Basic Coding for Oral and Maxillofacial Surgeons

Online Course 2012
About the Speaker

Dawn W. Jackson, DrPH, RHIA, CCS-P, FAHIMA
Ms. Jackson is a Professor and the Program Director for the Health Services Administration program at Eastern Kentucky University. She obtained her bachelor’s degree from East Carolina University (Greenville, NC) in Medical Record Administration, her master’s degree from Eastern Kentucky University (Richmond, KY) in Allied Health Education, and her doctor of public health degree in Health Services Management from the University of Kentucky (Lexington, KY).

Her areas of expertise include: healthcare reimbursement systems, coding and billing processes, medical law, and health care management. As a certified coding specialist, Ms. Jackson has trained physicians and their staff for over 20 years. Of particular significance, she has been presenting coding courses for the American Association of Oral and Maxillofacial Surgeons for over 16 years.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided to you in this course is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by you or anyone else in reliance on the information contained in this course. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisors.
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Background Information of ICD-9-CM

What is Coding?

Coding is the process of assigning numeric codes representing a diagnosis, service, or procedure. In an oral and maxillofacial surgery office, the following coding systems are used when filing claims to a medical insurance company.

ICD-9-CM

International Classification of Diseases - 9th Revision - Clinical Modification

CPT

Current Procedural Terminology

CDT

Current Dental Terminology

HCPCS Level II

Healthcare Common Procedure Coding System, Level II – National Codes

History of ICD-9-CM

17th Century  

London Bills of Mortality - Developed by John Graunt, this system attempted to identify the proportion of children who died before reaching six years of age. It was the first real attempt to study disease from a statistical point of view.
1837  William Farr performed groundwork for *International List of Causes of Death.*

1893  Dr. Jacques Bertillon developed *Bertillon Classification of Causes of Death.* This classification system was adopted by the American Public Health Association and was to be updated every 10 years.

1900  The first revision (second edition) was in 1900 in Paris. The name was changed to *International Classification of Causes of Death.* This revision is considered to be the first edition of *International Classification of Diseases.*

1948  In 1948, the sixth revision was completed by the World Health Organization (WHO). The title was changed to *International Statistical Classification of Diseases, Injuries, and Causes of Death (ISC).* This edition included morbidity in addition to mortality.

- **Morbidity:** a diseased state (cause of illness)
- **Mortality:** death (cause of death)

1956  The American Medical Association and the American Health Information Management Association (then the American Medical Record Association) carried out a pilot study comparing ISC with Standard Nomenclature of Diseases and Operations (SNDO). ISC only permitted the coding of diseases. Hospitals needed a coding system for coding procedures as well as diseases. It was determined that ISC could accomplish the goal if modifications were made.

1958  **International version** - (Seventh revision) *International Classification of Diseases* was published by WHO.

ICD was (and still is) sufficient in some countries for hospital coding. However, some countries began to modify the standard ICD publication to increase specificity.

The United States was one of these countries. Based on the 1956 pilot study, an adaptation was developed for use in the USA.
1959  In 1959, the *International Classification of Diseases, Adapted for Indexing of Hospital Record and Operation Classification* (ICDA) was published by the U.S. Public Health Service for use in the United States.

1968  **International version** - (Eighth Edition) ICD-8 was published by WHO.

**United States’ version** - In the same year, the U.S. Public Health Service revised and published ICDA-8.

1978  **International version** - ICD-9 was published by WHO for world-wide use.

**United States’ version** - ICDA-8 was also revised and published under the title of *International Classification of Diseases, 9th Edition, Clinical Modification*.

1988  The Medicare Catastrophic Coverage Act of 1988 requires providers to submit a diagnosis code on claim forms in order to receive reimbursement.

1993  **International version** - ICD-10 was adopted by WHO. The international version was released for use in 1999.

2009  **United States’ version** – In January the final rule on adoption of ICD-10-CM and ICD-10-PCS was published. It specified an anticipated implementation date of October 1, 2013. AAOMS will be offering training over the next couple of years.

**Implementation of ICD-10-CM**

The 2012 version of ICD-10-CM is available for public viewing at the National Center for Health Statistics’ website (http://www.cdc.gov/nchs/icd/icd10cm.htm). However, the codes in ICD-10-CM are not currently valid for any purpose or use.

According to the final regulation published in January 2009, the implementation date for ICD-10-CM is October 1, 2013. AAOMS will be offering educational training in the future to assist you in your preparation.
ICD-10-CM Structural Changes

When compared to ICD-9-CM, ICD-10-CM will undergo significant structural changes. A few of the more obvious changes include the following.

- **Alphanumeric format**
  
  All codes in ICD-10-CM have a letter for the first character followed by numbers.
  
  K13.1 Cheek and lip biting
  K13.4 Granuloma and granuloma-like lesions of oral mucosa

- **Fourth, fifth, and sixth characters**
  
  To add specificity, ICD-10-CM will have up to six characters.

- **Laterality**
  
  ICD-10-CM adds specific codes representing laterality (i.e., left, right, bilateral). However, laterality has not been assigned to all potential cases. The majority of codes affected by this modification are found in the Neoplasm and Injury chapter.

- **Expansion of Injury Codes**
  
  ICD-10-CM will permit the identification of the injury, site, size, and laterality.

- **Combination Codes**
  
  Some common manifestations and complications have been combined with the etiology into one code. There has always been confusion as to the sequencing or use of two codes when a patient’s condition is stated as “XYZ due to ABC.” These combination codes should reduce coding errors in these situations.

- **Movement of Categories**
  
  A major modification for oral and maxillofacial surgeons is the fact that codes representing dentofacial anomalies and jaw disorders have been moved from Diseases of the Digestive System to Diseases of the Musculoskeletal System and Connective Tissue.
Purposes of ICD-9-CM

ICD-9-CM is based on the World Health Organization’s (WHO) *Manual of the International Classification of Diseases, Injuries, and Causes of Death* (ICD-9). ICD-9-CM is a statistical classification that was expanded in the United States to include the coding of clinical diagnoses (morbidity). It also includes a procedure classification, which is found in Volume III.

ICD-9-CM is used for two main purposes. First, ICD-9-CM has been traditionally used by healthcare facilities and government agencies to assign codes to diagnoses, symptoms, and procedures for statistical purposes.

- Identifying patterns of diseases (trends),
- Forecasting health care needs,
- Conducting epidemiological studies,
- Analyzing physician practice patterns, and
- Assessing the quality of patient care received in hospitals and nursing facilities.

Second, ICD-9-CM is required for billing most third-party payers (insurance companies) for health care services rendered. Diagnosis codes identify the need for health care services and procedure codes identify the health care services rendered.

*Note:* Hospitals use all three volumes of ICD-9-CM. Volumes I and II represent diagnoses and Volume III represents procedures. Most outpatient settings only use Volumes I and II. Procedures in outpatient settings are assigned CPT codes, which are maintained by the American Medical Association.

