Outpatient Facility Coding Alert

Reader Question: Know How to Handle LCD Non-Covered Dxs

Question: Does Medicare restrict coverage to only the diagnoses listed under the code's Local Coverage Determination (LCD)? If so, are you able to appeal in order to argue medical necessity with a non-covered diagnosis?

California Subscriber

Answer: If you know you are submitting a claim with a diagnosis code that is not covered based on the CPT® code's LCD, you have a few options in place. First, you should have the patient sign an ABN (advanced beneficiary notice) when performing this procedure with a diagnosis not covered under the LCD. This way, should you not be successful in getting Medicare to pay for the procedure, you can bill the patient for the service. When the ABN is signed, you should submit the service with a GA (Waiver of liability statement issued as required by payer policy, individual case) modifier, which tells your Medicare carrier that you have a properly executed ABN on file.

If you submit the claim electronically, you should expect to receive a denial due to medical necessity. Your next step is to resubmit the claim on paper. In doing so, you'll want to take all the appropriate measures to ensure that your Medicare Administrative Contractor (MAC) understands why the diagnosis is medically relevant and necessary to the service it is connected to. This includes a surgical note, a written explanation from the physician, and even peer-reviewed data that backs up your claims. Consider looking to your specialty society webpage for any relevant information.

If you know that you will be submitting a specific, noncovered diagnosis on a regular basis, you should consider submitting a request to your MAC Carrier Advisory Committee (CAC) that the diagnosis be added to the LCD as covered. Just because an appeal is won and the off-LCD diagnosis is paid, note that the LCD will not be changed without going through the CAC and requesting a change.