

# SBSCS | SAUDI BILLING SYSTEM CODING STANDARDS

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# About

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The private health insurance market in Saudi Arabia is regulated by the Council of Health Insurance (CHI). To support the market, one of CHI's strategic aims is to provide a standardized code set for billing interventions that providers submit to health insurers. The following is a description of all healthcare services rendered in an ambulatory, secondary, or tertiary environment that should be coded and billed:

1. Outpatient Medical Services
2. Admitted Care Medical Services
3. Consultation & Rounding Services
4. Dental Services
5. Laboratory & Pathology Services
6. Radiology and Imaging Services
7. Ambulance & Transportation Services
8. Mortuary Services
9. Emergency Medical Services (EMS)
10. Room & Board

## Special Acknowledgement

Dr. Shabab Al Ghamdi - Secretary General - Council of Health Insurance

## Project Leads

Mr. Abdullah Al Maghrabi - CHI

Ms. Susan E. Young, CHIM, CTR - CHI

## Team Members

Ms. Roa'a Al Kharashi, CHIP, IFCE3 – CHI

Mr. Fawaz Al Omran, - CHI

## Consultants

Dr. Anitha K. Dhamodharan, BDS, PMCC, CC – ACCUMED

Ms. Honaida G. Mansouri, CC – ACCUMED

## Contributors

Mr. Awad Al Wadai, PHARM, CC – ACCUMED

Ms. Esraa Takrouni, BDS, CC – ACCUMED

Ms. Faizah Jamalallali MSc Clinical Embryology, CC – ACCUMED

Ms. Fay Alsolieman, B.BIOCHEM, CC – ACCUMED

Ms. Lamia Almutlaq, BDS, CC – ACCUMED

Mr. Mohammed Faghih, BENG, CC – ACCUMED

Ms. Nada Youssef, MPM, HIS, CC – ACCUMED

Ms. Norah Alsaif, BDS, CC – ACCUMED

Ms. Raghda Aljumah, BENG, CC – ACCUMED

Ms. Wegdan Alhaidri, B.BIOMED, CC – ACCUMED

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Address all inquiries to the Council of Health Insurance  
([cchi-bs@chi.gov.sa](mailto:cchi-bs@chi.gov.sa))

# Acknowledgment

The Saudi Billing System coding standards (SBSCS) are based on the Australian Consortium for Classification Development (2017) *Australian Coding Standards (ACS) for the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)* and *Australian Classification of Health Interventions (ACHI)*, both 10<sup>th</sup> Edition. Sydney: Publisher: Independent Hospital Pricing Authority.

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# Glossary of terms

**Additional diagnosis (ADx):** A condition or complaint either co-existing with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a healthcare establishment, as represented by a code. For coding purposes, additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following: commencement, alteration or adjustment of therapeutic treatment; diagnostic procedures; increased clinical care and/or monitoring

**Administration of pharmacological agent:** Pharmacological agents can be administered for therapeutic reasons or to aid in dental treatment. Therapeutic drugs include antiseptics, steroids, analgesics, antimicrobials, or antifungals. These agents can be administered in many routes, such as Intra-arterial, Enteral, Intracavitary, Intramuscular, Intrathecal, or Intravenous

**Admitted care:** Admitted care encompasses services provided to patients who undergo a formal admission process in a hospital to undergo treatment.

**Ambulatory:** Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services.

**Agar:** A gelatinous type of sugars used in culture medium to support the growth of microorganisms.

**Antibody (Ab):** Proteins produced in blood by the immune system in response to a specific antigen of a foreign pathogen such as bacteria or viruses (immunoglobulin is a type of Ab).

**Antigen (Ag):** A toxin, organism, or other substance (e.g., bacteria) which enter the human body and stimulate the immune response to produce antibodies against it.

**Alveolar osseous procedure:** The alveolar osseous procedure is aimed at acquiring access to the tooth roots to remove calculus and remove pockets in the alveolar bone covering the teeth.

**Basic life support, or BLS:** Generally, refers to the type of care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress or an obstructed airway.

**Bleaching, internal:** The modification of the colour of the discoloured crown of an endodontically treated tooth using chemical and/or physical methods applied internally.

**Bleaching, external:** The modification of the colour of a tooth using chemical and/or physical methods applied externally.

**Bleaching, home application:** The prescribed use of a custom-made tray for the application of bleaching medicaments to the patient's dentition. This procedure describes the complete course of treatment by a patient at home.

**Catheterization laboratory:** Is commonly known as a Cath lab, is an examination room in a hospital, clinic, or diagnostic centre where several types of tests and procedures like ablation, angiogram, angioplasty, implantation of pacemakers, etc. are performed.

**Comprehensive cancer examination and risk assessment of head and neck by a dental surgeon:** Includes a comprehensive examination and assessment of the head and neck's extraoral and intraoral tissues used for the detection and diagnosis of any disease or tissue abnormality. This may aid in the detection of early indications of oral or tonsillar cancer, allowing for prompt diagnosis and treatment.

**Comprehensive oral examination:** Includes a complete inspection of oral mucosa, hard and soft tissue, salivary glands and all structures present in the oral cavity is performed.

**Comprehensive orthodontic exam:** An orthodontic examination is the first step in orthodontic treatment, preparing the patient for any possible intervention.

**Concentrated remineralisation and/or cariostatic agents, application – single tooth:** A procedure to promote caries resistance in a specific situation, involving isolation and control of the target area and prolonged application of a concentrated fluoride or remineralisation and/or cariostatic agent.

**Culture:** Method of growing and maintaining microorganisms in vitro.

**Culture media:** A medium which contains nutrients and controlled parameters used in order to grow different kinds of microorganisms.

**Cytogenomics:** Study of chromosomes and their inheritance utilizing molecular techniques.

**Definitive complete denture:** A complete denture is a removable acrylic replacement for teeth, soft tissue, and bone lost in an entire dental arch.

**Diagnostic model:** The production of a model from an impression or digital data. The model is used for examination and treatment planning procedures.

**Displaced flaps:** These include rotational and transposition flaps. A rotation flap is a semi-circular flap of skin and subcutaneous tissue that rotates about a pivot point into a defect.

**DNA methylation:** Biological process of adding methyl groups to a DNA sequence which result in regulating gene expression. Changes in the methylation patterns of genes or proteins can influence risk of disease development, such as cancer.

**Duplication/Deletion (Dup/Del):** Molecular testing to assess copy numbers changes (or dosage) of a particular genomic region. The normal gene dosage is two copies for each cell, excluding sex chromosomes (X and Y). A zero to one copy represents a deletion while a three or more represents a duplication. Duplications and deletions can affect gene dosage and thus the resulting phenotype (individual physical properties).

**Emergency ambulance service:** Is when an ambulance supplier responds immediately at the Basic life support (BLS) or Advanced Life Support (ALS) level of service to an emergency call.

**Emergency medical service:** Emergency medical services, also known as ambulance services or paramedic services, are emergency services that provide urgent pre-hospital treatment and stabilisation for serious illness and injuries and transport to definitive care.

**Exome:** A part of the human genome which reflects the protein-coding portion (all the coding regions).

**Exon:** One coding region of a gene which contain information necessary to encode a protein (all the exons in a genome are known as the exome).

**Exploration or negotiation of calcified root canal:** Calcified root canals occur when calcium gets deposited in the tooth's canal. Calcification causes the canal space to shrink.

**Extirpation of pulp or debridement of root canal(s), emergency or palliative procedure:** A pulp extirpation is part of a root canal treatment that is performed to save a tooth where the innermost part (the pulp) has become badly infected.



**Familial variant:** Mutations typically inherited within a patient's family.

**Gas chromatography:** A technique which utilize gases to separate sample components for analysis.

**Gene:** Unique nucleic acid sequence which contains instruction for coding and regulating proteins. Genes contain multiple protein expression regions (exons) separated by non-protein coding regions or intragenic regions (introns).

**Genome:** The entire genetic information of an organism (includes coding and non-coding regions).

**Guided tissue regeneration:** Guided tissue regeneration is a surgical procedure that specifically aims to regenerate the periodontal tissues when the periodontal disease is advanced. It is a method used to repair periodontal defects so that a tooth, or set of teeth, has more support and stability.

**Incision and drainage of abscess:** A periodontal abscess is a localized accumulation of pus within the periodontal tissues, which may be confined to the marginal gingiva or be a deeper infection associated with periodontal pockets, and bone loss.

**Infrared spectrometer:** An instrument used to study and identify chemical substances or functional groups in solid, liquid, or gaseous forms based on absorbance or transmittance of infrared light interacting with a molecule.

**Immunoassay:** A biochemical test that detects the presence of a specific antibody or a specific antigen

**Infiltration:** The local infiltration technique anesthetizes the terminal nerve endings of the dental plexus. This technique is indicated when an individual tooth or a specific isolated area requires anaesthesia. The procedure is performed within the direct vicinity of the site of infiltration.

**Interim therapeutic root filling:** This term is used to describe a restoration that has been placed in a tooth after the previous restoration, cracks and/or caries have all been removed at the commencement of endodontic treatment (i.e., the "investigation" stage of treatment).

**Interim complete denture:** This is a temporary prosthesis for the use of a limited period of time, to be replaced by a definitive prosthesis.

**Intraoral osseointegrated implants:** Intraoral osseointegrated implant insertion is a one- or two-stage procedure which involves the implantation of an implant, used to support dentures or artificial tooth crowns, constructed of titanium or other biocompatible material.

**Limited oral examination:** A single tooth (crown, root, periodontal ligament) examination or examination of a region or affected tooth, gums, tongue, oral mucosa, palate, periodontal structures, alveolar bone, floor of mouth or any other region limited to the definition of oral cavity.

**Local anaesthesia:** Several techniques can be used to achieve local anaesthesia of the dentition and the surrounding hard and soft tissues of the maxilla and mandible. There are three main anaesthetic agents that can be used, Lidocaine, Bupivacaine, and Mepivacaine.

**Mass spectrometry:** A lab technique used to identify the elements or molecules by their masses by measuring the mass-to-charge ratio.

**Mutations:** Are variants resulting from altered gene function which changes the DNA sequence of an organism causing disease (pathogenic).

**Nerve block, trigeminal:** The nerve block anesthetizes the main branch of the trigeminal nerve, allowing treatment to be performed in the region innervated by that nerve.

**Non admitted care:** Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed.

**Non-displaced flaps:** These include periodontal flaps that are usually performed to gain better access for scaling and root planning, (e.g., periodontal flaps, flaps used for curettage) or for crown lengthening procedures.

**Obturation of resorption defect or perforation:** Resorption is defined as a condition associated with either a physiologic or a pathologic process resulting in loss of dentin, cementum, or bone. A perforation is a hole that occurs in the root canal space of a tooth. Obturation is the technical term for a method of filling and sealing a tooth with root canal material.

**Oral examination; post operative re-evaluation:** Post operative examination initiated after suture removal, or any complications related to the surgery.

**Panel:** Is a group of tests measuring different substances at the same time.

**Partial pulpotomy:** Partial pulpotomy, rather than direct pulp capping or complete pulpotomy, is the treatment of choice following traumatic or carious pulp exposure in immature permanent teeth.

**Periodic oral examination:** An evaluation of the dentition, mouth and associated structures performed on a patient of record to determine any changes in the patient's oral and medical health status since a previous comprehensive or periodic examination (e.g., once in 6 months or a year).

**Periodontal flaps:** A periodontal flap is a section of gingiva, mucosa, or both that is surgically separated from the underlying tissues to provide for the visibility of and access to the bone and root surface.

**Periodontal scaling and root planning:** The removal of plaque, calculus and stains from supragingival and subgingival tooth surfaces. Root planning is the removal of cementum and dentine that is rough and/or permeated by calculus.

**Pulp capping:** Two different types of pulp capping are in use. These methods are used when the pulp is visibly exposed (vital pulp exposure) due to caries, trauma, or iatrogenic insults such as accidental exposure during tooth preparation or caries removal.

**Principle diagnosis(PDx):** For admitted care (inpatient, day case) , the principal diagnosis is:

The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment.

For non-admitted patients, the principal diagnosis is:

The diseases, conditions or injuries influencing the outpatient encounter, as determined by the clinician at the end of the visit.

**Prosthesis with fixed metal frame attached to implants:** A fixed prosthesis carrying artificial teeth on a cast or milled metal frame, supported by the implants to which it is attached and not designed for self-removal. This is inclusive of the sealing of the access to the abutment screws.

**Prosthesis with removable metal frame attached to implants; per arch:** A removable prosthesis is one that carries artificial teeth on a cast, wrought or milled metal frame, supported by the implants to which it is attached. This prosthesis is designed for self-removal.

**Prosthesis with removable resin base attached to implants, per arch:** A removable prosthesis is one that carries artificial teeth on a resin base supported by the implants to which it is attached. This prosthesis is designed for self-removal.

**Qualitative assay:** Tests which aim to identify the presence or absence of analysed substance (analyte). Results are typically reported as positive/negative or detected/not detected. These tests are useful for initial screening, and monitoring of disease or progress of treatment.

**Quantitative assay:** Tests which aim to quantify in numbers the amount of tested analyte. Some laboratory assays produce only quantitative results, qualitative results (western blot, pregnancy tests), or both (enzyme linked immunosorbent assay (ELISA)).

**Regional block, nerve of head or neck, other than trigeminal nerve division:** The nerve block anesthetizes the main branch of a specific nerve other than trigeminal nerve division, allowing treatment to be performed in the region innervated by that nerve.

**Removal of root filling, per canal:** A Procedure to remove root canal filling material from the tooth followed by cleaning, shaping and obturation of the canals

**Repair of wound:** Repair of wound process is the restoration of structure and function of injured or diseased tissues.

**Restoration:** Dental restoration, dental fillings, or simply fillings are treatments used to restore the function, integrity, and morphology of missing tooth structure resulting from caries or external trauma.

**Reagent:** A substance or compound used in the lab test to facilitate chemical reactions.

**Root canal treatment:** Root canal treatment (endodontics) is a dental procedure used to treat infection at the centre of a tooth, where a complete extirpation of pulp, biomechanical preparation (BMP) of root canal, and obturation where the canals are filled with an inert filling material.

**Smear:** A thin layer of specimen spread over a slide surface.

**Serum:** The fluid portion of blood that contains important components such as proteins, electrolytes, antibodies, antigens and hormones.

**Sequential plastic aligners:** Sequential plastic aligners an orthodontic treatment option that moves the teeth closer to their desired position.

**Space maintainer:** A space maintainer is an appliance used to maintain the space exited by a primary tooth lost due to decay or injury. It keeps the area held until the permanent tooth emerges. Without the space maintainer, the permanent teeth can shift into the space created by the loss of the baby tooth and could make teeth crowd.

**Topical application of remineralisation and/or cariostatic agents, one treatment:** Application of remineralisation and/or cariostatic agents to the surfaces of the teeth. This may include activation of the agent. Not to be used as an intrinsic part of the restoration.

**Topical remineralisation and/or cariostatic agents, home application – per arch:** The prescribed use, by a patient at home, of a custom-made tray for the application of remineralisation and/or

cariostatic agents to the patient's dentition. This procedure describes the complete course of treatment per arch. For provision of the tray and medicaments or other remineralisation agents.

**Variant:** A variant is a change in the genetic sequence (DNA) of the cell by mechanisms as substitution, inversions, deletions, insertions, among others. By changing the nucleotide sequence, this often result in a change in the protein made by the gene. A variant may or may not alter gene function.

# Introduction

The SBS includes the following classification standards:

- The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- The Saudi Billing System (SBS) procedure codes
- The Saudi Billing System Coding Standards (SBSCS)
- Australian Coding Standards (ACS)
- The Saudi Food and Drug Authority -GTIN - for Medications and Herbals/Vitamins
- The Saudi Food and Drug Authority -GMDN -for Medical Devices and Consumables

As of 01 January 2020, Saudi Arabia has mandated the 10<sup>th</sup> Edition of ICD-10-AM/ACHI/ACS.

SBS is built on the Australian systems, specifically ICD-10-AM and ACHI, but differs from the Australian system in two fundamental ways:

1. Many new codes have been added (for example, for laboratory, evaluation and management-type interventions, emergency services, laboratory and pathology, and mortuary), more extensive unilateral and bilateral splits and the code structure has been modified from ACHI.
2. SBS is intended for both admitted and non-admitted care, unlike ACHI. Non-admitted care includes hospital outpatient visits, office-based specialist physician visits, emergency department visits, home health care and primary care.

The SBS V2.0 Coding Standards are an update and replacement of the previously released “Standards and Guidelines of CCHI Billing System”, July 2020, and must be used in conjunction with the ACS, i.e., both sets of standards are to be reviewed together.

The level of detail in these standards reflects the assumption that users of the document will have had training in abstracting relevant information from clinical records and in the structure of ICD-10-AM and SBS.

The clinical record should be the primary source for the coding of ambulatory cases, again as for admitted care cases. If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. A joint effort between the clinician, clinical coder and Clinical Documentation Improvement Specialist is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

In the Dental SBS list of codes, the codes are flagged as applicable to either admitted care, non-admitted care or both.

## Description of the Saudi Billing System

As mentioned above, SBS is made up of ICD-10-AM, SBS procedure codes, ACS and SBSCS.

A classification of diseases can be defined as a system of categories to which morbid entities are assigned according to established criteria. The purpose of the SBS is to standardise data for claims, and for morbidity analysis and mandated reporting.

The SBS enables the translation of diagnoses and procedures and other health problems from words into an alphanumeric/numeric code, which permits easy storage, retrieval and analysis and use of the data.

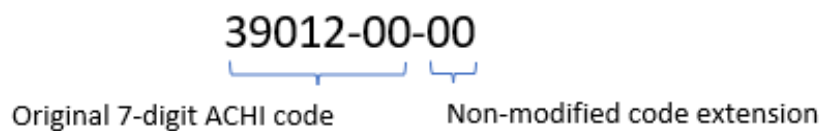
The 'ICD' was first used to classify causes of mortality as recorded at the registration of death. Later, the scope was extended to include diagnoses for morbidity reporting. It is important to note that although the ICD is primarily designed for the classification of diseases and injuries with a formal diagnosis, not every problem or reason for coming into contact with health services can be categorised in this way. Consequently, the ICD provides for a wide variety of signs, symptoms, abnormal findings, complaints and social circumstances that may stand in place of a diagnosis.

## Basic structure and principles of SBS procedure codes

The *Saudi Billing System* (SBS) is a modification of the Australian Classification of Health Interventions (ACHI). The classification uses a hierarchical structure with the following axes:

- First level – anatomical site axis
- Second level – procedure type axis
- Third level – block axis

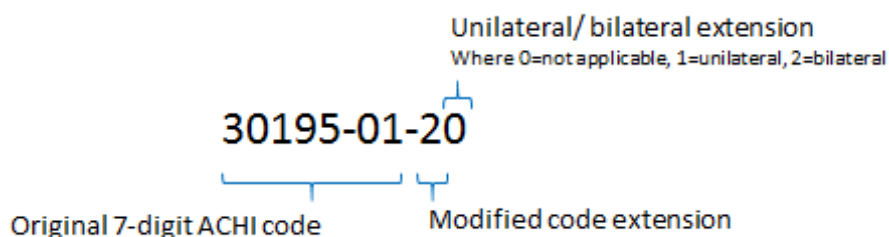
ACHI codes have been modified for Saudi Arabia to allow inclusion of additional codes (including laboratory and pathology, ambulance and transport services, service codes or billing services) and further splits on unilateral/ bilateral procedures. SBS retains the same core 7-digit code as ACHI and includes two-digit extensions where greater specificity has been added to an ACHI code, including laterality. However, if there are no modifications to the ACHI code, the terminal extension will be -00.