Cooperating Parties

The parties responsible for establishing and approving ICD-9-CM coding guidelines and policies include:

- the Centers for Medicare and Medicaid Services (CMS),
- the National Center for Health Statistics (NCHS),
- the American Health Information Management Association (AHIMA), and
- the American Hospital Association (AHA).
Updating ICD-9-CM

ICD-9-CM is published annually and updated two times per year, April 1 and October 1. Codes can be added, revised, or deleted. The changes are printed in an Official Authorized Addendum. These addenda are published with the approval of the World Health Organization by the National Center for Health Statistics and the Centers for Medicare and Medicaid Services (CMS).

The National Center for Health Statistics is responsible for maintaining diagnosis codes (Volumes I & II) and CMS is responsible for procedure codes (Volume III).

Due to the 2013 implementation of ICD-10-CM, a partial freeze of ICD-9-CM and ICD-10 is now occurring as follows.

- The last regular, annual update to both ICD-9-CM and ICD-10 code sets was made on October 1, 2011.

- On October 1, 2012, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases.

- On October 1, 2013, there will be only limited code updates to the ICD-10 code sets to capture new technologies and diseases. There will be no updates to ICD-9-CM, since it will no longer be used for reporting purposes.

- On October 1, 2014, regular updates to ICD-10 will begin.

- On October 1, 2014, regular updates to ICD-10 will begin.
Format and Structure of ICD-9-CM

Format

ICD-9-CM has three volumes:

- **Volume I:** *Tabular List of Disease and Injuries*
- **Volume II:** *Alphabetic Index for Disease and Injuries*
- **Volume III:** *Tabular List and Alphabetic Index for Procedures*

Doctors’ offices utilize Volumes I & II of ICD-9-CM to report diagnosis codes to insurance companies. Volume III (Procedure Manual) is only used by hospitals when reporting procedures performed on an inpatient basis.

Since doctors’ offices only use ICD-9-CM diagnosis codes, only Volumes I and II will be covered in this course.

Volume I (Tabular List)

Coding Specificity

Volume I (Tabular List) is structured to provide subdivisions consisting of the following components.

- **Chapters**
  (There are 17 chapters in ICD-9-CM. Turn to the Table of Contents of Volume I to review these topics.)
- **Sections:** *Groupings of 3-digit categories*
  (Chapters are divided into groupings of related 3-digit categories)
- **Categories:** *3-digit codes*
- **Subcategories:** *4-digit codes*
- **Subclassifications:** *5-digit codes*
To familiarize yourself with these components, take the time to review the following portions of Volume I.

**Step 1**

*Turn to category 520 in the Tabular List. This is the first category in Chapter 9. Above the category title, you will see both section and chapter titles. Chapter 9 is divided into seven sections – or seven groups of related conditions.*

*Chapter: Diseases of the Digestive System (520-579)  
Section: Diseases of Oral Cavity, Salivary Glands, and Jaws (520-529)*

**Step 2**

*Turn to category 524 in the Tabular List. This category will provide you an opportunity to view categories, subcategories, and subclassifications.*

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Subclassification</th>
</tr>
</thead>
<tbody>
<tr>
<td>524</td>
<td>&quot;Dentofacial anomalies, including malocclusion&quot;</td>
<td>524.0 Major anomalies of jaw size</td>
</tr>
<tr>
<td></td>
<td></td>
<td>524.00 Unspecified anomaly</td>
</tr>
</tbody>
</table>

**Note:** In the official version of ICD-9-CM, codes that require a fifth digit will be preceded by a section mark ($\$\$). However, commercial publishers will commonly develop their own method of alerting coders to the need for a fifth digit. This could include having the code highlighted in a special color or adding a unique symbol next to the code. Normally, a legend is provided explaining the different notations seen within the coding book.

**Exercise 1**

For each of the following, label the code as being a category, subcategory, or subclassification.  
*Note: This does not require the use of the coding book.*

1. 524.10 _____________________________
2. 830 _____________________________
3. 823.1 _____________________________
4. 524.09

5. 523.8

Impact on Coding

Fourth and fifth digits provide specificity or more information regarding etiology (cause of disease), site (location), or manifestation (resulting condition of the underlying disease).

When a category has been divided into subcategories, the 3-digit category code is no longer considered valid. Likewise, when a subcategory code is divided into subclassifications, the 4-digit subcategory code is no longer valid. Coders are required to assign a code from the most specific level available within the category.

When coders submit invalid codes to an insurance company, the associated claims will be rejected resulting in delayed payment.

Exercise 2

Look up each of the following in the Tabular List to determine their validity. Place a check mark beside those that are NOT valid ICD-9-CM codes.

Example: 524.04 Mandibular hypoplasia (This is a valid code. It does not need an additional digit)
          524.5 Dentofacial functional abnormalities (This is an invalid code. Subcategory 524.5 has been assigned 5th digits. As such, 524.5 is incomplete or invalid.)

_____523  Gingival and periodontal diseases
_____524.3  Anomalies of tooth position of fully erupted teeth
_____524.73  Alveolar maxillary hypoplasia
_____486  Pneumonia, organism unspecified
Residual Subcategories

Whenever possible, residual subcategory codes have been assigned to classify those conditions not given a separate title within the category. The codes are usually represented with a .8 (other) or a .9 (unspecified). These codes are to be used when a more specific subcategory or subclassification code is not available.

- **527.8** Other specified diseases of the salivary glands
- **527.9** Unspecified disease of the salivary glands

Volume II (Alphabetic Index)

Structure

The Alphabetic Index consists of the following components:

**Main Terms:** Main terms are arranged by condition rather than an anatomical site. These codes appear in bolded print in the Alphabetic Index.

**Subterms:** Subterms are modifiers that allow for specificity in the assignment of codes. All subterms should be scanned before assigning codes.

> Locate the main term “Atrophy” in Volume II – Alphabetic Index. Review the subterms listed under “Atrophy” until you find “gum”.

**Gum Atrophy** 523.20

Notice that the subterms under “Atrophy” represent both sites and specific types of atrophy.
Additional Major Portions

In addition to the standard Alphabetic Index to Disease, Volume II also contains the following:

Table of Drugs and Chemicals

The Table of Drugs and Chemicals is located toward the back of the Alphabetic Index. The table includes poisoning codes (categories 960-979) and five columns of various E codes. These E codes represent Accident, Suicide, Assault, or Undetermined poisonings. An additional column of E codes represents Therapeutic Use. Therapeutic Use E codes are only used when coding adverse reactions to drugs.

Note: This table is discussed in the Advanced Coding Course offered by AAOMS.

Alphabetic Index to External Causes (E-Codes)

The last section of the Volume II Alphabetic Index is the index to E codes. E codes are used to identify how an injury occurred. These codes represent events such as motor vehicle accidents, gunshot injuries, falls, and fire-related events.

Note: This table is discussed in the Advanced Coding Course offered by AAOMS.

Five Easy Steps to Locating Diagnosis Codes

Step 1. Identify the Main Term

Review the medical record or encounter form to identify the main term. In ICD-9-CM, the main term will normally represent the abnormal condition from which the patient suffers. Adjectives (e.g., acute, chronic, severe) and anatomical sites (e.g., jaw, mandible, tooth) are rarely listed as main terms in the Alphabetic Index (Volume II). The main terms in the following diagnoses have been highlighted.

Mandibular retrognathia
Impacted tooth
Subacutely inflamed mandibular vestibule
Tooth erosion due to medication
Step 2.  Look Up the Main Term in the Alphabetic Index.

