

CONTENTS

FOREWORD	iii
DISCLAIMER	iv
TERMINOLOGY	1
INTRODUCTION	33
Sources of the Data and Data Analysis.....	33
Format of the Listings.....	33
CDT Listing Example.....	34
CPT Listing Example	35
ICD-9-CM Listing Example	35
Linking Diagnosis Codes to Procedure Codes.....	36
CDT CODING	37
Key points regarding CDT.....	37
Structure of the CDT Coding System	37
Guidelines.....	38
Subsection Information.....	38
Unlisted Service or Procedure	38
Special Report	38
Modifiers	39
How to use the CDT Coding System.....	39
CDT CODES	40
Diagnostic Procedures (D0100-D0999).....	40
Preventive Services (D1000-D1999).....	56
Restorative Procedures (D2000-D2999).....	61
Endodontics (D3000-D3999).....	86
Periodontics (D4000-D4999).....	93
Prosthodontics – Removable (D5000-D5899).....	99
Implant Services (D6000-D6199).....	122
Prosthodontics – Fixed (D6200-D6999).....	138
Oral and Maxillofacial Surgery (D7000-D7999).....	157
Orthodontics (D8000-D8999).....	200
Adjunctive General Services (D9000-D9999).....	207
CPT CODING	217
Key points regarding CPT	217
Structure of the CPT Coding System.....	217
How to use the CPT Coding System	218
CPT Modifiers	218
Unlisted Procedures or Services	218

CPT Changes, Additions, and Deletions	219
Place (Location) of Service	219
Documentation Guidelines	219
National Correct Coding Policy.....	221
CPT CODES	242
Surgery Services.....	242
Integumentary System	246
Wound Repair (Closure).....	264
Skin Replacement Surgery	267
Musculoskeletal System	271
Digestive System	285
Radiology Services.....	335
Pathology & Laboratory Services.....	353
ICD-9-CM CODING	373
Historical Perspective	373
Key Points Regarding ICD-9-CM	373
Format of ICD-9-CM.....	374
ICD-9-CM Official Guidelines for Coding and Reporting	376
ICD-9-CM CODES	383
Malignant Neoplasm of Lip.....	363
Malignant Neoplasm of Tongue	384
Malignant Neoplasm of Major Salivary Glands	384
Malignant Neoplasm of Gum	384
Malignant Neoplasm of Floor of Mouth.....	384
Malignant Neoplasm of Other and Unspecified Parts of Mouth.....	384
Other Malignant Neoplasm of Skin.....	385
Benign Neoplasm of Lip, Oral Cavity and Pharynx	385
Benign Neoplasm of Skin.....	385
Carcinoma in Situ of Skin.....	385
Neoplasm of Uncertain Behavior of Digestive and Respiratory Systems	385
Acute Pain	385
Chronic Pain	385
Disorders of Tooth Development and Eruption.....	385
Diseases of Hard Tissues of Teeth.....	385
Diseases of Pulp and Periapical Tissues	387
Gingival and Periodontal Diseases	387
Dentofacial Anomalies Including Malocclusion	388
Other Diseases and Conditions of the Teeth and Supporting Structures	389
Diseases of the Jaws	390
Diseases of the Salivary Glands	390
Diseases of the Oral Soft Tissues (Excluding Gingiva and Tongue).....	391
Diseases and Other Conditions of the Tongue.....	391
Congenital Anomalies	391
Fracture of Face Bones.....	391
Infection and Inflammatory Reaction	392

Personal History of Malignant Neoplasm..... 392
Fitting and Adjustment of Prosthetic Device..... 362

INSURANCE CLAIM FORMS..... 394

Dental Notation 397
Dental Claim Form 398
CMS1500 Claim Form 405

TERMINOLOGY

Understanding the coding and compliance process requires a fundamental working knowledge of the words and acronyms used by medical professionals, government agencies and health insurance carriers to describe services, benefits and reimbursement policies. While many publications place the terminology section in an appendix at the back of the book, we feel that you should have an opportunity to review and learn the terminology before you encounter it within the text itself. Following is a comprehensive list of billing, coding, compliance, HIPAA and reimbursement words, terms and acronyms, including some that may not appear in the text of the book.

Ablation: The removal or destruction of a body part or tissue or its function. Ablation may be performed by surgery, hormones, drugs.

Abrasion: Removal of tooth structure due to rubbing and scraping (e.g. incorrect brushing method).

Abscess: A localized infection due to a collection of pus in the bone or soft tissue caused by severe decay, trauma or gum disease that may cause pain and swelling.

Abstract: The collection of information from the medical record via hard copy or electronic instrument.

Abutment: A tooth or implant used to support a prosthesis; the natural teeth (or implanted teeth) that hold a fixed or removable bridge in place.

Access: The ability to obtain needed medical care.

Accident and health insurance: Health insurance under which benefits are payable in case of disease, accidental injury or accidental death.

Actual charge: One of the factors determining a physician's payment for a service under Medicare; equivalent to the billed or submitted charge. See Customary, Prevailing and Reasonable.

Acute: Refers to the condition that is the primary reason for the current encounter.

ADA : American Dental Association

Add-on codes: Procedures listed in the CPT coding system that are commonly carried out in addition to the primary procedure performed.

Adhesive Dentistry: Contemporary term for dental restorations that involve "bonding" of composite resin or porcelain fillings to natural teeth.

Adjusted historical payment basis (AHPB): The average historical payment in a specific locality for a specific service.