### Examples of ACHI codes without modifications:

**39012-00-00** Burr holes

The SBS Procedure codes relate to ACHI 10<sup>th</sup> Edition codes as follows:



### Examples of codes without a unilateral/ bilateral extension are as follows:

**30195-01-10** Curettage of lesion of skin, 1 to 14 lesions

**30195-01-20** Curettage of lesion of skin, 15 or more lesions

**Examples of codes with a unilateral/ bilateral extension are as follows:**

**55030-00-21** Ophthalmic biometry by ultrasound echography, with intraocular lens power calculation, unilateral

**55030-00-22** Ophthalmic biometry by ultrasound echography, with intraocular lens power calculation, bilateral

## **How to use this document**

This document is to be used in conjunction with ACS 10<sup>th</sup> Edition. The ACS 10<sup>th</sup> Edition standards have been extended in this document to include areas that ACHI does not cover (e.g., laboratory and pathology, ambulance and transport, service codes and mortuary), or to extend the standards to non-admitted services, which are not included in the ACS.

Given that it is a supplement to the ACS, coding standards are only provided for:

- Procedures that are specifically for non-admitted patients (such as many of the dental procedures), OR
- Procedures that apply to admitted and/or non-admitted patients that are not in the ACS (including laboratory and pathology, ambulance and transport services, evaluation and management interventions, emergency medical services and mortuary services).

Where there are not separate coding standards in this document for procedures that may be classified as admitted or non-admitted, such as dialysis, radiotherapy, and chemotherapy, the standards for non-admitted patients are the same as for same day admitted patients.

In this document the standards are arranged by section. Additional information may be available in the glossary or the introduction.

The term 'clinician' is used throughout the document and refers to the treating physician but may also refer to midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline.

SBS V2.0 includes additional codes to those in V1.0, including non-billable codes; take care not to miss these additional codes that are required to be coded.

# Section 1 – General standards

## SBSCS 3000 Unlisted codes

Unlisted codes are reserved for services that have not been defined in the current SBS list. Unlisted codes help expedite and finalize the coding, billing and reimbursement processes in situations where an unlisted code is the only option for reporting certain services or procedures performed by the provider, for example advancement in medical science, including new procedures, technology, and devices introduced prior to code expansion. Unlisted codes serve a very important function – Analysis of unlisted codes will aid in identifying areas for future code development or areas in which education and or guidance may be provided where there is an existing code.

Multiple unlisted codes are available for use in more than one SBS chapter, including:

- Dental – 7
- Imaging services -1
- Laboratory and pathology – 17
- Ambulance and Transportation services – 1
- KSA Service codes – 1
- No chapter assignment - 1

Unlisted ambulatory service (99999-99-99)– should be used solely in cases where the performed service description does not match any existing SBS code description and does not fit into any of the other Unlisted code categories.

Table 1 contains the unlisted codes by SBS chapter and block.

Table 1: Unlisted codes in SBS V2.0, by SBS chapter

SBS code	Long description	Block	Block name
<b>Chapter 6: Dental Services</b>			
97089-00-10	Unlisted oral medicine/ oral pathology procedure	452	Other dental diagnostic services
97179-00-10	Unlisted preventive dental procedure	455	Other preventative dental service
97399-00-10	Unlisted oral surgery procedure	461	Other dental surgical procedure
97459-00-10	Unlisted restorative or endodontic procedure	464	Other endodontic service
97789-00-10	Unlisted prosthodontic procedure	477	Other prosthodontic service
97879-00-10	Unlisted orthodontic procedure	483	Other orthodontic service
97989-00-10	Unlisted adjunctive dental service	490	Miscellaneous dental services
<b>Chapter 20: Imaging Services</b>			
99999-99-92	Unlisted imaging procedure	2016	Imaging services
<b>Chapter 21: Laboratory and Pathology</b>			
73050-39-70	Unlisted chemistry procedure	3050	Chemistry & Microbiology
73050-60-60	Unlisted Immunoassay detection with direct visual observation	3050	Chemistry & Microbiology
73050-61-60	Unlisted microbiology procedure	3050	Chemistry & Microbiology
73100-27-21	Unlisted assay for Virus Antibodies	3100	Study of Blood Products & Antibodies
73100-09-80	Unlisted Haematology procedure	3100	Study of Blood Products & Antibodies
73100-18-20	Unlisted antigen delayed type hypersensitivity (DTH) test	3100	Study of Blood Products & Antibodies
73100-22-00	Unlisted assay for Fungus Antibodies	3100	Study of Blood Products & Antibodies
73100-25-50	Unlisted assay for Protozoa Antibodies	3100	Study of Blood Products & Antibodies



SBS code	Long description	Block	Block name
73150-01-20	Unlisted urinalysis procedure	3150	Clinical Pathology & Urinalysis
73200-03-60	Unlisted cytopathology procedure	3200	Cell study - Disease Analysis & Genetics; Specimen study
73200-06-30	Unlisted cytogenetic study	3200	Cell study - Disease Analysis & Genetics; Specimen study
73200-10-60	Unlisted surgical pathology procedure (histo-diagnostic procedure)	3200	Cell study - Disease Analysis & Genetics; Specimen study
73250-03-80	Unlisted blood bank procedure (transfusion procedure)	3250	Blood Screening & Transfusion related Procedures
73300-03-70	Unlisted Quantitative Therapeutic Drug Test	3300	Drug Assays & Chemical toxicology
73350-06-00	Unlisted molecular diagnostic procedure	3350	Molecular Pathology including Gene Sequencing
73400-00-40	Unlisted in vivo laboratory procedure	3400	Fertility Medicine, In Vivo and Other Lab Procedures
73400-01-50	Unlisted clinical pathology procedure	3400	Fertility Medicine, In Vivo and Other Lab Procedures
73400-05-10	Unlisted assisted reproduction procedure (male or female)	3400	Fertility Medicine, In Vivo and Other Lab Procedures
<b>Chapter 22: Ambulance and transportation services</b>			
83500-00-80	Unlisted ambulance service	3500	Emergency
<b>Chapter 23: KSA Service Codes</b>			
83700-00-00	Unlisted services yet to be defined	3700	Unlisted
<b>No chapter Assignment</b>			
99999-99-99	Unlisted ambulatory service	4021	

Submission of an unlisted code on a claim must be accompanied by a description of the actual services provided. See example below.

**Example:**

A 32-year-old male patient came to the clinic complaining of a dark pigmentation of his gums. The dentist performs a depigmentation procedure (microdermabrasion technique) to remove the pigmented areas of the gum tissues.

**K06.8** Other specified disorders of gingiva and edentulous alveolar ridge

**97281-00-00 [456]** Unlisted nonsurgical periodontal treatment

**Description:** Depigmentation procedure (microdermabrasion technique) to remove the pigmented areas of the gum tissues

**Note:** SBS unlisted codes may not be used to report medications nor medical devices and consumables. There is a specific set of unlisted codes for various categories of medications as well as one unlisted code for medical devices. For more information regarding these unlisted codes, refer to CHI's Guidelines for Mapping Provider Service Lists to Standard Code Sets,

# Section 2 – Coding standards for non-admitted care

## SBSCS 3010 General guidelines for procedures for non-admitted patients

For ambulatory settings, a **'procedure'** means a **medical service or a minor surgical intervention and includes diagnostic imaging and laboratory tests**. It excludes drugs and medical supplies, such as walking aids or dressings, which should not be coded.

For the purposes of coding, procedures for non-admitted patients are different from those for admitted patients in that they include procedures that would not normally be coded for admitted patients. For example, the following procedures, which are not coded for admitted patients, should be coded for non-admitted patients:

- Doppler recordings
- X-rays
- Electromyography
- Electrocardiography

When coding procedures for non-admitted patients, select the procedure or service that accurately describes the service performed. All services or procedures should be adequately documented in the medical record.

The order of codes should be determined using the following hierarchy:

- Procedure performed for the treatment of the principal diagnosis
- Procedure performed for treatment of any additional diagnosis
- Diagnostic/exploratory procedure related to the principal diagnosis
- Diagnostic/exploratory procedure related to any additional diagnosis.

Any anaesthesia used in the non-admitted setting should also be coded, as for admitted patients (although some forms of anaesthesia, such as general anaesthesia, will not be used in non-admitted settings). **The American Society of Anesthesiologists (ASA) Physical Status Classification code should also be used for non-admitted patients (see ACS 0031 as well as Table 2, p. 10 in this document).**

The tabular listing of procedures sometimes contains inclusions and exclusions, and 'code also' instructions, as for admitted patient coding. Ensure that you follow these, except where the standards in this document overrule these instructions.

As mentioned earlier, in this document, given that it is a supplement to the ACS, coding standards are only provided for procedures that are specifically for non-admitted patients (such as many of the dental procedures), OR for procedures that apply to admitted and/or non-admitted patients that are not in the ACS (that is, laboratory and pathology, ambulance and transport services, evaluation and management interventions, emergency medical services and mortuary services). **Therefore, the SBSCS must be used in conjunction with the ACS.**

Note again that where there are not separate coding standards in this document for procedures that may be classified as admitted or non-admitted, such as dialysis, radiotherapy, and chemotherapy, **the standards for non-admitted patients are the same as for same day admitted patients.**

## **SBSCS 3011 Bilateral procedures**

Bilateral procedures are those which involve the same organ/structure on different sides of the body at the same operative episode.

### 1. Procedures with separate unilateral/ bilateral codes

Compared with ACHI, SBS provides many more separate codes for unilateral/ bilateral procedures where the procedure may be performed on one or both organs/ structures. For example:

- Probing of lacrimal passages
- Ear toilet
- Myringotomy
- Ophthalmological examination
- Incision of eyelid
- Magnetic resonance imaging of breast, with contrast medium
- Radiography of clavicle
- Removal of intraocular lens

Where a code is provided for a unilateral vs. a bilateral procedure, assign the appropriate code.

### 2. Inherently bilateral procedures

There are procedures that are 'pseudo-bilateral', which are not explicitly described as bilateral in SBS. They include diagnostic or therapeutic interventions which have one entry point but affect bilateral structures, usually vessels, for example, coronary angiography or tonsillectomy. Where a procedure is inherently bilateral, assign the code once.

### 3. Procedures with no code option for bilateral

Where a procedure does not have a unilateral/bilateral option, and the procedure is performed bilaterally, assign the code twice.

## Section 3 – Dental services

In this section, general conventions applicable to Dental services (SBS Chapter 6) are included, followed by dental specialty standards.

### Dental services general coding conventions

Code the problem as a primary diagnosis if known / if the problem is not known, code the underlying condition as a principal diagnosis.

When a procedure has been discontinued, for any reason, before completion, the assigned code should indicate the stage at which the procedure has been stopped and a code for discontinued service has to be listed to provide an opportunity for the procedure to be done again if medically necessary.

The tooth number(s) should be recorded with every dental procedure where applicable. Coders or billing specialists are to select the appropriate tooth numbers in the NPHIES system while appending code information and generating claim for submission to insurance.

Notes on anaesthesia status and tooth numbering are listed in this section for easy reference, as they apply to all dental subspecialties listed subsequently.

Table 2: Anaesthesia status

First character:

ASA class	Description
1	A normal healthy patient
2	A patient with mild systemic disease
3	Patient with severe systemic disease that limits activity
4	Patient with severe systemic disease that is a constant threat to life
5	A moribund patient who is not expected to survive longer than 24 hours without surgical intervention
6	A declared brain-dead patient whose organs are being removed for donor purposes
9	No documentation of ASA score

Second character:

Emergency modifier	Character	Description
<b>E</b>	<b>0</b>	Procedure being performed as an emergency
	<b>9</b>	Nonemergency or not known

Table 3: Tooth numbering system, permanent teeth

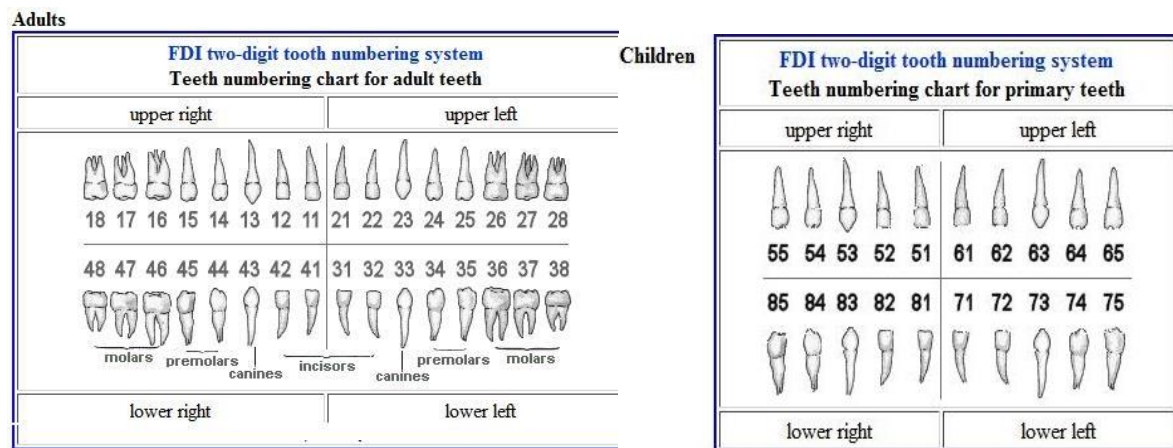
11 Upper right permanent central incisor	31 Lower left permanent central incisor
12 Upper right permanent lateral incisor	32 Lower left permanent lateral incisor
13 Upper right permanent canine	33 Lower left permanent canine
14 Upper right permanent 1st premolar	34 Lower left permanent 1st premolar
15 Upper right permanent 2nd premolar	35 Lower left permanent 2nd premolar
16 Upper right permanent 1st molar	36 Lower left permanent 1st molar
17 Upper right permanent 2nd molar	37 Lower left permanent 2nd molar
18 Upper right permanent 3rd molar	38 Lower left permanent 3rd molar

21 Upper left permanent central incisor	41 Lower right permanent central incisor
22 Upper left permanent lateral incisor	42 Lower right permanent lateral incisor
23 Upper left permanent canine	43 Lower right permanent canine
24 Upper left permanent 1st premolar	44 Lower right permanent 1st premolar
25 Upper left permanent 2nd premolar	45 Lower right permanent 2nd premolar
26 Upper left permanent 1st molar	46 Lower right permanent 1st molar
27 Upper left permanent 2nd molar	47 Lower right permanent 2nd molar
28 Upper left permanent 3rd molar	48 Lower right permanent 3rd molar

Table 4: Tooth numbering system, primary teeth

51 Upper right primary central incisor	71 Lower left primary central incisor
52 Upper right primary lateral incisor	72 Lower left primary lateral incisor
53 Upper right primary canine	73 Lower left primary canine
54 Upper right primary first molars	74 Lower left primary first molar
55 Upper right primary second molars	75 Lower left primary second molar
61 Upper left primary central incisor	81 Lower right primary central incisor
62 Upper left primary lateral incisor	82 Lower right primary lateral incisor
63 Upper left primary canine	83 Lower right primary canine
64 Upper left primary first molars	84 Lower right primary first molars
65 Upper left primary second molars	85 Lower right primary second molars

Figure 1: Numbering system FDI for adults and children



## Oral medicine and diagnosis

### SBSCS 4000 Examination and diagnostics

A dental exam is a check-up of teeth, gums and surrounding hard and soft tissue. Most children and adults should receive a dental exam every six months. These exams are important for protecting oral health. Depending on the type of exam provided, examinations can be divided to the following:

- **Comprehensive oral examination**

Includes a complete inspection of oral mucosa, hard and soft tissue, salivary glands and all structures present in the oral cavity is performed.

- **Comprehensive cancer examination and risk assessment of head and neck by a dental surgeon**

Includes a comprehensive examination and assessment of the head and neck's extraoral and intraoral tissues used for the detection and diagnosis of any disease or tissue abnormality. This may aid in the detection of early indications of oral or tonsillar cancer, allowing for prompt diagnosis and treatment.

- **Periodic oral examination**

Comprehensive or Limited Oral cavity examination done on a periodic basis (e.g., once in 6 months or a year).

- **Limited oral examination**

A single tooth (crown, root, periodontal ligament) examination or examination of a region or affected tooth, gums, tongue, oral mucosa, palate, periodontal structures, alveolar bone, floor of mouth or any other region limited to the definition of oral cavity.

- **Oral examination; post operative re-evaluation**

Post operative examination initiated after suture removal or any complications related to the surgery.

### **Classification**

It is important to recognize the reason for the dentist visit to assign the most appropriate code. For the first dental visit, most patients will need a full mouth examination to assess the oral health state and determine the final treatment plan. Assign code **97011-00-00 [450]** Comprehensive oral examination for new patients or those who undergo a full mouth examination. **97012-00-00 [450]** Periodic oral examination should only be assigned if the dentist has met the patient (or individual) earlier or scheduled for a later visit. Otherwise, it should be coded as Comprehensive or Limited based on definition.

In emergency visits or visits where the patient has a chief complaint, the dentist is only focused on treating the problem area which is why the assignment of **97013-00-00 [450]** limited oral examination code is suitable rather than the comprehensive oral examination code.

**97011-00-10 [450]** Oral examination; post operative re-evaluation, should only be assigned when the dentist's examination is only focused on examining a previously treated area (e.g., for suture removal, or any complications related to the surgery).

**Example 1:**

A 14-year-old patient came to the clinic for the first time, clinical examination revealed good oral health. Fluoride application was done as a preventive measure.

<b>Z01.2</b>	Dental examination
<b>97011-00-00 [450]</b>	Comprehensive oral examination
<b>97121-01-00 [454]</b>	Topical application of remineralization agent, 1 treatment

## SBSCS 4001 Diagnostic models

Diagnostic models, also named as diagnostic casts or study models, are typically used to study the patients jaw relation and are beneficial in determining the patient's final treatment plan. These casts can be traditionally fabricated (using plaster or other materials) or digitally fabricated.

### Classification

Preparation of dental diagnostic cast **97071-00-00 [452]** is used for the production of a model from an impression or digital data. This code covers taking the impression and the model fabrication. However, it does not cover the bite registration or the mounting of the model. If the cast or model is being used for occlusal analysis or for the fabrication of indirect tooth restoration (e.g., inlays, crown, fixed and removal dentures, etc.) then an additional code for the registration and mounting of model for occlusal analysis **97964-00-00 [489]** should be added.

**Example 1:**

A patient came to the dental clinic. Clinical examination revealed excessive wear and loss of vertical dimension of occlusion. Impression was taken and a diagnostic cast was fabricated to assess occlusal relation. Assign and sequence as:

<b>Z01.2</b>	Dental examination
<b>97011-00-00 [450]</b>	Comprehensive oral examination
<b>97071-00-00 [452]</b>	Preparation of dental diagnostic cast
<b>97964-00-00 [489]</b>	Registration and mounting of model for occlusal analysis

# Preventive

## SBSCS 4005 Preventive procedures

Preventive dentistry can help identify problems early in children's lives before dental problems become worse or require more invasive interventions. Services typically include promoting good dental habits, including brushing and flossing, guidance on minimizing or avoiding thumb sucking, and also advice on eating habits that help improve dental health. Regular teeth cleanings and oral exams, usually every 6 months. Routine X-rays may be taken as well to help track jaw and teeth development.

Fluoride may be applied as a preventive caries measure (up to a certain age – usually for children up to 14 years) or in some cases with deep fissures, fissure sealants may be applied as well.

### A. Remineralization and cariostatic agents

The remineralization process is a natural repair mechanism to restore the minerals to the tooth. It occurs when calcium and phosphate mineral ions are redeposited within the demineralized lesion from saliva resulting in the formation of a surface more resistant to acid dissolution. Remineralizing agents can be broadly classified into fluorides and non-fluoride remineralizing agents (Alpha tricalcium phosphate (TCP), Amorphous calcium phosphate, CPP-ACP, Sodium calcium phosphor-silicate (bioactive glass), Xylitol, etc.) The modes of delivery of remineralizing agents may be as dentifrices, mouth rinses, lozenges or chewing gums.

#### Classification

Fluoride is effective in protecting against tooth decay and in repairing early lesions in the teeth that can turn into cavities. As such, it is usually used as a prevention method. When indicated assign code **97121-01-00 [454]** Topical application of remineralisation agent, 1 treatment.

