Oral Surgery Coding & Reimbursement Alert

CPT® Coding Strategies: 2 Scenarios Perfect Your Palatal Lesion Excision Reporting

Hint: Watch for scenarios that warrant additional E/M code.

When your oral surgeon excises a palatal lesion, you will have to report an appropriate code based on the extent of resection and on the type of closure performed. You will also need to be aware of Correct Coding Initiative (CCI) edits when other procedures are performed with the excision.

Here are two case scenarios that will help you get proficient with reporting a palatal excision procedure. Check on it and see if you can crack the coding.

Coding Scenario 1: The patient is a 25-year-old male patient with a four month history of a slow growing mass (4cmx4cm) on the right side of the hard palate. Your surgeon had previously biopsied the mass and had ordered a CT scan. From the results of the previously conducted tests and imaging studies, a diagnosis of pleomorphic adenoma was confirmed.

After the patient was anesthetized, prepped and maximum visualization was obtained your surgeon marked the periphery of the lesion (that included about a centimeter of healthy structure) and then he incised down to the periosteum. Next, he elevated the tissue to allow proper access to the lesion which he then excised along with the delineated margins so that no part of the lesion was left behind. He then cauterized the tissue to achieve hemostasis and performed irrigation of the wound following which he advanced the adjacent mucosa to form a flap to allow adequate closure of the wound to allow proper healing.

Coding Scenario 2: The patient is a 50-year-old male patient with a 2cmx2cm ulcerative lesion on the left side of the hard palate. The patient had a history of smoking for the past 20 years and used to occasionally consume alcohol. Your oral surgeon had previously obtained a biopsy sample that showed dysplastic changes but could not confirm squamous cell carcinoma.

Prior to the procedure, your surgeon evaluated the patient for his sugar levels that were elevated during the previous visit. Since the levels were normal, your surgeon decided to go ahead with the surgical excision of the lesion.

Once the patient was prepped and placed under anesthesia, your surgeon delineated the margins of the lesion that included healthy and sound tissue. He then incised to the level of the periosteum and excised the entire lesion. Since the periosteum was not affected, it was left intact. Your surgeon did not perform any wound closure and it was left to heal by secondary intention. He also proceeded to perform a biopsy of a whitish appearing lesion that your clinician found on the soft palate that he suspected to be caused due to the smoking habit to check for dysplastic changes.

Choose Apt Palatal Excision Code Based on Closure Type

When your oral surgeon performs an excision of a lesion of the palate, you will have to choose from one of the four codes that are available for excision. You will have to base your decision on the type of closure your surgeon performs at the end of the procedure. The four codes that you can choose from for palatal lesion excision are:

- 42104 (Excision, lesion of palate, uvula; without closure)
- 42106 (...with simple primary closure)
- 42107 (...with local flap closure)

- 42120 (Resection of palate or extensive resection of lesion).

You choose 42104 if your clinician performs excision of the lesion and does not close the wound and allows for healing by secondary intention. "The decision for wound closure depends on pathology, squamous cell carcinoma or a benign tumor and the size and involvement of the tumor,"says **Barry Shipman, DMD,** clinical professor, University of Florida School of Dentistry, Hialeah Dental Center. You will use 42106 or 42107 if your surgeon closes the wound after the procedure.

You will reserve the use of 42120 only for procedure that involve extensive resection of the lesion or areas of the palate. "If there is a communication to the sinus from palatal removal, a surgical prosthesis may be used to close this oral antral communication (CPT® 21076, Impression and custom preparation; surgical obturator prosthesis). The prosthesis cannot be made by an outside laboratory," Shipman adds.

In coding scenario 1 described above, as your surgeon performed closure of the wound site using a flap, you will have to report the procedure with 42107.

Exercise Caution When Reporting Biopsy With Excision Codes

In the second coding scenario described, your surgeon performed an excision of a stage I tumor of the hard palate. Since your surgeon did not perform any wound closure after the removal of the lesion, you will have to report the procedure with 42104. However, in addition, your oral surgeon also performed a biopsy of another lesion that was found extending into the soft palate. Since this biopsy was in no way related to the excision of the lesion that your surgeon performed, you will have to report it separately with another CPT® code. You report the biopsy with 42100 (Biopsy of palate, uvula).

However, if you look at Correct Coding Initiative (CCI) edits, you will see that biopsy codes are bundled into 42104. The modifier indicator for this edit bundle between the biopsy code and 42104 is '1' which indicates that you can use a modifier to unbundle the codes with a suitable modifier. Since the biopsy code is the column 2 code in the edit bundle, you will have to use a suitable modifier with this code. The modifier that you will use is 59 (Distinct procedural service) or XS (Separate structure).

Coding tip: Though you ran into edits when trying to report a biopsy code with 42104, you should not assume that you will experience edits with every excision code. If you are trying to report 42100 with either 42106 or 42107, you do not face any edits from CCI and you can report the two codes together without using any modifier.

Look For Instances to Report an Additional E/M Code

Your oral surgeon will perform a preoperative evaluation of the patient prior to performing the excision procedure. You cannot report a separate E/M code for the preoperative management of the patient prior to the procedure. Also, CCI edits are in place that prohibits you from using an E/M code for evaluation of the patient prior to the procedure.

However, the modifier indicator for the bundling of E/M codes with excision codes carry the modifier indicator '1,' which indicates that you can unbundle and report both the codes if a suitable modifier is used. Since the E/M codes form the column 2 codes in the edits with excision codes, you will have to append the modifier to it. The appropriate modifier that you will have to use with the E/M code is 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

In the instance described above, where your clinician evaluated the patient for his blood sugar levels and evaluated him to check if it will have any effect on the procedure or on post-operative healing, you are allowed to report a separate E/M code. This can be done as a separate and significantly identifiable E/M service was provided to the patient that is not a direct evaluation of the patient for the persisting problem for which the procedure has been planned.

Conclusion: Summing it up Together

The final summary of coding is:

Case Scenario 1:

- 42107 for the excision of the lesion with flap closure
- 210.4 (Benign neoplasm of other and unspecified parts of mouth) if you are using ICD-9 codes or D10.39 (Benign neoplasm of other parts of mouth) if your are using ICD-10 codes to report the diagnosis of pleomorphic adenoma.

Case Scenario 2:

- 42104 for the excision performed without closure
- 239.0 (Neoplasm of unspecified nature of digestive system) or use the ICD-10 code, D49.0 (Neoplasm of unspecified behavior of digestive system) to support the decision for excision
- 42100-59 for the biopsy
- 528.79 (Other disturbances of oral epithelium, including tongue) to support the necessity of the biopsy. If you are using ICD-10 codes, switch to K13.24 (Leukokeratosis nicotina palati).