



CODING GUIDE

OMS

An essential coding, billing and reimbursement resource for oral and maxillofacial surgery

2022

optum360coding.com

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Getting Started with Coding Guide

The *Coding Guide for OMS* (Oral Maxillofacial Services) is designed to be a guide to the specialty procedures classified in the CDT® and CPT® books. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CDT and CPT Codes

For ease of use, evaluation and management codes related to Oral Maxillofacial Services are listed first in the CPT code section of the Coding Guide. All other CDT and CPT codes in *Coding Guide for OMS* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CDT code is followed by its official code description and nomenclature and each CPT code is followed by its official code description.

Resequencing of CDT and CPT Codes

The American Dental Association (ADA) and the American Medical Association (AMA) employ a resequenced numbering methodology. According to the associations, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the ADA and AMA have assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum360 *Coding Guide* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific CDT and CPT code and its narrative is a combination of features. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the pages following the example.

Appendix Codes and Descriptions

Some codes are presented in a less comprehensive format in the appendix. The CDT and CPT codes appropriate to the specialty are included the appendix with the official code description. The codes

are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

CCI Edit Updates

The *Coding Guide* series includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. The CCI edits are now located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding Guide* series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is <https://www.optum360coding.com/ProductUpdates/>. The 2022 edition password is: XXXXXXXX22. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index

Comprehensive indexes for both the CPT and the CDT coding systems are provided for easy access to the codes. The indexes have several axes. A code can be looked up by its procedure name or by the anatomical site associated with it. For example:

21199 Osteotomy, mandible, segmental; with genioglossus advancement

could be found in the index under the following main terms:

