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Coding Guide

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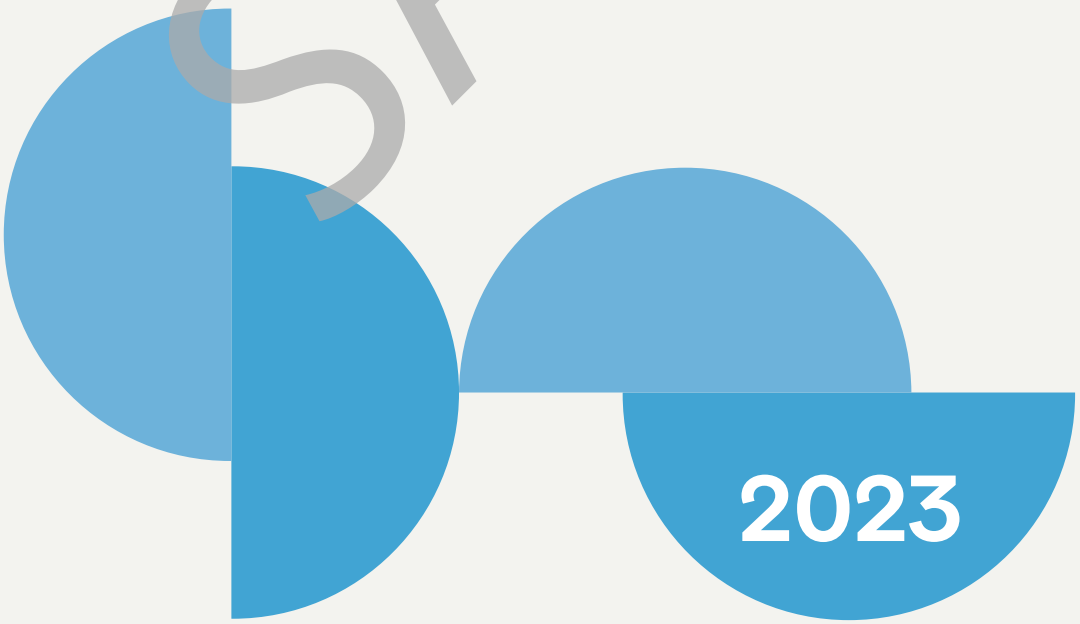
An essential coding, billing and reimbursement resource for oral and maxillofacial surgery



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Contents

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 CPT 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.

The CDT codes print in numeric order. We have included a table that lists the resequenced code and the preceding or following code to help locate the CDT code, when you are referencing the ADA's CDT book.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

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 Edits and Other Coding Updates

This *Coding Guide* includes the 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. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are now located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes), CDT, and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is https://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXXX**. Log in frequently to ensure you receive the most current updates.

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

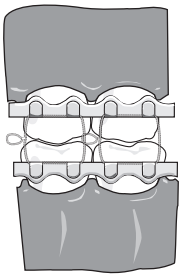
Telehealth/Telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) identify additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE) some services have been designated as temporarily appropriate for telehealth. These CMS-approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's home, 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.

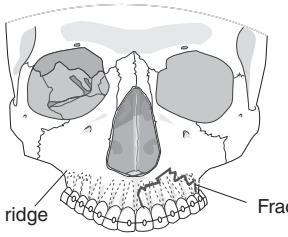
21440

21440 Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)



Erich arch-type of fixation

Affected teeth may be wired to two stable teeth on either side of fracture



Reduction, when required, is by closed manipulation

Explanation

The physician stabilizes and repairs a fracture of the mandibular or maxillary alveolar bone without making incisions. The physician moves the fractured bone into the desired position manually. The fracture is stabilized by wiring both the involved teeth and adjacent stable teeth to an arch bar. Another technique utilizes dental composite bonding of both involved and stable teeth to a heavy, stainless steel wire. A customized acrylic splint may be used to stabilize the teeth. Intermaxillary fixation may also be applied.

Coding Tips

This separate procedure is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures or services, it may be reported. If performed alone, list the code; if performed with other procedures or services, list the code and append modifier 59 or an X{EPSU} modifier. Local anesthesia is included in the service. For re-reduction of a fracture and/or dislocation performed by the primary physician, use modifier 76. For open treatment of a mandibular or maxillary alveolar ridge fracture, see 21445.

Documentation Tips

Documentation of traumatic fractures should include the type of fracture (i.e., open, closed, transverse, etc.), the specific anatomical site, displaced vs. nondisplaced, laterality when appropriate, routine vs. delayed healing, how the injury occurred, any sequela, and the type of treatment provided.

