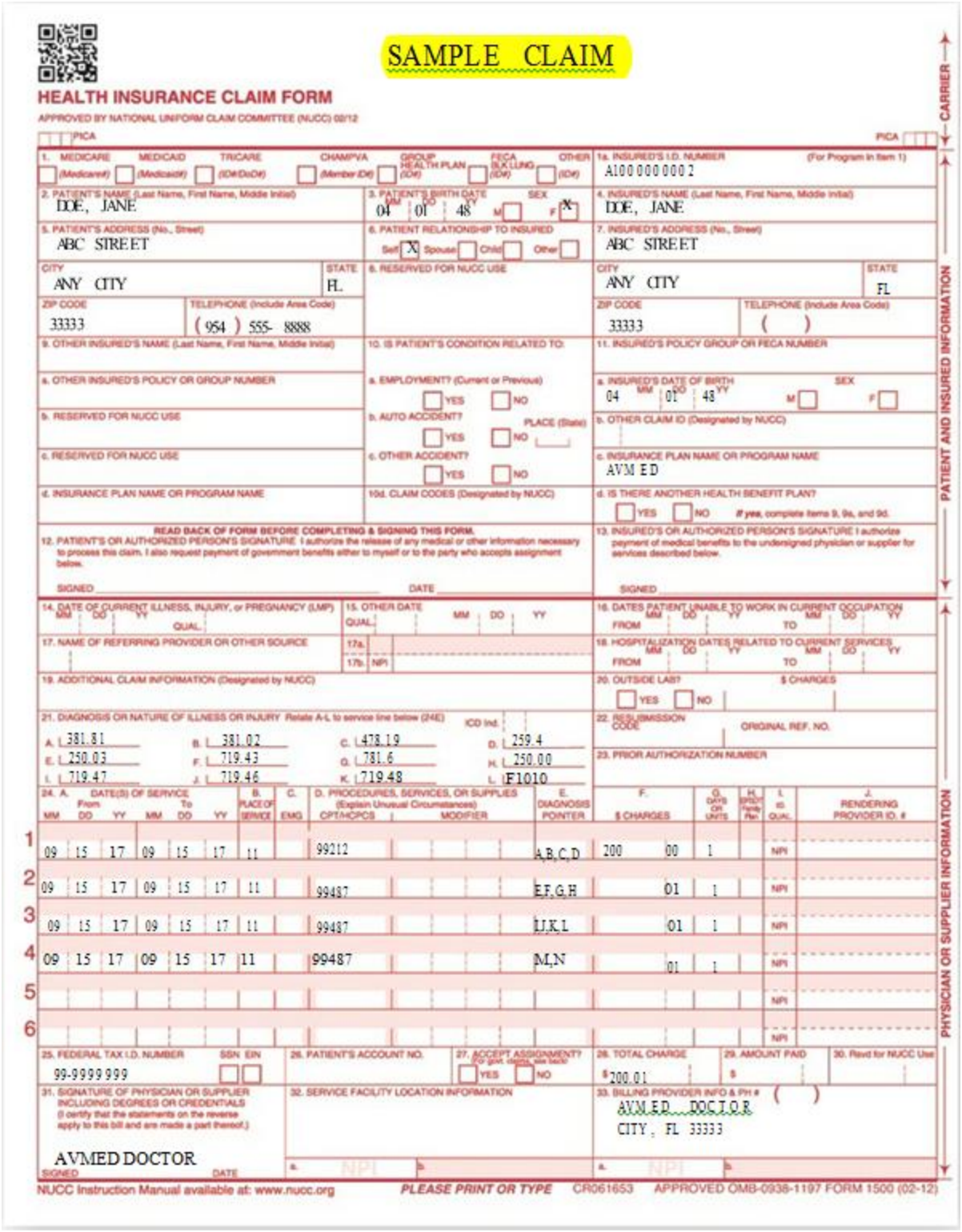
HCFA Box 24:

Dates Of Service	Place Of Service	Procedure Code	Modifier	Diagnosis Pointer (24e)	Charges
09/15/17	11	99212		A B C D	$200.00
09/15/17	11	99487		E F G H	
09/15/17	11	99487		I J K L	
09/15/17	11	99487		M N	$0.01

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.



SAMPLE CLAIM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): A100000002

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

3. PATIENT'S BIRTH DATE: 04 01 48 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE, JANE

5. PATIENT'S ADDRESS (No., Street): ABC STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): ABC STREET

CITY: ANY CITY | STATE: FL.