Admission date: The date the patient was admitted for inpatient care, outpatient service, or start of care.

Admitting diagnosis code: Code indicating patient's diagnosis at admission.

Adverse: Any response to a drug that is noxious and unintended and occurs with proper dosage.

AFDC: Aid to Families with Dependent Children

Aftercare: An encounter for something planned in advance, for example, cast removal.

AHFS: American Hospital Formulary Service.

AHPB: Adjusted Historical Payment Basis **Air Abrasion:** Removal of tooth structure by blasting a tooth with air and abrasive, a relatively new technology that may avoid the need for anesthetic.

Allergy: Unfavorable systemic response to a foreign substance or drug.

Allograft: A transplant process wherein a tissue or organ is taken from one individual (donor) and placed into another (recipient)

Allowed charge: Payment for a physician service under the customary, prevailing and reasonable system; includes the payment from Medicare and the beneficiary's coinsurance, but not any balance bill. See Balance Bill; Coinsurance; Customary, Prevailing and Reasonable.

Alphabetic index: The portion of ICD-9-CM that lists definitions and code sets in alphabetic order. Also referred to as Volume 2.

Alveolar Bone: The jaw bone that anchors the roots of teeth.

Alveoloplasty: A surgical procedure used to reshape supporting bone structures in preparation of a complete or partial denture.

AMA: American Medical Association **Amalgam:** A silver-colored filling made of a mixture of silver, tin, mercury and some other trace elements such as copper.

Analgesia: A state of pain relief or an agent that lessens pain.

Anastomosis: An operation to connect two body parts.

Anesthesia: Loss of sensation or feeling; induced artificially with drugs to permit painful procedures such as surgery. Numbing a tooth is an example of local anesthesia; general anesthesia produces partial or complete unconsciousness.

Anesthetic: A class of drugs that eliminates or reduces pain. See local anesthetic.

ANSI: American National Standards Institute

Anterior: Refers to the teeth and tissues located towards the front of the mouth (upper or lower incisors and canines).

Anterior Teeth: The six upper or six lower front teeth.

Antibiotic: A drug that stops or slows the growth of bacteria.

ANUG: An acronym for Acute Necrotizing Ulcerative Gingivitis, commonly known as trench mouth or Vincent's disease, which can be aggravated by stress and/or smoking.

CDT CODING

CDT is an acronym for Current Dental Terminology. Current Dental Terminology (CDT) is a listing of codes and descriptions used to report dental services performed by dentists, oral surgeons and ancillary professionals. The purpose of the CDT coding system is to provide a uniform language that accurately describes dental services and to provide an effective means for reliable nationwide communication among dentists and health insurance companies.

CDT codes and terminology serve a variety of important functions in the field of medical nomenclature for the reporting of physician procedures and services under government and private health insurance programs. CDT is also used for administrative management purposes such as claims processing and for the development of guidelines for medical care review.

KEY POINTS REGARDING CDT

- CDT codes describe dental procedures, services, and supplies.
- CDT codes are five-digit alphanumeric codes.
- CDT codes are accepted or required by all third-party payers.
- CDT codes are self-definitive. With the exception of a few codes that contain the term *specify* in the description, each code has only one meaning.
- CDT codes are revised by the American Dental Association every two years. The new edition becomes effective January 1st of the year following publication. Each new edition includes new and changed codes and supplemental material. It is important to purchase a copy of each new edition of the CDT book.
- Accurate CDT coding puts you in control of the reimbursement process.

STRUCTURE OF THE CDT CODING SYSTEM

The CDT coding system is a systematic method for coding procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit numeric code. The use of CDT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the dental professional is accurately identified.

The CDT coding system is divided into several sections. Within each section are subsections with anatomic, procedural, condition, or descriptor subheadings. The sections of the CDT coding system are:

Diagnostic Procedures	D0100-D0999
Preventive Services	D1000-D1999
Restorative Services	D2000-D2999
Endodontics	D3000-D3999
Periodontics	D4000-D4999
Prosthodontics – Removable	D5000-D5899
Maxillofacial Prosthetics	D5900-D5999
Implant Services	D6000-D6199
Prosthodontics - Fixed	D6200-D6999
Oral And Maxillofacial Surgery	D7000-D7999
Orthodontics	D8000-D8999
Adjunctive General Services	D9000-D9999

GUIDELINES

In addition to the information presented in the INTRODUCTION, several other items unique to this section are defined or identified here:

SUBSECTION INFORMATION

Some of the listed subheadings or subsections have special needs or instructions unique to that section. Where these are indicated, special “notes” will be presented preceding or following the listings. Those subsections within the DENTAL PROCEDURES section that have “notes” are as follows:

Root canal therapy	D3310-D3350
Surgical services	D4210-D4274
Complete dentures	D5110-D5140
Partial dentures	D5211-D5281
Extraoral prostheses	D5911-D5921
Prosthodontics, fixed	D6200-D6999
Oral surgery	D7000-D7999
Complicated suturing	D7911-D7912
Professional consultation	D9310

UNLISTED SERVICE OR PROCEDURE

A service or procedure may be provided that is not listed in this edition of HCPCS. When reporting such a service, the appropriate “unlisted procedure” code may be used to indicate the service, identifying it by “special report” as defined below. HCPCS terminology is inconsistent in defining unlisted procedures. The procedure definition may include the term(s) “unlisted”, “not otherwise classified”, “unspecified”, “unclassified”, “other” and “miscellaneous”. Prior to using these codes, try to determine if a Local Level III code or CPT code is available. The “unlisted procedures” and accompanying codes for DENTAL PROCEDURES are as follows:

