Introduction to Diagnostic Coding

I. INTRODUCTION

This article presents basic guidelines for diagnostic coding for oral and maxillofacial surgery (OMS) using the (ICD-9-CM) International Classification of Diseases, Ninth Revision, Clinical Modification.

These coding guidelines have been developed by the AAOMS Committee on Healthcare and Advocacy (CHCA) to assist you in learning and using these coding systems. In no way are the guidelines a substitute for a working knowledge of the coding books and systems which are required for claims reporting in your practice today, and which will continue to be required in the future. Proper linkage of diagnosis and procedure codes is necessary for the claim to be processed (improperly coded claims will be rejected).

Both ICD-9-CM/ICD-10-CM diagnostic and CPT/CDT procedural coding involve transforming verbal descriptors of patient care into code numbers for reporting to insurance companies. The more familiar you become with terminology and the guidelines of the various coding systems, the easier it will become to file accurate and complete claims. The reported CPT and CDT codes explain what the oral and maxillofacial surgeon did (procedure) for the patient and the ICD-9-CM/ICD-10-CM codes explain the reasons (diagnoses) for which the procedure was performed. ICD-9-CM/ICD-10-CM (Diagnostic) codes and CPT (Procedural) codes must correspond.

A. REQUIRED CODING MATERIALS

Before attempting to code any claims for services, it is necessary to have a current copy of the American Medical Association Current Procedural Terminology (CPT), and the two-volume set of ICD-9-CM. Volumes 1 and 2 of the ICD-9-CM cover diagnostic coding which is mandatory in filing claims with Medicare and other third party payers. Volume 1 represents a tabular listing of conditions, diseases, and symptoms; while volume 2 is the alphabetical listing. Volume 3 of the ICD-9-CM is only for hospitals, and is not necessary for the OMS office. CDT (Current Dental Terminology) for dental claims does not require diagnostic linkage. However, if “D – codes” are submitted on medical claim forms, diagnostic codes are mandatory. New ADA claim form instructions, which took effect January 1, 2013, now allow for up to four diagnosis codes per dental procedure to be reported. According to the instructions, a diagnosis code will be required when the diagnosis may affect claim adjudication when specific procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

CPT, CDT and ICD-9-CM are revised annually. Beginning with CDT 2013, the CDT coding manual will be updated annually just as the CPT and ICD-9-CM manuals. The new edition of CPT becomes available in mid-November for the following year. ICD-9-CM has previously been revised twice a year, in April and October. However, with ICD-10-CM implementation approaching, the government has placed a freeze on ICD-9-CM changes. It is unclear at this time how often ICD-10-CM will be updated once it takes effect. Thus, reporting a current procedure or diagnosis using a previous year’s edition may be inaccurate and adversely affect reimbursement.

B. PATIENT RECORD DOCUMENTATION

Good documentation in the patient record has always been important. In coding and reimbursement, this is especially true with “Evaluation and Management” (E/M) codes. It is imperative to have specific and precise patient records that include:

- Documentation of the patient’s chief complaint (reason the patient came into the office);
- What was wrong with the patient (condition or symptom);
- What was done to arrive at the diagnosis (history, physical examination, consultations, tests, radiographs, etc.);
- Development of a treatment plan; and
- What steps were taken to alleviate the patient’s problem(s)

The OMS should verify patient records to ensure that the services are properly entered and legible. When delegating
claim-coding authority to a staff member, the doctor must recognize that a signature on the claim form serves as his/her attestation that the services indicated have been provided. The doctor has the ultimate responsibility.

II. CODING FOR REIMBURSEMENT

A. CODING CLAIMS FROM THE DIAGNOSIS

When coding a case, decide whether to approach the claim from the perspective of the diagnosis (ICD-9-CM code) or the procedure (CPT/CDT code). The majority of the time, you will determine the diagnosis first. In some cases the diagnosis cannot be determined without additional documentation, e.g., imaging or pathology reports. In such cases, the most accurate clinical diagnosis should be used. Pathology claims (biopsies, excisions) may need to be delayed until the report is received. If the postoperative diagnosis is different from the preoperative diagnosis when the claim is filed, use the postoperative diagnosis for coding. It is never appropriate to code undocumented diagnoses described by words such as “probable,” “suspected,” ‘questionable,” or “to rule out,” on a claim reporting professional services. Most forms no longer allow for written descriptors, but rely solely on accurate numerical codes. If the level of certainty documented does not allow for an exact diagnosis, codes that describe “Symptoms, Signs, and Ill-defined Conditions,” (codes 780.0-799.9, Chapter 16 of Volume 1) may be appropriate.

In ICD-9-CM coding, you may code only to the highest degree of certainty and you must use codes with the greatest level of specificity.

With electronic claim submission, typically only one diagnostic code is allowed for each CPT procedure. No allowance is made for written descriptors.