Reimbursement Tips

Some payers may require that this service be reported using the appropriate CDT code. When the result of an accident or injury while at work, the patient's medical insurance may not be the primary payer.

Associated HCPCS Codes

D7620 maxilla - closed reduction (teeth immobilized, if present)
D7640 mandible - closed reduction (teeth immobilized, if present)
D7670 alveolus - closed reduction, may include stabilization of teeth
D7720 maxilla - closed reduction
D7740 mandible - closed reduction
D7771 alveolus, closed reduction stabilization of teeth

ICD-10-CM Diagnostic Codes

S02.42XA Fracture of alveolus of maxilla, initial encounter for closed fracture
S02.671A Fracture of alveolus of right mandible, initial encounter for closed fracture ☑

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: **21440** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21440	3.44	16.17	0.34	19.95
Facility RVU	**Work**	**PE**	**MP**	**Total**
21440	3.44	12.23	0.34	16.01

	FUD	Status	MUE	Modifiers				IOM Reference
21440	90	A	2(3)	N/A	51	N/A	80*	None

* with documentation

Terms To Know

alveolar process. Bony part of the maxilla or mandible that supports the tooth roots and into which the teeth are implanted.

mandibular. Having to do with the lower jaw.

maxillary. Located between the eyes and the upper teeth.

1. CDT/CPT Codes and Descriptions

This edition of *Coding Guide for OMS* is updated with CDT and CPT codes for year 2023.

The following icons are used in the *Coding Guide*:

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- \+ This CPT code is an add-on code.
- ★ This CPT code is identified by CPT as appropriate for telemedicine services.
- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

2. Illustrations

The illustrations that accompany the *Coding Guide* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most CPT pages will have an illustration, there will be some pages that do not. The pages for the CDT procedures do not have illustrations.

3. Explanation

Every CDT or CPT code or series of similar codes is presented with its official CDT code description and nomenclature or CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Guide for OMS*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the physician is included and defined. *Coding Guide for OMS* describes the most common method of performing each procedure.

4. Coding Tips

Coding and reimbursement tips provide information on how the code should be used, provides related Illustrations, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CDT or CPT book.

5. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the medical record to support code assignment. Documentation should be complete and support the CDT, CPT, or ICD-10-CM codes reported.

6. Reimbursement Tips

Medicare and other payer guidelines that could affect the reimbursement of this service or procedure are included in the Reimbursement Tips section.

7. Associated CPT/HCPCS Codes

The 2022 edition of the *Coding Guide for OMS* contains a crosswalk from the driver Dental or CPT code to its corresponding CPT or Dental or other associated HCPCS code. CDT codes should be reported for the majority of dental services. On occasion, coverage of trauma, injury, or neoplasm may be covered by the healthcare insurer. This heading will not appear if there is no valid crosswalk.

8. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty.

Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side (the right side) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to a right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

9. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

10. Relative Value Units/Medicare Edits

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service

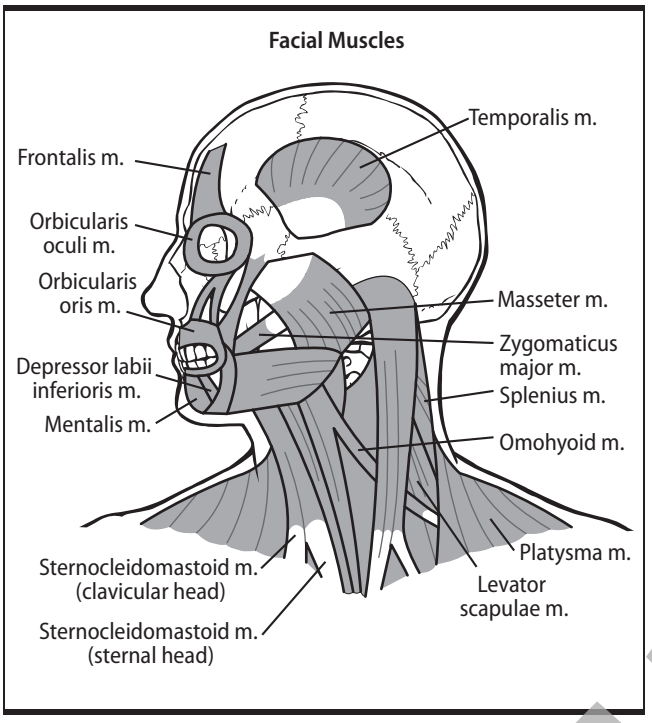
There are two groups of RVUs listed for each CPT code. The first RVU is for nonfacilities, which represents provider services performed in practitioner offices, patient's homes, or other nonhospital settings. The second RVU group is for facilities, which includes services provided by the practitioner in hospitals, ambulatory surgical centers, or skilled nursing facilities.