D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2999	Unspecified restorative procedure, by report
D3999	Unspecified endodontic procedure, by report
D4999	Unspecified periodontal procedure, by report
D5899	Unspecified removable prosthodontic procedure, by report
D5999	Unspecified maxillofacial prosthesis, by report
D6199	Unspecified implant procedure, by report
D6999	Unspecified, fixed prosthodontic procedure, by report
D7899	Unspecified TMD therapy, by report
D7999	Unspecified oral surgery procedure, by report
D8999	Unspecified orthodontic procedure, by report
D9999	Unspecified adjunctive procedure, by report

SPECIAL REPORT

A service, material or supply that is rarely provided, unusual, variable or new may require a special report in determining medical appropriateness for reimbursement purposes. Pertinent



CDT CODES

DIAGNOSTIC PROCEDURES (D0100-D0999)

CLINICAL ORAL EXAMINATIONS

D0120 Periodic oral evaluation established patient

Medicare Policy: Non-covered by Medicare

Linked Diagnosis Codes:

- 180.9** Malignant neoplasm of cervix uteri unspecified site
- 521.00** Unspecified dental caries
- 521.02** Dental caries extending into dentine
- 521.03** Dental caries extending into pulp
- 522.5** Periapical abscess without sinus
- 523.6** Accretions on teeth
- 525.10** Acquired absence of teeth, unspecified
- 525.8** Other specified disorders of the teeth and supporting structures
- 528.3** Cellulitis and abscess of oral soft tissues
- V15.89** Other specified personal history presenting hazards to health
- V72.2** Dental exam

D0140 Limited oral evaluation problem focused

Medicare Policy: Non-covered by Medicare

Linked Diagnosis Codes:

- 210.1** Benign neoplasm of tongue
- 210.4** Benign neoplasm of other and unspecified parts of mouth
- 235.1** Neoplasm of uncertain behavior of lip oral cavity and pharynx
- 520.6** Disturbances in tooth eruption
- 521.00** Unspecified dental caries
- 521.02** Dental caries extending into dentine
- 521.03** Dental caries extending into pulp
- 522.0** Pulpitis
- 522.1** Necrosis of the pulp
- 522.5** Periapical abscess without sinus
- 522.6** Chronic apical periodontitis
- 522.7** Periapical abscess with sinus
- 525.10** Acquired absence of teeth, unspecified
- 525.3** Retained dental root
- 525.8** Other specified disorders of the teeth and supporting structures
- 525.9** Unspecified disorder of the teeth and supporting structures
- 528.3** Cellulitis and abscess of oral soft tissues
- 528.6** Leukoplakia of oral mucosa including tongue
- 528.9** Other and unspecified diseases of the oral soft tissues
- 697.0** Lichen planus

- 738.19 Other acquired deformity of head other specified deformity
 784.0 Headache
 873.63 Tooth (broken) (fractured) (due to trauma) , without mention of complication
 V70.0 Routine general medical exam at a health care facility
 V72.2 Dental exam

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver

Medicare Policy: Non-covered by Medicare

Linked Diagnosis Codes:

- V70.0 Routine general medical exam at a health care facility
 V72.2 Dental exam

D0150 Comprehensive oral evaluation new or established patient

Medicare Policy: Special coverage instructions

CIM: 5026 **MCM:** 2136, 2336

Linked Diagnosis Codes:

- 141.2 Malignant neoplasm of tip and lateral border of tongue
 202.80 Other malignant lymphomas unspecified site
 210.4 Benign neoplasm of other and unspecified parts of mouth
 520.0 Anodontia
 521.00 Unspecified dental caries
 522.5 Periapical abscess without sinus
 523.6 Accretions on teeth
 524.60 Temporomandibular joint disorders unspecified periodontal disease
 525.10 Acquired absence of teeth, unspecified
 525.3 Retained dental root
 526.81 Exostosis of jaw
 526.89 Other specified diseases of the jaws
 527.7 Disturbance of salivary secretion
 528.2 Oral aphthae
 528.3 Cellulitis and abscess of oral soft tissues
 528.6 Leukoplakia of oral mucosa including tongue
 528.9 Other and unspecified diseases of the oral soft tissues
 784.0 Headache
 V72.2 Dental exam

D0160 Detailed and extensive oral evaluation problem focused, by report

Medicare Policy: Non-covered by Medicare

Linked Diagnosis Codes:

- 141.2 Malignant neoplasm of tip and lateral border of tongue
 202.80 Other malignant lymphomas unspecified site

CPT is an acronym for Current Procedural Terminology. *Physicians' Current Procedural Terminology* (CPT) is a listing of over 8,000 codes and descriptions used to report medical services and procedures performed by physicians and other medical professionals. The purpose of the CPT coding system is to provide a uniform language that accurately describes medical, surgical, and diagnostic services and to provide an effective means for reliable nationwide communication among physicians, hospitals, and health insurance companies.

CPT codes and terminology serve a variety of important functions in the field of medical nomenclature for the reporting of physician procedures and services under government and private health insurance programs. CPT is also used for administrative management purposes such as claims processing and for the development of guidelines for medical care review.

KEY POINTS REGARDING CPT

- CPT codes describe medical procedures, services, and supplies.
- CPT codes are five-digit, numeric or alphanumeric codes.
- CPT codes are accepted or required by all third-party payers.
- CPT codes are self-definitive. With the exception of a few codes that contain the term *specify* in the description, each code has only one meaning.
- CPT codes are revised each fall and become effective January 1. Hundreds of CPT codes are added, changed, or deleted each year. You need to purchase a new copy of the CPT coding system each year.
- Accurate CPT coding puts you in control of the reimbursement process.