B. KEY STEPS TO DIAGNOSTIC CODING

1. Identify all main terms included in the diagnostic statement in your patient’s record (e.g., “fracture,” “mandible,” “condylar process,” “coronoid process,” “open,” “closed,” “inferior”).

2. Locate each main term in the Alphabetic Index (Volume 2), starting with the most general main term.

3. Refer to any key words indented under the main term. This information forms individual line entries and describes essential differences by sites (location on the body), etiology (cause of the problem) or clinical type (symptoms of the illness).

In the following example, “fracture” is the main term. Key words indented under “fracture” are “jaw,” “angle,” and “open”.

Example: Fracture
Jaw (bone) (lower) (closed) (see also Fracture, mandible) 802.20 angle 802.25 open 802.35 open 802.30 upper - see Fracture, maxilla

4. Verify the code selected from the Alphabetic Index of Volume 2 by looking at that actual descriptor in the Tabular Listings of Volume I.

5. Read and be guided by any instructional terms for that specific diagnosis in Volume I.

6. Use the most specific classification (fifth-digit). If no fifth digit is available, use fourth digit. Very few acceptable diagnoses can be reported with three digits.

7. Follow cross-reference instructions if the needed code is not located under the first main entry consulted.

Example: 730 Osteomyelitis, periostitis, and other infections involving bone Excludes:
jaw (526.4-526.5)
petrous bone (383.2)

In this example, 730 cannot be used for osteomyelitis involving the jaw. The appropriate code would be found in section 526.4-526.5

8. Continue coding diagnoses until all conditions for which the patient was treated are identified. Up to four diagnosis codes may be listed on the CMS 1500 form. The diagnosis that is chiefly responsible for the visit or procedure should be listed first.

What is the specific reason you are seeing this patient? Are there additional diagnoses or “co-morbidities” that should be included and are important to your care of this patient (e.g., insulin dependent diabetes, COPD, personal history of cancer, etc.)? If so, the information is relayed to the carrier by including the appropriate additional codes; however, always list the primary or principle diagnosis first.
C. LOCATING ICD-9-CM CODES IN VOLUME 2

**Eponyms** – Names of a disease, structure or procedure derived from the name of the person who discovered or described it.

In the ICD-9-CM Index (Volume 2), such entries are listed as main terms in alphabetical sequence and under the main term for “disease,” “syndrome,” “disorder,” etc.

**Example:** Ludwig’s angina can be located in the Index (Volume 2) under “Ludwig’s” and “angina.”

**Special Notes:**

When the main term has been located in Volume 2, be alert for instructions that appear in a box immediately after a main term or subterm. These notes usually warn that five-digit codes are necessary. Identifying the fifth-digit for the following section is outlined in Volume 2 as follows:

**Example:** 801 Fracture of base of skull

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**Note** – Use the following fifth-digit subclassification with categories 800, 801, 803, and 804:

- 0 unspecified state of consciousness
- 1 with no loss of consciousness
- 2 with brief [less than one hour] loss of consciousness
- 3 with moderate [1-24 hours] loss of consciousness
- 4 with prolonged [more than 24 hours] loss of consciousness, return to pre-existing conscious level
- 5 with prolonged [more than 24 hours] loss of consciousness, without return to pre-existing conscious level
- 6 with loss of consciousness of unspecified duration
- 9 with concussion, unspecified

with:

- contusion, cerebral 803.1
- epidural hemorrhage 803.2
- extradural hemorrhage 803.2
- hemorrhage (intracranial) NEC 803.3
- intracranial injury NEC 803.4
- laceration, cerebral 803.1
- other bones -- see Fracture, multiple, skull
- subarachnoid hemorrhage 803.2
- subdural hemorrhage 803.2
- base (antrum)(ethmoid bone)(fossa) (internal ear) (nasal sinus) (occiput)(sphenoid)(temporal bone) (closed) 801.0

with:

- contusion, cerebral 801.1
- epidural hemorrhage 801.2
- extradural hemorrhage 801.2
- hemorrhage (intracranial) NEC 801.3
- intracranial injury NEC 801.4
- laceration, cerebral 801.1
- subarachnoid hemorrhage 801.2
- subdural hemorrhage 801.2
Third-Digit Codes
Few ICD-9-CM diagnosis codes for OMS have only three digits. These codes describe general diagnoses (e.g., 802 - Fracture of face bones). Most codes used by OMSs will be fourth- or fifth-digit codes.

Fourth-Digit Codes
Fourth-digit ICD-9-CM codes represent three-digit codes extended to provide subcategories with more information regarding cause, site, characteristic signs or symptoms.

