Outpatient Facility Coding Alert

Reader Question: Don't Report Ordering Dx Without Addendum

Question: If you've got a report without a diagnosis that meets the CPT® code's Local Coverage Determination (LCD) requirement, but the diagnosis on the order does meet the LCD requirement, can I submit the claim using the ordering diagnosis?

Montana Subscriber

Answer: There are a few points to unpack here. First, you should not submit a claim with a diagnosis that the provider does not document in the dictation report. If the order includes a different diagnosis than what's included in the report's indication, then you should send the report back for an addendum before reporting the ordering diagnosis.

However, if the impression yields significant findings that render the ordering and/or indicating diagnoses insignificant, then you should not include either set of diagnoses. You should not report secondary diagnoses that are considered insignificant or irrelevant separately. With respect to redundancy involving signs and symptoms, have a look at this ICD-10-CM guideline:

- "Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification."

However, according to the following ICD-10-CM guideline, it's up to your discretion if you choose to include signs and symptoms that are unrelated to the underlying diagnosis:

- "Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present."

While the guidelines only make references to signs and symptoms, you should take a similar approach to secondary conditions included in the indication or as an ordering diagnosis. If the ordering diagnosis does not meet these sets of criteria to be included as a primary or secondary diagnosis, you should not go through the trouble of obtaining an addendum to the report.

If ultimately the diagnosis reported does not meet medical necessity per the LCD and Medicare payment denial is expected, then the beneficiary should be issued an Advance Beneficiary Notice of Noncoverage (ABN), form CMS-R-131, prior to the service.