In some cases, it maybe indicated to use mineralization substances into a carious enamel surface to interrupt the carious process and aid in the remineralization process. When indicated, assign code **97123-01-10 [454]** Application of concentrated remineralisation or cariostatic agent, per tooth.

\*\*Care should be taken to identify the material used and the patient age to assign the appropriate code.

#### **Example 1:**

A 7-year-old patient came to the clinic for a periodic check-up. Examination showed good oral health. The dentist performed a topical application of fluoride as part of a preventive program. Assign and sequence as:

<b>Z01.2</b>	Dental examination
<b>97012-00-00 [450]</b>	Periodic oral examination
<b>97121-01-00 [454]</b>	Topical application of remineralisation agent, 1 treatment



## B. Bleaching

The main goal of tooth bleaching or whitening is to restore the tooth's natural shine and whiteness which have diminished over time with exposure to factors that cause discoloration. It can be performed in the office (both externally and internally) or at home (externally).

### Classification:

In some cases, dentists will perform the in-office treatment and then fabricate a tray for the patient at-home treatment to achieve the best results or maintain it. In such cases when indicated, custom trays should be coded in addition to the home application of bleaching.

#### **Example 1:**

18-year-old female patient came to the clinic for a periodic oral evaluation. Her radiographic images are up to date, and she is interested in at-home teeth whitening as her teeth were discoloured.

<b>K03.6</b>	Deposits [accretions] on teeth
<b>97012-00-00 [450]</b>	Periodic oral examination
<b>97119-00-00 [453]</b>	Bleaching, home application, per arch
<b>97926-00-00 [485]</b>	Fabrication of mandibular or maxillary tray for self-application of Medicament

## C. Administration of pharmacological agent

Pharmacological agents can be administered for therapeutic reasons or to aid in dental treatment. Therapeutic drugs include antiseptics, steroids, analgesics, antimicrobials, or antifungals. These agents can be administered in many routes, such as Intra-arterial, enteral, intracavitary, intramuscular, intrathecal, or intravenous.

Table 5: Pharmacological agents

Antidote
Anti-infective
Antineoplastic
Electrolyte
Insulin
Nutritional substance
Psychotherapeutic
Steroid
Thrombolytic

### Classification

Clear documentation of the mode of administration is needed to assign the appropriate code. The code should be assigned **once** in the duration of admission regardless of the number of times

administered. In cases where the same pharmacological agent is being administered in different entry routes, different codes should be assigned to reflect the specific administration route used. In cases, where multiple pharmacological agents are administered, codes should be added to reflect the different agents used.

**Example 1:**

18-year-old female patient previously diagnosed with multiple sclerosis. She was admitted for same-day IV infusion of methylprednisone.

**G35** Multiple sclerosis

**96199-03-00 [1920]** Intravenous administration of pharmacological agent, steroid

**Example 2:**

52-year-old male patient previously diagnosed with prostate cancer was admitted for same-day chemotherapy. Intravenous (IV) cyclophosphamide was given and the patient was discharged same-day.

**Z51.1** Pharmacotherapy session for neoplasm

**C61** Malignant neoplasm of prostate

**M8000/3** Neoplasm, malignant

**96199-00-00 [1920]** Intravenous administration of pharmacological agent, antineoplastic

# Dental anaesthesiology

## SBSCS 4010 Dental anaesthesiology

Several techniques can be used to administer anaesthesia in the dental field. Some dental procedures are performed utilizing one anaesthesia method, while others may be performed using a combination of two or more techniques. When indicated assign the different anaesthesia methods used.

The amount of anaesthesia used should be recorded for documentation purposes. However, the codes used can only be reimbursed once regardless of the amount of anaesthesia used. Assigning an appropriate code should follow the guidelines for coding anaesthesia, including applicable ASA score. These techniques are as follows:

### A. Sedation

Sedation is the reduction of irritability or anxiety by administration of sedative drugs, generally to facilitate a medical, dental or diagnostic procedure. Examples of drugs which can be used for sedation include isoflurane, diethyl-ether, propofol, etomidate, ketamine, pentobarbital, lorazepam and midazolam. Sedation methods in dentistry include inhalation sedation (using nitrous oxide), and intravenous (IV) sedation.

#### Classification

The use of sedation in a dental setting does not eliminate the need for local anaesthesia use in dental procedures. Assigning a code should follow the guidelines for coding anaesthesia, including applicable ASA score. If other types of anaesthesia are used (e.g., infiltration, nerve blocks) they should be coded separately.

#### **Example:**

A patient came to the clinic for surgical extraction of partially impacted wisdom tooth #38. The patient was anxious and was put under sedation for 45 minutes. The procedure was performed under local anaesthesia, inferior alveolar nerve block. Assign and sequence as:

<b>K01.1</b>	Impacted teeth
<b>97321-01-00 [458]</b>	Surgical removal of impacted tooth; partial bony impacted tooth; per tooth
<b>92509-99-10 [1909]</b>	Administration of anaesthesia, trigeminal division block, regional block, nerve of head or neck, ASA 99
<b>92515-99-00 [1910]</b>	Sedation, ASA 99

### B. Local anaesthesia

Several techniques can be used to achieve local anaesthesia of the dentition and the surrounding hard and soft tissues of the maxilla and mandible. There are three main anaesthetic agents that can be used, Lidocaine, Bupivacaine, and Mepivacaine. The type of procedure to be performed as well as the location of the procedure determine the technique of anaesthesia to be used, such as:

- **Infiltration**

The local infiltration technique anesthetizes the terminal nerve endings of the dental plexus. This technique is indicated when an individual tooth or a specific isolated area requires anaesthesia. The procedure is performed within the direct vicinity of the site of infiltration.

- **Nerve block, trigeminal**
- **Regional block, nerve of head or neck, other than trigeminal nerve division**

The nerve block anesthetizes the main branch of a specific nerve other than trigeminal nerve division, allowing treatment to be performed in the region innervated by that nerve.

### **Classification**

Assigning a code should follow the guidelines for coding anaesthesia, including applicable ASA score. Most dental services are performed under infiltration or trigeminal nerve blocks. However, some oral and maxillofacial surgeries may require the use of a block other than trigeminal nerve block. When different types of local anaesthesia methods are used, assign codes that reflect the region used.

#### **Example 1:**

A patient came to the clinic for the extraction of a non-restorable tooth #36. Nerve block was administered, and surgical extraction of the tooth was performed. Assign and sequence as:

<b>K01.1</b>	Impacted teeth
<b>97321-05-00 [458]</b>	Surgical removal of one tooth; soft tissue (not requiring removal of bone or tooth division)
<b>92509-99-10 [1909]</b>	Administration of anaesthesia, trigeminal division block, regional block, nerve of head or neck, ASA 99

#### **Example 2:**

62 years old male, diagnosed with pleomorphic adenoma, is admitted for total excision of parotid gland with preservation of the facial nerve. The patient has an increased risk for complications from a general anaesthesia. The procedure was performed under local or regional anaesthesia. ASA score is 3. Assign and sequence as:

<b>D11.0</b>	Benign neoplasm of Parotid gland
<b>M8940/0</b>	Pleomorphic adenoma
<b>30250-00-00 [397]</b>	Total excision of parotid gland with preservation of facial nerve
<b>92509-39-00 [1909]</b>	Regional block, nerve of head or neck, ASA 39

## **C. General anaesthesia**

Dental treatment under general anaesthesia is reserved for patients whose behaviour cannot be managed by nonpharmacological (e.g., tell-show-do, positive reinforcement, voice control, distraction) or pharmacological (nitrous oxide sedation, oral sedation) techniques.

## **Classification**

Assigning this code should follow the guidelines for coding anaesthesia, including applicable ASA score. If other types of anaesthesia are used (e.g., infiltration, nerve blocks) they should be coded separately.

### **D. ASA scores**

Based on the American Society of Anaesthesiologists (ASA) Physical Status Classification, coding anaesthesia requires a two-character extension which represents the patient's ASA score. For the listed scores, refer to Table 2, p. 14.

## **Classification**

The first character of the two-character extension of the procedure code is the ASA score. The second character of the extension represents whether the procedure that is being performed as an emergency or not. This information must be documented at the time of the procedure. Where there is no documentation of ASA score or the emergency modifier is not indicated, filler digits of '9' should be assigned. An ASA score where a single ASA value is not clearly documented, should be clarified with the anaesthetist, however, if this is not possible, assign the code representing the higher score.

# Periodontics

## SBSCS 4020 Periodontal therapy

Periodontal diseases may be treated conservatively or non-surgically using periodontal therapy. It aims to monitor and control periodontal conditions, without surgical interventions. Ultimately, it promotes periodontal health, preventing tooth loss.

### A. Periodontal scaling and root planning

This procedure consists of the removal of plaque, calculus and stains from supragingival and subgingival tooth surfaces. Root planning is the removal of cementum and dentine that is rough and/or permeated by calculus.

#### **Classification:**

Periodontal scaling and root planning procedure can be performed in one visit or up to four visits. When indicated, special care should be taken with regard to the visit, or encounter, number to assign the appropriate code. Assign **97281-00-10 [456]** Generalized scaling and root planning; severe plaque and calculus deposition, first appointment for the first visit and assign **97115-00-00 [453]** Removal of calculus from surfaces of teeth – subsequent appointment for subsequent visits.

### Periodontal maintenance visit

This visit is scheduled following periodontal therapy. It constitutes a full mouth re-evaluation and removal of plaque, supragingival and subgingival calculus and teeth polishing. However, if new or recurring periodontal disease appears then additional diagnostic and treatment must be coded.

### B. Periodontal surgery

Periodontal surgery may occasionally be required to treat some gum diseases and disorders, such as gingivitis or periodontitis. The operation is intended to address periodontal disease and any harm it may have done by repair of harmed tissues and bones. These procedures include:

#### **Periodontal flaps**

A periodontal flap is a section of gingiva, mucosa, or both that is surgically separated from the underlying tissues to provide for the visibility of and access to the bone and root surface. The flap also allows the gingiva to be displaced to a different location in patients with mucogingival involvement. Periodontal flaps can be classified based on the flap position after the surgery as:

#### **Non-displaced flaps:**

These include periodontal flaps that are usually performed to gain better access for scaling and root planning, (e.g., periodontal flaps, flaps used for curettage) or for crown lengthening procedures.

#### **Displaced flaps:**

These include rotational and transposition flaps. A rotation flap is a semi-circular flap of skin and subcutaneous tissue that rotates about a pivot point into a defect. The donor site is typically repaired with wide undermining and direct, layered closure. The vector of greatest tension is directed from the pivot point outward to the defect's furthest radial point.

Transposition flaps are generally smaller in size than advancement and rotation flaps. Transposition flaps, like all flaps, utilize tissue adjacent to the wound for reconstruction, generally offer a good colour and textural match.

**Classification:**

Assigning a code for periodontal flap procedure depends either on the flap position after surgery, or on the number of teeth, or the area treated. When a flap procedure is being performed on multiple teeth in one quadrant, assign **97232-00-10 [456]** Periodontal flap procedure, per quadrant. When open flap procedure is recorded assign **97271-01-00 [456]** Open flap or curettage surgery; per tooth or implant.

Only assign **97238-00-10 [456]** Periodontal flap procedure for crown lengthening, per tooth when the reason for the procedure (crown lengthening) is documented.

**Example:**

A patient came to the clinic presenting with inflamed gingival tissue around an implant replacing tooth #26, bleeding upon probing, and deep pocket depths (4mm). Scaling and debridement as treatment for inflammation of an implant were done. Open flap procedure was also done. Assign and sequence as:

<b>K05.5</b>	Other periodontal disease
<b>97271-01-00 [456]</b>	Open flap or curettage surgery; per tooth or implant
<b>97281-00-60 [456]</b>	Scaling and debridement in the presence of inflammation or mucositis of an implant, including cleaning of the implant surfaces, without flap entry and closure; per implant

## **SBSCS 4021 Guided tissue regeneration**

Guided tissue regeneration is a surgical procedure that specifically aims to regenerate the periodontal tissues when the periodontal disease is advanced. It is a method used to repair periodontal defects so that a tooth, or set of teeth, has more support and stability. In addition to this procedure a resorbable or non-resorbable artificial membrane may be used to aid in the osseous regeneration.

**Classification:**

Non-resorbable membranes are bio-inert and require a second surgical procedure to remove after bone regeneration is complete. Resorbable membranes are naturally biodegradable and have varying resorption rates. If documented, a separate code must be used to indicate it.

\*\*This procedure does not include flap entry and closure, and it should be coded separately when indicated.

**Example:**

A patient came to the clinic for Guided tissue regeneration as treatment of infra-bony periodontal defect on tooth #26. Conventional flap was used and a resorbable membrane was placed to aid in the osseous regeneration process. Assign and sequence as:

<b>K05.3</b>	Chronic periodontitis
<b>97271-00-00 [456]</b>	Apically positioned periodontal flap
<b>97236-00-00 [456]</b>	Guided tissue regeneration, per tooth or implant
<b>97260-01-00 [456]</b>	Administration of biologic materials to aid in soft and osseous tissue regeneration with periradicular surgery, per tooth

## SBSCS 4022 Incision and drainage of abscess

There are two main types of dental abscess- periodontal abscess and periapical abscess.

A periodontal abscess is a localized accumulation of pus within the periodontal tissues, which may be confined to the marginal gingiva or be a deeper infection associated with periodontal pockets, and bone loss. A periapical abscess occurs in the apex of the tooth root, and commonly results from bacterial infection of the pulp secondary to caries, traumatic tooth fracture, or prior dental work. While periapical abscess may require treatment of the offending tooth, a periodontal abscess usually requires incision and drainage.

### **Classification:**

Identifying the cause of the abscess is important to arrive at the appropriate treatment. Proper documentation of the diagnosis is required to assign the intervention code.

**Example 1:**

A patient came to the clinic with erythema, throbbing and radiating pain, and swelling of the gingiva over teeth #36 and #37. Examination showed tooth mobility. The patient was diagnosed with Acute periodontitis and incision and drainage of the abscess were performed. Assign and sequence as:

<b>K05.2</b>	Acute periodontitis
<b>97213-00-00 [456]</b>	Treatment of acute periodontal infection

**Example 2:**

A patient came to the clinic with pain and swelling of the gingiva over teeth #33 and #34. Examination showed tooth mobility. The patient was diagnosed with Acute apical periodontitis related to tooth# 33. An endodontic treatment of the tooth was performed:

<b>K04.4</b>	Acute apical periodontitis of pulpal origin
<b>97420-01-00 [462]</b>	Root canal treatment, anterior (includes extirpation of pulp, chemomechanical preparation, obturation)



# Restorative

## SBSCS 4030 Restoration

Dental restoration, dental fillings, or simply fillings are treatments used to restore the function, integrity, and morphology of missing tooth structure resulting from caries or external trauma.

Dental restorative materials that are used for filling tooth cavities or treating dental caries are classified into four categories: amalgam, resin-based composites, glass ionomer, and resin-modified glass ionomer.

### Classification

1) The tooth contains 4 layers from outside to inside

First layer Enamel (crown), second layer cementum (root), third layer dentine then fourth layer pulp.

When coding restorative treatment operative procedures, to the extent of caries needs to be identified and then the extent of caries assigned from ICD-10-AM,

either K02.0 Caries limited to enamel or K02.1 Caries of dentine or K02.2 Caries of cementum or K02 Caries with pulp exposure,

and only assign one code layer, the deepest one.

The procedure starts with excavation of caries, etching, and bonding then dental restoration is applied, and all four steps are included in one SBS procedure code.

2) In the case of one surface restoration, assign **97521-01-10 [466]** Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), 1 surface, direct or **97511-01-10 [465]** Metallic restoration of tooth, 1 surface, direct, based on the material used for restoration.

For each additional surface, assign **97521-02-00 [466]** Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), each additional surface, direct or **97511-02-00 [465]** Metallic restoration of tooth, each additional surface, direct, according to the number of surfaces and material used.

### **Example:**

Basic oral evaluation history: A patient who had not been seen by the clinic before did not report any complaints, but requested a "complete dental check-up".

The doctor performed a complete head and neck exam, including both extra and intra-oral soft and hard tissues, evaluated the TMD and found that lymph nodes were within normal limits. An orthopantomogram and 4 bitewing radiographs were taken, then positive findings appeared on the bitewing, the patient has class II in tooth #15. Caries excavated up to dentine; etching, and bonding were performed followed by a final restoration for a three surfaces resin composite for premolar followed by finishing and polishing the restoration. Assign and sequence as:

<b>Z01.2</b>	Dental examination
<b>K02.1</b>	Caries of dentine

<b>97011-00-00 [450]</b>	Comprehensive oral examination
<b>57960-00-00 [1967]</b>	Orthopantomography
<b>97022-00-20 [451] x 4</b>	Intraoral bitewing radiography, per exposure
<b>97521-01-10 [466]</b>	Adhesive restoration (e.g., compomer, composite glass ionomer, polymer glass, resin composite), 1 surface, direct
<b>97521-02-00 [466] x 2</b>	Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), each additional surface, direct

# Endodontics

## SBSCS 4040 Pulp capping

Two different types of pulp capping are in use. These methods are used when the pulp is visibly exposed (vital pulp exposure) due to caries, trauma, or iatrogenic insults such as accidental exposure during tooth preparation or caries removal.

In direct pulp capping, the protective dressing is placed directly over an exposed pulp; and in indirect pulp capping, a thin layer of softened dentin, that, if removed, would expose the pulp, is left in place and the protective dressing is placed on top.

### **Classification**

Use SBS code **97411-00-10 [462]** Direct pulp capping or **97411-01-00 [462]** Indirect pulp capping appropriately along with K02 Caries with pulp exposure.

#### **Example:**

A 16-year-old male patient scheduled for routine dental treatment, reported discomfort associated with physical stimulation on the permanent mandibular left first molar. No history of spontaneous pulpal pain was reported. The status of the pulp and periradicular tissues were carefully evaluated. The clinical examination revealed a normal appearance of adjacent gingival tissue and a small enamel caries lesion. A slight colour change was noticed through occlusal enamel (Figure 2). Bitewing radiograph revealed a deep distal caries lesion. No radiolucency at the periapical regions or thickness of the periodontal spaces were noticed in periapical radiograph (Figure 3). Pulp sensitivity compatible with a reversible stage of inflammation was confirmed with thermal tests. The pain quickly disappeared after the cold stimulus. (Figures sourced from Fagundes et al. (2009)).



Figure 2



Figure 3



After cavity access, initial removal of soft carious dentin is carried out with an excavator which is included in the SBS procedure code.



View of the cavity floor after removal of infected dentin



Dressing of cavity floor with calcium hydroxide paste directly over the affected dentin as an indirect pulp capping technique



Temporary restoration with resin-modified glass-ionomer cement

Second visit after 60 days:

Recall to inspect the dry dentin on cavity floor, after 60 days



After 60 days, no signs of apical radiolucency or dentin resorption



A resin-modified glass-ionomer cement base is placed over a thin layer of calcium hydroxide cement



Occlusal view of the final restoration with adhesive/resin composite system



Assign and sequence code as follows:

**First visit:**

- Z01.2** Dental examination
- K02** Caries with pulp exposure
- 97013-00-00 [450]** Limited oral examination
- 97022-00-20 [451]** Intraoral bitewing radiography, per exposure
- 97411-01-00 [462]** Indirect pulp capping

**Second visit after 60 days:**

- 97022-00-20 [451]** Intraoral bitewing radiography, per exposure
- 97521-01-10 [466]** Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), 1 surface, direct

## SBSCS 4041 Pulpotomy

### 1. Pulpotomy for immature permanent dentition

An immature permanent tooth is a young/newly erupted permanent tooth with incomplete root apex formation. After a permanent tooth emerges in the mouth, it usually takes three more years for the root development to complete.