Example: “520.6 – Disturbances of tooth eruption,” which includes “impacted teeth” may be the medically necessary diagnosis for an extraction procedure. If this were to be reported only as “520”, the carrier would identify the diagnosis simply as “Disturbances of tooth eruption”. The diagnosis code “520” alone does not indicate an impacted tooth.

Fifth-Digit Codes
Many fourth-digit subcategories have been expanded to the fifth digit for increased specificity. Category 524.6, Temporomandibular Joint Disorders, was expanded to fifth-digit classification in October, 1991. Categories 524.0, Major anomalies of jaw size; and 524.7, Dental alveolar anomalies, were also expanded to fifth-digit classification in October, 1992. Most recently, categories 524.2, 524.3, 524.5, 525.4, 525.5, 525.6 and 526.6 were also expanded out to the fifth-digit level. Claims submitted with three or four-digit codes where four and five-digit codes are available, may result in denial of the related services. Code with the greatest level of specificity. While a specific diagnosis may not be known at the time of an initial visit, this is not an acceptable reason to submit a three-digit code using general categories.

D. LOCATING “NEOPLASMS” IN ICD-9-CM VOLUME 2
Neoplasms (any new and abnormal growth, specifically in which the growth is uncontrolled and progressive - e.g., tumor, lesion, etc) are indexed under “Neoplasm” in Volume 2 of ICD-9-CM in alphabetical order by anatomical site. For each site, there are six possible code numbers according to whether the neoplasm in questions is:

- malignant (primary or secondary);
- benign (non-invasive lesions that do not spread to other sites);
- in situ (malignant lesion, presently contained and not yet invading surrounding normal tissue);
- of uncertain behavior (“histo-morphologically well-defined neoplasm, subsequent behavior unpredictable from present appearance” - this does not mean the coder is uncertain, but the pathologic behavior of the neoplasm is uncertain.); or
- of unspecified nature (unspecified morphology and behavior).
Because the neoplasm table is so specific, coding from it does not need to be verified in Volume 1. This is one of the few exceptions to the ICD 9 CM basic rule of verifying all information from Volume 2 in the specific section of the classification in Volume 1.

When the primary malignant neoplasm originates at a junction between two sites or in contiguous sites, it may not be possible to identify the exact site of origin. For example, the diagnosis “carcinoma involving the tip and the ventral surface of the tongue” indicates that the primary site is either the tip of the tongue or the ventral surface of the tongue, but the primary site cannot be determined. In those cases, the malignant neoplasm should be classified to the subcategory .8 “other.” In the above example, the classification would be 141.8.

When specific descriptors are not present in the Neoplasm table, the other sections of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed: e.g., Rower’s disease see Neoplasm, skin, in situ.

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### III. DIAGNOSIS CODING FROM ICD 9 CM BOOK 1

Volume 1 of ICD 9 CM contains 17 Chapters of the Classifications of Diseases and Injuries. Some chapters represent classifications by etiology or cause of disease.

**Example:**

- Chapter 1  Infectious and Parasitic Diseases
- Chapter 2  Neoplasm
- Chapter 14  Congenital Anomalies

In these three chapters, disorders are classified by cause. Other chapters classify diagnoses by anatomical systems (e.g., Chapter 9  Diseases of the Digestive System).

In Volume 1, codes which would be used in OMS are located in the following sections:
- Sections 252-253 (Endocrine Disorders)
- Sections 286-287 (Bleeding Dyscrasias)
- Sections 350-352 (Cranial Nerve Disorders)
- Sections 460-464; 470-475; 478 (Upper Respiratory infections and Condition Including sinuses)
Sections 520-529 (Diseases of Oral Cavity, Salivary Glands, and Jaws)
[524.0 524.5 Dentofacial Anomalies, Malocclusion]
[524.6 TMJ Disorders]
Sections 680; 682-683 (Infections, Skin and Subcutaneous Tissues)
Section 694 (Pemphigus/Pemphigoid)
Section 697 (Lichen planus)
Sections 701; 702.0; 706.2 (Conditions of Skin and Subcutaneous Tissues)
Sections 710-711; 714-716 (Musculoskeletal and connective Tissue Disorders)
(Where indicated, use 5th digit "8" - "other specified sites [includes head].")
Sections 744; 749; 750; 754 (Congenital Anomalies)
Sections 780-782; 784-785; 787 (Symptoms, Signs, III defined Conditions)
Sections 802; 830; 848; 870 874; 910; 925; 932 933; 935; 940 941; 947; 959 (Injuries [fractures, lacerations, contusions, sprain/strain, burns])
Sections 905 909 (Late Effect of Injury)
Section 951 (Nerve Injury)
Sections 996.4-996.7; 998 (Complications of Surgical and Medical Care)
Sections V10-11; V14-15 (Personal History of Potential Health Hazards)
Sections V16-19 (Family History of Disease)
Sections V40-49 (Condition influencing health status [e.g.: organ or tissue Replacement])
Sections V50-54; V58 (Encounter for specific procedures and aftercare)
Section V65.5 (Encounter without complaint or sickness)
Section V67 (Follow-up exam)

CONVENTIONS OF ICD 9 CM CODING

The Tabular list for the Disease Classification makes use of certain abbreviations, punctuation, symbols and other conventions that must be understood.

