Catheters and PCS Coding
By Mary Chelucci, RHIA, CCS

Can you name 3 different types of catheters and what their purpose is?

Catheters have many uses and many functions in medicine. When we used to code them in ICD 9, there was a limited number of codes to use and we really didn’t have to know the purpose or intent of the procedure. Some of the time you didn’t even need to know the body part either. It was easy to have certain codes memorized and use them without truly thinking about it. Now, in ICD 10, there are a large number of codes used for catheter insertion and you must know the intent of the procedure as well as the location placed in order to capture the correct PCS code.

Here are some of the common reasons (purposes) for catheters with examples:
- Infusion (for example: a PICC)
- Dilation (for example: a PTCA catheter)
- Measurement/Monitoring (for example: a Swan Ganz catheter)
- Drainage (for example: a suprapubic catheter)

Knowing the intent and purpose of a catheter as well as location makes coding in PCS much easier. When looking in the Index of the ICD-10-PCS book under “Catheterization”, you are directed to:
- “see Dilation”
- “see Drainage”
- “see Insertion of device in”
- “see Irrigation”
- “Heart, see Measurement, Cardiac”
- “Umbilical vein for infusion”

Not knowing the reason the catheter is being inserted makes coding this in PCS almost impossible.

If, for example, you want to code a Foley catheter insertion, you must know that the intent of the procedure is to drain the bladder. This directs you to the Root Operation of Drainage and the Body Part of bladder.

Some PCS codes also require you to know the “resting” place (ie: where the catheter ends). This is the case in CVC or PICC lines. You may need to view an xray report to find this information if the provider doesn’t document it.

Providers must also tell you their approach when inserting the catheters since they can be inserted Open, Percutaneous or Percutaneous Endoscopic.

Knowledge is key as well as good documentation. Think about why the provider is inserting the catheter and where this catheter is located. Query if you are unsure. Bone up on the different types of catheters and why they are used. Coding Clinic also has some excellent references about Catheters and coding them in PCS. Good documentation as well as good knowledge makes for excellent codes.

Mary Chelucci, RHIA, CCS, has been in HIM for 30 years. She has worked as a Coder, Trauma Registrar, Medical Records Supervisor and Medical Records Coordinator for Acute Care Hospitals and one Outpatient Clinic. (all in the Bay Area of California). Mary is also an AHIMA approved Train the Trainer, and has been with RMC since December of 2013.
Hierarchal Condition Category (HCC) coding plays an increasingly important role in today’s ever-changing world of insurance benefits and reimbursement. With the creation of the Affordable Care Act (ACA), HCC code capture is no longer only for Medicare Advantage plans.

**What is Risk Adjustment?**
Risk adjustment payment methodologies mean that insurance companies receive additional reimbursement for the illness burden of a particular patient rather than for quantity of services rendered. Some health plans in turn share this increased revenue with providers. Payments for HCC capture are paid prospectively, so diseases captured this year in 2016 won’t be paid until 2017.

**Risk Scoring**
ICD-10-CM codes are translated to one of 79 HCC categories. Not all diagnoses are included in risk scoring, typically the diagnoses involved will be chronic diseases that are costly to care for. For example, diabetes, CHF, COPD, malignant neoplasms, etc. Most acute conditions are not part of risk scoring calculations because they are less costly. However, there are some acute conditions like CVA, MI, hip fracture that are included in the plan. Each diagnosis must only be documented and reported once per year to be included in risk scoring.

**Provider Documentation**
Official ICD-9-CM and ICD-10-CM guidelines state that accurate coding cannot be achieved without clear, consistent, complete documentation in the medical record.

Guidelines further instruct to: Code all documented conditions that exist at the time of the encounter, and require or affect patient care, treatment or management. A simple list of problems or diagnoses is not acceptable documentation. Documentation must prove that the patient’s condition(s) were monitored, evaluated, addressed and treated. Additionally, compliant documentation must be legible and include a patient name, date of service and provider signature.