Advancement

Genioglossus, 21199

Mandible

Osteotomy, 21198-21199

Osteotomy

Mandible, 21198-21199

Telehealth/Telemedicine Services

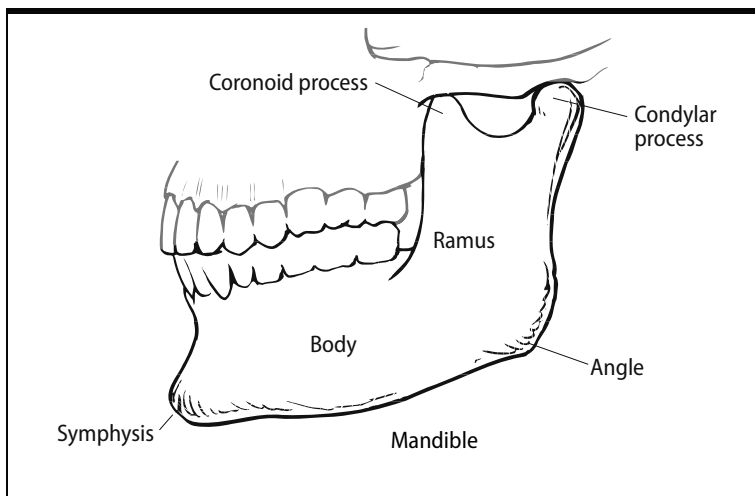
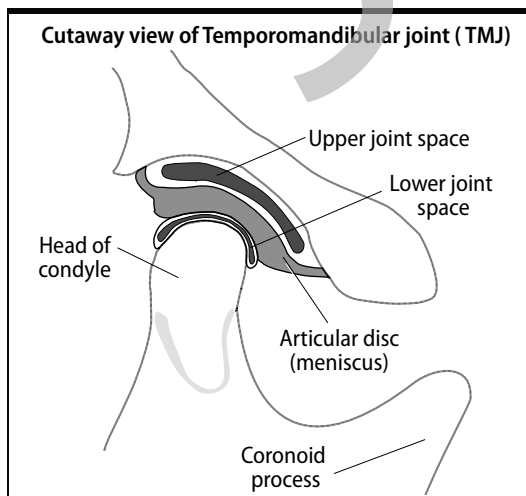
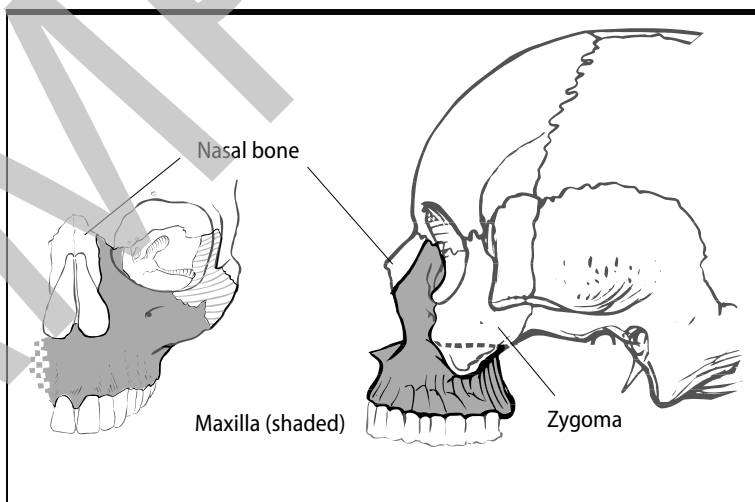
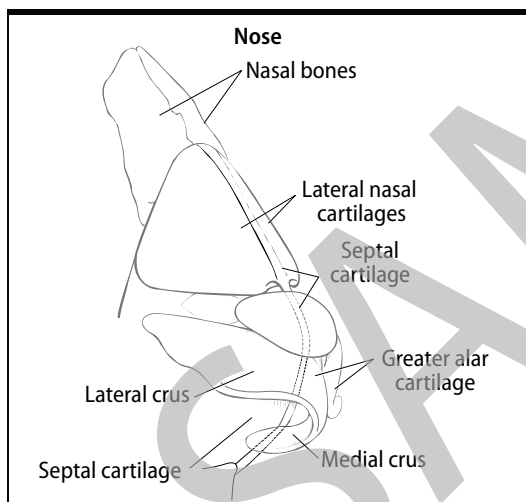
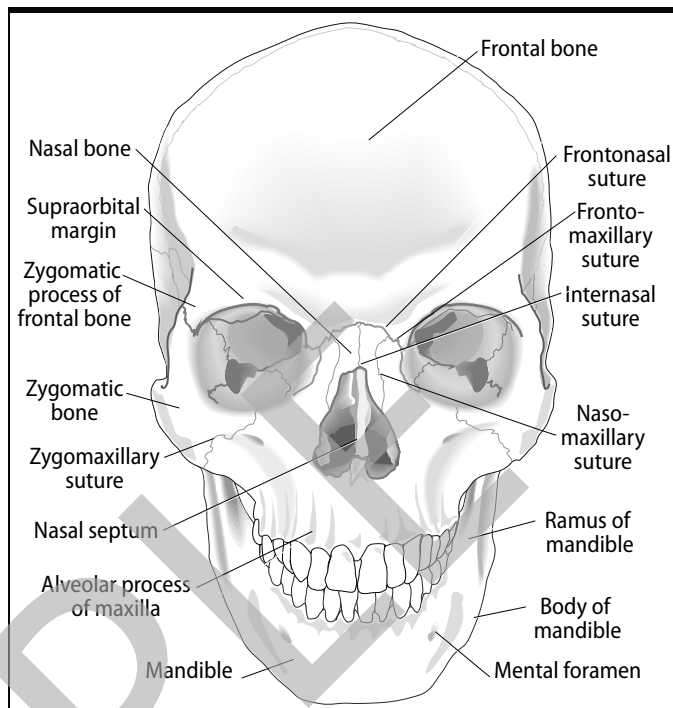
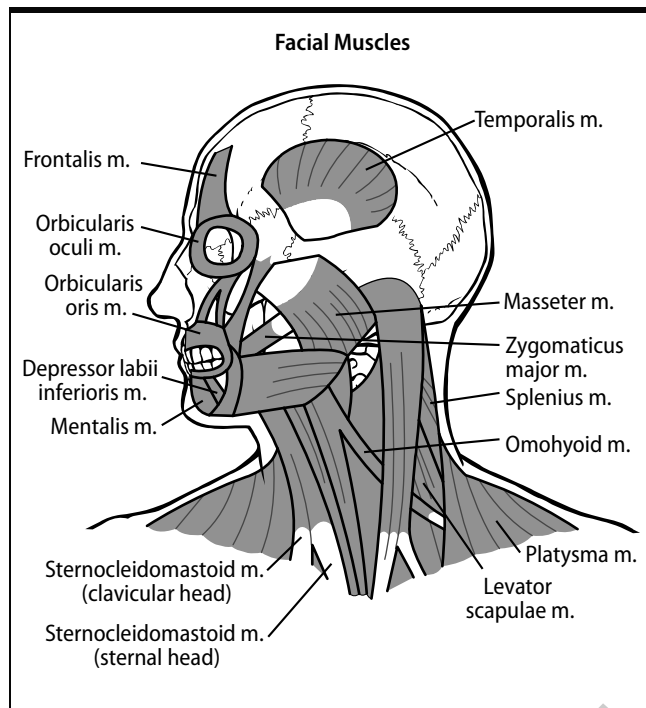
Telehealth/Telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) identify additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE) some services have been designated as temporarily appropriate for telehealth. These CMS-approved services are identified in the coding tips where appropriate. Most payers require telehealth/telemedicine to be reported with place of service 02 Telehealth and modifier 95 appended. If specialized equipment is used at the originating site, code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services.