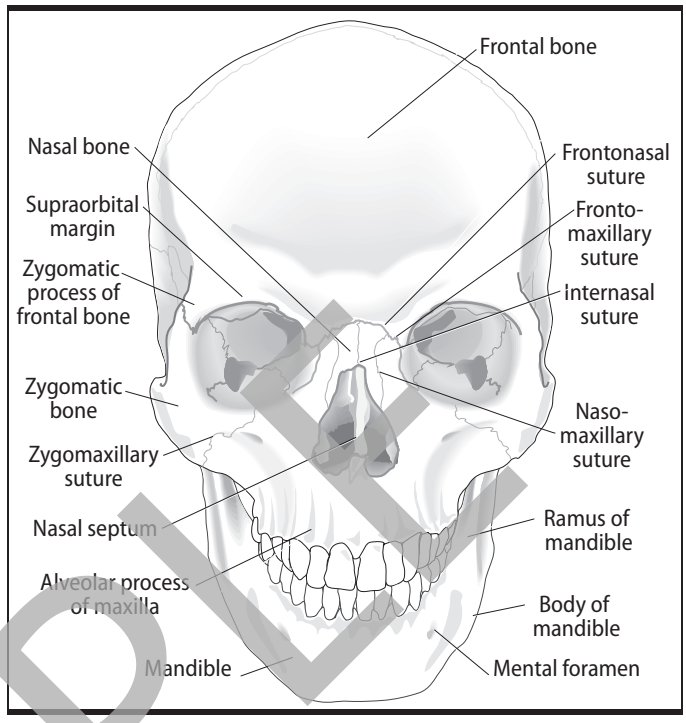
Medicare Follow-Up Days (FUD)

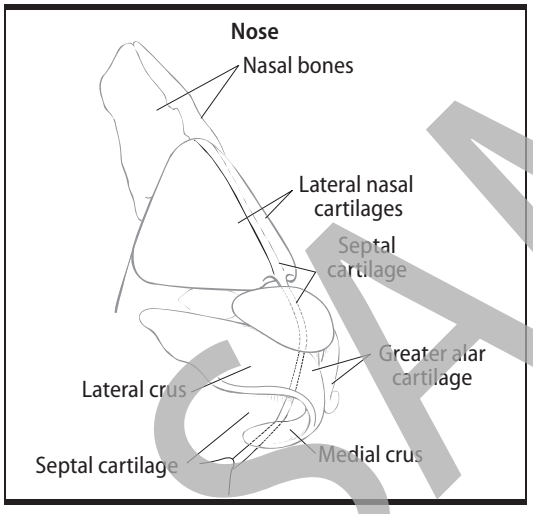
Information on the Medicare global period is provided here. The global period is the time following a surgery during which routine care by the physician is considered postoperative and included in the surgical fee. Office visits or other routine care related to the original surgery cannot be separately reported if they occur during the global period.