**How to ensure proper HCC capture**
ICD-10 brought us increased code specificity and increased requirements for detailed documentation. Work with your providers to make sure that they understand what is required with codes that they commonly use. Make sure that manifestations of certain diseases are not overlooked. For example, when coding diabetic nephropathy (E11.2X), make sure to follow your coding notes and also capture the CKD code (N18.X). Additionally, we see all too often that chronic conditions are not assessed, addressed because the patient only comes in for a specific minor complaint. Chronic conditions that might be managed by a specialist, get completely left out of the PCP documentation. Make sure that your providers are assessing chronic conditions at least once a year as pertinent, so that documentation can be coded for capture of these conditions.

Many times status codes are left off of billings and/or these diagnoses are never assessed. History of amputation, ostomy status, transplant status and dialysis status are all commonly left out of provider assessments. Another commonly forgotten diagnosis is alcoholism; even if in remission, this should be documented when it affects the care of the patient, so that it is codeable and captured.

If it isn’t documented we can’t code it, so ongoing documentation improvement is of utmost importance. RMC offers a wide variety of coding, auditing and education services. If you are interested in knowing more please let us know!

*Monique Vanderhoof, RHIT, CPC, CCA, CRC joined RMC in 2011, and is the Manager of Coding Services. She has over 15 years of experience in health care as a Coding Manager and a Clinic Manager with extensive experience working in outpatient physician settings with an expertise in cardiology. Her skills also include EHR implementation, HIPAA, eRx and Meaningful Use readiness and attestation. Ms. Vanderhoof is an AHIMA approved ICD-10 trainer and is dedicated to preserving coding quality by leading coding education presentations.*
Let’s get back to the basics and review some conditions of the vertebra and their ICD-10-CM codes.

Myelopathy is a condition of the spinal cord, which causes disruption of the normal transmission of neural impulses. Myelopathy can be the result of a traumatic injury, viral illness or degenerative changes of the spine. Symptoms include pain, numbness, tingling or weakness along the course of the nerve. Myelopathy codes to G95.9, however if the myelopathy is due to intervertebral disc disorder/degeneration or displacement of the intervertebral disc, the ICD-10-CM index links the disc disorder with the myelopathy and codes would fall into the M50.xx, M51.xx or M53.x code series.

Another condition of the vertebra is radiculopathy. Radiculopathy is caused by nerve root impingement and/or inflammation. This can be the result of a herniated disc, arthritis, spondylolisthesis or trauma. Radiculopathy is most common in the low back and in the neck. Radiculopathy codes to M54.1x, however if the radiculopathy is due to a disc disorder of the cervical spine the index refers to M50.1x codes, and due to displacement of intervertebral disc, the ICD-10-CM index links the disc disorder with the radiculopathy to M50.xx, M51.xx or M53.x.

Disc herniation refers to a disc that has been displaced from its normal position. This can also be referred to as a prolapsed or a bulging disc. Disc herniation occurs when the nucleus pulposus of the disc pushes against or through the outer annulus fibrosus, which then places pressure on the spinal canal and/or nerve roots. Symptoms can include pain, numbness or muscle weakness. Some of the most common causes of disc herniation include lifting, twisting, pulling or bending injuries, but it can also be due to the aging process. Disc herniation codes to displacement of the intervertebral disc at M50.xx, M51.xx or M53.x, but also provides codes when linked with myelopathy, radiculopathy or sciatica (as above).

Degenerative disc disease is due to shrinkage and wear and tear of the intervertebral discs that occurs with age. The disc structure changes and becomes less elastic, the discs collapse, which causes the facet joints to rub together and ends up causing pain. Degenerative disc disease codes to M50.xx or M51.xx, but also provides codes when linked to myelopathy, radiculopathy or sciatica (as above).

Osteoarthritis is another condition of the spine. This is also known as degenerative joint disease (DJD), which is degeneration of the cartilage between the facet joints. This includes osteophyte formation (bone spurs) on the facet joints. There is no cure for osteoarthritis or DJD of the spine, only symptom control. Symptoms include pain, stiffness and swelling. Osteoarthritis codes to spondylosis via the ICD-10-CM index at M47.9. The index also provides a link between osteoarthritis/spondylosis with or without myelopathy or radiculopathy at M47.xx.

