Coding Paper

American Association of Oral and Maxillofacial Surgeons

Coding for Oral and Maxillofacial Pathology

I. INTRODUCTION

For procedures that require a specimen to be sent for diagnostic or pathological evaluation, it is recommended that claim submission be delayed until a written report has been received from the pathologist. This applies regardless of the procedure performed (for example, an incisional biopsy versus a more extensive surgical procedure). Although this may ultimately delay billing and reimbursement, holding a claim for a definitive diagnosis is consistent with coding guidelines and best practices. In fact, delaying claim submission by a few days well serves both the patient and the OMS. The pathologist's clinical findings are essential in order for the OMS to accurately code and report the patient's condition to the highest degree of certainty and specificity possible.

According to ICD-10-CM coding guidelines, "a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." For a coder to ensure accurate code selection and claim submission, it is necessary to become familiar with key pathology-related terms such as "biopsy," "destruction," excision" and "introduction." This becomes especially important when coding retrospectively from the OMS's clinical documentation or operative report.

- A biopsy is defined as the removal of a portion of tissue for pathological study. This may also be referred to as an incisional biopsy.
- Destruction involves the use of a laser or electrocautery to burn the lesion, cryotherapy to freeze the lesion or chemicals to destroy the lesion. This procedure may apply to benign, premalignant and malignant lesions.
- An excision, or excisional biopsy, involves making an incision through the skin or mucosa and undermining the subcutaneous or submucosal tissue beneath the lesion to remove the entire lesion.
- Introduction is when the physician uses a syringe to inject a pharmacological agent underneath, or directly into, lesions of the skin or oral cavity. The lesion may be any skin or oral lesion including post-surgical scar bands. The physician may inject steroids or anesthetics into these lesions.

Helpful tips for coding biopsy procedures include:

- If a biopsy and a related therapeutic procedure occur during the same operative encounter, only the therapeutic procedure is reported. (A therapeutic procedure may be non-surgical treatment of an injury, condition or disease.)
- If a biopsy of one location and a therapeutic procedure of another are performed during the same operative encounter, both procedures can be reported.
- Local anesthesia is included in the biopsy service.
- Simple suture repair of the biopsy site is included in the service.

II. ICD-10-CM CODES

Chapter 2 of the ICD-10-CM manual, titled "Neoplasms (C00-D49)," encompasses codes for all malignant neoplasms and the majority of benign ones. However, certain benign neoplasms are categorized under their respective body system chapters. For example, diagnosis codes that may be appropriate for oral pathology cases may be found in the following ICD-10-CM categories of codes:

K09	Cyst of oral region, not elsewhere classified
K11	Diseases of salivary glands
K12	Stomatitis and related lesions
K13	Other diseases of lip and oral mucosa
K14	Diseases of tongue
M27	Other disease of jaws
M35.0	Sjogren syndrome

Note: The list of ICD-10-CM codes provided above is not all inclusive and includes only the code categories in which an applicable diagnosis code may be found. Some of the codes within these ranges will require the use

of a placeholder and/or additional characters. Refer to current ICD-10-CM coding manual guidelines to ensure submission of a complete valid code.

Locating Neoplasms

Diagnosis codes for neoplasms may be found in the ICD-10-CM coding manual under the Neoplasm Table. The neoplasm table includes codes for primary and secondary malignancies, carcinoma-in-situ, benign, uncertain behavior and unspecified behavior by anatomical site. The ICD-10-CM code set is updated annually; therefore, OMSs and their staff must utilize the most up-to-date coding materials and manuals.

When locating neoplasms:

1. Refer to the main term (and subterm if necessary) in the Alphabetic Index representing the morphological type of the neoplasm.