The treatment for immature permanent teeth with pulp exposure due to caries or trauma gives evidence of extensive coronal pulpitis, and also, requires an emergency procedure for permanent mature teeth until root canal treatment can be accomplished.

### 2. Pulpotomy for primary dentition

A pulpotomy is performed in a primary tooth when caries removal results in a pulp exposure in a tooth with a normal pulp or reversible pulpitis or after a traumatic pulp exposure and there is no radiographic sign of infection or pathologic resorption

#### Partial pulpotomy

Partial pulpotomy, rather than direct pulp capping or complete pulpotomy, is the treatment of choice following traumatic or carious pulp exposure in immature permanent teeth.

A partial pulpotomy is indicated in a young permanent tooth for a carious pulp exposure in which the pulpal bleeding is controlled within several minutes. The tooth must be vital, with a diagnosis of normal pulp or reversible pulpitis.

#### Classification

Use SBS code **97414-00-10 [462]** Pulpotomy for immature permanent, primary dentition or **97414-01-00 [462]** Partial pulpotomy, permanent tooth, assign the appropriate SBS code procedure along with a diagnosis code of K02 Caries with pulp exposure.

## SBSCS 4042 Root canal treatment

Root canal treatment (endodontics) is a dental procedure used to treat infection at the centre of a tooth and it is performed in 3 stages:

**Stage 1:** Extirpation of pulp – involves the removal of the dead nerve and the gross infected pulp.

**Stage 2:** Bio Mechanical preparation (BMP) of root canal – this involves further cleaning and shaping of the canals.

**Stage 3:** Obturation – this is the last stage in the completion of treatment which involves filling the canals with an inert filling material.

#### Classification

To code Root canal treatment operative procedure use, **97420-01-00 [462]** Root canal treatment, anterior or **97420-02-00 [462]** Root canal treatment, premolar or **97420-03-00 [462]** Root canal treatment, molar. Only one SBS code is assigned, per tooth, which Includes extirpation of pulp, chemomechanical preparation, obturation.

Diagnosis code ICD-10-AM must be K04.0 Pulpitis.

### **\*Note**

The code K02.5 Caries with pulp exposure cannot be assigned unless the pulp was exposed during the removal of caries and the pulp test did not indicate irreversible pulpitis.

#### **Example:**

35- year-old male patient complaining of pain in upper left quadrant. A limited oral evaluation was done. Bitewing radiographic images and periapical radiographic images were taken and evaluated. After evaluation with pulp test a definitive diagnosis was made – Irreversible pulpitis in tooth #25. Root canal treatment was performed followed by a final restoration (resin-based composite – three surfaces, premolar)

<b>Z01.2</b>	Dental examination
<b>K04.0</b>	Pulpitis
<b>97061-00-00 [452]</b>	Pulp vitality test, per tooth
<b>97013-00-00 [450]</b>	Limited oral examination
<b>97022-00-20 [451]</b>	Intraoral bitewing radiography, per exposure
<b>97022-00-10 [451]</b>	Intraoral periapical radiography, per exposure
<b>97420-02-00 [462]</b>	Root canal treatment, premolar (includes extirpation of pulp, chemomechanical preparation, obturation)
<b>97521-01-10 [466]</b>	Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), one surface, direct
<b>97521-02-00 [466] x 2</b>	Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), each additional surface, direct

### **Extirpation of pulp or debridement of root canal(s), emergency or palliative procedure**

A pulp extirpation is part of a root canal treatment that is performed to save a tooth where the innermost part (the pulp) has become badly infected. The pulp and bacteria inside the pulp chamber are removed and the infection is cleaned till the pain is relieved and the patient is asymptomatic.

#### **Classification**

Generally, incisors, canines, and premolars have one root except for the maxillary upper first premolar with two roots, whereas molars will have two or three roots.

In cases where only extirpation of pulp or debridement of root canal is done, code **97419-00-10 [462]** Extirpation of pulp or debridement of root canal(s), emergency or palliative procedure.

For molars and upper premolars involving more than one root, code the add-on code **97419-10-00 [462]** Extirpation of pulp or debridement of root canal(s), emergency or palliative procedure for any additional root canal (beyond the usual number of roots per tooth).

### **\*Note**

1) If the dentist extirpates the pulp, and continues with chemomechanical preparation, and obturation for the canal then the code **97419-00-10 [462]** Extirpation of pulp or debridement of root canal(s), emergency or palliative procedure is not valid anymore, instead code as a root canal treatment operative procedure, by assigning **97420-01-00 [462]** Root canal treatment, anterior or **97420-02-00 [462]** Root canal treatment, premolar or **97420-03-00 [462]** Root canal treatment, molar.

2) ICD-10-AM code must be K04.0 Pulpitis.

3) ICD-10-AM code, K02.5 Caries with pulp exposure, cannot be assigned unless the pulp was exposed during the removal of caries and the pulp test did not indicate irreversible pulpitis.

#### **Example 1:**

30- year-old patient complaining of sharp pain in the lower right quadrant. A limited oral evaluation was done. Bitewing radiographic images were taken and evaluated. After the pulp vitality test has been carried out, a definitive diagnosis was made - Irreversible pulpitis in tooth #46. Pulp extirpation as an emergency procedure was performed to relieve the pain followed by a temporary restoration.

<b>Z01.2</b>	Dental examination
<b>K04.0</b>	Pulpitis
<b>97061-00-00 [452]</b>	Pulp vitality test, per tooth
<b>97013-00-00 [450]</b>	Limited oral examination
<b>97022-00-20 [451]</b>	Intraoral bitewing radiography, per exposure
<b>97419-00-10 [462]</b>	Extirpation of pulp or debridement of root canal(s), emergency or palliative procedure

#### **Example 2:**

30- year-old patient complaining of sharp pain in the lower right quadrant. A limited oral evaluation was done. Bitewing radiographic images were taken and evaluated. After the pulp vitality test has been carried out, a definitive diagnosis was made – Irreversible pulpitis in tooth #46, pulp extirpation as an emergency procedure was performed to relieve the pain then the patient opted for root canal treatment, so the dentist continued the Root canal treatment followed by a final restoration (resin-based composite – three surfaces, premolar)

<b>Z01.2</b>	Dental examination
<b>K04.0</b>	Pulpitis
<b>97061-00-00 [452]</b>	Pulp vitality test, per tooth
<b>97013-00-00 [450]</b>	Limited oral examination
<b>97022-00-20 [451]</b>	Intraoral bitewing radiography, per exposure
<b>97420-03-00 [462]</b>	Root canal treatment, molar (includes extirpation of pulp, chemomechanical preparation, obturation)

**97521-01-10 [466]** Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), one surface, direct

**97521-02-00 [466] x 2** Adhesive restoration (e.g., compomer, composite, glass ionomer, polymer glass, resin composite), each additional surface, direct

**\*Note**

**97419-00-10 [462]** Extirpation of pulp or debridement of root canal(s), emergency or palliative procedure code is not valid anymore because the dentist continues a comprehensive Root canal treatment, so code **97420-03-00 [462]** Root canal treatment, molar is assigned.

**Removal of root filling, per canal**

A Procedure to remove root canal filling material from the tooth followed by cleaning, shaping and obturation of the canals.

**Exploration or negotiation of calcified root canal**

Calcified root canals **occur when calcium gets deposited in the tooth's canal**. The tooth canal is the space in the middle of its root. In healthy teeth, this space contains pulp tissue, which is mainly made up of nerve and vascular tissue. Calcification causes the canal space to shrink. The cause of calcification varies, may be due to prolonged infection, trauma, etc.

**Interim therapeutic root filling**

This term is used to describe **a restoration that has been placed in a tooth after the previous restoration, cracks and/or caries have all been removed at the commencement of endodontic treatment** (i.e., the "investigation" stage of treatment).

**Obturation of resorption defect or perforation**

Resorption is defined as a condition associated with either a physiologic or a pathologic process resulting in loss of dentin, cementum, or bone. Perforation on the other hand is a hole that occurs in the root canal space of a tooth. Obturation is the technical term for a method of filling and sealing a tooth with root canal material.



# Dental implants

## SBSCS 4050 Intraoral osseointegrated implants

Intraoral osseointegrated implant insertion is a one- or two-stage procedure which involves the implantation of an implant, used to support dentures or artificial tooth crowns, constructed of titanium or other biocompatible material.

### Classification:

A one-stage endosseous implant involves surgical insertion of an implant into the bone of the maxilla or mandible. Assign **45846-00-00 [400]** Insertion of one-stage endosseous implant; per implant.

The first stage of a two-stage endosseous implant (or fixture) is placed as a meticulous subperiosteal procedure, under local or general anaesthesia. The mucosa is closed over the implant for a period of time. Assign **45845-00-10 [400]** Insertion of intraoral osseointegrated dental implant; first stage. The second stage of a two-stage endosseous implant is performed three to six months later and involves the application of a superstructure (abutment) to the previously buried implant. Assign **45847-00-10 [400]** Insertion of intraoral osseointegrated dental implant; second stage.

The number of implants for any individual patient may vary from one to ten or more, each implant should be reported separately.

### **Example:**

A 35-year-old female patient has lost her upper right canine a year ago. She would like to replace her missing tooth. After clinical evaluation the dentist placed a one-stage implant.

<b>K08.1</b>	Loss of teeth due to accident, extraction or local periodontal disease
<b>45846-00-00 [400]</b>	Insertion of one-stage endosseous implant; per implant
<b>92513-99-00 [1909]</b>	Infiltration of local anaesthetic, ASA 99

## SBSCS 4051 Partial dentures implant supported

### **1. Prosthesis with removable resin base attached to implants, per arch**

A removable prosthesis is one that carries artificial teeth on a resin base supported by the implants to which it is attached. This prosthesis is designed for self-removal.

### Classification:

Abutments attached to implants should be assigned as **97661-00-10 [473]** Fitting of implant abutment, custom, or **97661-01-00 [473]** Fitting of implant abutment, pre-fabricated.

Retention components within prosthesis should be assigned **97735-00-00 [474]** Precision or magnetic attachment, denture.

### **Sequencing of codes (3 codes):**

The main procedure code should be assigned first **97665-00-00 [473]** Prosthesis with removable resin base attached to implants, per arch. Followed by a code for Abutments **97661-00-10 [473]** or **97661-01-00 [473]** and then retention components within prosthesis **97735-00-00 [474]**.

## **2. Prosthesis with fixed metal frame attached to implants**

A fixed prosthesis carrying artificial teeth on a cast or milled metal frame, supported by the implants to which it is attached and not designed for self-removal. This is inclusive of the sealing of the access to the abutment screws.

### **Classification:**

Abutments attached to implants should be reported as **97661-00-10 [473]** Fitting of implant abutment, custom, or **97661-01-00 [473]** Fitting of implant abutment, pre-fabricated.

### **Sequencing of codes (2 codes):**

The main procedure code should be assigned first **97666-00-00 [473]** Prosthesis with fixed metal frame attached to implants, followed by Abutments **97661-00-10 [473]** or **97661-01-00 [473]**.

## **3. Prosthesis with removable metal frame attached to implants; per arch**

A removable prosthesis is one that carries artificial teeth on a cast, wrought or milled metal frame, supported by the implants to which it is attached. This prosthesis is designed for self-removal.

### **Classification:**

Abutments attached to implants should be reported as **97661-00-10 [473]** Fitting of implant abutment, custom, or **97661-01-00 [473]** Fitting of implant abutment, pre-fabricated; retention components within prosthesis should be reported as **97735-00-00 [474]** Precision or magnetic attachment, denture.

### **Sequencing of codes (3 codes):**

The main procedure code should be assigned first **97667-00-00 [473]** Prosthesis with removable metal frame attached to implants; per arch followed by Abutments **97661-00-10 [473]** or **97661-01-00 [473]** and then retention components within prosthesis **97735-00-00 [474]**.

### **Example:**

A 64-year-old female patient came to the clinic for final prosthesis after healing of the implant. A prosthesis with removable resin base attached to implants was fabricated. A pre-fabricated abutment was used tooth #16 and magnetic attachment.

<b>K08.1</b>	Loss of teeth due to accident, extraction or local periodontal disease
<b>97665-00-00 [473]</b>	Prosthesis with removable resin base attached to implants, per arch
<b>97661-01-00 [473]</b>	Fitting of implant abutment, pre-fabricated
<b>97735-00-00 [474]</b>	Precision or magnetic attachment, denture

# Removable prosthodontics

## SBSCS 4060 Dentures

### 1. Interim complete denture:

This is a temporary prosthesis for the use of a limited period of time, to be replaced by a definitive prosthesis.

#### Classification

When an interim complete denture is fabricated for the **maxilla** assign **97713-00-20 [474]** Interim complete maxillary denture.

When an interim complete denture is fabricated for the **mandible** assign **97714-00-10 [474]** Interim complete mandibular denture.

When an interim complete denture is fabricated for **both jaws (maxillary and mandibular)**. Assign the combination code **97715-00-10 [474]** Interim complete maxillary and mandibular dentures.

### 2. Definitive complete denture:

A complete denture is a removable acrylic replacement for teeth, soft tissue, and bone lost in an entire dental arch.

#### Classification

When a complete denture is fabricated for the **maxilla** assign **97711-00-00 [474]** Removable complete denture; maxillary

When a complete denture is fabricated for the **mandible** assign **97712-00-00 [474]** Removable complete denture; mandibular

When a complete denture is fabricated for **both jaws (maxillary and mandibular)**. Assign the combination code **97719-00-00 [474]** Removable complete denture, maxillary and mandibular.

#### **Example:**

A 78-year-old edentulous female patient wants to replace her missing teeth. A removable complete denture for both arches were fabricated.

**K08.1** Loss of teeth due to accident, extraction or local periodontal disease

**97719-00-00 [474]** Removable complete denture, maxillary and mandibular

#### Classification

The codes below are used to identify each step of the fabrication of a partial or complete dentures, therefore these codes should be assigned for documentation purposes. However, for reimbursement purposes, these steps are included in the main procedure code and may not be billed. The main procedure code should be assigned at the end of treatment (**denture insertion visit**).

All of the seven codes listed below are solely for documentation purpose and are non-billable:

- **97719-01-10 [474] Primary impression for maxilla /mandible for denture processing**
  - A negative replica of oral tissues and teeth. Includes impressions for Overdentures, immediate, interim, partial, and complete removable dentures.
- **97719-01-80 [474] Tooth preparation for crown/ FPD**
  - Removal of all defects and provide necessary protection to the pulp along with necessary tooth preparation to fit the crown/FPD.
- **97719-01-20 [474] Border moulding**
  - Shaping of the border areas of an impression tray by functional or manual manipulation of the tissue adjacent to the borders to duplicate the contour and size of the vestibule.
- **97719-01-30 [474] Final impression for maxilla / mandible**
  - A negative replica of oral tissues and teeth. Includes impressions for Overdentures, immediate, interim, partial, and complete removable dentures.
- **97719-01-40 [474] Face bow transfer**
  - A facebow is an instrument that records the relationship of the maxilla to the hinge axis of rotation of the mandible. It allows a maxillary cast to be placed in an equivalent relationship on the articulator.
- **97719-01-50 [474] Bite registration**
  - An impression of the occlusal relationship of the maxilla and mandible.
- **97719-01-60 [474] Try in of the upper / lower denture**
  - A wax try-in of the denture teeth is an important step in the fabricating process. This allows the dentist to confirm fit and function and allows the patient to preview their new smile before it is finished.
- **97719-01-70 [474] Denture insertion**
  - Delivery of denture.

**Example:**

A 79-year-old edentulous male patient came to the clinic for the try in of his upper and lower complete dentures.

**K08.1** Loss of teeth due to accident, extraction or local periodontal disease

**97719-01-60 [474]** Try in of the upper / lower denture

## SBSCS 4061 Appliances for diagnosed snoring and obstructive sleep apnoea

**97985-00-00 [490]** Oral appliance for diagnosed snoring and obstructive sleep apnoea Includes:  
Mandibular Advancement Device (MAD)  
Tongue-Stabilizing Device (TSD)  
Rapid Maxillary Expansion (RME)

### Classification

For single arch oral appliance, **the code should be assigned once**. For bi-maxillary oral appliance (both jaws), **assign the code twice**.

#### **Example:**

A 35-year-old male patient who has been diagnosed with snoring came to the clinic as a referral to fabricate an oral appliance to help open his airway while sleeping. A bi-maxillary oral appliance was fabricated for the patient.

**R06.5** Mouth breathing

**97985-00-00 [490]** Oral appliance for snoring and obstructive sleep apnoea

**97985-00-00 [490]** Oral appliance for snoring and obstructive sleep apnoea

# Pedodontics

## SBSCS 4070 Space maintainer

A space maintainer is an appliance used to maintain the space of a primary tooth lost due to decay or injury before its permanent replacement has developed or is ready to erupt. It maintains the space until the permanent tooth emerges. Without the space maintainer, the permanent teeth can shift into the space created by the loss of the baby tooth and could cause tooth crowding.

### Classification

Space maintainer codes **98003-00-11 [490]** Fixed space maintainer placement, unilateral, and **98003-00-12 [490]** Fixed space maintainer placement; bilateral, only includes preparing and placement of the appliance.

The distal shoe is a unique type of space maintainer. A regular code for a space maintainer placement does not accurately describe this appliance, as it extends sub gingivally and distally to guide the eruption of the first permanent molar. Therefore, it should only be reported using its applicable code **98006-00-10 [490]** Distal shoe appliance placement.

Re-cementation or removal of the appliance are included in separate codes: **98003-01-10 [490]** Space maintainer re-cementation.

### **Example:**

A 7 - year - old female presents with extracted tooth #85. The patient was advised to have a distal shoe fixed space maintainer on the right side. Impression was taken, and the space maintainer delivered.

**K08.1** Loss of teeth due to accident, extraction or local periodontal disease

**98006-00-10 [490]** Distal shoe appliance placement

# Orthodontics

## SBSCS 4080 Comprehensive orthodontic exam

An orthodontic examination is the first step in orthodontic treatment, preparing the patient for any possible intervention.

### Classification

The comprehensive orthodontic exam **97011-00-20 [450]** code includes several procedures, which are:

- Photographic records, intraoral
- Photographic records, extraoral
- Orthopantomography
- Cephalometry/cephalography
- Preparation of dental diagnostic cast
- Pantographic tracing
- Radiographs

Therefore, none of the of the above listed procedures separately when applying codes for a comprehensive orthodontic exam.

#### **Example 1:**

A 24 – year – old male with Class II malocclusion presents for orthodontic treatment. An orthodontic examination was done for this session.

**K07.4** Malocclusion, unspecified

**97011-00-20 [450]** Comprehensive oral examination for orthodontic treatment

**Unlisted orthodontic procedure 97879-00-10 [483]** should only be used **when no other code is available for the given specific description.**

#### **Example 2:**

A 27-year-old male presents to the clinic with a chief complaint of a sharp edge on one of his sequential plastic aligners to treat his crowded teeth. Polishing was done to that edge.

**K07.3** Anomalies of tooth position

**97879-00-10 [483]** Unlisted orthodontic procedure

## SBSCS 4081 Sequential plastic aligners

Sequential plastic aligners an orthodontic treatment option that moves the teeth closer to their desired position.

### **Classification**

When sequential plastic aligners are used to treat a portion of the dentition, a suitable limited orthodontic treatment code should be applied first.

#### **Example:**

A 24-year-old male with crowded teeth presents for orthodontic treatment. The examination was done in the previous session, and the patient accepted to be treated using sequential plastic aligners in maxilla.

**K07.3** Anomalies of tooth position

**97881-00-20 [483]** Limited orthodontic treatment of the adolescent dentition

**97825-00-00 [479]** Insertion of sequential plastic aligners; per arch



# Oral and maxillofacial surgery

## SBSCS 4090 Alveolar osseous procedure

The alveolar osseous procedure is aimed at acquiring access to the tooth roots to remove tartar and remove pockets in the alveolar bone covering the teeth

### Classification:

Alveolar osseous procedure code **97233-00-10 [456]** includes the following procedures:

- Flap procedures
- Gingivectomy

Therefore, these procedures should not be reported when applying the alveolar osseous procedure code. However, if the procedure has stopped for any reason before completion, then code the stage completed along with a discontinued code from Adjunctive services.

