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A dental guide to cross-coding for oral cancer screening

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Dental professionals are a patient's primary source of screening within the oral cavity; thus attention must be paid to the most common oral malignancy: squamous cell carcinoma. Historically such malignancies were attributed only to patients with a history of extensive alcohol and tobacco use.

However, other risk factors such as human papilloma virus and medication use are shifting the profession's perception of who may be at risk for oral cancer.

According to experts, "the dentist must consider all patients at risk and act accordingly in the history-taking and examination phases of the dental visit."[1] Due to the newfound understanding of oral cancer risk, the dental professional should take seriously the options for insurance coverage from both the dental and medical insurer for the patient's exam.

The facts

Historically dental professionals relied solely on health history and visual exams to detect abnormalities in the oral cavity. While within acceptable limits, the variance in training and experience of the practitioner is enough to leave the patient questioning reliability. What is more, recent evidence suggests high rates of clinical misdiagnosis by general oral health practitioners[1]. Thus, studies suggest that augmenting the traditional approach with technology can in fact assist the practitioner in "One of the most difficult decisions a clinician may face…when to refer a lesion for further investigation and biopsy."[2]

It would stand to reason that implementing the most comprehensive exam available be enough to garner the use of a targeted risk factor checklist including (but not limited to) information on the patient's history of tobacco use, alcohol consumption, exposure to HPV, and recreational drug use; as well as the use of a chemiluminescent device to augment the risk assessment visual exam. However, many patients are bound financially to what will and will not be covered by their insurance plans. So to further the argument for use of oral cancer screening devices mentioned above, it is worth noting that both dental and medical insurance codes can and should be utilized during the process.

Cross-coding for oral cancer screening

Nearly 41,000 Americans will be diagnosed with oral cancer in 2014. The survival rate of this cancer, when found in late stages is at best grim. However, equipped with new evidence regarding risk factors for the disease as well as innovative tools to add to an office armament like oral cancer screening devices and comprehensive health history forms, patients can be confident their dental team can alert them in the case malignancies are suspected.

If something is found, the patient's dental insurance should be billed first, utilizing appropriate CDT codes.

Dental codes

CDT D0480 for adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures. A copy of the pathology report is needed for hard and soft tissue biopsies: D7285-D7286.

CDT D7285	code for biopsy of oral tissue (hard)
CDT D7286	code for biopsy of oral tissue (soft)
CDT D7287	code for exfoliative cytological sample collection (For collection of non-transepithelial cytology sample via mild scraping of the oral mucosa.)
CDT D7288	code for brush biopsy- transepithelial sample collection.[3] For collection of oral disaggregated transepithelial cells via rotational brushing of the oral mucosa.)

Medical codes

If the patient's dental plan does not cover the procedure, a medical claim can be used. The International Classification of Disease codes (ICD) are required each time a claim is submitted to describe what abnormalities have been detected. The most common in the case of oral cancer screening are listed under the new ICD 10 codes. The encounter, follow up and "why" are found under these categories. This is just a sample of the list, but the most common within the dental practice for oral cancer.

Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm.

Z09	Medical surveillance following completed treatment. Use additional code to identify any applicable history of disease code (Z86.-. Z87.-)
Z12.81	Encounter for screening for malignant neoplasm of oral cavity
Z77.22	Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic). Exposure to second hand tobacco smoke (acute) (chronic) Passive smoking (acute) (chronic)
Z87.891	Personal history of nicotine dependence Z codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed.

Categories Z00-Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as 'diagnoses' or 'problems'.

This can arise in two main ways:

(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.

(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

Excludes:

Aftercare following medical care (Z43-Z49, Z51)

Surveillance of contraception (Z30.4-)

Surveillance of prosthetic and other medical devices (Z44-Z46)

Nonspecific abnormal findings disclosed at the time of these examinations are classified to categories R70-R94.

D00.00 Carcinoma in situ of oral cavity, unspecified site

D10.1 Benign neoplasm of tongue

Benign neoplasm of lingual tonsil

D10.2 Benign neoplasm of floor of mouth

D36.9 Benign neoplasm, unspecified site

D10.30 Benign neoplasm of unspecified part of mouth

D10.39 Benign neoplasm of other parts of mouth

Benign neoplasm of minor salivary gland NOS

Excludes: Benign odontogenic neoplasms (D16.4-D16.5)
Benign neoplasm of mucosa of lip (D10.0)
Benign neoplasm of nasopharyngeal surface of soft palate (D10.6)

D10.4 Benign neoplasm of tonsil

Benign neoplasm of tonsil (faucial) (palatine)

Excludes: Benign neoplasm of lingual tonsil (D10.1)
Benign neoplasm of pharyngeal tonsil (D10.6)
Benign neoplasm of tonsillar fossa (D10.5)
Benign neoplasm of tonsillar pillars (D10.5)

Malignant codes should only be used if the doctor is 100 percent sure of the diagnosis.

C00.0	Malignant neoplasm of external upper lip
C00.1	Malignant neoplasm of external lower lip
C00.2	Malignant neoplasm of external lip, unspecified
C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C00.5	Malignant neoplasm of lip, unspecified, inner aspect
C00.6	Malignant neoplasm of commissure of lip, unspecified
C00.8	Malignant neoplasm of overlapping sites of lip

The other set of medical codes used are called Current Procedural Terminology (CPT) codes. These codes can be used to cover things like the exam, screening devices, radiographs and other procedural tools. In this case the CPT code for the use of an oral cancer-testing device is:

82397	Chemiluminescent assay. (A device is used to measure the light given off by certain chemicals)
40490	Biopsy of lip
40808	Biopsy, vestibule of mouth
41100	Biopsy of tongue; anterior two-thirds
41105	Biopsy of tongue; posterior one-third
40799	Unlisted procedure, lips
40899	Unlisted procedure, vestibule of mouth
41599	Unlisted procedure, tongue, floor of mouth
42100	Biopsy of palate, uvula

The bottom line

As a patient's first line of defense dental screening for oral cancer is a necessary part of the dental practitioner's job. With the advances in diagnostic and screening technology and the safe-guard of cross-billing, there is no reason patients should not be offered a comprehensive oral cancer screening utilizing the latest technology as part of their regular dental visit.

There are complexities within both dental and medical billing. Classes, consulting and training are recommended for practitioners new to one or both systems. For a consult on all types of billing, including that discussed here, dental professionals should contact consultant Christine Taxin at Links2Success.biz.

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Christine Taxin is the founder and president of Links2Success, a practice management consulting company to the dental and medical fields. Prior to starting her own consulting company, Taxin served as an administrator of a critical care department at Mt. Sinai Hospital in New York City and managed an extensive multi-specialty dental practice in New York. With over 25 years of experience as a practice management professional, she now provides private practice consulting services, delivers continuing education seminars for dental and medical professionals and serves as an adjunct professor at the New York University (NYU) Dental School and Resident Programs for Maimonides Hospital. She can be reached through www.links2success.biz.

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