Sample Page and Key

On the following pages are a sample page from the book displaying the format of *Coding Guide* with each element identified and explained on the opposite page.

Illustrations

Facial Muscles and Bones



D0322

D0322 tomographic survey

Explanation

Tomographic examination is performed, which provides a more accurate image of the quantity and quality of the osseous structures. The images allow the provider to accurately measure the amount of bone that is available typically for implants. The patient is asked to remove any jewelry from the head and neck, so that it does not interfere with the study. The patient is positioned face up on the CT scanner bed, and the head is placed on a padded cradle and immobilized with a Velcro strap. The scanner bed slides through the CT scanner and images are taken.

Coding Tips

This code includes interpretation. When reporting digital subtraction of two or more images (of the same modality), report D0394 in addition to the appropriate code for obtaining the image.

Reimbursement Tips

This service may not be covered by the patient's dental insurance. However, coverage may be available through the patient's medical insurance. Check with third-party payers for specific coverage information. Services submitted to the payer of medical coverage will require that the service be reported with the appropriate CPT code on the CMS-1500 claim form.

Associated CPT Codes

- 70486 Computed tomography, maxillofacial area; without contrast material
- 70487 Computed tomography, maxillofacial area; with contrast material(s)
- 70488 Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections

ICD-10-CM Diagnostic Codes

- C41.0 Malignant neoplasm of bones of skull and face
- C41.1 Malignant neoplasm of mandible
- C76.0 Malignant neoplasm of head, face and neck
- C79.51 Secondary malignant neoplasm of bone
- D10.39 Benign neoplasm of other parts of mouth
- D16.4 Benign neoplasm of bones of skull and face
- D16.5 Benign neoplasm of lower jaw bone
- D48.7 Neoplasm of uncertain behavior of other specified sites
- D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin
- M26.601 Right temporomandibular joint disorder, unspecified
- M26.602 Left temporomandibular joint disorder, unspecified
- M26.603 Bilateral temporomandibular joint disorder, unspecified
- M26.609 Unspecified temporomandibular joint disorder, unspecified side
- M26.611 Adhesions and ankylosis of right temporomandibular joint ✓
- M26.612 Adhesions and ankylosis of left temporomandibular joint ✓
- M26.613 Adhesions and ankylosis of bilateral temporomandibular joint ✓
- M26.619 Adhesions and ankylosis of temporomandibular joint, unspecified side
- M26.621 Arthralgia of right temporomandibular joint ✓
- M26.622 Arthralgia of left temporomandibular joint ✓
- M26.623 Arthralgia of bilateral temporomandibular joint ✓
- M26.629 Arthralgia of temporomandibular joint, unspecified side
- M26.631 Articular disc disorder of right temporomandibular joint ✓

- M26.632 Articular disc disorder of left temporomandibular joint ✓
- M26.633 Articular disc disorder of bilateral temporomandibular joint ✓
- M26.639 Articular disc disorder of temporomandibular joint, unspecified side
- M26.641 Arthritis of right temporomandibular joint ✓
- M26.642 Arthritis of left temporomandibular joint ✓
- M26.643 Arthritis of bilateral temporomandibular joint ✓
- M26.649 Arthritis of unspecified temporomandibular joint
- M26.651 Arthropathy of right temporomandibular joint ✓
- M26.652 Arthropathy of left temporomandibular joint ✓
- M26.653 Arthropathy of bilateral temporomandibular joint ✓
- M26.659 Arthropathy of unspecified temporomandibular joint
- M27.0 Developmental disorders of jaws
- M27.2 Inflammatory conditions of jaws
- M27.49 Other cysts of jaw

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D0322	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
D0322	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D0322	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

CT. Computed tomography.

osseous. Related to, consisting of, or resembling bone.