**97999-00-10** Discontinued service

### Example:

A 32-year-old male with 7 mm periodontal pocket depth in teeth #35 and #36 presents for the alveolar osseous procedure. The patient was not cooperative, moving and unstable during the session at the flap step. The dentist had to stop the operation and reschedule the appointment.

**K05.3** Chronic periodontitis

**97232-00-10 [456]** Periodontal flap procedure, per quadrant

**97999-00-10 [490]** Discontinued service

## SBSCS 4091 Repair of wound

Repair of wound process is the restoration of structure and function of injured or diseased tissues. In SBS, coding repair of wound is based on the size of the repaired area, and is classified as follows:

Small – less than 2.5 cm:

- **30032-00-10 [1635]** Repair of wound of skin and subcutaneous tissue of face or neck, superficial, small
- **30035-00-10 [1635]** Repair of wound of skin and subcutaneous tissue of face or neck, involving soft tissue, small

Medium – 2.6 cm to 15.0 cm:

- **30032-00-20 [1635]** Repair of wound of skin and subcutaneous tissue of face or neck, superficial, medium
- **30035-00-20 [1635]** Repair of wound of skin and subcutaneous tissue of face or neck, involving soft tissue, medium

Large – 15.1 cm or larger:

- **30032-00-30 [1635]** Repair of wound of skin and subcutaneous tissue of face or neck, superficial, large
- **30035-00-30 [1635]** Repair of wound of skin and subcutaneous tissue of face or neck, involving soft tissue, large

### **Classification:**

Repair of wound codes are not to be used for closure of surgical incisions, as this is already included in the surgical procedure code. In addition, any evaluation or radiograph must be reported separately.

#### **Example:**

A 22-year-old male presents with a 3 cm open wound on his lower lip due to a fall. The wound size was around 3 cm, sutured under infiltration anaesthesia, and instructions were given.

<b>S01.51</b>	Open wound of lip
<b>W19</b>	Unspecified fall
<b>30032-00-20 [1635]</b>	Repair of wound of skin and subcutaneous tissue of face or neck, superficial, medium
<b>92513-99-00 [1909]</b>	Infiltration of local anaesthetic, ASA 99

## **SBSCS 4092 Excision of lesion**

Excision of lesion is a procedure that removes tissue lesion or any abnormal growth which can be either benign or malignant.

### **Classification**

When an excision of lesion is reported, for example **31205-00-10 [1620]** Excision of lesion of skin and subcutaneous tissue of other site, small during a surgical session in conjunction with a biopsy, biopsy of the same site should not be reported separately as it is included in Excision.

#### **Example:**

A 34-year-old male was admitted for surgical excision of a small basal cell adenocarcinomas on his tongue performed under general anaesthesia. Biopsy was taken from the margins to ensure the area was cancer free.

<b>C02.1</b>	Malignant neoplasm of border of tongue
<b>M8098/3</b>	Adenoid basal carcinoma
<b>31205-00-10 [1620]</b>	Excision of lesion of skin and subcutaneous tissue of another site, small
<b>92514-99-00 [1910]</b>	General anaesthesia, ASA 99

# Section 4 – Imaging services

## SBSCS 5000 Imaging procedures for non-admitted care

While only selected imaging procedures are coded for admitted patients, for non-admitted patients, all imaging is coded.

### Definitions

**Medical imaging**, also known as radiology, is the field of medicine in which medical professionals recreate various images of parts of the body for diagnostic or treatment purposes. Medical imaging procedures include non-invasive tests that allow clinicians to diagnose injuries and diseases without being intrusive.

**Radiology** utilizes imaging to diagnose and treat diseases within the body.

**Ultrasound** is a non-invasive imaging test that shows structures inside the body using high-intensity sound waves. Healthcare providers use ultrasound exams for several purposes, including during pregnancy, for diagnosing conditions and for image guidance during certain procedures.

**Tomography** is an x-ray technique in which shadows of superimposed structures are blurred out by a moving x-ray tube.

**Computerized tomography (CT)** is an x-ray imaging procedure in which a narrow beam of x-rays is aimed at a patient and quickly rotated around the body, producing signals that are processed by the machine's computer to generate cross-sectional images, or "slices."

**CT angiography** is a type of medical test that combines a CT scan with an injection of a special dye to produce pictures of blood vessels and tissues in a part of the body. The dye is injected through an intravenous (IV) line started in the arm or hand.

**Imaging services** in in-patient cases, imaging services are not usually coded, as they are routine services performed for most patients or are components of another procedure.

### Classifications

**Imaging services** – codes in ACHI Chapter 20 *Imaging services* (blocks [1940] to [2016]) and block [451] *Dental radiological examination and interpretation* are not coded for admitted patients, as they are routine services or are expected components of other procedures. There are some exceptions where these should be coded, including (1) Endoscopic ultrasound (EUS) **30688-00 [1949]**, (2) Transesophageal echocardiogram (TOE) **55118-00 [1942]** (ACS 0042).

However, imaging codes should be assigned if these services were performed in a non-admitted setting.

## SBSCS 5010 Angiography

### Definition

Angiography is a medical imaging technique used to check blood vessels.

## Classifications

There are many Angiography *codes available in the SBS, and* clinical coders need to determine the following to assign the appropriate code:

- **Type of the angiography** (with Digital subtraction, Direct method, Magnetic resonance angiography, etc.).
- **Site of the angiography** (with Chest, Pelvis, Thorax, Abdomen, Lower limb, Cholangiography, etc.).
- **Whether the image was unilateral or bilateral.**
- **Number of vessels** (in case of Digital subtraction selective arteriography or venography).
- **Number of data acquisition runs.**

If the clinical coder encounters a case where the site of the image is mentioned but not covered in the SBS, then use the "Other site" code. The "Not elsewhere classified" code should only be applied when no site is mentioned.

## **SBSCS 5020 Digital subtraction angiography and Digital subtraction selective**

### Definitions

Digital subtraction angiography (DSA) is a procedure that provides a fluoroscopy-guided image of the blood vessels (both arteries and veins) in a bony or dense soft tissue environment to detect a problem with blood flow. The procedure involves inserting a catheter (a small, thin tube) into an artery in the leg and passing it up to the blood vessels. A contrast dye is injected through the catheter, and X-ray images of the blood vessels are taken. DSA can be used to explore the head and neck, thorax, abdomen, and upper and lower limbs region.

Digital subtraction selective (arteriography and venography) is similar to the DSA. However, in some cases, a digital subtraction angiography is not needed entirely, and a specific artery or vein would be selected to be assessed by a practitioner. Data acquisition is the first integral step in image formation. It is an acquisition of raw imaging data of a body and contains the original information about captured physical quantities describing internal aspects of the body. This information becomes the primary subject for all subsequent steps of image processing.

### Classifications

Digital subtraction angiography codes shouldn't be confused with Digital Subtraction selective codes since they both have a specific medical goal. For example, angiography is more inclusive, while arteriography or venography focuses on particular arteries or veins. Furthermore, clinical coders must take care to the site of the procedure and data acquisition runs, also known as DAQ, before choosing the correct code. If the documentation was unclear, code **59970-01-00 [1998]** Digital subtraction angiography, not elsewhere classified. In addition, since the nature of this procedure requires fluoroscopy guidance, assign **60503-00-00 [1999]** Fluoroscopy when DSA is documented.

**Example 1:**

A 65-years-old patient previously diagnosed with the peripheral vascular disease was admitted for a digital subtraction Angiography (two runs).

<b>I25.9</b>	Chronic ischemic heart disease, unspecified
<b>60048-00-00 [1996]</b>	Digital subtraction angiography of lower limb, <= 3 data acquisition runs, unilateral
<b>60503-00-00 [1999]</b>	Fluoroscopy

**Example 2:**

A 54-years-old female patient previously diagnosed with Raynaud's Syndrome was admitted for venography using the digital subtraction method in the femoral vein of the leg.

<b>I73.00</b>	Raynaud's syndrome without gangrene.
<b>60072-00-00 [1998]</b>	Digital subtraction selective arteriography or venography, 1 vessel
<b>60503-00-00 [1999]</b>	Fluoroscopy

**Example 3:**

A 56-years-old patient complaining of claudication (pain on walking), an ulcer on the left foot. Digital subtraction angiography was performed, which showed a complete occlusion (blockage) of the left superficial femoral artery just above the knee joint. Blood flow was restored to the foot following open transluminal balloon angioplasty and stenting using a self-presenting Nitinol stent performed under general anaesthesia.

<b>I74.3</b>	Embolism and thrombosis of arteries of lower extremities
<b>L98.4</b>	Non-pressure chronic ulcer of lower limb, not elsewhere classified
<b>60060-00-00 [1997]</b>	Digital subtraction angiography of aorta and lower limb, <= 3 data acquisition runs, unilateral
<b>60503-00-00 [1999]</b>	Fluoroscopy
<b>35309-08-00 [754]</b>	Open transluminal balloon angioplasty with stenting, a single stent
<b>92514-99-00 [1910]</b>	General anaesthesia, ASA 99

## SBSCS 5030 Diagnostic ultrasound of the eye

### Definition

Ophthalmic ultrasound, also known as ocular echography, is when the provider uses high-frequency sound waves to examine the eye structure and diagnose disorders using:

A-scan, or amplitude scan, is a method used for ocular assessment via ultrasound. The tear film is an adequate agent for acoustic transmission, thus absolving the need for ultrasound coupling jelly. In addition, there is only a single sound beam is sent from the transducer in the A-scan method.

B-scan, or brightness scan, is another method used for ocular assessment via ultrasound. It can be performed directly on the anesthetized eye. In trauma cases or children, B-scan can be performed over the eyelid with coupling jelly.

### Classifications

Clinical coders should take care to the type and location of the scan. If only one scan (with A or B) is being performed assign a proper code for each. However, if both the B-scan and the quantitative A-scans are being performed during the same encounter, clinical coders should assign **55030-00-41[1940]** or **55030-00-42[1940]**.

*\*The specification of the type of ophthalmic ultrasound guides the coder to assign the correct code.*

#### **Example:**

A 61-year-old male presents with retinal detachment symptoms in his left eye (experiences flashes of light and a sudden loss of peripheral vision). A B-scan ultrasound imaging with a non-qualitative A-scan superimposed confirmed retinal detachment.

**H33.2** Serous retinal detachment

**55030-00-51 [1940]** Ophthalmic ultrasound, diagnostic, B-scan (with or without superimposed nonquantitative A-scan), unilateral.

# Section 5 – Laboratory and pathology services

## Introduction

Laboratory and pathology codes (SBS Chapter 21) are a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals, or entities. Each procedure or service is identified with a nine-digit code. The use of codes simplifies the reporting of procedures and services. In the code set, the term "procedure" is used to describe services, including diagnostic tests.

Pathology and laboratory procedure codes describe services to evaluate specimens (e.g., blood, body fluid, tissue) obtained from patients in order to provide information to the treating physician.

Generally, pathology and laboratory specimens are prepared, screened, and/or tested by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory.

Certain types of specimens and tests are reviewed or interpreted personally by the pathologist. Coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist.

Table 6 shows the subcategories under which all the sections of laboratory and pathology codes are divided.

Table 6: Laboratory and pathology subsections

Block	Subsection	Min range	Max range
3000	Essential Test Panels	73000-00-00	73000-03-30
3050	Chemistry & Microbiology	73050-00-00	73050-61-60
3100	Study of Blood Products & Antibodies	73100-00-00	73100-29-70
3150	Clinical Pathology & Urinalysis	73150-00-00	73150-01-20
3200	Cell Study – Disease Analysis & Genetics; Specimen Study	73200-00-00	73200-10-60
3250	Blood Screening & Transfusion related Procedures	73250-00-00	73250-03-80
3300	Drug Assays	73300-00-00	73300-09-80
3350	Molecular Pathology including Gene Sequencing	73350-00-00	73350-07-20
3400	Fertility Medicine, In Vivo and Other Lab Procedures	73400-00-00	73400-05-10

## Laboratory and pathology blocks

### [3000] Essential test panels (73000-00-00; 73000-03-30)

Laboratory Essential panels or chemistry panels are groups of tests that are ordered together.

The below points are important for consideration of the Panel Test (Code).

#### Essential test panel

- Providers may bill either a panel code or an individual code.
- Each panel code comprises multiple tests.

- The panel code should be reported when all individual components in the panel have been performed.
- The code or codes to describe the individual tests performed should be reported if any test defined as part of the panel is not performed.
- Two or more panel codes that include any of the same constituent tests performed from the same patient collection should not be reported.
- If a group of tests overlaps two or more panels, the panel that incorporates the greater number of tests to fulfill the code definition should be reported and the remaining tests should be reported using individual test codes.
- Each test billed under the panel must be reasonable and necessary.

### **Testing panels (Evocative/suppression)**

Evocative/suppression testing refers to a class of tests performed where one substance is measured both before and after the administration of another substance to determine if the levels are stimulated ("evocative") or suppressed.

They are most commonly performed in the evaluation of possible endocrine disorders.

## **[3050] Chemistry and microbiology (73050-00-00; 73050-61-60)**

Chemistry panels are groups of tests that are routinely ordered to determine a person's general health status. They help evaluate, for example, the body's electrolyte balance and/or the status of several major body organs. The tests are performed on a blood sample, usually drawn from a vein. Codes describes microbiological culture studies.

This area typically includes automated analysis of blood

- Tests are quantitative OR qualitative unless specified otherwise
- Same analyte in multiple specimens
- Molecular diagnostics

Coded by procedure not analyte

Microbiology is the study of microscopic organisms, such as bacteria, viruses, archaea, fungi and protozoa. This discipline includes fundamental research on the biochemistry, physiology, cell biology, ecology, evolution and clinical aspects of microorganisms, including the host response to these agents.

### **Definitions**

A urine culture is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder is

normally sterile. This means it does not contain any bacteria or other organisms (such as fungi). But bacteria can enter the urethra and cause a urinary tract infection (UTI).

Susceptible means they can't grow if the drug is present. This means the antibiotic is effective against the bacteria.

Resistant means the bacteria can grow even if the



drug is present. Intermediate means a higher dose of the antibiotic is needed to prevent growth.

## **[3100] Study of blood products and antibodies (73100-00-00; 73100-29-70)**

### **Blood Products**

It involves treating diseases that affect the production of blood and its components, such as blood cells, haemoglobin, blood proteins, bone marrow, platelets, blood vessels, spleen, and the mechanism of coagulation.

### **Antibodies**

Antibody and Antigen Tests. Antibodies are part of the body's defence (immune) system. Antigens are the particles that cause the body to create an antibody.

Tests to detect antibodies and antigens help to identify certain infections and some other medical conditions

## **[3150] Clinical pathology and urinalysis (73150-00-00; 73150-01-20)**

A clinical pathology consultation is a service performed by a physician (pathologist) in response to a request from the attending physician regarding test results requiring additional medical interpretive judgment.

Pharmacokinetic consultations regarding therapeutic drug levels may be reported with this code. Code 80500 reports a limited consultation not requiring review of the patient's history and medical records.

Code 80502 reports a comprehensive consultation related to more complex diagnostic problems and requires review of the patient's history and medical records.

### **Urinalysis**

A urinalysis is used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes. A urinalysis involves checking the appearance, concentration and content of urine. The tests can be done for Routine quantitative or Qualitative analysis, with or without microscopy or for screening the bacterial growth etc.

## **[3200] Cell study for disease and genetic analysis and surgical specimen study (73200-00-00; 73200-10-60)**

### **Cell study – Disease analysis**

Cell Study is the study of individual cells and cytopathology is the study of individual cells in disease. Cytology is most often used as a screening tool to look for disease and to decide whether or not more tests need to be performed. An example of screening would be the investigation of a breast lump

Obtained by several methods

- Washing or brushing
- Smears
- Fine needle aspiration

## **Genetic analysis**

Cytogenetics is a field of study that deals with chromosomes and related abnormalities. Chromosome analysis is also known as karyotyping and involves the pairing of homologous chromosomes. Cytogenetic analysis is very crucial in the diagnosis of oncologic and hematologic disorders.

## **Surgical specimen(s)**

Surgical pathology is the study of tissues removed from living patients during surgery to help diagnose a disease and determine a treatment plan. Often, the surgical pathologist provides consultation services in a wide variety of organ systems and medical subspecialties.

- The unit of service is the SPECIMEN.
- Specimen – tissue sample - Has to be separately identifiable
- Divided into levels of progressive complexity
  - Level I – gross
  - Level II-IV gross and microscopic
- Additional codes for special stains

## **[3250] Blood screening and transfusion related procedures (73250-00-00; 73250-03-80)**

Transfusion medicine is the field of medicine that encompasses blood banking (the collection, preparation, testing, and storage of blood components and plasma derivatives) as well as the therapeutic uses of blood components, plasma derivatives, and apheresis technology. It also includes the collection, storage, and use of hematopoietic and other blood-derived cells.

## **[3300] Drug assays (73300-00-00; 73300-09-80)**

Drug Assay (Active Ingredients and Dosage Forms) - An assay is an investigative (analytic) procedure for qualitatively assessing or quantitatively measuring the presence, amount, or functional activity of a target entity (the analyte). Therapeutic drug monitoring (TDM) is a branch of clinical chemistry and clinical pharmacology that specializes in the measurement of medication levels in blood. Its main focus is on drugs with a narrow therapeutic range, i.e., drugs that can easily be under- or overdosed

## **[3350] Molecular pathology including gene sequencing (73350-00-00; 73350-07-20)**

This category is further subdivided into Molecular pathology, genotyping, Genome sequencing and Multianalyte Assays with Algorithm Analyses

Molecular topographic genotyping, also called molecular anatomic pathology, combines advanced molecular genetics with current pathology practices for a definitive diagnosis from existing specimens, which is focused on the study and diagnosis of disease through the examination of molecules within organs, tissues or bodily fluids.

Genome sequencing is figuring out the order of DNA nucleotides, or bases, in a genome—the order

of As, Cs, Gs, and Ts that make up an organism's DNA. Today, DNA sequencing on a large scale—the scale necessary for ambitious projects such as sequencing an entire genome—is mostly done by high-tech machines

Multianalyte Assays with Algorithmic Analyses (MAAAs) are procedures that utilize multiple results derived from panels of analyses of various types, including molecular pathology assays, fluorescent in situ hybridization assays, and non-nucleic acid- based assays (e.g., proteins, polypeptides, lipids, carbohydrates).

## **[3400] Fertility medicine, in vivo and other lab procedures (73400-00-00; 73400-05-10)**

Fertility testing is the process by which fertility is assessed, both generally and also to find the fertile window. General health affects fertility, and STI testing is an important related field.

### **In Vivo**

The term *in vivo* refers to a medical test, experiment or procedure that is done on (or in) a living organism, such as a laboratory animal or human.

### **In Vitro**

The term *in vitro*, in contrast to *in vivo*, refers to a medical study or experiment which is done in the laboratory within the confines of a test tube or laboratory dish.

# Laboratory and pathology standards

## Chemistry

*Chemistry* is also known as clinical chemistry, the testing of chemical substances and processes inside the human body. The department of clinical chemistry includes biochemical measurements, urinalysis, test panels, and drug & chemical toxicology.

### SBSCS 6000 Biochemical measurements

Refers to body fluids analysis to determine the levels of different chemical compounds.

#### Classification

The most commonly tested specimens in clinical chemistry are blood and urine. When more than one specimen is obtained, assign a code for each sample tested and from each source.

When no information is available regarding the test type: quantitative or qualitative, the test should be coded as **quantitative**.

#### **Example:**

A 14-year-old patient came to the clinic complaining of very little urine, fever, and swelling in the hands and feet. The doctor ordered a total protein assay for blood and urine. Results revealed elevated proteins in urine (proteinuria) which confirms the patient has kidney damage.