Main terms are printed in bold print in the Alphabetic Index (Volume II).

Step 3.  Scan the Subterms for Specificity

Indented beneath many main terms are subterms that allow for more specificity in the assignment of codes. All subterms should be scanned before assigning codes. Notice the difference in code assignments in the following excerpt.

<table>
<thead>
<tr>
<th>Gingivitis</th>
<th>523.10</th>
</tr>
</thead>
<tbody>
<tr>
<td>acute</td>
<td>523.00</td>
</tr>
<tr>
<td>necrotizing</td>
<td>101</td>
</tr>
</tbody>
</table>

Step 4.  Follow Any Cross References in the Alphabetic Index

Jaw - see condition
Laceration - see also Wound, open, by site

Step 5.  Verify the Code in the Tabular List

Coding solely from the Alphabetic Index is tempting, but can lead to coding errors. The Tabular List contains many instructions that must be followed to ensure coding accuracy.

Exercise 3

Underline the main term for each of the following.

1.  Mandibular retrognathia

2.  Subacutely inflamed mandibular vestibule

3.  Impacted malpositioned tooth

4.  Posterior maxillary vertical hypertrophy
5. Tooth erosion due to medication

Exercise 4

Assign the diagnosis code for each of the following.

Example: Impacted malpositioned tooth

1. Main term: It could be either “impacted” or “malpositioned”. For this example, the main term will be “Malpositioned.”
2. Look up “Malpositioned” in the Alphabetic Index
3. Scan the subterms for “tooth”
   There is an additional subterm for “with impaction”
4. Follow any cross references – not applicable in this example
5. Verify code 520.6 in the Tabular List.

1. Mandibular micrognathia

2. Abscess in the left posterior bony mandibular area

3. Salivary gland retention cyst

4. Alveolar hyperplasia; mandible

5. Bilateral incomplete cleft lip/palate

6. Zygomatic hypoplasia

7. Tooth erosion due to medication

8. Odontoclasia
Nonessential Modifiers

Nonessential modifiers are those words that appear in parentheses after a main term in the Alphabetic Index. These terms may or may not be included in the diagnosis and still not have an impact on the code assignment.

### Practice 1

<table>
<thead>
<tr>
<th>Term</th>
<th>Code(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gingival infection</td>
<td>________</td>
</tr>
<tr>
<td>(Chronic) gingival infection</td>
<td>________</td>
</tr>
</tbody>
</table>

Abbreviations

**NEC** *(Not Elsewhere Classified)*

Some entries in the Alphabetic Index and the Tabular List will have the abbreviation NEC following them. This abbreviation appears when there is insufficient information to code a diagnosis to a more specific category or subcategory.

**NOS** *(Not Otherwise Specified)*

This abbreviation is the equivalent of “unspecified” and only appears in the Tabular List.
Punctuation Marks

[] Brackets enclose synonyms, alternate words, or explanatory phrases.

( ) Parentheses enclose supplementary words (nonessential modifiers) which may or may not be present in the diagnosis.

: A colon follows an incomplete term that needs one or more of the modifiers that follows it in order to make the diagnosis assignable to the category.

Cross References

See

Found in the Alphabetic Index, “See” directs the user to look for entries under another main term.

---

Practice 2

Refer to “maxilla.”

Fractured maxilla Code(s): __________

No code is available at this point. The coder has no choice but to follow the cross reference “see condition”.

---

See also

Found in the Alphabetic Index, “See also” directs the user to look under another main term, if all the information sought cannot be located under the first main term entry.
Practice 3

Jaw strain (current) Code(s): __________

Instructions Found in Tabular List

Inclusions

Inclusion notes list terms (such as adjectives, sites, or conditions) contained in the section or category.

Exclusions

Exclusion notes list terms (such as adjectives, sites, or conditions) NOT contained in the code and should therefore be classified elsewhere. A box always prefaces exclusion notes and appears in italics.

Practice 4

Refer to code 830.1 in the Tabular List.

Does this code include open subluxation of the mandible? __________

Refer to code 524.69 in the Tabular List.

Would this code be appropriate for a TMJ strain due to being hit today in the face with a football? __________
Use Additional Code

This note is found in the Tabular List where an additional code may give a more thorough picture of the diagnosis. The additional code must be used if the information is available in the medical record.

When the phrase “if desired” appears in the instructional term, the phrase is interpreted as “Use additional code, if the condition is documented in the medical record at the time the claim is being submitted.”

Practice 5

A patient presented with a palpable mass behind the right mandible; examination showed an acutely inflamed lymph node that was excised and cultured as streptococcal in nature. Code(s): __________

Code First Underlying Disease

This instruction, the code, and the title of the code appear in italics to show that the code cannot be sequenced first or stand alone. The underlying disease (etiology) must be listed first. Occasionally, manifestations and etiology codes are found listed together in the Alphabetic Index. When this occurs, both codes must be used and sequenced in the order they appear in the Alphabetic Index.

Practice 6

Diabetic bone changes affecting the maxillofacial region; the patient is insulin dependent Code(s): __________
Exercise 5

Assign diagnosis codes to each of the following.

1. Tubercular arthritis of the jaw

2. Fractured maxilla

3. Extra salivary gland

4. Staphylococcal arthritis of the jaw
Principles of ICD-9-CM

Signs and Symptoms

Coding Signs or Symptoms

A sign or symptom should not be coded when a definite related condition has been identified. However, if no related condition is confirmed, the sign or symptom can be coded. While many symptoms are assigned to specific body system chapters, general symptoms (fever, nausea, abdominal pain, etc…) are assigned to Chapter 16 (Nonspecific Signs and Symptoms).

Abnormal Test Findings

Categories 790-796, found in Chapter 16, should be used ONLY when NO related diagnosis is established. These codes should also be used ONLY when the physician indicates that the abnormal test finding is significant.

These codes can be found in the Alphabetic Index under the main term “Findings, abnormal, without diagnosis.”

Suspected Conditions

If the diagnosis at the end of the encounter is stated as “suspected”, “questionable”, “possible”, or “rule out”, DO NOT code the condition as though it definitely exists. Rather, code only to the highest level of certainty. This will most likely be a sign, symptoms, or abnormal test finding.

Note: The above list of terms is not all inclusive. Any time the doctor describes the diagnosis in a tentative manner, (rather than a definitive manner) this rule should be applied.
Acute and Chronic Conditions

When a specific condition is stated in the diagnosis as both acute (or subacute) and chronic, and the Alphabetic Index provides separate codes at the subterm level for the two conditions, use both codes sequencing the acute condition before the chronic condition.

If both are not listed at the subterm level, assign only the code at the subterm level.

Practice 7

Acute and chronic periodontitis  Code(s): __________

Nonspecific Condition

If a specific condition is given along with a general or nonspecific condition from the same category of ICD-9-CM, code only the more specific one.

In the body of the progress note, the doctor documents “periodontal disease”. At the conclusion of the same progress note, the doctor documents gingival recession.

Gingival Recession  523.20
Periodontal Disease  523.9

Both codes are assigned to category 523. Therefore, only 523.20 would be assigned.