8. RESERVED FOR NUCC USE

CITY: ANY CITY | STATE: FL

ZIP CODE: 33333 | TELEPHONE (Include Area Code): (954) 555- 8888

ZIP CODE: 33333 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH: 04 01 48 SEX: M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AVMED

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

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. F1010

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 15 17	09 15 17	11		99212		A,B,C,D	200 00	1		NPI	
2 09 15 17	09 15 17	11		99487		E,F,G,H	01	1		NPI	
3 09 15 17	09 15 17	11		99487		I,J,K,L	01	1		NPI	
4 09 15 17	09 15 17	11		99487		M,N	01	1		NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE: $ 200.01

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

AVMED DOCTOR

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

AVMED DOCTOR

CITY, FL 33333

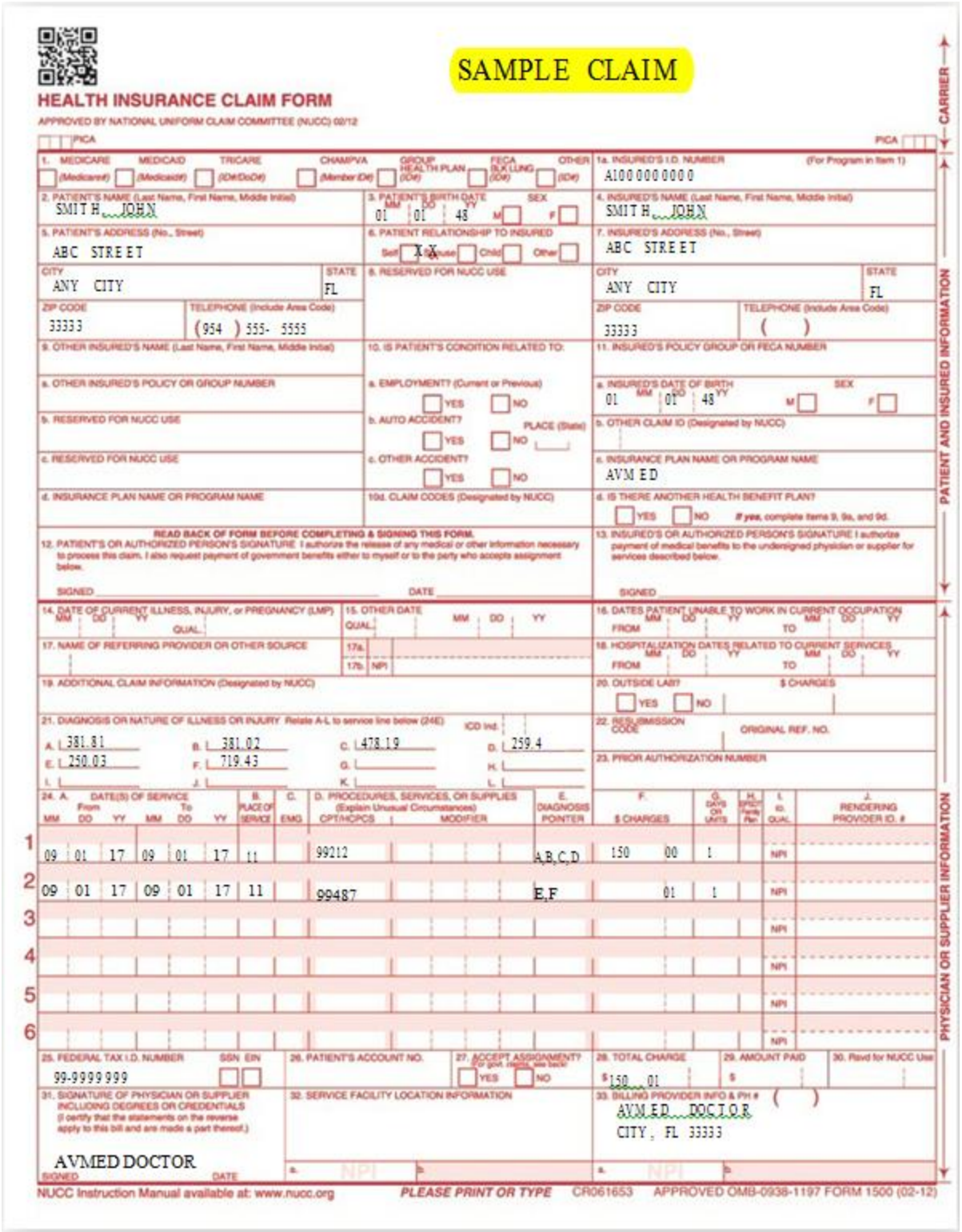
a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



SAMPLE CLAIM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): A100000000

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 48 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SMITH, JOHN

5. PATIENT'S ADDRESS (No., Street): ABC STREET

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): ABC STREET

CITY: ANY CITY STATE: FL

8. RESERVED FOR NUCC USE

CITY: ANY CITY STATE: FL

ZIP CODE: 33333 TELEPHONE (Include Area Code): (954) 555-5555

ZIP CODE: 33333 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY: 01 01 48 SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AVMED

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

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

E. 250.03 F. 719.43 G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 01 17	09 01 17	11		99212		A,B,C,D	150 00	1		NPI	
2 09 01 17	09 01 17	11		99487		E,F	01	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $150 01

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

AVMED DOCTOR

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

AVMED DOCTOR

CITY, FL 33333

a. NPI b.

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