D5931-D5933, D5936

D5931 obturator prosthesis, surgical

Synonymous terminology: Obturator, surgical stayplate, immediate temporary obturator. A temporary prosthesis inserted during or immediately following surgical or traumatic loss of a portion or all of one or both maxillary bones and contiguous alveolar structures (e.g., gingival tissue, teeth). Frequent revisions of surgical obturators are necessary during the ensuing healing phase (approximately six months). Some dentists prefer to replace many or all teeth removed by the surgical procedure in the surgical obturator, while others do not replace any teeth. Further surgical revisions may require fabrication of another surgical obturator (e.g., an initially planned small defect may be revised and greatly enlarged after the final pathology report indicates margins are not free of tumor).

D5932 obturator prosthesis, definitive

Synonymous terminology: obturator. A prosthesis, which artificially replaces part or all of the maxilla and associated teeth, lost due to surgery, trauma or congenital defects. A definitive obturator is made when it is deemed that further tissue changes or recurrence of tumor are unlikely and a more permanent prosthetic rehabilitation can be achieved; it is intended for long-term use.

D5933 obturator prosthesis, modification

Synonymous terminology: adjustment, denture adjustment, temporary or office reline. Revision or alteration of an existing obturator (surgical, interim, or definitive); possible modifications include relief of the denture base due to tissue compression, augmentation of the seal or peripheral areas to affect adequate sealing or separation between the nasal and oral cavities.

D5936 obturator prosthesis, interim; *Synonymous terminology: immediate postoperative obturator. A prosthesis which is made following completion of the initial healing after a surgical resection of a portion or all of one or both the maxillae; frequently many or all teeth in the defect area are replaced by this prosthesis. This prosthesis replaces the surgical obturator, which is usually inserted at, or immediately following the resection. Generally, an interim obturator is made to facilitate closure of the resultant defect after initial healing has been completed. Unlike the surgical obturator, which usually is made prior to surgery and frequently revised in the operating room during surgery, the interim obturator is made when the defect margins are clearly defined and further surgical revisions are not planned. It is a provisional prosthesis, which may replace some or all lost teeth, and other lost bone and soft tissue structures. Also, it frequently must be revised (termed an obturator prosthesis modification) during subsequent dental procedures (e.g., restorations, gingival surgery) as well as to compensate for further tissue shrinkage before a definitive obturator prosthesis is made.*

Synonymous terminology: immediate postoperative obturator. A prosthesis which is made following completion of the initial healing after a surgical resection of a portion or all of one or both the maxillae; frequently many or all teeth in the defect area are replaced by this prosthesis. This prosthesis replaces the surgical obturator, which is usually inserted at, or immediately following the resection. Generally, an interim obturator is made to facilitate closure of the resultant defect after initial healing has been completed. Unlike the surgical obturator, which usually is made prior to surgery and frequently revised in the operating room during surgery, the interim obturator is made when the defect margins are clearly defined and further surgical revisions are not planned. It is a provisional prosthesis, which may replace some or all lost teeth, and other lost bone and soft tissue structures. Also, it frequently must be revised (termed an obturator prosthesis modification) during subsequent dental procedures (e.g., restorations, gingival surgery) as well as to compensate for further tissue shrinkage before a definitive obturator prosthesis is made.

Explanation

Facial trauma, as well as surgery to the maxilla, maxillary sinus, palate, and alveolus, particularly for cancer, can result in severe impairment of speech and swallowing. Postoperatively, the patient is fitted with a series of obturators depending on the particular needs to restore function, as well as for aesthetic purposes. An immediate surgical obturator (D5931) is placed, usually in the operating room, and helps to restore oral function and aesthetics, as well as to support healing and prevent the formation of scarring and hold packing in place. When the packing is removed, this device is replaced by an interim obturator prosthesis (D5936). This device is used during the healing phase and requires frequent modification while it is in place. Once the defect is stable, a definitive obturator prosthesis (D5932) is fabricated that further augments oral function and aesthetic appearance.