Rule Summary: Two codes from the same three-digit category CAN be used together UNLESS one of the two presents “unspecified.” This will normally be represented by the residual subcategory of “.9”.
Exercise 6

Assign diagnosis codes to the following.

1. The patient is referred for consultation due to facial pain near the ear. She has been undergoing weekly cervical traction for a previous neck injury. Due to increasing pain, she presents for evaluation. Unfortunately, the patient is not experiencing any pain today.

   **Diagnosis:** Possible TMJ disorder.

2. Acute and chronic gingivitis

3. Swollen tissue of mouth; periodontal abscess ruled out

4. Painful tongue; rule out glossitis

5. A patient presents with pain in jaw, especially upon opening wide. He was hit in the face during a fist fight. He is diagnosed with a closed dislocation.

6. Soft oral tissue disorder; Ludwig’s angina

7. Apertognathia; maxillary hypoplasia
Background of CDT

History of CDT

CDT (Current Dental Terminology) is maintained by the American Dental Association (ADA) and represents dental procedures and services rendered. An OMS office uses these procedure codes when submitting claims to dental insurance companies.

The first edition of CDT, released in 1991, was the result of a combined effort from general practitioners and specialists. The development of CDT-1 began with a grant from the American Fund for Dental Health, to give dentists and their staff the ability to accurately report the services provided to their patients. Since then several versions have been released containing numerous revisions and additions. The current manual in use is CDT 2011/2012. Oral and Maxillofacial Surgeons must purchase a new CDT manual every time it is revised.

CDT Content

The CDT 2011/2012 is comprised of several components. The largest portion is the Code on Dental Procedures and Nomenclature, simply called The Code. In addition to The Code, the book contains the following.

- Instructions for using The Code
- Tooth numbering systems
- Questions and Answers (Q&A)
- ADA Dental Claim form instructions
- Glossary of dental terms
- Alphabetic Index to The Code


**Code Revision Committee**

The development and maintenance of dental codes are the responsibility of the Code Revision Committee (CRC). Representatives seated on the CRC include six representatives from the ADA recognized dental specialties (including oral and maxillofacial surgery) and six payer representatives to include CMS, four other nationally recognized payer organizations and a national purchaser of dental benefits. The CRC will continue to enhance the CDT so that future versions reflect the latest advances in dentistry.

**Survey of CDT 2011/2012**

Initially, the dental coding system was a five-digit numeric system. However, in 2000 CDT was amended to an alphanumeric system, with the first character of each code being “D” to denote “dental system.” This change was initiated by the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The decision by the ADA to change to an alphanumeric system was made in anticipation of the eventual elimination of D codes in HCPCS Level II.

All sections of CDT contain codes that can be used by OMS offices. Most often these include:

- **Clinical Oral Evaluations** (D0120-D0170 and D9310)
- **Radiographs** (D0210-D0363)
- **Tests and Laboratory Examinations** (D0460-D0470)
- **Endodontics** (D3310-D3330)
- **Apicoectomy/Periradicular Services** (D3410-D3470 and D3920)
- **Periodontics** (D4210-D4999)
- **Adjustments to Dentures** (D5410-D5422)
- **Denture Reline** (D5730-D5741)
- **Tissue Conditioning** (D5850-D5851)
- **Modification of Removable Prosthesis Following Implant Surgery** (D5875)
- **Maxillofacial Prosthetics** (D5911-D5999)
- **Implant Services** (D6010-D6199)
- **Oral and Maxillofacial Surgery** (D7111-D7999)
- **Anesthesia** (D9210-D9248)
Updating CDT

The Current Dental Terminology (CDT) is updated every two years and is available through the American Dental Association (ADA) or other commercial booksellers.

SNODENT

The Systemized Nomenclature of Dentistry (SNODENT) is an effort of the American Dental Association (ADA) to develop a controlled terminology that addresses the needs of clinical dentistry. The ADA, collaborating with the College of American Pathologists, developed and incorporated SNODENT as a subset of SNOMED-CT (Systematized Nomenclature of Medicine – Clinical Terms). SNODENT includes the terms and codes that will be used to identify a patient’s clinical diagnosis in the electronic health record. While currently not mandated for any purpose, it may become of increased importance in the future.
Structure and Use of CDT 2010/2012

Code on Dental Procedures and Nomenclature

The Code on Dental Procedures and Nomenclature is found in Section 1 of the CDT 2010/2012 book. It contains a list of codes in straight alphanumeric order, code titles, and explanatory notes. These notes provide explanation of proper interpretation and use of the code.

The Code on Dental Procedures and Nomenclature also contains three symbols.

- **Bullet:** Indicates that the code is new to the revision of CDT

- **Triangle:** Indicates that the code has been revised

Alphabetic Index

The Alphabetic Index is located in Section 8 of the CDT 2010/2012 book.

The Code Reference Guide contains:

- Main terms (found in bold type)
- Subterms
- Codes
- Page numbers (of nomenclature/descriptor as well as to changes chapter, Q&As and glossary when code referenced in these sections)
Finding CDT 2010/2012 Codes

1. Identify the service rendered
2. Look up the main term in the alphabetic section
3. Scan the subterms for specificity
4. Look up the code(s) or page(s) in the numeric section

**Practice 8**

Comprehensive oral examination

**Code(s): __________**

**Exercise 7**

Find the CDT 2010/2012 code for each of the following.

1. Extraction of an impacted tooth, partial bony

2. Alveoloplasty without extractions, 1 quadrant

3. Removal of lateral exostosis
4. Closed reduction of mandibular fracture

5. Consultation

6. Excision of benign non-odontogenic cyst (.92 cm)

7. Nonarthroscopic lysis and lavage

8. Surgical splint

9. Apicoectomy, anterior tooth

10. Diagnostic arthroscopy
Understanding HCPCS
(Healthcare Common Procedure Coding System)

Organization

Level I: CPT

As previously discussed, Level I HCPCS is composed of CPT codes. Most of the services provided to patients are billed under CPT codes. However, CPT has traditionally been deficient in providing detailed codes for supplies, materials, injections, and services provided by nonphysician providers.

CPT is maintained by the American Medical Association (AMA).

Level II: National Codes

Because of the above-mentioned deficiencies of CPT, CMS developed codes to identify certain supplies, drugs, materials, equipment, and services rendered by nonphysicians. Medicare and many commercial carriers will accept HCPCS Level II codes.

These codes are alphanumeric and consist of a letter from A-V followed by four digits.

Example:  
- J2250 Injection, midazolam HCl (Versed), per 1 mg
- A4550 Surgical tray
- J2550 Injection, promethazine HCl (Phenergan), up to 50 mg

There are more than 2400 Level II codes and a copy can be obtained from a variety of publishing companies.

HCPCS Level II is maintained by the Centers for Medicare and Medicaid Services (CMS).
Guidelines for Proper Use of HCPCS Codes

CMS does not publish any coding guidelines on the proper use of HCPCS Level II codes. Any information regarding HCPCS Level II coding is published by each individual Medicare carrier.

While CPT codes tend to cover most of the services provided to patients, there are situations where a Level II code must be used to optimize reimbursement.

Example: There is only one CPT code for medical and surgical supplies. However, there are more than 1000 specific Level II codes representing medical and surgical supplies.

