Urology Coding Alert

ICD-10-CM: Heads Up: Your Diagnosis Choice Can Affect Your Pay

There's more at stake than ever before.

Correctly linking a patient's diagnosis code and corresponding CPT® code on claims ensures you get paid fairly for the procedures you perform, but that's not the sole purpose of ICD-10. Now, diagnosis coding - and specifically, coding comorbidities - has a far-reaching impact thanks to the shift toward value-based reimbursement.

Be careful: The ICD-10-CM code(s) you choose at each patient visit will have a lasting effect on your revenue. And since comorbidities can be quite common for patients your urologist sees, be conscientious about every nuance of the diagnoses you assign.

MIPS Ramp-Up Means Details Are Needed

Gone are the days when diagnosis coding is over and done within 30 days when your claim gets paid, according to **Matthew Menendez**, a Health Information Technology expert at White Plume Technologies in his recent Webinar. Instead, diagnosis coding "is going to have a two-year tail on it," states Menendez. That's because the diagnosis is used to determine risk-adjusted payments and to establish providers' target scores for the resource use and quality categories in the Merit-based Incentive Payment System (MIPS) program.

MIPS is still in its infancy, and only a relatively small percentage of providers currently have risk-based payer contracts (you are more likely to have one if you're hospital-based or a member of an accountable care organization [ACO]). But that doesn't mean you can continue coding the same way you have been under fee-for-service.

Ramp up: "You have an opportunity to make a big impact in value-based reimbursement transparency by doing two things," says **Kelly Loya, CPHT, CPC-I, CHC, CRMA**, managing director at Pinnacle Enterprise Risk Consulting Services. "First, you need to make sure your physicians are ... describing in their documentation, the patient's comorbid conditions, how they are treating them, and the effects the treatments are having," says Loya. "Even more importantly, you need to be consistently coding those comorbidities on your claims when they are documented."

If you're reporting only the current diagnosis your surgeon is actively treating without documenting comorbidities that impact care and outcomes, you are not accurately reflecting the "disease burden" of your patients. That means you're setting yourself up for future failure based on the following three ways that payers are starting to use diagnostic data.

Diagnosis Codes Are Tied to Risk-Adjusted Payments

Government and private payer programs are increasing their use of "risk-adjusted" payment models to determine physician pay. Risk adjustment is a way of accounting for the fact that some patients are sicker than others, and that there may be conditions out of the physician's control that affect the cost of care and quality of outcomes.

Example: Your surgeon performs a radical prostatectomy for patients A and B for carcinoma of the prostate. However, Patient B has a BMI >40 - he is morbidly obese. He also has type 2 diabetes mellitus with hypoglycemia, and suffers from rheumatoid arthritis.

In a fee-for-service payment model, you would be paid the same reimbursement for each of these patients. You would list carcinoma of the prostate, C61 (Malignant neoplasm of prostate), as your diagnostic code to demonstrate medical necessity for the radical procedure.

In a risk-adjusted contract, payers determine your payment based on the patient's expected healthcare costs. In addition

to the diagnosis the surgeon is actively treating, the payer considers comorbid conditions that impact the severity of illness (SOI) and patient risk. To go back to the previous example, Patient B would yield higher reimbursement than Patient A because documentation shows that Patient B is sicker.

Warning: If you are not completely coding all of a patient's comorbid conditions, your payers may underestimate expected healthcare costs and penalize your surgeon with lower pay warranted for a healthier patient.

Diagnosis Codes Play Into MIPS Scores

Risk-adjusted payer contracts are not the only place you will encounter the need for complete diagnostic coding. Under Medicare's new MIPS program, you can earn bonus payments by keeping quality high and costs low, as compared to your peers.

Going back to the example, patient B's care is likely to cost more, take more time, and have more complications. If you omit comorbid conditions from your claim, patient B will appear "average" in condition, but high in cost and low in quality, thus dragging down your Quality and Resource Use MIPS category score and penalizing your pay.

Do this: Report diagnosis codes for patient B's comorbid conditions to inform Medicare **of** the expected higher cost of care due to higher patient SOI.

Check Out Website That Shares Quality and Cost Data

CMS's Physician Compare website is intended to help Medicare beneficiaries "make informed choices about the healthcare they receive through Medicare." The idea is to steer patients toward providers with higher quality ratings and lower cost ratings. Of course, it's not just your Medicare patients who can view the data - it's publicly available.

Bottom line: If you aren't coding a patient's comorbidities, your cost and quality data will be unfairly skewed. With each claim you file, "you are supplying payers with mounds of data, and they are analyzing that data," Menendez says. Make sure it's the right data.