STRUCTURE OF THE CPT CODING SYSTEM

The CPT coding system is a systematic method for coding procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit numeric code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physicians is accurately identified.

The CPT coding system is divided into code sections. Within each section are subsections with anatomic, procedural, condition, or descriptor subheadings. The procedures and services with their identifying codes are presented in numeric order except for codes found in the Evaluation and Management section (99200-99499). These codes are located at the beginning of the CPT coding system because they are used by all medical professionals and they are the most frequently used codes. The sections of the CPT coding system are:

Evaluation and Management	99200-99499
Anesthesia	00100-01999
Surgery	10000-69999
Radiology	70000-79999
Pathology and Laboratory	80000-89999
Medicine	90000-99199
Category II Codes	0001F-0011F
Category III Codes	0001T-0061T

HOW TO USE THE CPT CODING SYSTEM

A health care professional using CPT for coding selects the name and associated code of the procedure or service that most accurately identifies and describes the service(s) performed. In surgery, this may be an operation; in medicine, an office visit, hospital visit, consultation, or diagnostic procedure; in radiology, an x-ray. The professional selects names and codes for additional services or procedures and, when necessary, selects and adds modifiers for additional or reduced services or for extenuating circumstances. Any services or procedures coded in this manner are also documented in the patient's medical record.

It is important to recognize that the listing of a service or procedure and its code number in a specific section of the CPT coding system does not restrict its use to a specific specialty group. Any procedure or service in any section of the CPT coding system may be used to designate the services rendered by any qualified physician or other medical professional.

The codes and descriptions listed in the CPT coding system are those that are generally consistent with contemporary medical practice and being performed by medical professionals in clinical practice. Inclusion in CPT does not represent endorsement by the American Medical Association of any particular diagnostic or therapeutic procedure. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

CPT MODIFIERS

A CPT modifier provides the means to report that a service or procedure has been altered or modified by some specific circumstance but not changed in its definition or code. The proper use of modifiers reduces the need for separate procedure listings to describe the modifying circumstance. Modifiers are typically used to indicate that:

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

A complete listing of CPT modifiers is found in Appendix A of the CPT coding system. In addition, a list of modifiers common to each of the six sections described above is located in the Guidelines of each section.

UNLISTED PROCEDURES OR SERVICES

The AMA and CMS recognize that there may be services or procedures performed by medical professionals that are not found in CPT or HCPCS. Therefore, a number of specific code numbers have been included for reporting unlisted procedures. When an unlisted procedure code is used, the service or procedure must be described and a report describing the service or procedure must be submitted with the health insurance claim.

reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

INCISION AND DRAINAGE

Incision and drainage services, as related to the integumentary system, generally involve cutaneous or subcutaneous drainage of cysts, pustules, infections, hematomas, seromas, or fluid collections. In cases in which, in the course of an excision of a lesion, an area of involvement is identified that requires drainage, either as a part of the procedure or in order to gain access to the area of interest, coding/billing for incision and drainage of this fluid collection would be inappropriate if the excision or other procedure is performed in the same session.

Example: A patient who presents with a pilonidal cyst may require simple incision/drainage or may require an extensive excision. In the former case, the appropriate CPT coding is 10080 (or 10081 if complicated). If the pilonidal cyst is excised, while it is obvious that drainage from the cyst will occur in the course of its excision, the appropriate coding is CPT code 11770 (or 11771 or 11772, depending on the complexity), not CPT codes 10080 *and* 11770. If it is evident that an extensive cellulitis is present around the cyst that prevents the complete procedure from being accomplished, it may be reasonable to bill for CPT code 10080. Then, after perhaps a week of antibiotic therapy, you may complete the procedure using code 11770-78 (Return to the operating room for a related procedure during the postoperative period). The nature of the treatment should be driven by medical decision making rather than by coding conventions.

Procedure codes such as incision and drainage of hematomas (e.g., CPT code 10140) are not to be reported during the same session or at the same site as an excision, repair, destruction, removal, etc.

Codes describing services necessary to address complications, such as CPT code 10180 (incision and drainage, complex, postoperative wound infection), should not be submitted for services rendered at the same surgical session that resulted in the complication. If performed in conjunction with the primary procedure, it would be included in the primary, column 1, procedure.

For example, if a patient has undergone a thoracotomy and a necrotizing pneumonia with empyema develops, it may be necessary to perform a lobectomy through the previous incision. The reason for the surgery is to perform the lobectomy; therefore the lobectomy code should be reported. Since the drainage of the empyema is necessary to accomplish the lobectomy, it would be inappropriate to bill for CPT code 10180 (incision and drainage). On the other hand, if the patient would require only drainage of a thoracotomy wound infection (without lobectomy) and it is determined to be medically necessary to place a gastrostomy tube at the same time, the CPT code 10180 could be reported with the appropriate gastrostomy tube placement code.