<b>N28.9</b>	Disorder of kidney and ureter, unspecified
<b>73050-30-40 [3050]</b>	Measurement of total protein in serum, plasma or blood
<b>73050-30-50 [3050]</b>	Measurement of total protein in urine

### Thyroid function

Hyperthyroidism is a condition that occurs when the thyroid gland produce thyroid hormones excessively, while hypothyroidism is the reduction of thyroid hormones production.

#### Classification:

For better evaluation for hypothyroid or hyperthyroid state, the free thyroxine should be measured instead of total thyroxine and thyroid hormone binding ratio.

If both total thyroxine and thyroid hormone binding ratio are documented, you should assign one code for the free thyroxine measurement **73050-35-30 [3050]**.

The free thyroxine measurement code should not be combined with total thyroxine measurement nor thyroid hormone binding ratio.

### SBSCS 6001 Urinalysis

Urinalysis (urine test) is the identification and evaluation of different chemical compounds and components within a urine sample.

### **Classification**

If the provider performs a urinalysis test for infection detection and a culture method is required, then it must be reported separately. When multiple urine specimens are obtained, assign a code for each urine collection.

#### **Example:**

A 50-year-old male presents with symptoms of frequent and painful urination. The doctor ordered a urine test. The lab analyst performed a three-glass urine test and urine culture. Result revealed staphylococcus urinary tract infection (UTI)

**N39.0** Urinary tract infection, site not specified

**B95.8** Unspecified staphylococcus as the cause of diseases classified to other chapters

**73150-00-90 [3150]** Three-glass Urinalysis Test

**73050-41-20 [3050]** Urine culture, isolation, identification for bacteria

## **SBSCS 6002 Drug and chemical toxicology**

Screening and testing for certain drugs and chemicals to monitor substance levels or to evaluate drug intoxication or overdose.

### **Classification:**

When the provider performs a qualitative test to detect the presence of different heavy metals, assign only one code; however, when the provider performs a quantitative test to detect the amount of different heavy metals, assign a code for each measured heavy metal.

### **Validity testing**

Specimen validity testing is used for analysis of a urine specimen to ensure that it is consistent with normal human urine and not adulterated with chemicals.

### **Classification:**

Where a validity testing is performed in addition to other laboratory urine test, do not code the validity testing and assign only one code for the laboratory procedure.

#### **Example:**

A patient came to the clinic for creatinine test on urine specimen, the providers performed validity testing on the sample to confirm it is not adulterated, results and other tests confirmed the patient has urinary tract obstruction.

**N13.9** Obstructive and reflux uropathy, unspecified

**73050-09-90 [3050]** Measurement of Creatinine in other source

## SBSCS 6003 Test panels

A test panel is a group of individual laboratory tests performed together in order to determine a person's general health status. The tests are performed on a blood sample.

### Classification

To assign a test panel code, all tests included within the panel must be documented and performed.

If the provider performed only a few tests within the panel, do not assign the panel code. Instead, assign individual codes for each test. If the provider performed more tests that exceeds the ones listed in the panel, assign the panel code first, followed by individual codes for each extra test performed that is not listed the panel description.

When the provider performs **two or more** test panels which includes the same tested analytes (from the same patient specimen), code only the panel that includes the greater number of tests.

#### **Example:**

A 55-year-old female patient admitted for general health check-up. Basic metabolic panel (BMP) and comprehensive metabolic panel (CMP) are ordered by the physician.

**Z00.0** General medical examination

**73000-00-40 [3000]** Comprehensive metabolic Panel [albumin, bilirubin, total, calcium total, carbon dioxide (bicarbonate), chloride, creatinine, glucose, phosphatase, alkaline, potassium, Protein total, sodium transferase, alanine amino (ALT) (SGPT), transferase, aspartate amino (AST) (SGOT), Urea nitrogen (BUN)]

**Note:** CMP panel includes a greater number of tested analytes.

# Microbiology

*Is the study and testing of bacteria, parasites, viruses and other pathogens using different lab techniques for culturing, examination, and identification. The area of microbiology includes: examination & culture procedures, isolation & detection procedures, and smears & antimicrobial susceptibility.*

## SBSCS 6010 examination & culture procedures

Culturing specimen from any source (e.g., body fluids, hair, skin, tissue samples) by spreading it out on an agar under controlled conditions, to observe any microbial growth and examine the specimen to identify cause of an infection.

A screening culture is performed often to test if the culture grows any microbes, followed by a definitive identification culture test to specifically identify the microbes.

### Classification

The screening culture and definitive identification culture are not performed on the same day on the same specimen and therefore, do not code both if reported together and code the screening culture only.

Assign a code for each media (agar) plate used by the lab analyst for the culture test.

#### **Example:**

A female patient admitted for suspected bacterial infection. The physician ordered a stool sample for culture and sensitivity of aerobic bacteria. The lab analyst performed the procedure on three media; however, it did not reveal any bacterial growth and the patient was discharged.

**Z03.8** Observation for other suspected diseases and conditions

**73050-40-20 [3050] x3** Culture and sensitivity, isolation and identification of aerobic bacteria in stool

## SBSCS 6011 Isolation and detection procedures

The lab analyst performs isolation methods for a particular pathogen to identify an organism or evaluate its impact.

### Classification

When the provider performs isolation for more than one organism, assign code for each isolated organism.

#### **Example:**

A patient admitted to the clinic complaining of cold, cough and fever, the doctor suspected influenza and ordered a virus identification test. The lab analyst performed immunofluorescence stain virus identification using centrifuge enhanced technique. Two viruses were isolated: influenza A/H3 and influenza B.

<b>J10.1</b>	Influenza with other respiratory manifestations, other influenza virus identified
<b>73050-45-30 [3050] x2</b>	Centrifuge enhanced technique analysis of virus isolation and immunofluorescence stain identification

## SBSCS 6012 Smears and antimicrobial susceptibility

The smear technique is a quick method for determination of possible infections before culture results are available. It is performed on a thin sample of blood, body fluids, or a swab.

Antimicrobial Susceptibility tests evaluates the susceptibility (sensitivity) of an isolate (e.g., bacteria, fungus) to a specific antibiotic following a separate culture procedure. This is to select suitable antibiotics and determine the proper dosage for treating an infection.

### **Classification**

When the provider performs susceptibility study for multiple antimicrobial agents assign code for each tested antibiotic.

#### **Example:**

A patient admitted with bacterial meningitis. The doctor ordered antimicrobial susceptibility for Cefotaxime and Benzylpenicillin antibiotics. The lab analyst performed susceptibility study using macrobroth dilution method

<b>G03.9</b>	Meningitis, unspecified
<b>73050-44-00 [3050] x2</b>	Antimicrobe susceptibility studies by macrobroth dilution method



# Haematology

Is the study of blood to identify, diagnose, and monitor blood-related disorders. The department of haematology includes: blood & cell count, coagulation, immunology & serology, and blood bank.

## SBSCS 6020 Blood and cell count

This section utilizes quantitative cell counting methods (automated or manual) and various measurements of different blood components.

### Classification

Complete blood count (CBC) includes automated cell count. You should not report individual cell counts (e.g. WBC count) when included in the more comprehensive CBC test. Manual counting however, should be reported even when CBC is performed. Assign the code **73100-01-00 [3100]** *Manual cell count (RBC, WBC, or platelet)* for each blood cell type counted manually.

#### **Example:**

A case of chronic Systemic lupus erythematosus (SLE) on immunosuppressants present to the clinic for regular check-up. The doctor orders complete blood count (CBC) to test for white blood cell levels and other blood components. The laboratory analyst performs automated count, then counts the cell manually for confirmation.

<b>M32.9</b>	Systemic lupus erythematosus
<b>73100-00-90 [3100]</b>	Automated complete blood count (CBC)
<b>73100-01-00 [3100]</b>	Manual cell count (RBC, WBC, or platelet)

## SBSCS 6021 Coagulation

Provide comprehensive diagnostic testing for bleeding and clotting disorders to allow evaluation of abnormal coagulation profiles.

### Classification

You should not separately code **73100-09-50 [3100]** *Measurement of Partial thromboplastin time from plasma or whole blood* with **73100-09-60 [3100]** *Measurement of Partial thromboplastin time by plasma fractions* as this code includes the PTT test after addition of plasma fractions.

Ongoing monitoring (e.g., by thrombelastography (TEG)) of coagulation and fibrinolysis in whole blood is reported per day of service.

#### **Example:**

An open-heart surgery patient requires TEG monitoring post-surgery. A laboratory specialist evaluates the patient for clot formation and fibrinolysis for two days then provide interpretation and report for the results.

<b>Z48.8</b>	Other specified surgical follow up care
<b>Z94.1</b>	Heart transplant status

**73100-06-10 [3100] x 2** Coagulation of fibrinolysis (clot break down) function measurement with interpretation and written report, per day.

## SBSCS 6022 Immunology and serology

*Immunological investigations for the detection and quantitation of auto- antibodies. Services provided aid in diagnosing and monitoring the therapeutic response for a variety of systemic autoimmune diseases (e.g. Systemic Lupus Erythematosus, Rheumatoid Arthritis).*

### Classification

Quantitative total cells count (e.g., B cells, T cells, NK cells), do not require result interpretation and therefore must not be assigned **73200-03-30 [3200]**; **73200-03-40 [3200]**; **73200-03-50 [3200]** *Interpretation of flow cytometry results of # markers* even when flow cytometry is performed.

All codes in this section relate to antibody detection unless antigen detection is strictly specified. When testing bacterial antibodies, assign this code for each species or immunoglobulin class (e.g., IgG, IgM). For allergy testing, assign code for each tested antigen/allergen.

### **Example:**

A patient present to the dermatology clinic complaining of rash due to food reaction. She had eggs, milk, and bread for breakfast. The doctor orders a food allergy test for each of these substances to measure her immune reaction for levels of immunoglobulin E (IgE) antibodies.

<b>L27.2</b>	Dermatitis due to ingested food
<b>Z01.5</b>	Diagnostic skin and sensitization tests
<b>73100-10-10 [3100] x 2</b>	Quantitative/Semiquantitative measurement of antibody (IgE) to allergic substance

## SBSCS 6023 Blood bank

Blood bank laboratory encompasses all aspects of blood transfusion and blood products including donor services, blood grouping, crossmatching for compatibility testing, RBC identification or typing, and transfusion reactions.

### Classification

Assign a code for each substance used to treat red blood cells (RBC) before testing, each antibody, and each blood unit (1 unit = 500 mL). Apheresis codes are not included under the laboratory chapter codes; therefore, do not report **73250-02-70 [3250]** *Leukocyte Transfusion* for lymphocyte infusions or leukapheresis and use more specific codes from other chapters.

### **Example:**

A patient requires immediate blood transfusion of 3 blood units. The laboratory analyst thaws 3 units of frozen blood to be used for transfusion.

<b>Z51.2</b>	Blood transfusion without reported diagnosis
<b>73250-02-20 [3250] x 3</b>	Thawing of frozen blood

# Molecular diagnostics

*Molecular diagnostic procedures are a collection of techniques utilized for analysis of nucleic acids (DNA or RNA) for the purpose of disease prevention or detection. This field investigates human, viral, and microbial genomes to study infectious diseases, inherited conditions, as well as cancers. The department of molecular diagnostics include: genetic testing & sequencing, HLA typing, multianalyte & other molecular assays.*

## SBSCS 6030 Genetic testing and sequencing

Codes under this block describe testing for gene variants (i.e., mutations), inherited family conditions (familial variants), full gene sequencing, and evaluation of specific changes within a gene of interest (target sequencing, expanded sequence analysis). Genomic sequencing procedures can also simultaneously examine multiple genes, or the entire exome or genome utilizing next generation sequencing (NGS) to *assess variants in both cancer cells (somatic) and non-cancer cells (germline)*.

The term variant describes a permanent change in the DNA sequence of the gene. These changes are not always pathogenic; however, most of the investigations listed in SBS aim to screen for pathogenicity. Variants are either represented by their specific *intronic position* on the gene (e.g., IVS3-2A>G), *DNA change* which enlist the numerical position followed by the resulting nucleic acid change (e.g., MTHFR gene: 677C>T) or by their *protein change*. Majority of SBS codes describe variants by their amino acid (protein) change using a single letter amino acid code followed by the numerical position and the substituted amino acid (e.g., JAK2 gene: (V617F), Valine (V) at position 617 is replaced with Phenylalanine (F)).

Examples of proteins or common diseases associated with the genes are listed either in the code description or definition section. Unless otherwise specified, all the analyses conducted in the molecular diagnostic section are **qualitative** by default.

### **Classification**

Code selection is specifically based on the tested gene. All of the necessary analytical procedures required for testing are included in the molecular diagnostics service codes and should not be reported separately; such as cell lysis, nucleic acid extraction, stabilization, amplification, and detection. Assign codes for any other preparatory procedures documented which precedes cell lysis including: genetic analysis of archived tumour tissue, tissue microdissection, or special macroscopic dissection **73200-09-50 [3200]**, **73200-10-40 [3200]** or **73200-10-50 [3200]**.

Full gene sequencing codes include testing for all the variants within a gene; therefore, do not use separate variant codes unless strictly specified that the testing is for common gene variants or a specific variant of interest.

### **Example:**

A patient presented to the clinic with a history of sickle cell disease which runs in the family. The doctor suspects she might be a carrier for the condition, so he orders genetic testing of the HBB gene for common mutations related to the sickle cell trait. The laboratory analyst investigates the patient blood sample, performing all the necessary technical steps as nucleic acid extraction, digestion, cell lysis, amplification and detection of the target gene for mutation analysis and confirms carrier status.

<b>Z13.0</b>	Special screening examination for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism.
<b>Z83.2</b>	Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
<b>73350-02-60 [3350]</b>	Haemoglobin subunit beta (HBB) gene variant analysis (e.g., HbS, HbC, HbE)

## SBSCS 6031 HLA typing

The human leukocyte antigen genes (HLA), otherwise known as histocompatibility antigens are a group of genes that play an important role in the immune system. HLA typing is used for purposes of matching donors with recipients for bone marrow, cord blood, or other transplants.

### Classification:

The codes under this block are for tissue or HLA gene typing by molecular testing methods. Do not use HLA typing codes under the molecular diagnostic section for HLA typing by serology, instead refer to HLA codes in the Hematology section.

All of the necessary analytical procedures required to conduct testing are included in the molecular diagnostics service codes and should not be reported separately; such as cell lysis, nucleic acid extraction, stabilization, amplification, and detection. Assign codes for any other preparatory procedures documented which precedes cell lysis including: genetic analysis of archived tumour tissue, tissue microdissection, or special macroscopic dissection **73200-09-50 [3200]**, **73200-10-40 [3200]** or **73200-10-50 [3200]**.

### **Example:**

A close relative of a patient requiring kidney transplant present to the clinic in order to get tested for tissue compatibility. The laboratory analyst receives the donor patient sample and performs low resolution assessment of the human leukocyte antigen genes (HLA) for Classes I and II at all loci utilizing direct sequencing.

**Z00.5** Examination of potential donor of organ and tissue

**73350-03-10 [3350]** Low resolution analysis of certain loci for human leukocyte antigen genes (HLA) specific Class I loci (HLA-A, HLA-B) and Class II (HLA-DRB1)

## SBSCS 6032 Multianalyte and other molecular assays

Multianalyte assays report results from a panel of tests, including non-molecular biochemical markers (e.g., proteins, carbohydrates lipids) to provide an algorithmic estimation of disease recurrence, or risk score probability. These algorithms require certain information on gene expression, tumour size, or lymph node status to generate prognostic or predictive information about patient's transplant rejection or cancer probability, classifying it as low, intermediate, or high-risk.

### Classification

For procedures not found under the Genetic Testing & Sequencing or HLA typing blocks, refer to the Multianalyte & Other Molecular Assays block. Codes from **73350-04-40 [3350]** to **73350-05-20 [3350]** describe molecular pathology procedures level 1-9, analysing single genes based on the level

of technical resources and interpretive work utilized. Only in such cases, these codes do not describe the tested gene or method, report **73350-06-00 [3350]** (Unlisted molecular diagnostic procedure).

All of the necessary analytical procedures required to conduct Multianalyte testing (algorithmic risk assessment) are included in the service codes and should not be reported separately; such as cell lysis, nucleic acid extraction, stabilization, amplification, and detection. Only assign codes for any other preparatory procedures documented that precedes cell lysis, including genetic analysis of archived tumour tissue, tissue microdissection, or special macroscopic dissection **73200-09-50 [3200]**, **73200-10-40 [3200]** or **73200-10-50 [3200]**. You should not separately assign codes for each protein or analyte tested when it is included in the risk assessment.

**Example:**

A pregnant patient has a family history of down syndrome. As a preliminary test, the doctor requests a multianalyte chromosomal abnormality risk assessment.

**Z14.7** Special screening examination for congenital malformations, deformations and chromosomal abnormalities.

**Z33** Pregnant state, incidental

**73350-06-50 [3350]** Measurement of fetal aneuploidy (trisomies 13, 18 and 21) risk score by micro assay from pregnant maternal plasma

**Note:** **73200-05-30 [3200]** Molecular Cytogenetic Test by DNA Probe method [e.g., fluorescence in situ hybridization (FISH)] and Genome analysis by chromosomal microarray (CMA) were not assigned separately since these procedures are required to conduct risk testing.

# Clinical pathology

Is the study of disease and disease processes through analysis of body fluids by various chemical, microscopic, and serologic examinations. The department of clinical pathology includes: cytology(cytopathology), histology, cytogenetics, in vivo & other pathology procedures.

## SBSCS 6040 Cytology

The cytology block involves diagnostic techniques to examine single cell types extracted from tissues to screen for fetal abnormalities, cancers, and infectious organisms among others. Cell collection is done by exfoliation or scraping (e.g., pap smear), body fluid collection, fine-needle aspirations (FNA), or other tissue biopsy performed during routine diagnostic tests (e.g., cystoscopy, bronchoscopy)

### Classification:

Whenever pap smear results require pathologist interpretation, it should be reported in addition to the pap smear codes.

Fine needle aspirates are immediately sent to the lab to ensure adequate sample is collected for analysis to prevent unnecessary re-biopsy procedures. Assign a code **73200-02-50 [3200]** *Analysis of fine needle aspirate cytopathology specimen for evaluation of satisfactory sample* for the **first** specimen collected for analyses from **each** specific site. When more specimens are obtained from the same site, report each additional FNA collection by the code **73200-02-70 [3200]**. If a laboratory specialist (pathologist) analyses, interprets, and report the results, assign one code **73200-02-60 [3200]** *Analysis of fine needle aspirate cytopathology specimen with interpretation and report* for interpretation from each anatomical site, regardless of aspirate number.

### **Example:**

A patient present to the oncology clinic complaining from a small lump on his neck. The doctor suspects thyroid carcinoma and performs fine-needle aspirate and collects 2 biopsy samples from his thyroid. The doctor sends the sample to the lab to determine if there are enough cells present in the sample for further laboratory testing.

<b>D44.0</b>	Thyroid gland
<b>M8010/3</b>	Carcinoma NOS
<b>73200-02-50 [3350]</b>	Analysis of fine needle aspirate cytopathology specimen for evaluation of satisfactory sample (first evaluation, each site)
<b>73200-02-70 [3350]</b>	Analysis of fine needle aspirate cytopathology specimen for evaluation of satisfactory sample (Additional evaluation on same site)

## SBSCS 6041 Histology

Histology utilizes a group of techniques to examine whole tissue (i.e., tissue block) excised during surgery in order to diagnose disease or guide treatment plan. Service examples under this block include morphometric analysis, microdissections, in situ hybridization, surgical pathology procedures, immunohistochemistry and other special histochemical stains.

## Classification

Surgical specimens are assigned appropriate level (1-6) surgical pathology codes based on the service conducted. Level 1 involve non-microscopic examination of the specimen (e.g., by bare eye). Level 2 refer to both non-microscopic (gross) with microscopic examination. Level 3-6 require level 2 analysis in addition to increasingly complex physician work with each ascending level.