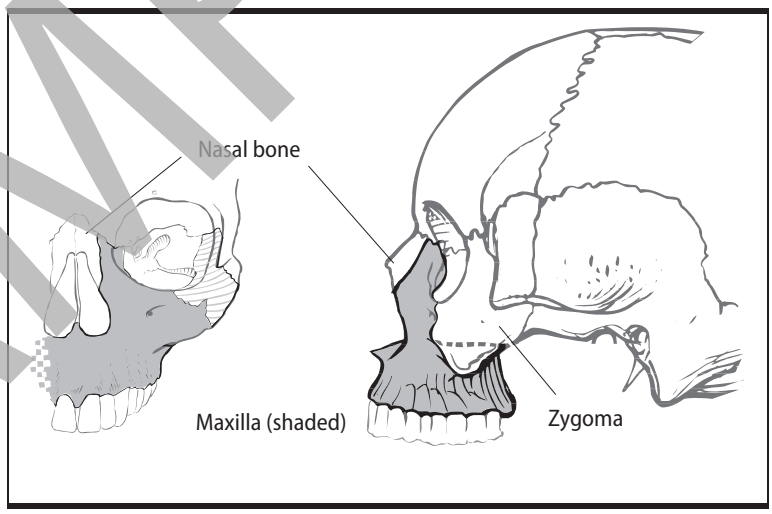
Illustrations

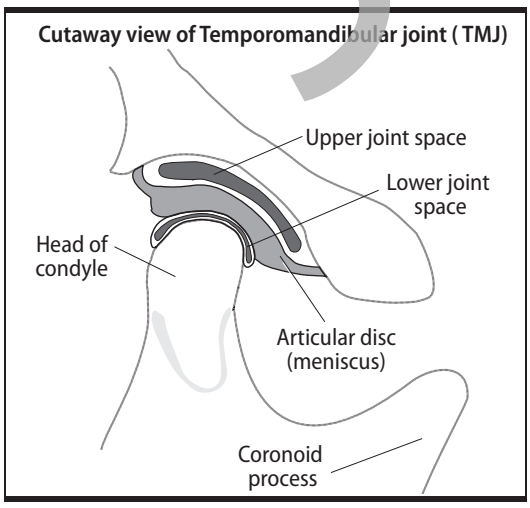
Facial Muscles and Bones

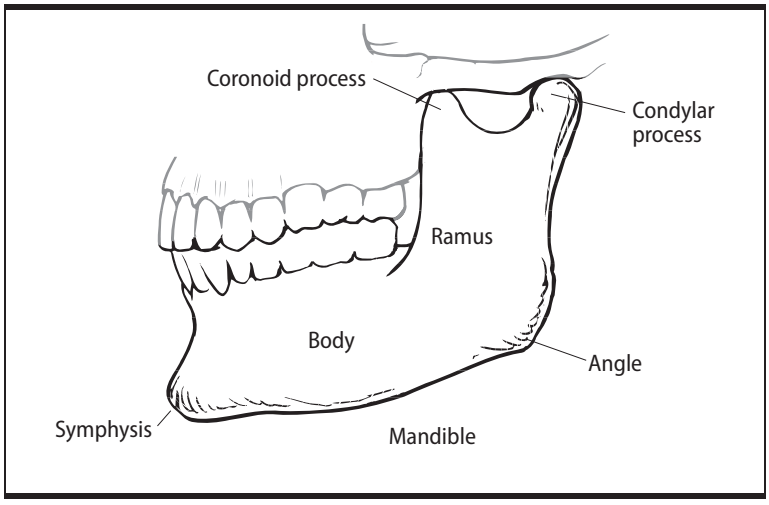












Procedure Codes

One of the keys to gaining accurate reimbursement lies in understanding the multiple coding systems that are used to identify services. To be well versed in reimbursement practices, coders should be familiar with the CDT, HCPCS Level II, ICD-10-CM, and CPT® coding systems. The first of these, the CDT system, is increasingly important to reimbursement, as it has been extended to a wider array of dental services.

Coding and billing should be based on the service and supplies provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.

Additionally documentation should:

- Be legible and signed with the appropriate name and credential of the provider.
- Reflect any treatment failure, change in diagnosis, and/or a change in treatment plan.
- Contain the initiation or reinstatement of a drug or treatment regime. It should also contain a record of the close and continuous skilled medical observation for such regime.

Reimbursement is dependent upon coverage and varies by payer and it is recommended that the provider check with the payer to determine coverage policies. Factors affecting reimbursement include the following:

- Third-party payers may not reimburse separately for specific services.
- When the result of an accident or injury while at work the patient's medical insurance may not be the primary payer but may instead be covered by worker's compensation coverage.
- Coverage for procedure varies by payer.

In some instances, prior to the payer processing the claim for coverage, it may be necessary that documentation such as tooth or periodontal charting or x-rays be provided.

Refer to Medicare coverage reference to determine whether the care provided is a covered service. The references are noted, when they apply, on the pages following.

HCPCS Level I or CPT Codes

Known as HCPCS Level I, the CPT coding system is the most commonly used system to report procedures and services. Copyright of CPT codes and descriptions is held by the American Medical Association (AMA). This system reports outpatient and provider services.

CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. Dental professionals may find that a third-party payer will occasionally require that a procedure be reported using a CPT code. Unless otherwise instructed, dental professionals should report services using the appropriate American Dental Association (ADA) dental code when one exists.

CPT Category II codes are supplemental tracking codes that are primarily used when participating in the Quality Payment Program (QPP) established by Medicare and are intended to aid in the collection of data about quality of care. Category II codes are alphanumeric, consisting of four digits followed by the letter F and should never be used in lieu of a Category I CPT code. A complete list of the Category II codes can be found at the AMA website at http://www.ama-assn.org/go/cpt. More information regarding QPP can be found on the CMS website at https://qpp.cms.gov/.