   Morphology – The form and structure of a neoplasm Examples include:

   - Carcinoma
   - Cementoma
   - Fibroma
   - Melanoma
   - Myoma
   - Sarcoma

2. Once the entry representing the morphology has been found, scan the subterms to identify the anatomical site affected.
3. If the anatomical site is not listed, refer to the cross reference that can be found at the morphology entry. Example: Osteogenic sarcoma – see also Neoplasm, bone, malignant.
4. Turn to the Table of Neoplasms (located after the Alphabetic Index) and find the entry representing the anatomic site.
5. Based on the cross-reference given from Step 3, assign the code from the appropriate column of the table.

Note: According to ICD-10-CM guidelines, "to properly code a neoplasm, it is necessary to determine from the record if the neoplasm is benign, in situ, malignant or of uncertain histologic behavior." However, the terms "uncertain" and "unspecified," as they apply to ICD-10-CM neoplasm codes, are frequently misinterpreted or incorrectly used. As the guidelines clarify, "codes titled 'unspecified' are for use when the information in the medical record is insufficient to assign a more specific code," meaning the physician does not have enough data to accurately categorize the neoplasm. Conversely, a neoplasm is classified as having "uncertain behavior" if, despite examination and analysis, it is still indeterminate whether the cells are malignant (cancerous) or benign (non-cancerous). It is important to note that the designation of uncertain behavior should not be made by a coder but should be based on a pathology report or an Alphabetic Index cross-reference.

Coding tip: There may be instances in which an ICD-10-CM code for a pathology-related encounter does not stem from the Neoplasm Table. For example, a patient is scheduled for a biopsy of a mandibular cyst; however, upon evaluation by the OMS, the patient is found not to have a mandibular cyst. Therefore, a code representing a neoplasm of the lower jaw would not be appropriate. In such a case, the OMS may consider reporting Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out). Alternatively, if something abnormal is found on the patient's x-ray or CBCT, consider R93.0 (Abnormal findings on diagnostic imaging of skull and head, not elsewhere classified). This would apply when the abnormality has been identified radiographically but a definitive diagnosis – such as an aneurysmal bone cyst – has not yet been established. Once the aneurysmal bone cyst is confirmed, the encounter should be coded using the specific diagnosis rather than the imaging-finding code.

III. CPT CODING FOR ORAL AND MAXILLOFACIAL PATHOLOGY

Whenever possible, CPT codes should be used for coding procedures related to oral and maxillofacial pathology, but, for certain services, dental or CDT coding may crosswalk with CPT and/or may be preferred by some carriers. The sections of CPT in which most OMS pathology codes may be found are: Integumentary System, Musculoskeletal System, Respiratory System and the Digestive System.

Additionally, most sections within CPT include codes for unlisted procedures by anatomical structure/area that may

be used if no other code exists that accurately captures the procedure being furnished. This is true for each of the sections outlined in this paper.

Coding tip: The CPT code book includes guidelines that pertain to each section of the code set and to certain families or groups of codes. It is important for OMSs and professional coders to read and understand these guidelines as they often provide information relevant to appropriate code selection, such as definitions and specific reporting instructions.

INTEGUMENTARY SYSTEM

This body system relates to the integument, which according to Stedman's medical dictionary, is "the enveloping membrane of the body; includes, in addition to the epidermis and dermis, all of the derivatives of the epidermis." If the procedure extends beyond these boundaries – such as those involving the deep fascia, muscle, tendons, nerves, blood vessels or other structures – other sections of CPT should be referenced. The following CPT codes found in the Integumentary System section include incision, drainage, biopsy, excision, destruction, introduction and repair:

Subheading	CPT Code Range
Incision and Drainage	10060 – 10061 10120 – 10180
Debridement	11000 – 11001 11010 – 11047
Paring or Cutting	11055 – 11057
Biopsy	11102 – 11107
Removal of Skin Tags	11200 – 11201
Shaving of Epidermal or Dermal Lesions	11305 – 11313
Excision – Benign Lesions	11420 – 11446
Excision – Malignant Lesions	11620 – 11646
Introduction	11900 – 11901
Adjacent Tissue Transfer or Rearrangement	14040 – 14302
Destruction, Benign or Premalignant Lesions	17000 – 17250
Destruction, Malignant Lesions, Any Method	17270 – 17286
Mohs Micrographic Surgery	17311 – 17315