With codes changing annually and billing regulations changing periodically, it is imperative that coders maintain a current listing of codes and review all information relating to HCPCS coding.

Exercise 8

Provide the correct answer to each of the following.

1. What organization maintains HCPCS Level II?

2. What organization maintains HCPCS Level I?

3. What level is referred to as national codes?

4. On what level does CPT fall?

5. What does the abbreviation CPT represent?

6. What does the abbreviation HCPCS represent?

7. What does the abbreviation CMS represent?
Using the Alphabetic Index and Numeric List, locate the appropriate HCPCS code for the following.

8. What is the HCPCS code for Demerol 100 mg IV?

9. What is the HCPCS code for Bactrim 10 ml IV?

10. What is the HCPCS code for Valium 5 mg IM?

11. What is the HCPCS code for a panoramic x-ray?
# Background Information of CPT

## History of CPT

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966</td>
<td>The first edition of <em>Current Procedural Terminology</em> was published by the American Medical Association (AMA). This edition was only 63 pages and contained four-digit codes.</td>
</tr>
<tr>
<td>1970</td>
<td>Editors of the second edition expanded the codes to five digits. In addition, guidelines to the various sections appeared.</td>
</tr>
<tr>
<td>1973</td>
<td>New features of the third edition included alphabetic modifiers and starred procedures marked with asterisks. Medical codes were moved to the front of the book. They stayed in this location until the introduction of Evaluation and Management codes in 1992.</td>
</tr>
<tr>
<td>1977</td>
<td>The fourth edition was the advent of the yearly revisions. Since this time, coders routinely purchase new books each year.</td>
</tr>
</tbody>
</table>

## Purposes of CPT

*Physicians’ Current Procedural Terminology* (CPT) is a five-digit coding system that describes services provided to or for the patient. It is used to report medical services and procedures performed by a physician. In addition, it is used by facilities to report the technical component of most outpatient services. Accurate use of these codes is essential for proper reimbursement from insurance companies and compliance with governmental programs.
Cooperating Parties

CPT is published annually by the American Medical Association. Revisions are prepared by the CPT Editorial Panel. The panel is composed of physicians of all specialties of medicine. In addition, contributions are made from third party payers, related medical specialty associations, and governmental agencies.

Updating CPT

CPT is updated biannually. A major release is available each year with the publication of a new CPT book. Mid-year updates are available at the AMA’s website.

Suggestions for change are made from practicing physicians, medical societies, state medical associations, and other related agencies. Suggestions are investigated by the AMA’s CPT Editorial Panel. Decisions are made after consultation with the appropriate medical specialty society. This investigatory period can often take several years.
Sections

The main body of CPT is listed in six sections. The procedure codes are in straight numeric order except the entire Evaluation and Management section (99201-99499).

- **Evaluation and Management**: 99201-99499
- **Anesthesia**: 00100-01999, 99100-99150
- **Surgery**: 10021-69990
- **Radiology**: 70010-79999
- **Pathology and Laboratory**: 80047-89356
- **Medicine**: 90281-99607

These are further divided into subsections, which are closely related clusters of codes.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td><strong>Subsection</strong></td>
</tr>
<tr>
<td><strong>Head</strong></td>
<td><strong>Heading</strong></td>
</tr>
<tr>
<td>Incision</td>
<td>Subheading</td>
</tr>
<tr>
<td>Excision</td>
<td>Subheading</td>
</tr>
<tr>
<td>Introduction or Removal</td>
<td>Subheading</td>
</tr>
</tbody>
</table>

Use of the Semicolon

In the numeric section of the CPT coding book, any term after the semicolon and indented entries are subordinate to the descriptor before the semicolon.

**Example**
- 41100  Biopsy of tongue; anterior two thirds
- 41105  posterior one-third

Code 41105 is read as “Biopsy of the posterior one-third of the tongue.”
Descriptors are listed from lowest to highest according to resource intensity. Documentation in the medical record needs to be reviewed to assure that the highest justified entry and corresponding code can be utilized.

**Guidelines**

Guidelines appear at various places within the CPT manual and must be read carefully for complete understanding of code assignment.

- Beginning of each of the six major sections
- Beginning of certain subsections
- Within code ranges in a subsection
- At a specific code

**CPT Icons**

- New CPT codes are identified by a bullet (●) preceding the code.
- Revised CPT code descriptors (titles) are identified by a triangle (▲) preceding the code.
- Revised text other than code descriptors are identify by symbols (► ◄) preceding and following the text.
- Add-on CPT codes are identified by a plus sign (+) preceding the code. Add-on procedures are always secondary procedures that should never be reported alone. Unlike most secondary procedures, add-ons do not require modifier -51 (Multiple Procedures). In addition to the symbol, all add-ons include the statement (*List separately in addition to code for primary procedure*). A complete list of these services is found in Appendix D.
- Modifier -51 exempt codes are identified by a universal NO symbol (⊗) preceding the code. These procedures are similar to add-ons in that they are usually components of a larger procedure. Unlike add-ons however, they may be reported alone as applicable. When reporting these codes, modifier -51 should not be used. A complete list of these services is found in Appendix E.
• CPT codes that include moderate (conscious) sedation are identified by a bullet symbol (•) preceding the code. Since these codes or services include moderate sedation, it is not appropriate to report both the procedure and the sedation codes. A complete list of these services is found in Appendix G.

• Vaccine codes pending FDA approval are identified by a lightening bolt (⚡) preceding the code.

Resequencing Initiative

Effective 2010, a code resequencing process is being used in CPT, rather than the former renumbering process. Historically, the American Medical Association would renumber codes (without changing the descriptors) when codes were deleted or added in an effort to keep like codes together. This practice presented technical challenges in long-term code maintenance and data integrity. In addition, changing code numbers without changing their intent or meaning sometimes caused reimbursement and contract problems with third party payers.

As a result of these issues, code numbers will now remain the same once assigned. As new codes are created, new numbers will be created. These new codes will be placed in the CPT book within a related subsection or area.

Two navigational aids have been created to alert the coder to a resequenced (or out of sequence) code.

1. A number symbol (#) appears before a resequenced code.

2. A reference note at the location where the code should be found straight numerically directs the coder to the resequenced location.

Alphabetic Index

The Alphabetic Index is composed of the following components:

• Main Terms Main terms are listed in bold print and identify procedure and anatomical sites.

• Subterms Subterms are indented beneath main terms and allow for specificity in the assignment of codes.
Cross References

Cross references appear only in the Alphabetic Index and provide guidance to the coder.

- **See**
  
  “See” directs the user to refer to entries under another main term.

- **See Also**
  
  “See Also” directs the user to look under another main term if the procedure being sought cannot be located under the first main term entry.

Using the Alphabetic Index

When using the Alphabetic Index, entries should be located using the following search sequence.

1. Look for the **Procedure** or **Service** performed. If not found,
2. look for the **Organ** involved. If not found,
3. look for the **Condition** involved. If not found,
4. look for an appropriate **Synonym**, **Eponym**, or **Abbreviation**.

Entries in the Alphabetic Index may show a single code or more than one code. As such, it is essential that code(s) be verified in the numeric portion of the coding book.