Spinal stenosis is also known as disc space narrowing, which creates pressure on the spinal nerve roots and on the spinal cord. Spinal stenosis is caused by aging, arthritis, trauma or heredity. Some common treatments of spinal stenosis include medications such as NSAIDs, rest or surgery such as a laminectomy, which treats the symptoms of pain, numbness and weakness in the legs. Stenosis codes to “intervertebral” (between the vertebrae) at M99.7x, and multi-level stenosis codes to M48.0x.

Finally, there is sciatica. This is a condition that is caused by irritation of the nerve root, which is the result of herniation or degeneration of the intervertebral disc, spinal stenosis or sacroiliac joint dysfunction. Pain from the sciatic nerve radiates from the buttock, down the leg, and can travel down as far as the feet and toes. There are different treatments for sciatica which include heat/ice, medication, epidural steroid injections, massage, chiropractic or acupuncture treatment. The index links sciatica with low back pain and codes to M44.4x, with low back pain due to intervertebral disc disorder to M50.xx, M51.xx and M53.x, and wallet sciatic codes to M54.3x. In the index, sciatica due to intervertebral disc displacement refers the coder to see disorder, disc, with radiculopathy.

Although not an all-inclusive list of all of the spinal conditions that can be responsible for back pain, hopefully this review of the most common conditions is helpful!

Jennifer Jones, CCS has 26 years of experience in the Health Information Management field. She has been a Certified Coding Specialist for 13 years, but has also worked as a Clinical Documentation Specialist, Manager of Coding Services, Medical Transcriptionist, Medical Assistant, Medical Biller, and Medical Receptionist. She has worked in hospitals ranging from a 25-bed Critical Access Hospital in Oregon to a 400-bed Community Hospital in Florida, and physician offices throughout Oregon, Washington and California. She has been pursuing education in the nursing field to help further her coding skills. Jennifer joined RMC in 2009 and currently is the Manager of Coding Services for RMC.
HIPAA Myth Scenario
Two Covered Entities are co-located. Covered Entity 1 asks the following of Covered Entity 2:
“Part of the Omnibus Rule requires that we review all business associate agreements, and that we have a thorough understanding of all non-covered entity personnel who will have access to the facility where we are co-located. The after hours janitorial staff falls into this category. I am assuming your organization has a process in place for background checks already (as it is required for HIPAA) for vendor employed janitorial staff present after hours.”

Mythbuster Question
Does HIPAA actually require that background checks be conducted on contracted janitorial staff? Background checks are run for all employees, but I didn’t know that this was a HIPAA requirement.
Also, is a general confidentiality agreement the “best practice” for janitorial staff?

HIPAA Truth
HIPAA requires a workforce clearance process that could include background checks, but background checks are not regulatorily required even for your workforce. It’s a good idea to have a contract similar to a BAA with your janitorial company and it’s a good idea to ask them to sign in. Per early guidance from OCR, janitorial companies aren’t business associates but with the advent of the Omnibus Rule, it’s wise to assess whether you think contracted janitorial staff potentially have access to or can view PHI. If you believe they do have access or can view PHI, they are your business associate and a business associate agreement should be executed with your janitorial vendor. As with any other vendor, the janitorial service vendor would be responsible for running background checks on their employees if they do need to be conducted. However, this is not a HIPAA requirement.

Word to the Wise
It may be Covered Entity 1’s business practice to run background checks on janitorial service employees. That would need to be limited to those who are employees of Covered Entity 1. If Covered Entity 1 requires background checks of vendors who will be onsite, they can require it by contract, but the vendor would be the entity to run the background checks, not Covered Entity 1. I do think it’s smart to require that any vendor employee who is onsite at Covered Entity 2 sign a confidentiality agreement, even though it’s not a HIPAA requirement.

Chris Apgar, founder of Apgar & Associates is a Certified Information systems Security Professional (CISSP). He is one of the country’s foremost experts and spokespersons on healthcare privacy, security, regulatory affairs, state and federal compliance and secure and efficient electronic health information exchange. Chris has more than 19 years of experience in regulatory compliance and is a leader of regional and national privacy, security and health information exchange forums. As a member of Workgroup for Electronic Data Interchange, and serving on the Board of Directors since 2006, Chris is an honest, reliable, trustworthy expert in the field of privacy and security. Email capgar@apgarandassoc.com for more details.

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Camille Walker: cwalker@rmcinc.org or Kristin Gibson: kristin@rmcinc.org