PUNCTUATION

1. [ ] Brackets are used to enclose synonyms, alternative wordings, or explanatory phrases.
   Example: 520.6 Disturbances in tooth eruption, primary [deciduous] teeth

2. ( ) Parentheses are used to enclose supplementary words in the statement of a disease without affecting the code number to which it is assigned. Example: 848 Other and ill defined sprains and strains.
   Example:
   848.1 Jaw
   Temporomandibular (joint)(ligament)

INSTRUCTIONAL NOTATIONS

1. “Includes”: This note appears immediately under a three digit code title to further define, or give an example of, the contents of the category.
   Example:
   830 Dislocation of Jaw
   Includes: jaw (cartilage) (meniscus)
   mandible
   maxilla (inferior)
   temporomandibular (joint)

2. “Excludes”: Terms following the word "excludes" are to be coded elsewhere as indicated in each case.
   Example:
   718 Other derangement of joint
   Excludes:
   current injury (830.0-848.9)
   jaw (524.60-524.69)

ABBREVIATIONS:

NEC: Not elsewhere classifiable. The category number for the term including NEC is to be used only when you lack the information necessary to code the term to a more specific category.

NOS: Not otherwise specified. This abbreviation is the equivalent of "unspecified."

If the postoperative diagnosis is different from the preoperative diagnosis, when the claim is filed, use the postoperative diagnosis for coding.
CODE ALL CONDITIONS AFFECTING YOUR CARE OF THE PATIENT

Code all of the documented conditions that co-exist at the time of the visit that require or affect patient care. However, code only the conditions affecting your treatment or management of the patient.

This may include “Non-surgical” diagnoses, e.g. 250.03 Diabetes mellitus, uncontrolled, without mention of complication. When you are providing concurrent care to a patient along with a doctor of another specialty, code only the diagnoses that justify your services. It is recommended that you submit documentation explaining your expertise in this case. Carriers are reluctant to pay for concurrent care unless it is documented that one of the doctors could not have effectively managed all of the patient’s needs.

USE OF V-CODES

V-codes are different from other ICD-9-CM codes in that they report conditions other than a disease or injury which may influence the patient’s health status, or may further clarify the reason for the patient’s visit/treatment. They should be used to report information that is an additional factor to the patient receiving care for illnesses or injuries classifiable to categories 001-999. These can be beneficial to a carrier’s evaluation of the medical necessity of the procedure being reported (e.g., personal history of malignant neoplasm, surgical aftercare, etc.).

Those V codes of particular use to OMS have been listed above.

IV. EXAMPLE: LOCATING A DIAGNOSIS CODE IN ICD-9-CM

To increase your familiarity with diagnosis coding, in this example we will locate the diagnosis code first. A patient has ankylosis of the temporomandibular joint with a maximum opening of 5 mm and lateral excursive movements of 2 mm. She is seen in consultation. Using the example of "ankylosis" as the diagnosis, located by looking in the ICD 9 CM Volume 2 Index, you are directed to Volume 1, "524.6 temporomandibular joint disorders" including "524.61 Adhesions and ankylosis of temporomandibular joint (bony or fibrous)."

In determining the diagnosis for this example, assume that we looked in the ICD-9-CM Index, noted that the first line of "ankylosis" indicates "fibrous or osseous ankylosis - 718.50," and accepted this as the appropriate code without checking Volume 1, Section 718. Such a double-check would reveal, however, that Section 718 excludes "jaw" and, therefore, 718.50 cannot be used to report this diagnosis.

V. AAOMS CODING WORKSHOPS

The AAOMS offers several coding and adjunctive courses throughout the year. The courses are both direct attendance and online. These sessions provide detailed ICD-9-CM, ICD-10-CM, CPT and CDT training. Coding principles are explained with practice problems from workbooks designed specifically for OMS. Oral and maxillofacial surgeon(s)/administrative staff team attendance is strongly encouraged. For more information, please visit aaoms.org. The CHCA encourages membership questions on coding and nomenclature issues. Inquiries will be handled individually by the AAOMS coding staff.

Note: 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 to you 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 you or anyone else in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisers.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery (OMS). This paper is an introduction to diagnostic coding. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-9-CM) and treatment (CPT/CDT) coding for oral and maxillofacial surgery. When indicated, you will be referred 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 continually updated or revised. The AAOMS Committee on Health Care and Advocacy has developed these coding guidelines in order to assist the membership to use the coding systems effectively and efficiently.

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