INTEGUMENTARY SYSTEM CODES

SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES

10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

RVUs: Transitioned NonFacility Total 2.67 Transitioned Facility Total 2.32



Medicare Policies: minor surgical procedure-followup period is 10 days standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid

Linked Diagnosis Codes:

- 380.10** Infective otitis externa unspecified
- 528.3** Cellulitis and abscess of oral soft tissues
- 682.0** Cellulitis and abscess of face
- 682.2** Cellulitis and abscess of trunk
- 706.2** Sebaceous cyst

NCCI Column 2 Codes: 11055^A, 11056^A, 11057^A, 11401^A, 11402^A, 11403^A, 11404^A, 11406^A, 11421^A, 11422^A, 11423^A, 11424^A, 11426^A, 11441^A, 11442^A, 11443^A, 11444^A, 11446^A, 11450^A, 11451^A, 11462^A, 11463^A, 11470^A, 11471^A, 11600^A, 11601^A, 11602^A, 11603^A, 11604^A, 11606^A, 11620^A, 11621^A, 11622^A, 11623^A, 11624^A, 11626^A, 11648, 11641^A, 11642^A, 11643^A, 11644^A, 11646^A, 11719^A, 11720^A, 11721^A, 11730^A, 11740^A, 11765^A, 20000^A, 20005^A, 20500^A, 30000^A, 36000^A, 36410^A, 37202^A, 51701^A, 51702^A, 51703^A, 62318^A, 62319^A, 64400^A, 64402^A, 64405^A, 64408^A, 64410^A, 64412^A, 64413^A, 64415^A, 64416^A, 64417^A, 64418^A, 64420^A, 64421^A, 64425^A, 64430^A, 64435^A, 64445^A, 64446^A, 64447^A, 64448^A, 64449^A, 64450^A, 64470^A, 64475^A, 64479^A, 64483^A, 69990^N, 90760^A, 90765^A, 90772^A, 90774^A, 90775^A, 97597^A, 97598^A, 97602^A, 97605^A, 97606^A, G0127^A

- 10061** Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple

RVUs: Transitioned NonFacility Total 4.63 Transitioned Facility Total 4.18

Medicare Policies: minor surgical procedure-followup period is 10 days standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid

Linked Diagnosis Codes:

- 526.4** Inflammatory conditions of jaw
- 682.0** Cellulitis and abscess of face

NCCI Column 2 Codes: 10060^A, 11055^A, 11056^A, 11057^A, 11406^A, 11424^A, 11426^A, 11440^A, 11444^A, 11446^A, 11450^A, 11451^A, 11463^A, 11470^A, 11471^A, 11604^A, 11606^A, 11623^A, 11624^A, 11626^A, 11643^A, 11644^A, 11646^A, 11719^A, 11720^A, 11721^A, 11730^A, 11740^A, 11750^A, 11760^A, 11765^A, 20005^A, 20500^A, 36000^A, 36410^A, 37202^A, 51701^A, 51702^A, 51703^A, 62318^A, 62319^A, 64400^A, 64402^A, 64405^A, 64408^A, 64410^A, 64412^A, 64413^A, 64415^A, 64416^A, 64417^A, 64418^A, 64420^A, 64421^A, 64425^A, 64430^A, 64435^A, 64445^A, 64446^A, 64447^A, 64448^A, 64449^A, 64450^A, 64470^A, 64475^A, 64479^A, 64483^A, 69990^N, 90760^A, 90765^A, 90772^A, 90774^A, 90775^A, 97597^A, 97598^A, 97602^A, 97605^A, 97606^A, G0127^A

- 11100** Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

ICD-9-CM CODING

ICD-9-CM is an acronym for *International Classification of Diseases, 9th Revision, Clinical Modification*, published under different names since 1900. *ICD-9-CM* is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Most *ICD-9-CM* codes are numeric and consist of three, four or five numbers and a description. The codes are revised approximately every 10 years by the World Health Organization and annual updates are published by Center for Medicare and Medicaid Services (CMS).

HISTORICAL PERSPECTIVE

The *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* is based on the official version of the *World Health Organization's (WHO) 9th Revision, International Classification of Diseases (ICD-9)*. *ICD-9* is designed for the classification of morbidity and mortality information for statistical purposes, and for the indexing of medical records by disease and operations, and for data storage and retrieval. *ICD-9-CM* replaced the Eighth Revision International Classification of Diseases, Adapted for Use in the United States commonly referred to as *ICDA*.

The concept of extending the International Classification of Diseases for use in hospital indexing was originally developed in response to a need for a more efficient basis for storage and retrieval of diagnostic data. In 1950, the U.S. Public Health Service and the Veterans Administration began independent tests of the International Classification of Diseases for hospital indexing purposes. In the following year, the Columbia Presbyterian Medical Center in New York City adopted the International Classification of Diseases, 6th Revision for use in its medical record department. A few years later, the Commission on Professional and Hospital Activities adopted the International Classification of Diseases for use in hospitals participating in the Professional Activity Study (PAS).

In view of the growing interest in the use of the International Classification of Diseases for hospital indexing, a study was undertaken in 1956 by the American Medical Association and the American Medical Record Association of the relative efficiencies of coding systems for diagnostic indexing. Following this study, the major uses of the International Classification of Diseases for hospital indexing purposes consolidated their experiences and an adaptation was published in December 1959. A revision containing the first “Classification of Operations and Treatments” was published in 1962.

In 1968, following a study by the American Hospital Association, the United States Public Health Service published the Eighth Revision International Classification of Diseases, Adapted for Use in the United States. This publication became commonly known as *ICDA*, and served as the basis for coding diagnostic data for official morbidity and mortality statistics in the United States.

KEY POINTS REGARDING ICD-9-CM

1. ICD-9-CM codes are three to five numeric or alphanumeric codes.
2. ICD-9-CM codes describe illnesses, injuries, signs and symptoms, and procedures.