Coding Tips

These are out-of-sequence codes and will not display in numeric order in the CDT book. To report interim obturator prosthesis services, see D5936.

Documentation Tips

Pertinent documentation to evaluate the medical appropriateness may be required with the claim when these codes are reported.

Reimbursement Tips

Coverage may be available through the patient's medical insurance for this service. Check with third-party payers for specific coverage information. Services submitted to the medical coverage will require that the service be reported with the appropriate CPT code on a CMS-1500 claim form.

Associated CPT Codes

21076	Impression and custom preparation; surgical obturator prosthesis
21080	Impression and custom preparation; definitive obturator prosthesis

ICD-10-CM Diagnostic Codes

C05.0	Malignant neoplasm of hard palate
C05.1	Malignant neoplasm of soft palate
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q37.0	Cleft hard palate with bilateral cleft lip
Q37.1	Cleft hard palate with unilateral cleft lip
Q37.2	Cleft soft palate with bilateral cleft lip
Q37.3	Cleft soft palate with unilateral cleft lip
Q37.4	Cleft hard and soft palate with bilateral cleft lip
Q37.5	Cleft hard and soft palate with unilateral cleft lip
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
S01.512A	Laceration without foreign body of oral cavity, initial encounter
S01.522A	Laceration with foreign body of oral cavity, initial encounter
S01.532A	Puncture wound without foreign body of oral cavity, initial encounter
S01.542A	Puncture wound with foreign body of oral cavity, initial encounter
S01.552A	Open bite of oral cavity, initial encounter
S02.42XA	Fracture of alveolus of maxilla, initial encounter for closed fracture
S02.42XB	Fracture of alveolus of maxilla, initial encounter for open fracture
S07.0XXA	Crushing injury of face, initial encounter
Z42.8	Encounter for other plastic and reconstructive surgery following medical procedure or healed injury

D7881

D7881 occlusal orthotic device adjustment

Explanation

The provider makes adjustments to a previously provided occlusal orthotic device. An occlusal orthotic device or splint is a device specifically fitted for people who have a history of temporomandibular joint pain or other conditions. Usually made of an acrylic resin, the provider may need to make adjustments to the device for a better fit by heating, filing, or other methods.

Coding Tips

Use this code to report the adjustment of a TMJ appliance. See D9943 for the adjustment of an occlusal guard. See code D7880 to report the provision of the occlusal orthotic device.

Documentation Tips

Documentation should clearly identify the condition necessitating the occlusal orthotic device. It should also identify the type of adjustment that was needed.

Associated CPT Codes

There are no direct CPT cross codes.

ICD-10-CM Diagnostic Codes

M26.611	Adhesions and ankylosis of right temporomandibular joint	✓
M26.612	Adhesions and ankylosis of left temporomandibular joint	✓
M26.613	Adhesions and ankylosis of bilateral temporomandibular joint	✓
M26.621	Arthralgia of right temporomandibular joint	✓
M26.622	Arthralgia of left temporomandibular joint	✓
M26.623	Arthralgia of bilateral temporomandibular joint	✓
M26.631	Articular disc disorder of right temporomandibular joint	✓
M26.632	Articular disc disorder of left temporomandibular joint	✓
M26.633	Articular disc disorder of bilateral temporomandibular joint	✓
M26.641	Arthritis of right temporomandibular joint	✓
M26.643	Arthritis of bilateral temporomandibular joint	✓
M26.649	Arthritis of unspecified temporomandibular joint	
M26.651	Arthropathy of right temporomandibular joint	✓
M26.653	Arthropathy of bilateral temporomandibular joint	✓
M26.659	Arthropathy of unspecified temporomandibular joint	

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D7881	0.0	0.0	0.0	0.0
Facility RVU	Work	PE	MP	Total
D7881	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D7881	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

D7910

D7910 suture of recent small wounds up to 5 cm

Explanation

The provider sutures recent small wounds of a traumatic nature in the oral mucosa totaling up to 5 cm. A local anesthetic may be given around the laceration and the wound is cleansed, explored, and often irrigated with a saline or antimicrobial solution. The physician sutures the wounds in a simple repair fashion that does not require complicated suturing techniques or undermining of tissues for closure.

