Add 12 Diagnosis Codes to a Claim

Some payers recognize the need to include more than four diagnosis codes for a procedure on a claim and provide alternate reporting methods. One commonly used method allows up to 12 diagnosis codes for a procedure by adding two more lines of service.

Each procedure code on the encounter can have a maximum of four diagnosis codes, so this method adds two additional service lines and divides the 12 diagnosis codes between the three lines of service. Line 1 has the main procedure code and four primary diagnosis codes. Lines 2 and 3 have additional services performed during the patient visit (e.g., BMI or blood pressure) and the remaining eight diagnosis codes. Note that the two additional procedure codes must be relevant to the patient visit, but they do not need to be associated with the diagnosis codes.

**Note:** This method may not apply to all payers. It’s important to contact the individual payer in advance to verify that this method is accepted.

To Create Additional Lines of Service

1. Enter the main service CPT and four primary diagnosis pointers (in priority order).
2. Enter up to two additional procedure codes related to the patient visit. (e.g., BMI or blood pressure codes) Do not duplicate a procedure code.
3. Add up to four diagnosis pointers for each new line of service.
4. When working in Kareo PM, enter a unit cost of $0.00 for service lines 2 and 3.