Supplemental Diagnosis Code Submission

Reimbursement Policy ID: RPC.0136.72AC

Recent review date: 01/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines the process for the submission of claims that require additional diagnosis codes above the 12 diagnosis code limitation on the CMS-1500 claim form.

Exceptions

N/A

Reimbursement Guidelines

The health plan has established a process for supplemental diagnosis code submission. Healthcare providers should submit a secondary claim using CPT code 99499 when additional diagnosis codes are needed beyond

the 12 diagnosis code limitation for professional claims. If appropriate, submit remaining diagnosis codes using CPT code 99499 with modifier 25.

Information on Submitting 99499 claims

- Claims using the 99499 submission should only be used when the primary claim contains the maximum amount of diagnosis codes
- The 99499 claim should be billed in addition to the primary claim
- The 99499 claim(s) should be priced at zero charge ($0.00)
- No other service should be billed on the 99499 claim
- 99499 claims are not corrected or replacement claims
- Date of service and rendering physician should match the primary claim
- All diagnosis codes must be supported in the record documentation

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
01/2026	Reimbursement Policy Committee Approval