Exercise 9

Assign the procedure code for each of the following.

1. Biopsy, floor of mouth

2. Simple incision and drainage of cyst of mouth
3. Arthrocentesis, TMJ

4. Alveoloplasty

5. Closed reduction of a mandibular fracture with interdental fixation

6. Excision of bone abscess from mandible
Miscellaneous Components of CPT

Unlisted Services

Unlisted service codes can be found at the beginning of each section. In addition, all unlisted service codes can be located in the Alphabetic Index under the main term "Unlisted Services or Procedures." These codes are used when no other CPT code adequately represents the procedure performed.

When an unlisted service code is used, documentation describing the service or procedure must accompany the claim. The documentation should contain:

- A description of the nature and need for the procedure
- The time, effort, and equipment needed for the procedure

Additional information may be:

- Description of symptoms
- Final diagnosis
- Pertinent physical findings
- Concurrent problems
- Follow-up care plans

Modifiers

Modifiers are to be used when specific circumstances occur and the circumstance is not indicated in the procedure code.

Types of Modifiers

CPT Modifiers - All CPT modifiers are listed and defined in Appendix A of the CPT coding book.
Modifiers commonly used in OMS practices include:

-22 Increased Procedural Services
-47 Anesthesia by Surgeon
-50 Bilateral Procedure
-51 Multiple Procedures
-52 Reduced Services
-53 Discontinued Procedure
-54 Surgical Care Only
-55 Postoperative Management Only
-57 Decision for Surgery
-58 Staged or Related Procedure or Service by the Same Physician during the Postoperative period
-59 Distinct Procedural Service
-62 Two Surgeons
-78 Unplanned Return to the Operating Room / Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure during the Postoperative Period
-79 Unrelated Procedure or Service by the Same Physician during the Postoperative Period
-80 Assistant Surgeon
-81 Minimum Assistant Surgeon
-82 Assistant Surgeon (when qualified surgeon not available)

In addition to these modifiers, there are two modifiers that can be used by those OMS practices that have been licensed as an ambulatory surgery center.

-73 Discontinued Out-patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
-74 Discontinued Out-patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

**HCPCS Level II Modifiers** – Level II modifiers are alpha or alphanumeric in format. These modifiers can be found in a HCPCS Level II coding book.

**Reporting Modifiers**

The most common method of reporting modifiers is by separating the procedure code and the modifier with a hyphen.

**Example:** 99201-24
CPT Categories

The AMA has been working on the CPT-5 Project for numerous years. It is their goal to extend the function of CPT, thus adding to its value as a reporting mechanism in our healthcare delivery system. One recommendation from the CPT-5 Executive Project Advisory Group was the creation of codes for emerging technology and performance measures. In response to this recommendation, CPT-4 was divided into three categories of codes, effective 2002.

Category I CPT Codes

Category I CPT codes are five digits in length and have an associated procedure descriptor. The inclusion of a code in this section is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations.

“In developing new and revised Category I CPT codes the Advisory Committee and the Editorial Panel require:

• that the service/procedure receive approval from the Food and Drug Administration (FDA) for the specific use of devices or drugs;
• that the service/procedure be performed across the country in multiple locations;
• that many physicians or other health care professionals perform the service/procedure; and
• that the clinical efficacy of the service/procedure be well established and documented.”

American Medical Association (internet site); September, 2002.

Category II CPT Codes – Performance Measurement

The use of Category II CPT codes is intended for healthcare providers that need to gather statistics for quality improvement activities, specifically performance outcome measurements. These codes may be services that are typically included in an Evaluation and Management (E/M) service or other component part of a service and are not appropriate for Category I CPT codes. The use of tracking codes for performance measures will decrease the need for record abstraction and chart review, thus minimizing administrative burdens on physicians and survey costs for health plans.

CPT Performance Measurement codes are alphanumeric with a letter in the last position (i.e., 1234A). They are located in a separate section of CPT, following the Medicine section. Instructions are placed in this code section to explain the purpose of these codes.

While the use of these codes is currently optional, and not required for correct coding, they are the basis for participation in Medicare’s Physician Quality Reporting Initiative (PQRI) and perhaps pay for performance programs of other third party payers as well. These programs are covered in more detail in AAOMS Beyond the Basics and Billing courses.

**Category III CPT Codes – Emerging Technology**

This category of codes is used to facilitate data collection relating to emerging technology, services, and procedures. This data will be used to substantiate widespread usage or in the FDA approval process.

Category III codes are alphanumeric with a letter in the last field (i.e., 0003T). These codes are located in a separate section of CPT, following the Medicine section. Codes may stay on the emerging technology list for five years. During that time, the service may be assigned a permanent CPT code. However, if that does not occur, the code will be archived, unless it is demonstrated that the code needs to remain on the Category III list.

To expedite the dissemination of newly approved codes, the AMA publishes the codes twice a year on its internet site. Mid-year additions occur in July. The complete list is published once a year in the CPT coding book.

**Exercise 10**

Assign CPT codes to each of the following.

1. Excision of torus mandibularis

2. Bilateral surgical TMJ arthroscopy

3. Excision of 1.0 cm benign lesion, skin of lip

4. 4.0 cm complex laceration repair, lower lip

5. LeFort I, 3 piece reconstruction with bone graft
6. Sagittal split osteotomies

7. Design and preparation of oral surgical splint, including impression(s)
Data Needed for Claims Submission

When a patient presents for an initial encounter, it is essential for office staff to obtain the following.

- Copies of insurance card(s)
- Information to process a workers’ compensation or automobile accident claim
- PCP referral, if applicable to the patient
- Copies of policy booklets

Typical patient registration forms contain both personal and financial data. The following is a list of common field items.

<table>
<thead>
<tr>
<th>Patient’s Name – Last, First, and Middle</th>
<th>Name of Primary/Secondary Insurance Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Address</td>
<td>Name of Insured</td>
</tr>
<tr>
<td>Patient’s Date of Birth</td>
<td>Insured’s Date of Birth</td>
</tr>
<tr>
<td>Patient’s Gender</td>
<td>Relationship to Insured</td>
</tr>
<tr>
<td>Patient’s Marital Status</td>
<td>Insured’s Address</td>
</tr>
<tr>
<td>Referral Physician Information – Name &amp; ID</td>
<td>Insured’s Social Security or ID Number</td>
</tr>
<tr>
<td>Emergency Notification</td>
<td>Insured’s Employer and Address</td>
</tr>
<tr>
<td>Employment Status/Student Status</td>
<td>Local Union, Plan, or Group Enrollment Number</td>
</tr>
<tr>
<td>Name of Employer or School</td>
<td>Signature of Insured</td>
</tr>
</tbody>
</table>

Coordination of Benefits (COB)

COB is a clause in an insurance policy to prevent duplication of payment. It states that if a patient is covered by more than one insurance plan, a determination must be made as to which
one is the primary payer.

**Minors Covered by Both Parents**

When a patient is dependent on two different parental insurance plans, the Birthday Rule is commonly used to determine the primary payer. The Birthday Rule states that the primary payer will be the policy held by the parent whose birthday occurs first in the calendar year.