Category III of the CPT coding system contains temporary tracking codes for new and emerging technologies that are meant to aid in the collection of data on these new services and procedures as well as facilitate the payment process. However, it should be noted that few payers reimburse for emerging technology procedures and services. CPT Category III codes consist of four numeric digits followed by the letter T. Like Category II codes, Category III codes are released twice a year (January 1 and July 1) and can be found on the AMA CPT website at https://www.ama-assn.org/practice-management/cpt/category-iii-codes. RVUs are not assigned for Category III codes and payment is made at the discretion of the payer. A service described by a CPT Category III code may eventually become a Category I code, as the efficacy and safety of the service are documented.

HCPCS Level II Codes

The following is a list of the HCPCS Level II supply codes used to identify supplies commonly used by dentists.

Medical and Surgical Supplies

The A and E code sections of the HCPCS Level II code system cover a wide variety of medical and surgical supplies, and some durable medical equipment (DME), supplies and accessories.

A4649 **Surgical supply; miscellaneous**
A4550 **Surgical trays**
E1700 **Jaw motion rehabilitation system**
E1701 **Replacement cushions for jaw motion rehabilitation system, package of six**
E1702 **Replacement measuring scales for jaw motion rehabilitation system, package of 200**

Drugs Administered Other Than Oral Method J0000–J8999

Drugs and biologicals are usually covered by Medicare if they:

- Cannot be self-administered
- Are not excluded immunizations
- Are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered
- Have not been determined by the Food and Drug Administration (FDA) to be less than effective

Generally, prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

The following list of drugs can be injected either subcutaneously, intramuscularly, or intravenously. Third-party payers may wish to determine a threshold and pay up to a certain dollar limit for the drug. Note that for Medicare purposes, special coverage instructions apply to these services—*see* Pub. 100-2, chap. 15, sec. 50.4.

J1790 **Injection, droperidol, up to 5 mg**
J2250 **Injection, midazolam HCl, per 1 mg**
J2400 **Injection, chloroprocaine HCl, per 30 ml**
J2515 **Injection, pentobarbital sodium, per 50 mg**
J2550 **Injection, promethazine HCl, up to 50 mg**
J3010 **Injection, fentanyl citrate, 0.1 mg**
J3360 **Injection, diazepam, up to 5 mg**

Temporary National Codes (Non-Medicare) (S0000–S9999)

S0020 **Injection, bupivicaine HCl, 30 ml**

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

D0120

▲ **D0120** periodic oral evaluation - established patient

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately.

Explanation

The periodic oral evaluation is done to determine the patient's dental health status since the previous check-up. It includes screening for periodontal disease and/or oral cancer and possibly the interpretation of information acquired through additional, separately reportable diagnostic oral health tests.

Coding Tips

When the patient is referred by another health care provider for an opinion or advice regarding a particular condition, see code D9310. When a comprehensive oral examination is performed, see code D0150. When a problem-focused limited oral evaluation is performed, see codes D0140-D0145. A detailed, problem focused, oral evaluation is reported using code D0160. A limited, problem-focused re-examination is reported using code D0170. A comprehensive periodontal evaluation, new or established patient is reported using code D0180. Code D0180 should not be reported in addition to this code as the components of D0120 are included in the comprehensive periodic evaluation. According to the ADA, codes D0120 and D4355 may be reported on the same date of service; however, it should be noted that some third-party payer policies prohibit billing these procedures concurrently. If the service provided is medical and not dental in nature, see the appropriate CPT evaluation and management codes. The ADA has not adopted a formal definition of an established patient. Check with third-party payers to determine if a standard definition applies. Any radiograph, prophylaxis, fluoride, restorative, or extraction service is reported separately. When an oral health assessment is performed by someone other than the provider (e.g., a licensed dental hygienist), some third-party payers may require that modifier DA Oral health assessment by a licensed health professional other than a dentist, be appended to this code. Check with the third-party payer for specific requirements.

Documentation Tips

The following information can be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process, and the type of service performed on intraoral structures other than teeth.

Reimbursement Tips

This procedure is a Medicare-covered service when the purpose is to identify a patient's existing infections prior to kidney transplantation or heart valve replacement.

Associated CPT Codes

See the Evaluation and Management Section.

