

Guide to using penny claims

WHAT IS A PENNY CLAIM?

A penny claim, also called a reporting-only or no-cost claim, is a non-reimbursable claim submitted with a \$0.01 charge to communicate clinical information when there is no billable encounter. Penny claims help ensure important clinical data is captured through the claims system and reflected in the Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare & Medicaid Services (CMS) Star Ratings, and other quality reporting programs.

WHY USE A PENNY CLAIM?

Penny claims can help:

- Capture clinical data obtained outside of an office visit
- Report qualifying exclusions or numerator events
- Improve HEDIS and Stars performance when documentation exists, but no billable encounter occurred
- Ensure data is available for quality reporting in a timely manner
- Reduce missed opportunities when services are completed, but not billed

When used appropriately, penny claims help ensure your clinic receives credit for care that has already been provided and documented.

Important: Penny claims should only be submitted when the underlying service, diagnosis, or clinical activity is appropriately documented in the medical record and complies with payer requirements. Health plans may validate reported information through medical record review or audit processes.

Quality Provider Program measures: Penny claim opportunities

Measure	Documentation requirements	Reporting codes
Controlling Blood Pressure: Many patients monitor their blood pressure at home and share readings with their care team outside of an office visit. When no billable encounter occurs, a penny claim may be used to report a qualifying blood pressure reading that has been documented in the medical record. Clinics may submit a penny claim with the appropriate hypertension diagnosis code and CPT II blood pressure codes.	• Date of the blood pressure reading • Systolic and diastolic values • Source of the reading (home monitor, remote monitoring, etc.)	• Common ICD-10 diagnosis code: • I10 - Essential (Primary) Hypertension • Blood pressure CPT II codes: • Systolic <130 mm Hg: 3074F • Systolic 130-139 mm Hg: 3075F • Systolic ≥140 mm Hg: 3077F • Diastolic <80 mm Hg: 3078F • Diastolic 80-89 mm Hg: 3079F • Diastolic ≥90 mm Hg: 3080F

Measure	Documentation requirements	Reporting codes
Statin Use in Persons with Diabetes: When a member has a qualifying statin exclusion and no billable encounter occurs, clinics may submit a penny claim using HCPCS G9781 along with the applicable exclusion diagnosis code.	• Must clearly identify the qualifying exclusion diagnosis, condition, history, or statin intolerance • The documented condition must support the diagnosis code submitted on the penny claim • Indicate that the exclusion is applicable during the measurement year	• HCPCS G9781 • Applicable exclusion code examples: • Cirrhosis: K70.30, K70.31, K74.3, K74.60, K74.69 • Dialysis: Z91.15, Z99.2 • End-stage renal disease: I12.0, I13.11, I13.2, N18.5, N18.6, N19 • Myopathy: G72.0, G72.89, G72.9 • Myositis: M60.80, M60.819, M60.829, M60.9 • Polycystic ovary syndrome: E28.2 • Prediabetes: R73.03, R73.09 • Rhabdomyolysis: M62.82 NOTE: Pregnancy exclusions include numerous qualifying diagnosis codes. If interested, your QPP representative can provide the complete code set.

While penny claims are commonly used to support quality reporting, they can also be used to support accurate risk adjustment by reporting diagnosis codes that could not be included on the original claim.

Risk Adjustment: Additional diagnosis reporting opportunities

Accurate risk adjustment relies on complete diagnosis reporting. CMS and Select Health encourage providers to report all active conditions that impact a member's care, treatment, or medical decision-making during the encounter.

Because claim forms, clearinghouses, or practice management systems may limit the number of diagnosis codes that can be submitted on a single claim, some active diagnoses may not be reported on the original claim. When this occurs, an additional reporting-only claim can be submitted to ensure all applicable diagnoses are captured.

When to use an additional reporting claim:

- Active diagnoses were addressed during the encounter but could not be included on the original claim
- The number of diagnosis codes exceeds system or claim form limitations
- Diagnosis codes are truncated during claim submission

How to submit the additional claim:

- Submit a second claim using CPT 99499 (unlisted evaluation and management service) as the primary procedure code
 - **NOTE:** This should be the only procedure code reported on the additional claim
- Include all applicable diagnosis codes that were omitted from the original claim

- To ensure the additional diagnosis codes are linked to the original encounter, make sure the additional claim exactly matches the original claim for:
 - Member information
 - Billing provider
 - Rendering provider
 - Date of service (DOS)
- For more in-depth information, reach out to your Risk Adjustment representative

While the processes above are part of the Quality Provider Program (QPP), clinics may also find penny claims useful for supporting other quality initiatives and reporting requirements. The following examples are not currently included in QPP but may provide value depending on a clinic's patient population and quality goals.

Non-QPP quality measures: Penny claim opportunities

Measure	Documentation requirements	Reporting codes
Care of Older Adults: The Care of Older Adults (COA) measure encourages annual assessments that help identify health risks, support medication safety, and improve the overall care of older adult patients. One of the key COA components is the medication review. When the medication review and medication list have been completed and documented, but no billable encounter occurred, a penny claim may be submitted.	• Evidence that a medication review was completed by a prescribing practitioner or clinical pharmacist • A current medication list maintained in the medical record at the time of review	• Medication review code: 1160F • Medication list code: 1159F or HCPCS G8427 NOTE: To receive credit for the COA medication review measure, a medication review code and a medication list code must be billed together.
Transitions of Care: For the Transitions of Care (TRC) medication reconciliation component, a penny claim may be submitted when discharge medications have been reviewed and reconciled with the patient's current medication list following hospitalization, but no billable encounter occurred.	• Complete a medication reconciliation within 30 days of hospital discharge • Document: • The current medication list • The discharge medication list, or documentation indicating awareness of the hospitalization • Evidence that medication reconciliation was completed • The date of the reconciliation	• CPT II: 1111F NOTE: If a qualifying transitional care management visit is billed, a penny claim is generally not needed.

Summary

Penny claims are a simple yet effective way to capture quality-related services, diagnoses, exclusions, and risk-adjustment information when no billable encounter occurs or when additional diagnoses cannot be reported on the original claim. When supported by appropriate documentation, reporting-only claims can help ensure clinics receive credit for the care they provide, improve quality performance, and accurately reflect patient risk.

Note: Reporting requirements, measure specifications, and billing guidance may change over time. Clinics should follow current payer requirements and consult their QPP representative with questions.