Coding Tips

Any evaluation or radiograph is reported separately. This code is not to be used for closure of surgical incisions.

Reimbursement Tips

When the condition is the result of an accident, the dental insurer may require that the medical insurance be billed first. When covered by the patient's medical insurance, the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Associated CPT Codes

12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less
40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex
42180	Repair, laceration of palate; up to 2 cm
42182	Repair, laceration of palate; over 2 cm or complex

ICD-10-CM Diagnostic Codes

S01.511A	Laceration without foreign body of lip, initial encounter
S01.512A	Laceration without foreign body of oral cavity, initial encounter
S01.521A	Laceration with foreign body of lip, initial encounter
S01.522A	Laceration with foreign body of oral cavity, initial encounter
S01.531A	Puncture wound without foreign body of lip, initial encounter
S01.532A	Puncture wound without foreign body of oral cavity, initial encounter
S01.541A	Puncture wound with foreign body of lip, initial encounter
S01.542A	Puncture wound with foreign body of oral cavity, initial encounter
S01.551A	Open bite of lip, initial encounter
S01.552A	Open bite of oral cavity, initial encounter

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

99202-99205

- ▲★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
- ▲★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
- ▲★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
- ▲★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number/complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the CPT revised 2021 Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

Documentation Tips

Medicare allows only the medically necessary portion of the visit. Although not used to determine code selection, history and exam performed should be documented. Medical decision making performed should be documented, and only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

Report these services with place-of-service code 11, representing the clinician's office location or 22, designating an outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service as being distinct from the other service performed on that date of service.

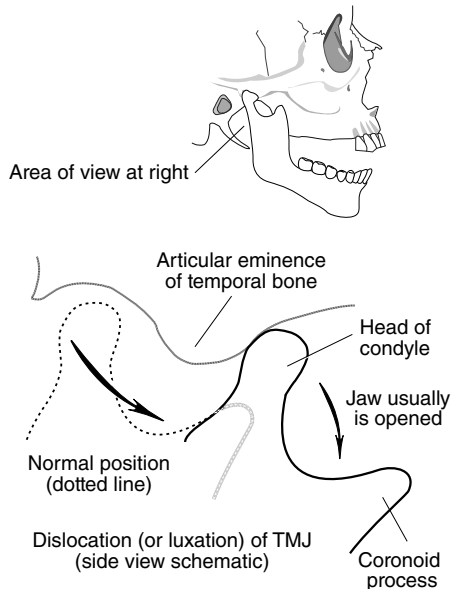
ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99205** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

21480-21485

- 21480** Closed treatment of temporomandibular dislocation; initial or subsequent
- 21485** complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent



Explanation

The physician repositions a dislocation of the temporomandibular joint. No incisions are made and no intermaxillary fixation is used. The physician corrects the dislocation manually to rearticulate the joint. In 21485, intermaxillary fixation is required because of a complicated or persistent dislocation.

Coding Tips

These procedures apply to initial or subsequent dislocation. When 21480 or 21485 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code, while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Local anesthesia is included in the service. For arthroplasty, temporomandibular joint, see 21240–21243. For arthroscopy, temporomandibular joint, surgical, see 29804.

Associated HCPCS Codes

D7820 closed reduction of dislocation

ICD-10-CM Diagnostic Codes

- S03.01XA Dislocation of jaw, right side, initial encounter ✓
- S03.01XD Dislocation of jaw, right side, subsequent encounter ✓
- S03.02XA Dislocation of jaw, left side, initial encounter ✓
- S03.02XD Dislocation of jaw, left side, subsequent encounter ✓
- S03.03XA Dislocation of jaw, bilateral, initial encounter ✓
- S03.03XD Dislocation of jaw, bilateral, subsequent encounter ✓

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that

support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

AMA: 21480 2018,Sep,7 21485 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21480	0.61	2.62	0.11	3.34
21485	4.77	20.0	0.44	25.21
Facility RVU	Work	PE	MP	Total
21480	0.61	0.2	0.11	0.92
21485	4.77	15.4	0.44	20.61