3. ICD-9-CM codes must be used on all health insurance claims.
4. Most ICD-9-CM codes have a specific definition; however, some ICD-9-CM codes have more than one definition.
5. Correct ICD-9-CM coding can make a significant difference in your reimbursement.
6. Accurate ICD-9-CM coding puts you in control of the reimbursement process.

FORMAT OF ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* consists of three separate volumes of diagnostic and procedure codes, descriptions and additional information. Current versions of the *ICD-9-CM* coding book are available as either two separate books containing Volume 1 and Volume 2 in one book or Volumes 1, 2 and 3 in the other. The two volume book is used by physicians, clinics and other health care providers providing (mostly) outpatient services. The three volume book is used by hospitals providing inpatient services and third party payers for health insurance claim review.

THE TABULAR LIST (VOLUME 1)

The Tabular List (Volume 1) is a *numeric* listing of diagnosis codes and descriptions consisting of 17 chapters that classify diseases and injuries, two sections containing supplementary codes (V codes and E codes) and six appendices.

CLASSIFICATION OF DISEASES AND INJURIES

The Classification of Diseases and Injuries includes the following 17 chapters:

- | | |
|------------|---|
| Chapter 1 | Infectious and Parasitic Diseases (001-139) |
| Chapter 2 | Neoplasms (140-239) |
| Chapter 3 | Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240-279) |
| Chapter 4 | Diseases of the Blood and Blood-Forming Organs (280-289) |
| Chapter 5 | Mental Disorders (290-319) |
| Chapter 6 | Diseases of the Nervous System and Sense Organs (320-389) |
| Chapter 7 | Diseases of the Circulatory System (390-459) |
| Chapter 8 | Diseases of the Respiratory System (460-519) |
| Chapter 9 | Diseases of the Digestive System (520-579) |
| Chapter 10 | Diseases of the Genitourinary System (580-629) |
| Chapter 11 | Complications of Pregnancy, Childbirth, and the Puerperium (630- 677) |
| Chapter 12 | Diseases of the Skin and Subcutaneous Tissue (680-709) |
| Chapter 13 | Diseases of the Musculoskeletal System and Connective Tissue (710-739) |
| Chapter 14 | Congenital Anomalies (740-759) |
| Chapter 15 | Certain Conditions Originating in the Perinatal Period (760-779) |
| Chapter 16 | Symptoms, Signs and Ill-defined Conditions (780-799) |
| Chapter 17 | Injury and Poisoning (800-999) |

Each chapter of the Tabular List (Volume 1) is structured into four components, namely:

Sections: groups of three-digit code numbers



- 520.4 Disturbances of tooth formation
- 520.5 Hereditary disturbances in tooth structure not elsewhere classified
- 520.6 Disturbances in tooth eruption
- 520.7 Teething syndrome
- 520.8 Other specified disorders of tooth development and eruption
- 520.9 Unspecified disorder of tooth development and eruption

DISEASES OF HARD TISSUES OF TEETH

- 521.0* Dental caries
- 521.00 Unspecified dental caries
- 521.01 Dental caries limited to enamel
- 521.02 Dental caries extending into dentine
- 521.03 Dental caries extending into pulp
- 521.04 Arrested dental caries
- 521.05 Odontoclasia
- 521.06 Dental caries pit and fissure
- 521.07 Dental caries of smooth surface
- 521.08 Dental caries of root surface
- 521.09 Other dental caries
- 521.1* Excessive attrition (approximal wear)(occlusal wear)
- 521.10 Excessive attrition, unspecified
- 521.11 Excessive attrition, limited to enamel
- 521.12 Excessive attrition, extending into dentine
- 521.13 Excessive attrition, extending into pulp
- 521.14 Excessive attrition, localized
- 521.15 Excessive attrition, generalized
- 521.2* Abrasion of teeth
- 521.20 Abrasion, unspecified
- 521.21 Abrasion, limited to enamel
- 521.22 Abrasion, extending into dentine
- 521.23 Abrasion, extending into pulp
- 521.24 Abrasion, localized
- 521.25 Abrasion, generalized
- 521.3* Erosion of teeth
- 521.30 Erosion, unspecified
- 521.31 Erosion, limited to enamel
- 521.32 Erosion, extending into dentine
- 521.33 Erosion, extending into pulp
- 521.34 Erosion, localized
- 521.35 Erosion, generalized
- 521.4* Pathological tooth resorption
- 521.40 Pathological resorption, unspecified
- 521.41 Pathological resorption, internal
- 521.42 Pathological resorption, external
- 521.49 Other pathological resorption
- 521.5 Hypercementosis
- 521.6 Ankylosis of teeth
- 521.7 Intrinsic posteruptive color changes of teeth
- 521.8* Other specified diseases of hard tissues of teeth
- 521.81 Cracked tooth

- 521.89** Other specific diseases of hard tissues of teeth
521.9 Unspecified disease of hard tissues of teeth

DISEASES OF PULP AND PERIAPICAL TISSUES

- 522.0** Pulpitis
522.1 Necrosis of the pulp
522.2 Pulp degeneration
522.3 Abnormal hard tissue formation in pulp
522.4 Acute apical periodontitis of pulpal origin
522.5 Periapical abscess without sinus
522.6 Chronic apical periodontitis
522.7 Periapical abscess with sinus
522.8 Radicular cyst
522.9 Other and unspecified diseases of pulp and periapical tissues