Code selection is based on the specimen. All procedures descriptors list specific specimens used for examination, although not solely sufficient for code selection. Do not assign codes based on organ or anatomic site only. Pay attention to whether examination of surgical margins was performed, presence of lymph tissue, or resection extent to accurately assign the correct code. For unlisted specimens, assign a code based on the level of work conducted by the physician. If more than one specimen is tested, assign code for each tested specimen. These services only include specimen collection, examination, and reporting. They do not include certain procedure like decalcification, in situ hybridization, Mohs surgery, or other Histology block procedures.

### **Example:**

Patient presented to the clinic complaining of a lump on her breast. The doctor performed a lumpectomy and sent her tissue sample to the laboratory for breast cancer evaluation. The laboratory pathologist examines the sample with surgical margins and report diagnosis of fibroadenoma.

**D24** Benign neoplasm of breast

**M9010/0** Fibroadenoma NOS

**31500-00-01 [1744]** Excision of lesion of breast, unilateral

**73200-06-80 [3200]** Level 5 examination of surgical pathology specimen (e.g., Brain biopsy, meninges, tumour resection, excision of lesion)

## **SBSCS 6042 Cytogenetics**

This block involves procedures which study chromosomes and how they relate to cell behaviour, especially during mitosis and meiosis. Common techniques utilized are karyotyping, chromosome analysis by various banding techniques, molecular cytogenetics (e.g., fluorescent in situ hybridization (FISH), comparative genomic hybridization (CGH), and chromosomal microarray analysis (CMA)).

## Classification

Pay attention to the number of karyotypes, cell counted, banding, and resolution studies performed in order to assign the correct code. Assign the appropriate additional code from **73200-05-80 [3200]** to **73200-06-10 [3200]** based on the technique used only **once** per study.

### **Example:**

A mother present to the obstetrician's office for prenatal testing. Her first newborn had down syndrome. To prevent inheritance of the condition to her future baby, the doctor collects amniotic fluid and cells from the uterus for laboratory genetic testing analysis and send it to the lab. The

laboratory specialist performs counting of 10 cells with 2 karyotyping and banding of chromosomes.

<b>Z36.2</b>	Other antenatal screening based on amniocentesis
<b>16600-00-00 [1330]</b>	Diagnostic amniocentesis
<b>73200-05-10 [3200]</b>	Amniotic Fluid chromosome analysis for genetic abnormality by 15 cell count and 1 karyotypes with banding
<b>73200-05-80 [3200]</b>	Additional Karyotypes to initial chromosomal analysis

## SBSCS 6043 In vivo and other pathology procedures

In vivo tests describe procedures performed on living subjects. This block includes all pathology consultations, *non-invasive* transcutaneous measurements, body fluids (other than blood), collection, and cell count.

### **Classification:**

Code **73400-01-30 [3400]** *Collection of sputum specimen (e.g., saliva, mucus, or pus) by aerosol mist induced technique* should only be reported as a separate procedure when performed alone and **not** as part of another procedure.

### **Example:**

Patient presents to the clinic complaining of abnormal brown sputum, he is a current smoker. The doctor orders sputum collection by aerosol mist induced technique for diagnostic purposes.

<b>R09.3</b>	Abnormal sputum
<b>Z72.0</b>	Tobacco use, current
<b>73400-01-30 [3400]</b>	Collection of sputum specimen (e.g., saliva, mucus, or pus) by aerosol mist induced technique



# Assisted reproduction

Assisted reproductive technologies (ART) primarily aid in fertility treatment utilizing procedures like in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), cryopreservation of reproductive cells or embryos, and fertility medication. The department of assisted reproduction includes female fertility and male fertility.

## SBSCS 6050 Female fertility

Female fertility testing utilizes advanced techniques to treat infertility. It involves handling, freezing, storing, and biopsy preparation of oocytes (eggs) and embryos for genetic testing. Indications for fertility testing include risk for transmission of inherited disorders (preimplantation genetic testing) or infertility concerns related to cancer therapy.

### Classification

For oocyte identification related to In vitro fertilization (IVF) procedures, assign one code per service only, regardless of oocyte number identified.

#### **Example:**

A woman presents to the fertility medicine department for in vitro fertilization related procedure. The doctor withdraws follicular fluid sample for egg collection. In the laboratory, fluid is examined for the presence of oocytes and a total of 15 oocytes were identified.

**Z31.2** In vitro fertilisation

**N97.9** Female infertility, unspecified

**13212-00-00 [3400]** Transvaginal oocyte retrieval

**73400-01-90 [3400]** Oocyte (egg) identification from ovarian fluid

## SBSCS 6051 Male fertility

Male fertility testing utilizes advanced techniques to treat infertility. It involves handling, freezing, storing, and biopsy preparation of sperms and testicular tissue for genetic testing. Indications for fertility testing include risk for transmission of inherited disorders (preimplantation genetic testing) or infertility concerns related to cancer therapy.

### Classification

Sperm isolation procedures **73400-02-40 [3400]** and **73400-02-50 [3400]** include all necessary semen analysis tests (e.g., motility, count) so these services should not be reported separately.

Code **73400-03-60 [3400]** *Semen analysis of sperm presence & motility* is usually performed 12-14 weeks following vasectomy procedure and therefore cannot be assigned with **73400-03-30 [3400]** *Semen analysis of sperm presence & motility with Sims-Huhner test (postcoital test (PCT))* which is a time sensitive test.

Code **73400-04-00 [3400]** *Analysis of sperm by the cervical mucus penetration test with or without spinnbarkeit mucus elasticity test* is not gender specific and can be assigned for both male and female patients.

**Example:**

A man presents to the fertility medicine department for in vitro fertilization related procedure. The doctor performs Percutaneous epididymal sperm aspiration (PESA) to collect sperm sample. In the laboratory, sperm isolation was performed using a swim-up test and sperm count and motility were also analysed.

**Z31.3** Other assisted fertilisation methods

**N46** Male infertility

**37605-00-01 [1177]** Percutaneous aspiration of epididymis, unilateral

**73400-02-40 [3400]** Sperm isolation by simple preparation techniques (e.g., swim up, sperm wash) w/ semen analysis, for insemination or identification of sperm abnormalities.

# Section 6 – Ambulance and transport services

This section includes standards for the set of codes used to report **ambulance services offered by hospitals or medical centers (SBS Chapter 22)**. Standards for services provided by independent emergency medical service providers (such as Red Crescent or other private companies) are covered under Section 6 Emergency medical services.

Ambulance and transportation services can be provided by land or air vehicles, and cases may be classified emergency or non-emergency. The call received by the ambulance dispatch call center will validate the following to classify the case as emergency or non-emergency:

- The patient's condition.
- Whether the patient is in a stable or unstable condition.
- Whether a paramedic or physician intervention is needed.

Ambulance teams should be certified to administer basic or advanced life support, including for neonates and children:

- **Basic life support, or BLS**, generally refers to the type of care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress or an obstructed airway. It requires knowledge and skills in cardiopulmonary resuscitation (CPR), using automated external defibrillators (AED) and relieving airway obstructions in patients of every age.
- **Advanced life support (ALS)**, also referred to as Advanced cardiac life support (ACLS), is a set of life-saving protocols and skills that extend beyond Basic Life Support (BLS). It is used to provide urgent treatment to cardiac emergencies such as cardiac arrest, stroke, myocardial infarction, and other conditions.

## Ambulance minimum documentation requirements

Documentation is key for accurately coding ambulance services and ensuring the appropriate level of reimbursement. Paramedics should be trained to document properly to support the coding of the service provided, as well as capture all relevant identification documents. At minimum, documentation should include the following details:

- Reason for calling ambulance
- Ambulance arrival time
- Findings
- Treatment plan
- Diagnosis on arrival at the place of transfer (in transferred case)
- Ambulance departure time
- Patient identification document(s)
- Patient insurance details (if available).

## SBSCS 7000 Emergency road transport

### **Definition:**

*Includes all road transports from home/site to a health care facility. Charges are by kilometer.*

### **Classification:**

Emergency transport codes are assigned based on the level of medical monitoring needed for patient transport, to either a Basic life support ambulance or an Advanced life support ambulance.

#### **Example:**

A 19-years-old patient complaining of low back pain. The patient fell down a flight of stairs at home and an BLS ambulance is taking him to the hospital.

<b>M54.5</b>	Low back pain
<b>W10.9</b>	Fall on and from other and unspecified stairs and steps
<b>U73.9</b>	Unspecified activity
<b>Y92.09</b>	Other and unspecified place in home
<b>83520-00-00 [3520]</b>	Basic life support ambulance charge per km

## SBSCS 7001 Emergency air transport

### **Definition**

*Emergency air transport includes transport via rotary or fixed wing aircraft.*

### **Classifications**

The SBS code for the type of emergency air transport (rotary or fixed wing) should be coded. Diagnoses should also be coded, and include the injury sustained as the principal diagnoses, as well as codes for the external cause of the incident, the activity being undertaken by the person when the incident occurred and the place of occurrence of the incident.

Documentation must also be provided to justify the use of emergency air transport in cases where emergency road transport could have also been used.

#### **Example:**

A 32-year-old woman is air lifted to hospital via helicopter following a car accident on a public highway.

<b>T04.1</b>	Crushing injuries involving thorax with abdomen, lower back and pelvis
<b>V49.9</b>	Car occupant [any] injured in unspecified traffic accident
<b>U73.9</b>	Unspecified activity
<b>Y92.49</b>	Unspecified public highway, street or road

**83510-00-10 [3510]** Rotary Wing Air Transport

**Documented justification:** Multiple trauma requiring time-critical retrieval to hospital not able to be achieved via road transport due to road congestion.

## **SBSCS 7002 Non-emergency transportation**

*Non-emergency ambulance transportation codes are assigned based on the level of medical monitoring needed for patient transport.*

### **Classification**

Ambulance transportation for patients that require a high level of medical monitoring and including those who need continuous IV drips, those on a chronic ventilator, and also those who require cardiac monitoring, should be coded as a non-Emergency Ambulance Service for a patient on Advanced life support. However, Basic life support transport is for patients who have lower extremity fractures, patients transferred to sub-acute care facilities or who are discharged to home care, psychiatric patients, and other non-emergency medical transportation. These cases should be coded as a non-Emergency Ambulance Service for a non- acute patient.

### **Non-emergency road transport**

For non-emergency patients transport several methods can be utilized to move patients from one zone to another. Assign an appropriate code based on the vehicle utilized (taxi, bus, etc.).

### **Example:**

A hospital needs to transfer several wheelchair patients from one building to another within the same hospital area using a van.

**83540-00-20 [3540]** Transport wheelchair non-emergency

# Section 7 – Emergency medical services (EMS)

This section includes standards for the set of codes used to report **EMS offered by independent EMS providers, such as Red Crescent or private companies** (SBS Chapter 24). Standards for hospital and medical centre-based ambulance services are covered under Section 5 Ambulance and transport services.

EMS can be provided using land or air vehicles, and cases may be emergency or non-emergency.

The call received by the ambulance dispatch center will validate the following to classify the case as emergency or non-emergency:

- The patient's condition.
- Whether the patient is in a stable or unstable condition.
- Whether a paramedic or physician intervention is needed.

Ambulance teams should be certified to administer basic or advanced life support, including for neonates and children:

- **Basic life support, or BLS**, generally refers to the type of care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress or an obstructed airway. It requires knowledge and skills in cardiopulmonary resuscitation (CPR), using automated external defibrillators (AED) and relieving airway obstructions in patients of every age.
- **Advanced life support (ALS)**, also referred to as Advanced Cardiac Life Support (ACLS), is a set of life-saving protocols and skills that extend beyond Basic Life Support (BLS). It is used to provide urgent treatment to cardiac emergencies such as cardiac arrest, stroke, myocardial infarction, and other conditions.

## Ambulance minimum documentation requirements

Documentation is key for accurately coding ambulance services and ensuring the appropriate level of reimbursement. Paramedics should be trained to document properly to support the coding of the service provided, as well as capture all relevant identification documents. At minimum, documentation should include:

- Reason for calling ambulance
- Ambulance arrival time
- Findings
- Treatment plan
- Diagnosis on arrival at the place of transfer (in transferred case)
- Ambulance departure time
- Patient identification document(s)
- Patient insurance details (if available).

## SBSCS 8001 Ambulance services

Care should be taken to the documented procedure, when assigning a code for Ambulance response and treatment with or without transport (either BLS or ALS), depending on whether the patient transport was carried out by a certified team (either BLS or ALS), the travelled distance, with or without medications, or if the documented procedure states that a Basic Life Support Ambulance has reached the scene and the team has physically attended and treated the patient but without transport. However, if the patient transport request was cancelled after EMS dispatch has deployed a BLS team and before the team has physically attended to the patient, assign **85130-00-00 [2050] Basic Life Support cancellation**.

In cases where Advanced life support protocol was used, assign **85320-00-00 [2050] Advanced Life Support transport declination** when the patient transport request was declined by the patient after EMS dispatch has deployed an ALS team and the team has physically attended to the patient. However, assign **85330-00-00 [2050] Advanced Life Support cancellation** when the patient transport request was cancelled after EMS dispatch has deployed an ALS team and before the team has physically attended to the patient.

### Example 1:

A 24-year-old patient was hit by a motor vehicle while walking on foot. EMS were called and the personnel arrived on the scene. The patient was transferred to the nearest major hospital, which was 70 km away in the city, no complications occurred during the transfer.

<b>T14.9</b>	Injury, Unspecified
<b>U73.9</b>	Unspecified activity
<b>V09.9</b>	Pedestrian injured in unspecified transport accident
<b>85200-01-00 [2050]</b>	Advanced Life Support transport up to 50 km
<b>85300-00-00 [2050]</b>	ALS Ambulance extra distance charge, after 50 km up to 300 km (add-on code)

### Example 2:

A 23-year-old patient was admitted due to falling off a mountain while rock climbing. He sustained threatening injuries and an aeromedical transport was needed for quick evacuation.

<b>T14.9</b>	Injury, Unspecified.
<b>W15</b>	Fall from cliff
<b>Y92.86</b>	Other specified countryside
<b>85500-00-00 [2050]</b>	Aeromedical transport (Medevac)
<b>85400-00-00 [2050]</b>	Advanced Life Support service by specialized team.

# Section 8 – KSA Service codes

## Introduction

Service codes (SBS Chapter 23) are used for billing physician/ancillary staff encounters with the patient, such as consultations and teleconsultations. They also include room charges.

The service codes can be used for coding encounters in both admitted and non-admitted care settings.

## SBSCS 9000 Consultations

### Definition

Any activity undertaken for the detection, treatment or management by a Medical Practitioner (General practitioner, Specialist-1 [First Registrar doctor], Specialist-2 [Second Registrar doctor], Consultant or allied health provider) of an illness, injury, medical condition or related symptom, including but not limited to the application of prescribed drugs or therapy (conventional or alternative).

### Follow up and repeat consultations

Follow up codes are used to describe ongoing surveillance, following the completion of treatment for a disease, condition, or injury, suggesting that the disease has been completely treated and is no longer present. On the other hand, repeat consultation visits cover circumstances where the patient requires continued care during the healing or recovery phase, or for the long-term progression of the disease, after the initial treatment has been performed. Care should also be taken to identify the clinician type, while assigning the most appropriate code.

### Classification

Follow up codes should not be confused with repeat consultation codes, which describe how a condition is being treated after it has healed or its effects. Follow-up codes may be utilized in conjunction with history codes, to give a complete picture of the healed condition and its treatment, the history code is put in order after the follow-up code. Care should also be taken to identify the clinician type while assigning the follow up code.

\*\*Care should be taken while assigning the Free Secondary treatment for the same condition codes as it should only be assigned for return visits within 14 days from the original/first treatment visit.

#### **Example 1:**

A 17-years-old patient previously diagnosed with Athlete's Foot (Tinea Pedis), came to the dermatology clinic for follow-up after 2 weeks. Specialist examination showed clear-up of area.

**L40.0** Tinea pedis

**83600-00-40 [3600]** Secondary follow up treatment with the same condition within the mandated timelines for Specialist-1



**Example 2:**

A 19-years-old patient previously diagnosed with mild Psoriasis vulgaris on his knees, came to the dermatology clinic complaining of swelling and redness on his elbow. Specialist examination revealed new flare up areas. The doctor prescribed topical steroids to reduce the swelling and redness.

**B35.3** Psoriasis vulgaris

**83600-00-70 [3600]** A repeated visit within 3 to 4 weeks from initial encounter for the same reported illness under OPD seen by Licensed Specialist -1

## Health screening

Health screening may be provided by either a registered nurse or physician; this service includes all services related to vital signs, weight, family history, and the early detection of heart disease and other conditions as well as general lifestyle assessment.

## Community based doctor (CBD)

Defined as physicians who work in ambulatory care facilities and refer patients that need surgery to secondary or tertiary care facilities due to their facility not having the capacity to perform the needed services. The surgery shall be done by the doctor himself.

In such cases, the surgeon's fee will be claimed by the doctor directly and the treating facility charges shall be claimed by them directly. It is also possible that the treating facility could claim for the whole service and then pay the CBD directly, by either a percentage, or pre-agreed surgeon fees.

## Rounding fees

Rounding fees are applicable only in admitted patient settings, where the physician visits the patient daily. This includes GP, Specialist, Intensivist and Consultant visits, whether in the Ward, ICU, NICU, or PICU.

## Surgeon assistant fees

When the support of another physician is sourced and utilized. This is usually applicable to GPs and Specialists.

## Admitted patient consultations

In the case of two or more Interrelated Conditions, each potentially meeting the definition for principal diagnosis. - charge ratio will be one only for any of the two conditions considered as primary reason for consultation. This includes Consultations for GP, Specialist, and Consultant.

## SBSCS 9010 Telemedicine

### Definition

A remote medical practice facilitated by the use of electronic means of information and communication technology through an electronic voice, video, and information system by linking it with different healthcare facilities via telehealth systems (telemedicine).

### Classification

Medical counselling and treatment can be provided by General Practitioner, Specialist, Consultant, Psychotherapy and emergency. Care should be taken to the type of physician providing the medical counselling and treatment, to assign the most appropriate code.

#### **Example:**

A 42-years-old patient is suffering from fever and cough, he used a telemedicine app where he was assessed by a General Practitioner.

**R50.9**                      Fever, unspecified

**R05**                         Cough

**83600-03-40 [3600]**    Telemedicine assessment for diagnosis treatment and counselling of a new or established patient by a General Practitioner

## SBSCS 9011 Homecare services

### Definition

Homecare services include all service provided to a patient while he/she is staying at home, where no hospitalization is required. It includes those who are convalescing, disabled, or terminally ill.

### Classifications

Most private insurance plans pay for services that home health agencies deliver. Payment from these sources depends on whether the care is medically necessary, and the individual meets specific coverage criteria. Assign also:

- The problem/condition being treated as the principal diagnosis code.
- Other problems or symptoms as additional diagnosis code(s).
- The appropriate procedure codes from block [3620].

#### **Example 1:**

A 46-years-old patient is scheduled for an in-home follow-up (by a GP). The patient had a planned joint replacement for traumatic arthritis of the left knee caused by a skiing accident several years ago. He also has hypertension and hyperlipidaemia.

**Z47.0**                      Aftercare following joint replacement surgery

**I10**                         Essential (primary) hypertension

**E78.5**                      Hyperlipidaemia, unspecified

<b>Z96.65</b>	Presence of left artificial knee joint
<b>83620-00-50 [3620]</b>	Home assessment for diagnosis treatment and counselling of a new or established patient by general practitioner

**Example 2:**

A 71-year-old patient recently had a colostomy placed due to metastatic cancer on her colon that spread to her left ovary. The patient is assigned a home health nurse for a full day (8 hours) to teach her on the care of the colostomy and management of the symptoms related to metastatic cancer.