	FUD	Status	MUE	Modifiers				IOM Reference
21480	0	A	1(2)	50*	51	N/A	N/A	None
21485	90	A	1(2)	50*	51	N/A	80*	

* with documentation

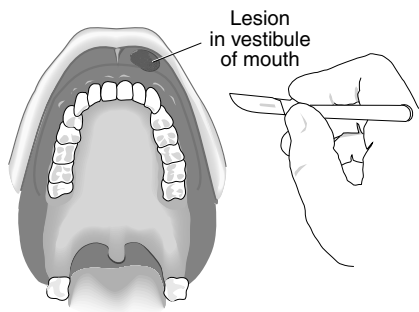
Terms To Know

dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.

temporomandibular joint. Joint or hinge formed by the connection of the lower jaw to the temporal bone of the cranium, located in front of the ear on both sides of the face.

40814

40814 Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair



Explanation

The physician removes a lesion in the vestibule of the mouth with complex repair. The vestibule consists of the mucosal and submucosal tissue of the lips and cheeks within the oral cavity, not including the dentoalveolar structures. An incision is made around the lesion and through submucosal tissue, removing the lesion. Complex repair of the surgical wound left after excision of the lesion is required. This may include advancement of tissue flaps, rearrangement of tissue, or complex suturing techniques.

Coding Tips

If only a portion of the lesion is removed, report 40808 for biopsy of the vestibule of the mouth. An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. For the excision of a lesion of the vestibule of the mouth with simple repair, see 40812. For the excision of a lesion of the mucosa and submucosa, vestibule of mouth with excision of underlying muscle, see 40816. For excision of lesions from the lips and mucous membranes, see 11440–11446.

Documentation Tips

Documentation should include a copy of the pathology report. Examine the documentation to verify the type of repair required.

Reimbursement Tips

Some payers may require that this service be reported using the appropriate CDT code.

Associated HCPCS Codes

D7410	excision of benign lesion up to 1.25 cm
D7411	excision of benign lesion greater than 1.25 cm
D7412	excision of benign lesion, complicated
D7413	excision of malignant lesion up to 1.25 cm
D7414	excision of malignant lesion greater than 1.25 cm
D7415	excision of malignant lesion, complicated

ICD-10-CM Diagnostic Codes

C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C04.8	Malignant neoplasm of overlapping sites of floor of mouth
C06.1	Malignant neoplasm of vestibule of mouth
C06.89	Malignant neoplasm of overlapping sites of other parts of mouth
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D03.0	Melanoma in situ of lip

D10.0	Benign neoplasm of lip
D10.39	Benign neoplasm of other parts of mouth
D23.0	Other benign neoplasm of skin of lip
D37.01	Neoplasm of uncertain behavior of lip
D37.09	Neoplasm of uncertain behavior of other specified sites of the oral cavity
K09.8	Other cysts of oral region, not elsewhere classified
K12.1	Other forms of stomatitis
K12.2	Cellulitis and abscess of mouth
K12.39	Other oral mucositis (ulcerative)
K13.21	Leukoplakia of oral mucosa, including tongue
K13.22	Minimal keratinized residual ridge mucosa
K13.23	Excessive keratinized residual ridge mucosa
K13.24	Leukokeratosis nicotina palati
K13.29	Other disturbances of oral epithelium, including tongue
K13.4	Granuloma and granuloma-like lesions of oral mucosa
K13.5	Oral submucous fibrosis
K13.6	Irritative hyperplasia of oral mucosa
K13.79	Other lesions of oral mucosa

Please note that this list of associated ICD-10-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

AMA: 40814 2014, Jan, 11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
40814	3.52	6.98	0.38	10.88
Facility RVU	Work	PE	MP	Total
40814	3.52	4.51	0.38	8.41

	FUD	Status	MUE	Modifiers	IOM Reference
40814	90	A	4(3)	N/A 51 N/A N/A	None

* with documentation

Terms To Know

repair. Surgical closure of a wound. The wound may be a result of injury/trauma or it may be a surgically created defect. Repairs are divided into three categories: simple, intermediate, and complex.

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