ICD-10-CM Diagnostic Codes

K01.0	Embedded teeth
K01.1	Impacted teeth
K02.3	Arrested dental caries
K02.51	Dental caries on pit and fissure surface limited to enamel
K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K03.0	Excessive attrition of teeth
K03.2	Erosion of teeth
K03.6	Deposits [accretions] on teeth
K03.81	Cracked tooth
K04.01	Reversible pulpitis
K04.02	Irreversible pulpitis
K04.1	Necrosis of pulp
K04.2	Pulp degeneration
K04.5	Chronic apical periodontitis
K04.6	Periapical abscess with sinus
K04.7	Periapical abscess without sinus
K04.8	Radicular cyst
K05.00	Acute gingivitis, plaque induced
K05.01	Acute gingivitis, non-plaque induced
K05.10	Chronic gingivitis, plaque induced
K05.11	Chronic gingivitis, non-plaque induced
K05.211	Aggressive periodontitis, localized, slight
K05.212	Aggressive periodontitis, localized, moderate
K05.213	Aggressive periodontitis, localized, severe
K05.221	Aggressive periodontitis, generalized, slight
K05.222	Aggressive periodontitis, generalized, moderate
K05.223	Aggressive periodontitis, generalized, severe
K05.311	Chronic periodontitis, localized, slight
K05.312	Chronic periodontitis, localized, moderate
K05.313	Chronic periodontitis, localized, severe
K05.321	Chronic periodontitis, generalized, slight
K05.322	Chronic periodontitis, generalized, moderate
K05.323	Chronic periodontitis, generalized, severe
K05.4	Periodontosis
K06.011	Localized gingival recession, minimal
K06.012	Localized gingival recession, moderate
K06.013	Localized gingival recession, severe
K06.021	Generalized gingival recession, minimal
K06.022	Generalized gingival recession, moderate
K06.023	Generalized gingival recession, severe
K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K08.0	Exfoliation of teeth due to systemic causes
K08.121	Complete loss of teeth due to periodontal diseases, class I
K08.122	Complete loss of teeth due to periodontal diseases, class II
K08.123	Complete loss of teeth due to periodontal diseases, class III
K08.124	Complete loss of teeth due to periodontal diseases, class IV
K08.131	Complete loss of teeth due to caries, class I
K08.132	Complete loss of teeth due to caries, class II
K08.133	Complete loss of teeth due to caries, class III
K08.134	Complete loss of teeth due to caries, class IV
K08.421	Partial loss of teeth due to periodontal diseases, class I
K08.422	Partial loss of teeth due to periodontal diseases, class II

D4240-D4241

D4240 gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant

A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes

D4241 gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant

A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4241 and should be reported separately using their own unique codes.

Explanation

A gingival flap procedure is done to alter the contours of the gums and carry out root planing or scaling of the root surface. The flap is designed and a scalloped incision is made parallel to the long axis of the teeth and extended interproximally to separate the underlying pocket of epithelium from the flap to be raised, and distally enough to raise the flap like an envelope, without cutting definitive sides squared at the ends. A second intracrevicular incision is made to release the collar of pocket epithelium and expose the alveolar bone a few millimeters. The superficial collar of tissue is removed. The root surface is thoroughly scaled and planed, the flaps are returned to position, all exposed bone is covered, and the flap is sutured in place. Periodontal packing is placed. Report D4240 for a gingival flap procedure with root planing performed in each quadrant on four or more contiguous teeth or bounded teeth spaces and D4241 for one to three teeth per quadrant.

Coding Tips

Use these codes to report gingival curettage. Local anesthesia is included in these services. Any evaluation or radiograph is reported separately. Pathology exam of tissue with interpretation is reported separately. Usual postoperative care is included in these services. These codes include postoperative care.

Documentation Tips

Third-party payers may require periodontal charting. Periodontal charting should include the identification of the quadrants and sites involved, a minimum of three pocket measurements per tooth involved, indication of recession, furcation involvement, mobility and mucogingival defects, and identification of missing teeth.

Reimbursement Tips

Many payers will not separately reimburse the following services when performed by the same provider, on the same date of service, and at the same surgical site: biopsy (D7285–D7286), frenulectomy (D7960), and/or excision of hard and soft tissue lesions (D7410–D7411, D7450–D7451). When one or more of the above services are provided on a different date of service, a narrative indicating the medical necessity of separating the services should be provided; otherwise, payers may deny those services.

Associated CPT Codes

41870 Periodontal mucosal grafting

ICD-10-CM Diagnostic Codes

K05.00 Acute gingivitis, plaque induced
K05.01 Acute gingivitis, non-plaque induced
K05.10 Chronic gingivitis, plaque induced
K05.11 Chronic gingivitis, non-plaque induced
K06.011 Localized gingival recession, minimal
K06.012 Localized gingival recession, moderate
K06.013 Localized gingival recession, severe
K06.021 Generalized gingival recession, minimal
K06.022 Generalized gingival recession, moderate
K06.023 Generalized gingival recession, severe
K06.1 Gingival enlargement
K06.2 Gingival and edentulous alveolar ridge lesions associated with trauma
K06.8 Other specified disorders of gingiva and edentulous alveolar ridge

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
D4240	0.0	0.0	0.0	0.0
D4241	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D4240	0.0	0.0	0.0	0.0
D4241	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D4240	N/A	N	-	N/A	N/A	N/A	N/A	None
D4241	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

gingivectomy. Surgical excision or trimming of overgrown gum tissue back to normal contours using a scalpel, electrocautery, or a laser.

gingivitis. Inflamed gingiva (oral mucosa) that surrounds the teeth.

gingivoplasty. Repair or reconstruction of the gum tissue, altering the gingival contours by excising areas of gum tissue or making incisions through the gingiva to create a gingival flap.