GINGIVAL AND PERIODONTAL DISEASES

- 523.0*** Acute gingivitis
523.00 Acute gingivitis, plaque induced
523.01 Acute gingivitis, non-plaque induced
523.1* Chronic gingivitis
523.10 Chronic gingivitis, plaque induced
523.11 Chronic gingivitis, non-plaque induced
523.2* Gingival recession
523.20 Gingival recession, unspecified
523.21 Gingival recession, minimal
523.22 Gingival recession, moderate
523.23 Gingival recession, severe
523.24 Gingival recession, localized
523.25 Gingival recession, generalized
523.3* Acute periodontitis
523.30 Aggressive periodontitis, unspecified
523.31 Aggressive periodontitis, localized
523.32 Aggressive periodontitis, generalized
523.33 Acute periodontitis
523.4* Chronic periodontitis
523.40 Chronic periodontitis, unspecified
523.41 Chronic periodontitis, localized
523.42 Chronic periodontitis, generalized
523.5 Periodontosis
523.6 Accretions on teeth
523.8 Other specified periodontal diseases
523.9 Unspecified gingival and periodontal disease

DENTOFACIAL ANOMALIES INCLUDING MALOCCLUSION

- 524.0*** Major anomalies of jaw size
524.00 Major anomalies of jaw size unspecified anomaly
524.01 Major anomalies of jaw size maxillary hyperplasia
524.02 Major anomalies of jaw size mandibular hyperplasia

INSURANCE CLAIM FORMS

THE ADA DENTAL INSURANCE CLAIM FORM

The ADA dental insurance claim form may be used for pre-authorization of proposed dental work, or for billing work completed. The ADA Dental Claim Form was revised in 2006 by the American Dental Association and now includes a field for the National Provider Identifier. Effective May 23, 2007 providers are required to have a NPI when transmitting electronic claims or other electronic transactions governed by HIPAA.

The ADA dental insurance form is used to report dental services and procedures only, using CDT codes. If the dentist performs any services or procedures classifiable as medical services or procedures, then the CMS1500 health insurance claim form should be used along with the appropriate CPT and ICD-9-CM codes. The ADA dental insurance claim form is divided into two major sections; patient information and dentist's information.

A brief description of each element on the ADA dental insurance form is listed following the sample claim form. Please note that the term "insured" as used in regard to the dental claim form is the same as the terms "policy holder" or "subscriber."

CMS1500 CLAIM FORM

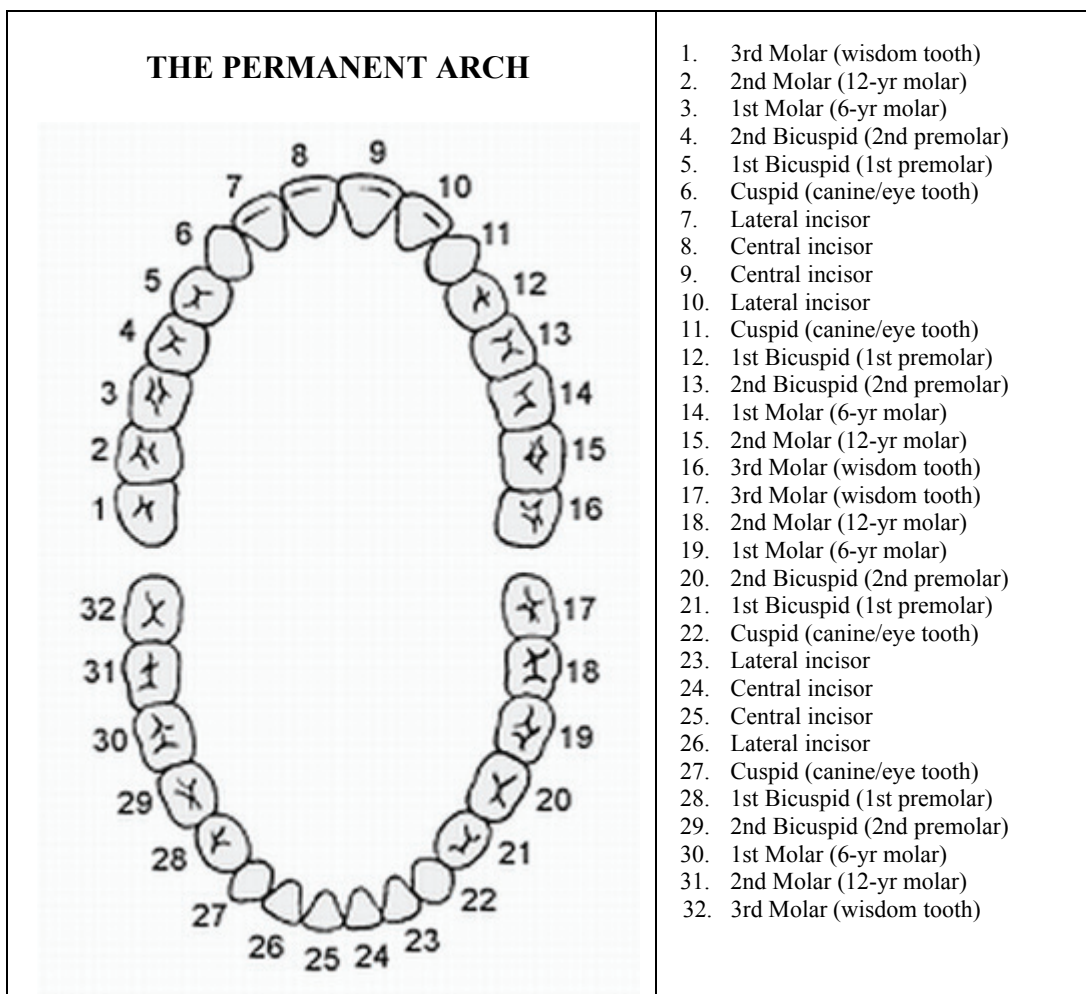
The CMS1500 health insurance claim form answers the needs of many health insurers. It is the basic form prescribed by The Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (CMS), for the Medicare and Medicaid programs for claims submitted by physicians and suppliers, except for ambulance services. It has also been adopted by CHAMPUS and has the approval of the AMA Council on Medical Services.