If neither insurance company follows the Birthday Rule, it is likely that the Gender Rule will be applied. This states that the primary payer will be the father’s insurance company.

**Patients Covered by Both Medical and Dental Plans**

Third party payers are more routinely accepting medical claims from OMS practices than in past years. However, inconsistencies still exist. Some payers cover nearly all medically-related OMS services; others cover only a portion; and still others cover none at all. As such, knowing which plans cover which services can be difficult for both the practice and the patient.

When a procedure is approved by both the medical and dental insurance company, the practice needs to consider which payment source will provide the greater reimbursement. In the managed care environment, this is often the dental coverage. Therefore, there are not set rules for filing medical over dental or visa versa. Each patient’s circumstances will need to be considered separately.

**Parameters of Coverage – A Glossary**

*Deductible* – The out-of-pocket expense that must be paid at the beginning of the policy year before the insurance will begin to provide coverage. **Example:** Medicare’s $124.00 annual deductible for physician-based services.

*Coinsurance* – Normally seen in indemnity plans or fee-for-service plans, a coinsurance is the percentage of the bill for which the patient will be responsible. **Example:** Medicare patients are responsible for 20% of the approved Medicare fees.

*Copayment* – An out-of-pocket expense that must be paid at every healthcare encounter. Commonly seen in managed care plans, patients are required to pay $10-30 for each doctor’s office visit.
**Frequency Clause** – A frequency clause places limits on the number of services covered within a specified period of time. If the patient receives services in excess to the clause, the insurance company will not provide coverage and the patient will be solely responsible for the bill.

**Annual Maximum** – This policy clause places an annual maximum dollar amount for which the patient can receive coverage. After the maximum paid benefit is exceeded, the patient will be solely responsible for the bill.

**Predetermination and Precertification**

**Predetermination** – The process of submitting a treatment plan to 1) verify benefits and 2) obtain an estimate of the potential reimbursement

**Preauthorization** – The process of obtaining permission or authorization from the insurance company to carry out the treatment plan

A predetermination of benefits should be established by submitting a cover letter to the patient’s insurance company(ies) detailing the treatment plan. The insurance company will evaluate each procedure in the plan separately to determine if it would be covered by their policy. In many cases, the predetermination will indicate some, but not all procedures are eligible for coverage. This is evident in the case of impacted vs. erupted wisdom teeth. Many medical insurance companies will cover extractions of *impacted* teeth, but not extractions of erupted teeth. By obtaining this predetermination of benefits, office staff can greatly reduce administrative frustrations resulting from misdirected claims submission.

---

**Items to Include in a Telephone Predetermination**

- Name of the Insurance Representative
- Date and Time of the Telephone Call
- Details of the Patient's Inpatient and Outpatient Benefits
- Deductibles for Major or Minor Services
- Reimbursement Rate
- Annual Maximum Clauses
- COB Policies Utilized by the Insurance Company
When submitting preauthorizations to dental carriers, the information should be submitted on an ADA dental form, either generic or supplied by the company, by marking appropriately the box for Preauthorization or Pretreatment estimates.

**Items to Include in a Preauthorization**

- Patient’s Name
- Patient’s Date of Birth
- Name of Policyholder and Policy Number
- Name of Admitting Doctor
- Name of Hospital or Place of Surgery
- Anticipated Admission Date and Type of Admission (inpatient, outpatient)
- Estimated Length of Stay
- Diagnosis
- Procedure/Treatment

**Encounter Forms and Superbills**

Superbills and encounter forms are effective internal office communication tools. They normally contain the patient’s name, diagnosis and procedure codes, date of service, and associated fees.

However, these documents are **NOT** considered a legal part of the medical record – even if stored in the patient’s folder. Every diagnosis and procedure designated on the superbill/encounter form **MUST** be documented in the medical record prior to submitting a claim to the insurance company.

**Electronic Claims Submission**

**Advantages**

- Lower administrative costs (paper, postage, employee time)
- Increased efficiency and faster claims processing
- Reduced paper handling
• Ability to track claims effectively

Disadvantages

• Transmission failures (power failure, software/hardware breakdowns)
• Processing fees that may be associated with some vendors

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA includes a variety of standards and provisions that apply to this topic of claims processing. The broad classifications include:

• Healthcare fraud and abuse
• Electronic claims submission
• Data security
• Patient privacy

All HIPAA-specified covered entities are required to abide by the requirements of the regulations. Covered entities include:

• Healthcare providers
• Healthcare plans (insurance companies)
• Data clearinghouses

Electronic Claims Submission Standards

The goal of these standards is to create one electronic format that is to be used by ALL covered entities.

The standards that will most closely affect OMS offices include:

• Creation of standardized health claim forms
• Creation of a standardized method of attaching additional documents to an electronic claim
• Online enrollment and disenrollment into a health plan (employers will be able to sign up new employees and remove former employees from health plans online)
• Online determination of a patient’s benefits
• Receipt of reimbursement and remittance advice electronically
• Online determination of a claim’s status after it leaves the office
• Online preauthorization

Exercise 11

1. ICD-9-CM codes can be submitted on a dental claim
   a. True
   b. False

2. The process of minimizing overpayment or duplication of payment is
   a. Coordination of Benefits
   b. Utilization Review
   c. Predetermination
   d. Preauthorization

3. An annual out-of-pocket expense paid by the insured to the health care provider before the insurance company begins to make the payment is
   a. Predetermination
   b. Coinsurance
   c. Copayment
   d. Deductible

4. In the case of a mother (DOB 5/10/60) and a father (DOB 12/23/58), whose insurance plan would be primary under the birthday rule?
   a. Father
   b. Mother

5. What does the abbreviation HIPAA represent?
   a. Health Information Promotion and Administration Act
   b. Health Insurance Portability and Accountability Act
   c. Health Information Privacy and Accountability Act
   d. Health Insurance Plan and Administration Act
6. What is the term used in insurance policies describing the number of times a service can be received during a specific period of time?
   a. Precertification
   b. Annual maximum
   c. Frequency clause
   d. Coordination of benefits

7. What is the process of obtaining permission from a carrier to carry out a surgery?
   a. Coordination of benefits
   b. Consent for treatment
   c. Predetermination
   d. Preauthorization
Appendix A

OMS Anatomy Lesson

Facial Bones

- Supraorbital Rim
- Lateral Orbital Rim
- Frontal Bone
- Nasal Bone
- Infraorbital Rim
- Maxilla
- Zygomatic Arch
- Zygoma or Malar Bone
Prevalence of Mandibular Fractures

- condyle: 29.1%
- coronoid: 24.5%
- ramus: 16%
- symphysis: 3.1%
- angle: 16%
- dentoalveolar segment: 1.7%
- body: 22%
- parasympphyssis: 24.5%
ZMC Fracture

A. ZMC Fracture

B. Zygomatic Arch Fracture

C. Zygomatic Arch Fracture
LeFort I

LeFort II
LeFort III

Dentofacial Anomalies

Maxillary prognathism  Jaw without prognathism  Mandibular prognathism
Orthognathic Surgery

Before and after profiles, showing correction of a protruding lower jaw

To correct a receding lower jaw, the jaw is moved forward from behind the teeth, a portion of the chin is moved forward and both areas of the jaw bone are held in place using plates and screws.