D7961-D7962

D7961 buccal/labial frenectomy (frenulectomy)
D7962 lingual frenectomy (frenulectomy)

Explanation

The surgeon removes the labial, buccal, or lingual frenum (frenectomy). The buccal frenum is a band of mucosal membrane that connects the alveolar (dental) ridge to the cheek and separates the lip vestibule from the cheek vestibule. The labial frenum is a connecting fold of mucous membrane that joins the lip to the gums at the inside mid center. The lingual frenum is a connecting fold of mucous membrane that joins the tongue to the floor of the mouth on the mid center of the tongue underside. Incisions are made around the frenum and through the mucosa and submucosa. The underlying muscle may be removed as well. The excision may extend to the interincisal papilla for the buccal and labial frenum. The mucosa is closed simply, or the dental surgeon may rearrange the tissue in z-plasty technique. Report D7961 for buccal or labial frenectomy and D7962 for lingual frenectomy.

Coding Tips

Local anesthesia is generally considered part of these services. These procedures are not usually separately reimbursed when done at the time of a more complex procedure. Check the guidelines for the more complex procedure or consult third-party payers for specific guidelines.

Reimbursement Tips

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

40806	Incision of labial frenum (frenotomy)
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
41010	Incision of lingual frenum (frenotomy)
41115	Excision of lingual frenum (frenectomy)

ICD-10-CM Diagnostic Codes

K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K06.8	Other specified disorders of gingiva and edentulous alveolar ridge
K14.0	Glossitis
K14.6	Glossodynia
Q38.1	Ankyloglossia
Q38.3	Other congenital malformations of tongue
Q38.6	Other congenital malformations of mouth

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
D7961	0.0	0.0	0.0	0.0
D7962	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D7961	0.0	0.0	0.0	0.0
D7962	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D7961	N/A	N	-	N/A	N/A	N/A	N/A	None
D7962	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

buccal frenum. Band of mucosal membrane that connects the alveolar (dental) ridge to the cheek, separating the lip vestibule from the cheek vestibule.

frenulectomy. Excision of the labial, buccal, or lingual frenum.

frenulum linguae. Tongue.

labial frenum. Connecting fold of mucous membrane that joins the upper or lower lip to the gums at the inside midcenter.

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 current CPT 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 and using the appropriate place of service. 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.

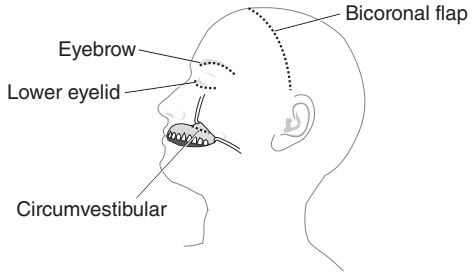
ICD-10-CM Diagnostic Codes

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.

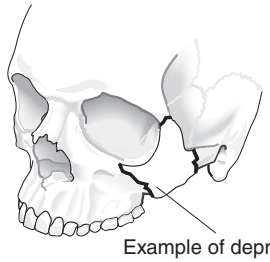
AMA: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13;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

21188

21188 Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)



Typical transcutaneous and transoral incisions



Example of depressed zygoma

Explanation

The physician reconstructs the midface to correct developmental or traumatic skeletal deformities. Reconstruction includes both osteotomies and bone grafts. The physician may use a variety of incisions, including a bicoronal scalp flap, eyelid, and transoral incisions. Through the incisions, the physician performs osteotomies as necessary of the midface with saws, burs, or osteotomes. The osteotomies performed here do not follow the standard LeFort surgical fracture lines. The midfacial bones are down-fractured from the stable cranial base. The midface is placed with precise measurement into a new position. Bone grafts are harvested from the patient's hip, rib, or skull and the surgically created wound is closed. The interpositional bone grafts are placed between the bony interfaces of the repositioned maxilla and midface. Internal fixation devices such as wires, plates, and screws are used to hold the reduction securely in place. The transoral incisions are closed in a single layer. Eyelid and scalp incisions are closed in layers. Intermaxillary fixation may be applied.