CMS implemented a revised CMS1500 health insurance claim form in 2007. This form is designated the 08-05 version, indicating the date (August 2005) that it was officially accepted. The major difference between the new CMS1500 (08-05) form and the prior CMS1500 (12-90) form is the split provider fields. The split fields enable reporting of the National Provider Identifier (NPI), in the fields labeled as NPI, and a corresponding legacy number in the unlabeled block above each NPI field. In addition, the bar code has been dropped from all versions of the new form.

DENTAL NOTATION

The American Dental Association recognizes two major systems used for numbering teeth. The Universal/National System is used primarily in the United States and the International Standards Organization System is used in most other countries. The Universal/National System for permanent (adult) dentition (1-32) includes: (1) is the patient's upper right molar and follows around the upper arch to the upper left third molar (16), descending to the lower left third molar (17) and follows around the lower arch to the lower right third molar (32).

The Universal/National System order for the primary (baby) dentition is the same as described for the permanent dentition, however, the primary teeth are designated by upper case letters A through T, with A being the patient's upper right second primary molar and T being the lower right second primary molar.



Source: American Dental Association



DENTAL CLAIM FORM

GENERAL INFORMATION

The ADA 2006 dental insurance claim form is designed so that the name and address of the third party payer receiving the claim (Box #3) is visible in a standard #10 window envelope. The form includes guide marks to fold the form into thirds before placing in the envelope.

In the upper-right of the form a blank space is provided for the third party payer who may use the space to record a claim or control number. This space should not be used by the reporting dentist.

All items on the form must be completed unless noted as optional or conditional on the form.

When a name and address field is required, the full name of the individual or a full business name, address, and zip code must be entered.

All dates must include the four-digit year and be in the format MM/DD/CCYY.

If the number of procedures to be reported exceeds the ten (10) lines available on a single claim form, the additional procedures must be listed on a separate, fully completed claim form.

HEADER INFORMATION

1. TYPE OF TRANSACTION

Place an "x" in the appropriate box to indicate if the claim is a statement of actual services, a request for redetermination/preauthorization or EPSDT/Title XIX.

2. PREDETERMINATION/PREAUTHORIZATION NUMBER

Fill in the Predetermination or Prior Authorization number if applicable.

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. COMPANY/PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE

Enter dental insurance carrier and billing address in appropriate boxes.

OTHER COVERAGE

4. OTHER DENTAL OR MEDICAL COVERAGE?

Place an "x" in the No or Yes box as appropriate.

5. NAME OF POLICY HOLDER/SUBSCRIBER IN #4

Complete only if #4 box marked "Yes." Enter policy holder/subscriber name in last name, first name, middle initial order.

6. DATE OF BIRTH (MM/DD/CCYY)



CMS1500 CLAIM FORM

The CMS1500 health insurance claim form answers the needs of many health insurers. It is the basic form prescribed by The Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (CMS), for the Medicare and Medicaid programs for claims submitted by physicians and suppliers, except for ambulance services. It has also been adopted by CHAMPUS and has the approval of the AMA Council on Medical Services.

CMS implemented a revised CMS1500 health insurance claim form in 2007. This form is designated the 08-05 version, indicating the date (August 2005) that it was officially accepted. The major difference between the new CMS1500 (08-05) form and the prior CMS1500 (12-90) form is the split provider fields. The split fields enable reporting of the National Provider Identifier (NPI), in the fields labeled as NPI, and a corresponding legacy number in the unlabeled block above each NPI field. In addition, the bar code has been dropped from all versions of the new form.

Mandatory Use Date

Only the revised CMS1500 (08-05) is to be used for all claims filed on or after 06/01/2007. All rebilling of claims must use the revised CMS1500 (08-05) from this date forward, even though earlier submissions may have been on the current CMS1500 (12-90).

On the previous page is a copy of the most current CMS1500 health insurance claim form. The form is mandatory for all Medicare health insurance claims. Following are field-by-field instructions for completing the CMS1500 form accurately and completely.

PATIENT INFORMATION

1. PROGRAM

Enter an "X" in the appropriate box to indicate proper carrier. Do not check all types of coverage that the beneficiary may have.

1A. INSURED'S IDENTIFICATION NUMBER

Enter the insured's primary identification number including any letters. The number is usually obtained from the patient's or insured's insurance identification card.

Medicare: Enter the Medicare number and suffix.

Medicaid: Enter the Medicaid number from the patient's current Medicaid card.

Commercial: Enter the insured's "member number" or "subscriber number" or "certificate number" from the insurance identification card. Most often this is the insured's social security number.

2. PATIENT'S NAME

Enter the patient's full name. Do not use nicknames or abbreviated names. The form specifies that the name be entered in last name, first name, middle initial order; however, our experience indicates that listing the name in the more normal order of "first name, middle initial, last name" has no detrimental affect.