MUSCULOSKELETAL SYSTEM (General)

This body system relates to the muscles and skeleton. The musculoskeletal system section of CPT is divided into several anatomical subsections; however, the two most applicable to OMS are "General" (20100 - 20999) and "Head" (21010 - 21499). The CPT codes in these sections may include procedures that involve incision, excision, introduction or revision/reconstruction:

Subheading	CPT Code Range
GENERAL	
Excision	20200 – 20245
Introduction or Removal	20500 – 20525 20605 20615
Other Procedures	20999
HEAD (Skull, facial bones and temporomandibular joint)	
Incision	21010
Excision	21011 – 21070
Manipulation	21073
Introduction or Removal	21100 – 21110
Repair, Revision and/or Reconstruction	21181 – 21196 21240 – 21243
Fracture and/or Dislocation	21497
Other Procedures	21299 21499

Note: Some CPT codes listed within this paper may only be billable in a facility setting. The Medicare Physician Fee Schedule Look-Up Tool is a helpful resource for determining code applicability.

RESPIRATORY SYSTEM

The beginning part of the Respiratory System section of CPT pertains to the nose, including the removal of foreign bodies and procedures of the sinuses. It is from this section that OMSs may code most of their pathology procedures related to the nose and accessory sinuses. The codes found in these sections may involve an incision, excision, introduction, destruction and endoscopy:

Subheading	CPT Code Range
NOSE	
Incision	30000 – 30020
Excision	30100 – 30160
Introduction	30200
Removal of Foreign Body	30300 – 30310
Destruction	30801 – 30802
Other Procedures	30901 – 30920 30999
ACCESSORY SINUS	
Incision	31000 – 31002 31020 – 31087
Excision	31200 – 31230
Endoscopy	31231 – 31294
Other Procedures	31299

DIGESTIVE SYSTEM

Similar to the sections of the CPT manual previously discussed, the Digestive System section is divided into multiple anatomical subsections. The first seven are the most applicable to oral and maxillofacial surgery including Lips (40490 - 40799), Vestibule of Mouth (40800 - 40899), Tongue and Floor of Mouth (41000 - 41599), Dentoalveolar Structures (41800 - 41899), Palate and Uvula (42000 - 42299), Salivary Gland and Ducts (42300 - 42699) and Pharynx, Adenoids and Tonsils (42700 - 42999):

Subheading	CPT Code Range
LIPS	
Excision	40490 – 40530
Other Procedures	40799
VESTIBULE OF MOUTH	
Incision	40800 – 40805
Excision, Destruction	40808 – 40820
Other Procedures	40899
TONGUE AND FLOOR OF MOUTH	
Incision	41000 – 41009 41015 – 41018
Excision	41100 – 41155
Other Procedures	41599
DENTOALVEOLAR STRUCTURES	
Incision	41800 – 41806
Excision, Destruction	41820 – 41850
Other Procedures	41870 – 41899
PALATE AND UVULA	
Incision	42000
Excision, Destruction	42100 – 42160
Other Procedures	42299
SALIVARY GLAND AND DUCTS	
Incision	42300 – 42340
Excision	42400 – 42450
Repair	42500 – 42510
Other Procedures	42550 – 42699
PHARYNX, ADENOIDS AND TONSILS	
Incision	42700 – 42725
Excision, Destruction	42800 – 42815
Other Procedures	42999

IV. CDT CODING FOR ORAL AND MAXILLOFACIAL PATHOLOGY

When CDT codes are used to report oral and maxillofacial pathology procedures, incisional biopsies should be reported with CDT codes D7285 and D7286 as follows:

D7285 incisional biopsy of oral tissue – hard (bone, tooth)

For partial removal of lesion. This procedure involves biopsy of osseous or intra-osseous lesions (example, cyst, tumor) and is not used for apicoectomy/periradicular surgery. This procedure does not entail an excision.