Before and after upper jaw surgery to correct an open bite. The upper jaw is held together with plates and screws.
Temporomandibular Joint
Dental Implants

Parts of an Implant

- Crown of Natural Tooth
- Manufactured Crown
- Implant Abutment
- Gum Tissue
- Gum Tissue
- Periodontal Ligament
- Bone
- Implant Screw
- Root
Implant

Healing Cap

Abutment

Impression Taken

Crown
Various Functions of Implants

Crows

Before

After

Bridges

Before

After

Dentures

Before

After

Before

After
Nerves to Avoid – Inferior Alveolar Canal and Nerve (2 mm)

Example: Incisor #8
Types of Implants

Blade

Transosteal
Answers

Exercise 1

1. Subclassification
2. Category
3. Subcategory
4. Subclassification
5. Subcategory

Exercise 2

523, 524.3, and 144

Exercise 3

1. Retrognathia
2. Inflamed
3. Malpositioned or impacted
4. Hypertrophy
5. Erosion

Exercise 4

1. 524.04
   Micrognathia, mandibular
2. 526.4
   Abscess, bone, jaw
3. 527.6
   Cyst, salivary gland, mucous extravasation or retention
4. 524.72
   Hyperplasia, mandibular, alveolar
5. 749.24
   Cleft, palate, with cleft lip, bilateral, incomplete
6. 738.12
Hypoplasia, zygoma

7. 521.30
   Erosion, teeth, due to, medicine

8. 521.05
   Odontoclasia

Practice 1
523.10
523.10
   Infection, gingival

Practice 2
802.4
   Maxilla – see condition
   Fracture, maxilla

Practice 3
848.1
   Strain – see also Sprain, by site
   Sprain, jaw

Practice 4
   Yes
   No

Practice 5
683; 041.00
   Inflammation, lymph node or gland (see also Lymphadenitis)
   Lymphadenitis, acute
   Infection, streptococcal
   
   Be sure to remember this method of locating organisms. You will use it again later.
Practice 6
250.80; 731.8; V58.67

Diabetic, bone change, insulin dependent

*Note it may be appropriate to also report code V58.67. The instructional note in the Tabular List beneath category 250, specifically beneath the fifth digit of “0”, states “Use additional code, if applicable, for associated long-term (current) insulin use V58.67”.*

Exercise 5

1. 015.80; 711.48

   Arthritis, tuberculosis – *see also* Tuberculosis
   Tuberculosis, arthritis, specified site NEC (5th digit = 0, since the method of identifying the TB is unknown)

   **Issue 1:** The Alphabetic Index provides two codes. Therefore, both must be used and sequenced in the order presented.
   **Issue 2:** When the codes are verified in the Tabular List, a 5th digit is needed to identify how the TB was confirmed.

2. 802.4

   Fracture, maxilla

3. 750.22

   Extra – *see* Accessory
   Accessory, salivary gland

4. 711.08, 041.10

   Arthritis, staphylococcal (5th digit = 8, to identify the joint of the body)
   *There is a “Use Additional Code” note at 711.0X requiring a second code to identify the specific organism. This can be confusing since you accounted for “staphylococcal” in the Alphabetic Index. However, review the title of code 711.0X carefully. It simply states “Pyogenic arthritis” – or pus producing arthritis. As such, you need to add a second code for the staphylococcus organism.*

   Infection, staphylococcus
Practice 7

523.33; 523.40

**Periodontitis**, acute

**Periodontitis**, chronic

*The title of 523.40 is specifically “Chronic periodontitis”. As such, it is appropriate to use both codes to reflect the diagnosis.*

Exercise 6

1. 784.0

**Pain**, face

*Because the doctor worded the diagnosis as “possible TMJ disorder”, the coder cannot assign a definitive code for TMJ disorder. Only the condition known with certainty is coded. In this case, the patient was referred for evaluation of facial pain.*

2. 523.00; 523.10

**Gingivitis**, acute

**Gingivitis**, chronic

3. 784.2

**Swelling**, mouth

*The periodontal abscess was *ruled* out – no abscess was found. As such, only the symptom is coded.*

4. 529.6

**Pain**, tongue

*Because the doctor worded the diagnosis as “rule out glossitis”, the coder cannot assign a definitive code for glossitis. Only the condition known with certainty is coded. In this case, that would be a painful tongue.*

5. 830.0

**Dislocation**, jaw

*The doctor made a definitive diagnosis of a jaw dislocation. Once a confirmed diagnosis is made, symptoms are no longer coded.*

6. 528.3

**Angina**, Ludwig’s

*Both “disorder of oral soft tissue” and “Ludwig’s angina” are assigned to category 528. One is a “.9” – unspecified. As such, only the more specific code from the category is assigned.*
7. 524.20; 524.03
   **Apertognathia**
   **Hypoplasia**, maxillary
   *Either diagnosis can be sequenced first.*

**Practice 8**
D0150
   **Evaluations**, comprehensive

**Exercise 7**
1. D7230
   **Extraction**, tooth
2. D7320
   **Alveoloplasty**
3. D7471
   **Exostosis**, removal of
4. D7640
   **Fractures**, treatment of, Mandible, Simple closed reduction
5. D9310
   **Consultation**
6. D7460
   **Cysts**, removal of
7. D7871
   **Arthroscopy**, Non-arthroscopic lysis and lavage
8. D5988
   **Splinting**, Surgical
9. D3410
   **Apicoectomy**
10. D7872
    **Arthroscopy**

**Exercise 8**
1. CMS
2. AMA
3. HCPCS Level II
4. HCPCS Level I
6. Healthcare Common Procedure Coding System
7. Centers for Medicare and Medicaid Services
8. J2175
   Demerol
   You can also locate drugs in Appendix 1 of the HCPCS. Notes: 1) These codes only represent the drug. As such, it would be appropriate to also use a drug administration (IV or IM) code from CPT. 2) A drug administered as a preanesthetic is not billed out separately.

9. S0039
   Bactrim

10. J3360
    Valium

11. D0330
    X-ray, dental

Exercise 9
1. 41108
   Biopsy, mouth (floor)
2. 40800
   Incision and Drainage, cyst, mouth
3. 20605
   Arthrocentesis, intermediate joint
4. 41874
   Alveolectomy
5. 21453
   Fracture, mandible, closed treatment, interdental fixation
6. 21025
   Abscess, mandible excision

Exercise 10
1. 21031
   Torus Mandibularis, Tumor Excision
2. 29804-50
   Arthroscopy, Surgical, Temporomandibular Joint
3. 11441
   Excision, Lesion, Skin, Benign
4. 13152
   Wound, Repair, Complex
5. 21147
   LeFort I, Midface Reconstruction
6. 21195
Reconstruction, Mandible
7. 21085
   Splint, Oral Surgical

Exercise 11

1. False
2. Coordination of Benefits
3. Deductible
4. Mother
5. Health Insurance Portability and Accountability Act
6. Frequency Clause
7. Preauthorization

Upon completion of this course, you will be ready to proceed to AAOMS’s Beyond the Basics coding workshop. Visit http://www.aaoms.org/coding_workshops.php for the dates and locations of upcoming workshops.