THERAPY NETWORK
A Health Network One Company

Understanding CPT Code 99499 for Supplemental Diagnosis Code Submission

Provider-submitted professional claims are limited to no more than 12 diagnoses on the CMS 1500, and provider-submitted institutional claims are limited to no more than 25 diagnoses.

What you need to know before submitting 99499 claims:

- All ICD-10 codes must be supported in the documentation of a face-to-face visit.
- The 99499 claim should only be used when there is a primary claim with an E&M.
- 99499 claims should only be used when the provider-submitted primary claim contains the maximum of 12 (professional) or 25 (institutional) diagnosis codes; if the maximum number of diagnosis codes was not submitted on the primary claim, use the corrected claim process to submit additional diagnoses instead of a 99499 claim.
- The member name, billing provider, rendering provider, and date of service must match the primary claim.
- Multiple units of 99499 are billable on same DOS.
- No other services should be billed on claim with 99499.
- 99499 claims are not corrected or replacement claims, so frequency codes 6 or 7 would not be needed.
- Modifier 25 is not needed on 99499 claims.
- Bill 99499 claims with zero-dollar ($0.00) charge.
- Please do not submit a claim with multiple CPT codes of 99499 in the service lines of the same claim; only one CPT code 99499 is appropriate per claim.

Supplemental diagnosis code submission process instructions electronic transactions must be submitted using the industry-standard HIPAA X12 837 Health Care Claim format. Please refer to the following table for specific requirements related to the supplemental diagnosis code submission process.

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	PWK01	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	Supplemental diagnosis (DX) codes
SV1 – Professional Service	2400	SV102	Monetary amount	0

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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	PWK01	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 version of code	
HI – Other Diagnosis Code	2300	HI01 – HI12 (as needed)	Code list qualifier code – 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	Supplemental DX codes
SV2 – Institutional Service Line	2400	SV203	Monetary amount	0

[1]ICD = Internal Classification of Diseases