D7286 incisional biopsy of oral tissue – soft

For partial removal of a lesion at the same time as codes for apicoectomy/periradicular curettage. This procedure does not entail an excision.

In the treatment of large odontogenic cysts, it may be necessary to gradually decrease the size of the cyst prior to performing a cystectomy. The procedure involves making a window on the cystic wall by incision, evacuation of the cyst contents and suturing the cystic lining to the oral mucosa. This process is called marsupialization and is appropriately reported with the following CDT code:

D7509 marsupialization of odontogenic cyst

Surgical decompression of a large cystic lesion by creating a long-term open pocket or pouch.

Coding Tip: Since there is no distinct code applicable for marsupialization of an odontogenic cyst in CPT, code D7509 would be appropriate to report on a medical claim form.

CDT codes for pathology-related procedures may come from several Categories of Service within the CDT book although the two most applicable are likely Periodontics and Oral & Maxillofacial Surgery.

PERIODONTICS

Procedure	CDT Code Range
Surgical Services (Including Usual Postoperative Care)	D4210 – D4212 D4240 – D4241 D4266 – D4270 D4286
Other Periodontal Services	D4999

ORAL & MAXILLOFACIAL SURGERY

Procedure	CDT Code Range
Other Surgical Procedures (biopsies)	D7284 – D7288
Excision of Soft Tissue Lesions	D7410 – D7465
Excision of Intra-Osseous Lesions	D7440 – D7461
Excision of Bone Tissue	D7471 – D7490
Surgical Incision	D7509 – D7560
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions	D7830 – D7854 D7860 D7870 – D7877
Other Repair Procedures	D7920 – D7922 D7955 D7956 – D7963 D7970 – D7971 D7979 – D7983 D7991 D7999

Medicare Providers and Biopsies

Generally, Medicare excludes coverage for biopsies and related pathology when the diagnosis is associated with a benign lesion or an otherwise odontogenic condition. Despite any clinical indications for the procedure, Medicare may deem services as not medically necessary based on such diagnoses and exclude coverage under Medicare for these services. Likewise, Medicare will typically deny any claims from the pathologist and/or laboratory related to the noncovered procedure(s) or service(s). It is advised that the OMS present the Medicare patient with the Advance Beneficiary Notice of Non-coverage (ABN). The ABN allows the patient to make an informed decision about whether to proceed with a service or procedure for which he or she may be personally financially responsible. Keep in mind, Medicare does not require an ABN for statutorily excluded services, as many dental services are. However, CMS strongly encourages providers to issue an ABN for care that is never covered.

For oral pathologies, an ABN is most appropriately used to notify a beneficiary that a procedure billable under Medicare is anticipated to be denied based on the diagnosis, rather than the procedure itself. When information regarding a potential Medicare denial is properly communicated to the beneficiary and documented in accordance with CMS's requirements via a signed ABN, it allows the OMS to transfer financial liability to the beneficiary when such a denial is received.

Providers supplying ancillary services in relation to oral pathology, such as pathologists and laboratories, may not be able to obtain an ABN directly from the patient. Therefore, in the case of oral pathology services for which a denial is anticipated, it is recommended for OMSs to include on the ABN a list of other providers supplying any related services, allowing ancillary providers to hold the patient financially responsible for non-covered services. OMSs also are encouraged to notify such providers of their inclusion in the ABN and be able to provide a copy of the waiver should it be required for claim submission.

A more in-depth article, *Use of the Medicare Advance Beneficiary Notice*, can be found on AAOMS.org, and additional information regarding the ABN form and instructions can be found on CMS.gov.

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Note: The list of CDT, CPT and ICD-10-CM codes in this coding paper is not all-inclusive. AAOMS recommends reporting codes applicable to the service(s) rendered and the patient's specific clinical condition as determined by the provider.

This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

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 in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by anyone in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-10-CM) and treatment (CPT/CDT) coding for oral and maxillofacial pathology. When indicated, a reference to the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.

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