<b>Z43.3</b>	Encounter for attention to colostomy
<b>C78.5</b>	Secondary malignant neoplasm of large intestine and rectum
<b>M8000/6</b>	Neoplasm, metastatic
<b>C56</b>	Malignant neoplasm of ovary
<b>M8000/3</b>	Neoplasm, malignant
<b>83620-00-00 [3620]</b>	Nurses fixed fee for a day time

**Example 3:**

A 45-year-old patient was involved in a head on collision with another vehicle. the patient dislocated his right shoulder as a result of bracing himself against the impact. The shoulder was relocated at the scene. He was taken to the hospital and was diagnosed with a whiplash associated disorder and mild concussion, as well as a right shoulder dislocation. He was referred to In-Home Physiotherapy for his shoulder and neck immediately following the accident due to his inability to drive because of concussion symptoms.

<b>S06.00</b>	Concussion
<b>S13.4</b>	Whiplash injury
<b>S43.00</b>	Shoulder dislocation
<b>47009-00-01 [1402]</b>	Closed reduction of dislocation of shoulder, unilateral
<b>83620-00-10 [3620]</b>	Physiotherapy, per session

**Example 4:**

A 66-year-old patient, previously diagnosed with chronic obstructive pulmonary disease (COPD) was discharged requiring respiratory home health care.

<b>J44.9</b>	Chronic obstructive pulmonary disease
<b>83620-00-20 [3620]</b>	Respiratory therapy, per session

## SBSCS 9012 Cardiac catheterization lab

### Definition

Catheterization laboratory is commonly known as a Cath lab, is an procedure room in a hospital, clinic, or diagnostic center where several types of tests and procedures like ablation, angiogram, angioplasty, implantation of pacemakers, etc. are performed. Usually, the patient is awake for these procedures. A Cath lab is staffed by a team of different specialists, usually led by an interventional cardiologist.

### Classification

Assign the problem/condition that is being treated as the principal diagnosis code. Assign other problems or symptoms as additional diagnosis code(s). Assign an appropriate Cath Lab charge, based on the inclusivity of consumables in the room (with or without inclusive or exclusive). Drugs and consumables should be billed separately if the Cath Lab Charge excluded consumables.

\*\*Anaesthesia should be billed /reported separately.

- **Cath Lab Charges – Including consumables – every 30 mins**
- **Cath Lab Charges – Excluding consumables – every 30 mins**

### **Example:**

A 65-years-old patient is admitted for cardiac catheterization to treat his unstable angina. He has a history of CABG a few years ago. Cardiac angiogram demonstrated occlusion of coronary artery in his grafted (SVG) vessels. Clinical documentation did not state if the occluded graft is related to the initial surgery. The procedure was carried out under sedation.

<b>I20.0</b>	Unstable angina
<b>I25.12</b>	Atherosclerotic heart disease of autologous bypass graft
<b>38218-02-00 [668]</b>	Coronary angiography with left and right heart catheterisation
<b>83640-00-00 [3640]</b>	Catheterization Lab Charges - Excluding consumables - every 30 mins
<b>92515-99-00 [1910]</b>	Sedation, ASA 99

## SBSCS 9013 COVID–19 packages

### Definition

COVID-19 is an acute respiratory illness in humans caused by the coronavirus, capable of producing severe symptoms and in some cases death, especially in older people and those with underlying health conditions.

### Classifications

#### ▪ **Diagnosis codes**

Assigning diagnosis codes for COVID-19 depends on the virus test results (Ministry of Health, 2022). Patients may present with different scenarios (whether with symptoms/contact with confirmed cases or not).

Table 7: COVID-19 diagnosis codes

Negative result	Scenario	Positive result	Scenario
<b>PDx</b> – Symptoms or Condition <b>ADx</b> – <b>Z20.8</b> <i>Contact with and exposure to other communicable disease</i> <b>ADx</b> – <b>U06.0</b> <i>Emergency use of U06.0</i>	<b>Present symptoms</b> + <b>Contact with positive COVID-19 case</b>	<b>PDx</b> – Symptoms or Condition <b>ADx</b> – B97.2 Coronavirus as the cause of the disease classified to other chapters <b>ADx</b> – U07.1 Emergency use of U07.1	<b>Present symptoms</b> + <b>Contact with positive COVID-19 case</b>
<b>PDx</b> – Symptoms or Condition <b>ADx</b> – <b>Z03.8</b> <i>observation for other suspected disease and condition</i> <b>ADx</b> – <b>U06.0</b> <i>Emergency use of U06.0</i>	<b>Present symptoms</b> + <b>No contact with positive COVID-19 case</b>	<b>PDx</b> – Symptoms or Condition. <b>ADx</b> – B97.2 Coronavirus as the cause of the disease classified to other chapters <b>ADx</b> – U07.1 Emergency use of U07.1	<b>Present symptoms</b> + <b>No contact with positive COVID-19 case</b>
<b>PDx</b> – <b>Z20.8</b> <i>Contact with and exposure to other communicable disease</i> <b>ADx</b> – <b>U06.0</b> <i>Emergency use of U06.0</i>	<b>No present symptoms</b> + <b>Contact with positive COVID-19 case</b>	<b>PDx</b> – B34.2 Coronavirus infection, unspecified. <b>ADx</b> – U07.1 Emergency use of U07.1	<b>No present symptoms</b> + <b>Contact with positive COVID-19 case</b>
<b>PDx</b> – <b>Z71.1</b> <i>Person with feared complaint in whom no diagnosis is made</i> <b>ADx</b> – <b>U06.0</b> <i>Emergency use of U06.0</i>	<b>No present symptoms</b> + <b>No contact with positive COVID-19 case</b> (Person suspects disease)	<b>PDx</b> – B34.2 Coronavirus infection, unspecified <b>ADx</b> – U07.1 Emergency use of U07.1	<b>No present symptoms</b> + <b>No contact with positive COVID-19 case</b> (Person suspects disease)
<b>PDx</b> – <b>Z11.5</b> <i>Special screening examination for other viral disease.</i> <b>ADx</b> – <b>U06.0</b> <i>Emergency use of U06.0</i>	<b>No present symptoms</b> + <b>No contact with positive COVID-19 case</b> (Mandatory test by facility)	<b>PDx</b> – B34.2 Coronavirus infection, unspecified. <b>ADx</b> – U07.1 Emergency use of U07.1.	<b>No present symptoms</b> + <b>No contact with positive COVID-19 case</b> (Mandatory test by facility)
<b>No Symptoms or Conditions present</b>			<b>Corona Virus and Pregnancy</b>
<b>PDx</b> - <b>O98.5</b> <i>Other viral diseases complicating pregnancy, childbirth and the puerperium</i> <b>ADx</b> - Follow the above codes based on each scenario wither positive or negative			
<b>Symptoms or Conditions present</b>			
<b>PDx</b> – <b>O99.-</b> <i>Other viral diseases complicating pregnancy, childbirth and the puerperium</i> <b>ADx</b> – Symptoms or Condition <b>ADx</b> – <b>O98.5</b> <i>Other viral diseases complicating pregnancy, childbirth and the puerperium</i> <b>ADx</b> Follow the above codes based on each scenario wither positive or negative			
<b>If it is negative:</b> <b>PDx</b> - <b>Z03.71</b> <i>Observation of newborn for suspected infectious condition</i> <b>ADx</b> - <b>U06.0</b> <i>Emergency use of U06.0</i> <b>If it is positive:</b> Codded as above			<b>Infants younger than 28 days</b>
<b>Z29.0</b> <i>Isolation</i> <b>Codded as ADx</b>			<b>Patient Isolation</b>

▪ **COVID-19 Admitted patient care**

Positive COVID-19 patients can be assigned different package service codes for COVID-19 care, depending on the severity of the patient’s condition using a specific room. These can range between mild, moderate, severe, or critical. Proper documentation of the symptoms and the provided treatment is needed to assign the most appropriate room code.

Table 8: COVID-19 admitted patient care codes

Code	Definition
83690-00-20 [3690] Per Diem – IP Care COVID-19 Mild	Mild patients usually do not require O2 treatment, showing no evidence of pneumonia or shortness of breath. However, they might present with other symptoms of COVID-19 e.g., fever.
83690-00-30 [3690] Per Diem – IP Care COVID-19 Moderate	Moderate patients usually do not require O2 treatment, showing no evidence of pneumonia or shortness of breath. However, they might present with other symptoms of COVID-19 e.g., fever.
83690-00-40 [3690] Per Diem – IP Care COVID-19 Severe	Severe patients usually show clinical signs of pneumonia (fever, cough, dyspnoea, fast breathing) and either a respiratory rate >30/min (adults); ≥40/min (children < 5 years, Blood oxygen saturation <93% on room air, Severe respiratory distress
83690-00-50 [3690] Per Diem – IP Care COVID-19 Critical	Critical patients usually show clinical signs of ARDS, respiratory failure requiring ventilation, Sepsis, or Septic Shock.

**Example 1:**

A 21-year-old confirmed COVID-19 patient was admitted to the hospital complaining from cough, fever, dyspnoea and severe respiratory distress.

**U07.1** COVID-19  
**83690-00-40 [3690]** Per diem – IP Care COVID- 19 Severe

**Example 2:**

A COVID-19 patient admitted to the hospital with acute hypoxic respiratory failure that progresses to ARDS (acute respiratory distress syndrome).

**U07.1** COVID-19  
**J80** ARDS  
**83690-00-50 [3690]** Per diem – IP Care COVID- 19 Critical

## SBSCS 9014 Room and board

**Definition**

Room and Board Services are provided to patients residing in a medical facility and are admitted in that facility for at least 24 hours while being provided lodging and meals.

**Classification**

When a room and board services code is reported, clinical coders determine the following to assign a suitable code:

- **Type of the room:** These include ICU (*intensive care unit*), NICU (Neonatal Intensive Care Unit), PICU (Paediatric intensive care unit), SCBU (Special care baby unit), SCU (Special care unit), Nursery, or Special care Nursery.
- **Level of the room:** These include VIP, First class, Suite, private room deluxe, Royal suite, Semi-private, private room standard, or Ward room.
- **Excluding or including consumables**

**Example:**

A 25-days-old infant suffering from hypoxia, was admitted to NICU (Neonatal Intensive Care Unit) to monitor the newborn health.

<b>P21.9</b>	Birth asphyxia unspecified
<b>83610-03-60 [3610]</b>	Newborn monitoring without any special lifesaving equipment in NICU environment per 24 hr interval

## SBSCS 9015 Room upgrade

**Definition**

A room rate difference code is used when a patient upgrades the type of hospital residency, and a different charge between the rooms needs to be estimated.

**Classification**

Three codes must be assigned, i) a code for the original room accommodation, ii) a second code for the room rate difference the patient upgraded to, iii) and finally, a code for the new room accommodation.

There are three types of room rate difference codes, and they must be assigned according to the type of room the patient will be upgrading to.

**83610-01-10 [3610] Room Rate difference – Daily Rate (Day 1 and more) - First Class Room**

**83610-01-60 [3610] Room Rate difference – Daily Rate (Day 1 and more) - Suite**

**83610-01-70 [3610] Room Rate difference – Daily Rate (Day 1 and more) - Royal Suite**

**Example:**

A 45-years-old admitted patient asked to upgrade his room from a regular room to a Royal suite for hospitalization.

<b>83610-00-10 [3610]</b>	Day Stay Room charges
<b>83610-01-80 [3610]</b>	Room Rate difference - Daily Rate (Day 1 and more) - Royal Suite
<b>83610-01-70 [3610]</b>	Room and Board: Royal Suite

## SBSCS 9016 Labour and delivery room

### Definition

Delivery room codes describe a special procedure room in a hospital where women give birth. The Labour and Delivery Room (LDR) is equipped to handle vaginal births only. An epidural or other pain medication can be administered in this room if they are needed. And, if required, forceps or vacuum delivery can be performed in the vast majority of LDR rooms as well. However, if a caesarean section is indicated at the hospital, the recovery will not be in the LDR, even if the patient has laboured in one.

The delivery room is also equipped to handle newborn care as well. Once the baby is born, if there were an emergency or the need for specialized equipment, the average LDR room is prepared with a warmer for the baby and life-saving resuscitation equipment.

### Classification

- **Delivery room for normal delivery including consumables**

Assign a code from O80–O84 Delivery as the principal diagnosis code. Assign 90467-00-00 [1336] Spontaneous vertex delivery or 90470-00-00 [1339] Spontaneous breech delivery. Assign 83630-00-10 [3630] Maternity Facilities for Normal Delivery (All Inclusive). \*\*Drugs reported Separately.

- **Delivery room for normal delivery excluding consumables**

Assign a code from O80–O84 Delivery as the principal diagnosis code. Assign 90467-00-00 [1336] Spontaneous vertex delivery or 90470-00-00 [1339] Spontaneous breech delivery. Assign 83630-00-00 [3630] Maternity facilities for normal delivery (All Inclusive). \*\*Drugs and consumables reported Separately.

#### **Example:**

A 28-years-old patient admitted for spontaneous vertex delivery. She delivered a healthy 4 kg baby girl.

<b>080</b>	Spontaneous delivery
<b>Z37.0</b>	Single liveborn
<b>90467-00-00 [1336]</b>	Spontaneous vertex delivery



# Section 9 – Mortuary services

This section includes standards for the set of codes used to report mortuary services (SBS Chapter 25)

## Definitions:

*Mortuary services describe provided services that include but not limited to the preparation and transportation of the dead for burial, and funerals.*

## SBSCS 9050 Mortuary preparation

**Mortuary preparation:** (Includes **Keeping body at mortuary, isolation per day, person with communicable (infectious) disease**).

This code is assigned when preparation for the burial of the bodies of persons who are known to have one of the communicable (infectious) diseases at the time of their death. This includes COVID 19 (Not to exceed 9 days), avian influenza in humans, diphtheria, plague, respiratory anthrax, severe acute respiratory syndrome (SARS), smallpox and any viral haemorrhagic fever (including Lassa, Marburg, Ebola and Crimean-Congo fevers).

The cause of death should be sequenced as the principal diagnosis, then followed by the appropriate service codes.

## SBSCS 9051 Mortuary transportation

### Definition:

Mortuary transport service means an individual or a business entity that, for compensation, removes and transports human remains or employs a transporter to remove or transport human remains via road or air transportation.

### Classification:

When mortuary transportation is reported, and the cause of death is unknown, assign **R99 Other ill-defined and unspecified causes of mortality** as the principal diagnosis. If the reason of the death is known then assign this as the principal diagnosis along with the appropriate service codes for transportation, road, depending on the distance in km.

When an air mortuary transportation is reported without mentioning the aircraft type, assign code **10021-00-00 [4010]** Mortuary transportation, air: Rotary wing ambulance serving as mortuary transportation, air mileage, per km as this type of aircraft is more commonly used than the fixed-wing.

### **Example:**

A 76-year-old male patient passed away due to a massive cerebral infarction shortly after admission to the hospital. The patient's body was transported to his family home via air ambulance.

**I63.9** Cerebral infarction, unspecified

**10021-00-00 [4010]** Mortuary transportation, air; Rotary wing ambulance serving as mortuary transportation, air mileage, per km

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# Appendix B: Clinical Coders' Creed

Although new codes are introduced regularly, on the whole the ICD-10-AM classification structure remains constant over time. Codes and coding standards need to change to try and keep pace with medicine, but ultimately, clinical coders will often need to make decisions which are based on their **experience and common sense** as well as the resources available to them.

When you look at what clinical coders do objectively, they assign numbers from a structured, classification system to complex, ever-changing medical concepts which are not documented in a standardised way – no wonder it can be difficult! To revisit the fundamental skills of the clinical coder:

- a clinical coder has a thorough, working knowledge of medical science and terminology.
- a clinical coder can read the clinical record and make decisions about the appropriate codes to assign, based on the clinical documentation.
- a clinical coder understands the structure and use of a statistical classification.

The important features of these three points are **medical science, make decisions** and **structure**.

- Medical science is complex and forever changing.
- Decision-making is subjective.
- Structure of the classification is static.

The point is, no matter how much one might hope there will be hard and fast rules to solve all our coding problems, it remains that no amount of rules will ever replace the educated judgments that clinical coders make about specific cases based on the...

## Clinical Coders' Creed

These things are the fundamentals of the art and science of clinical coding:

Clinical documentation

Communication with clinicians

Coding standards

Conventions

Classification experience

Common sense

sCience of medicine

All this serves to highlight the considerable and often forgotten skills of clinical coders.

Decisions in coding based on **Sailing the Seven Cs with the Clinical Coders' Creed** will ensure assignment of a code that is as good as possible – the work of a competent clinical coder.

# Appendix C: Standards for ethical conduct in clinical coding

To ensure national consistency in coding practice, the Standards for Ethical Conduct in Clinical Coding have been developed to provide guidance in defining and promoting ethical practices associated with clinical coding undertaken by Clinical Coders and/or Health Information Managers.

These standards should also assist other related health care administrators/stakeholders to understand the ethics surrounding the process of clinical coding.

Ethical practices are core to the clinical coding role to ensure the integrity of coded clinical data at a national level. Those performing the clinical coding function should endeavour to uphold the Standards for Ethical Conduct in Clinical Coding in all situations related to the collection and use of health information within the health care facility or organisation.

The Standards for Ethical Conduct in Clinical Coding applies regardless of the type of facility or organisation, level of authority within the facility or local coding protocols.

## Ethics in Clinical Coding Practice

A clinical coder should:

- ensure that they have access to all the relevant clinical information (electronic or paper-based) to undertake the abstraction and coding processes
- ensure that the documentation within the clinical record justifies selection of diagnoses and intervention codes, consulting clinicians as appropriate
- apply the Kingdom of Saudi Arabia Billing System Coding Standards (SBSCS) and other official reporting requirements for the purpose of:
  - abstracting diagnoses and procedures using the entire clinical record
  - selecting and sequencing diagnosis and procedure codes
- participate (as required) in interdisciplinary engagement for the purpose of clarification of diagnostic or interventional detail or ambiguity in clinical documentation and improve clinician understanding of the role of a clinical coder in the health setting. This may be via one-to-one interactions, team meetings, education sessions, publications or presentations.

A clinical coder should not:

- code diagnoses/interventions without supporting documentation for the purpose of 'maximising' hospital reimbursement. 'Maximising' for reimbursement is not an ethical practice.
  - 'maximising' is defined as undertaking a practice not based on fact (i.e., addition or alteration of codes for conditions not documented within the clinical record), for the sole purpose of increasing reimbursement

- this is not to be confused with 'optimisation' which is defined as using all documentation within the clinical record to achieve the best outcome.
- omit diagnoses/interventions for the purpose(s) of minimising financial loss, or legal liability.
- use the interdisciplinary engagement process inappropriately. This includes:
  - prompt or use leading questions for purposes of 'maximising' reimbursement
  - use details for potential financial gain as part of a clinician query process
  - seek additional documentation for conditions not already apparent in the existing clinical documentation. This includes use of pathology or radiology results as a basis for a clinician query.
- submit to pressure from others to manipulate coded data for any purpose.

### **Ethics in clinical coding quality and education**

A clinical coder should:

- participate in quality improvement activities to ensure that the quality of coding supports the use of data (such as for research, health care management and planning, evaluation and reimbursement).
- assist in the application of ethical coding protocols, including demonstration of courtesy towards, and mutual respect for, colleagues, and accountability for the individuals' work.
- participate in ongoing education to ensure that clinical coding skills and clinical knowledge meet the appropriate level of competence for the health care/organisational setting.
- contribute (where appropriate) to ongoing development of classification systems in conjunction with appropriate coding and clinical experts.
- participate in developing and strengthening of the clinical coding profession through supporting peers and networking with others interested in health information management, including non-traditional clinical coding/HIM activities (e.g., private health funds or casemix units).

### **Ethics in clinical coding and legal requirements**

A clinical coder should:

- observe policies and legal requirements regarding privacy, confidentiality, disclosure and security of patient related information.
- refuse to participate in, or conceal, illegal or unethical processes or procedures.

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