Coding Tips

The amount of midfacial bone to be removed or reconstructed is determined prior to surgery based on preoperative radiographs and a clinical examination. The surgical portion of the procedure includes surgical exposure, debridement, bone cuts, separation of midface, repositioning, fixation, wound closure, and normal postoperative follow-up care. This procedure includes obtaining autografts. Report radiology services separately. For harvest of bone by another physician, append modifier 52. For LeFort type operations, see 21141–21160. For cranioplasty, see 21179 and 21180.

Associated HCPCS Codes

D7955 repair of maxillofacial soft and/or hard tissue defect

ICD-10-CM Diagnostic Codes

C03.0 Malignant neoplasm of upper gum
C41.0 Malignant neoplasm of bones of skull and face
C79.51 Secondary malignant neoplasm of bone
D48.0 Neoplasm of uncertain behavior of bone and articular cartilage
M26.01 Maxillary hyperplasia
M26.02 Maxillary hypoplasia
M26.11 Maxillary asymmetry
M26.12 Other jaw asymmetry
M26.19 Other specified anomalies of jaw-cranial base relationship
M26.29 Other anomalies of dental arch relationship
M26.89 Other dentofacial anomalies
Q67.0 Congenital facial asymmetry
Q67.1 Congenital compression facies
Q75.4 Mandibulofacial dysostosis
Q75.5 Oculomandibular dysostosis
Q87.0 Congenital malformation syndromes predominantly affecting facial appearance
S02.2XXA Fracture of nasal bones, initial encounter for closed fracture
S02.2XXB Fracture of nasal bones, initial encounter for open fracture
S02.411A LeFort I fracture, initial encounter for closed fracture
S02.411B LeFort I fracture, initial encounter for open fracture
S02.412A LeFort II fracture, initial encounter for closed fracture
S02.412B LeFort II fracture, initial encounter for open fracture
S02.413A LeFort III fracture, initial encounter for closed fracture
S02.413B LeFort III fracture, initial encounter for open fracture
S02.42XA Fracture of alveolus of maxilla, initial encounter for closed fracture
S02.42XB Fracture of alveolus of maxilla, initial encounter for open fracture

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: **21188** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21188	23.15	21.87	2.15	47.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
21188	23.15	21.87	2.15	47.17

	FUD	Status	MUE	Modifiers				IOM Reference
21188	90	A	1(2)	N/A	51	N/A	80	100-02,16,10; 100-02,16,120; 100-02,16,180

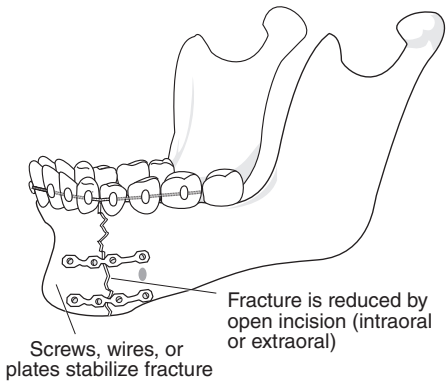
* with documentation

Terms To Know

osteotomy. Surgical cutting of a bone.

21461-21462

21461 Open treatment of mandibular fracture; without interdental fixation
21462 with interdental fixation



Explanation

The physician repositions and stabilizes a mandibular fracture. Incisions are made in the skin overlying the fractured area or intraorally through the mucosa. The tissue is dissected to the bone and the fracture exposed. The fracture is repositioned and the bones stabilized with plates, screws, or wires. The incisions are closed with sutures. Intermaxillary fixation is not applied in 21461. In 21462, intermaxillary or interdental fixation is applied. Arch bars are placed onto the patient's upper and lower dental arches with individual wire ligatures around the teeth and the jaws are wired together.

Coding Tips

When 21461 or 21462 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. For re-reduction of a fracture and/or dislocation performed by the primary physician, use modifier 76. For open treatment of a complicated mandibular fracture by multiple surgical approaches, including internal fixation, interdental fixation, and/or wiring of dentures or splints, see 21470.

Documentation Tips

Documentation of traumatic fractures should include the type of fracture (i.e., open, closed, transverse, etc.), the specific anatomical site, displaced vs. nondisplaced, laterality when appropriate, routine vs. delayed healing, how the injury occurred, any sequela, and the type of treatment provided.

Associated HCPCS Codes

D7630 mandible - open reduction (teeth immobilized, if present)
D7730 mandible - open reduction

ICD-10-CM Diagnostic Codes

S02.611A Fracture of condylar process of right mandible, initial encounter for closed fracture ☑
S02.611B Fracture of condylar process of right mandible, initial encounter for open fracture ☑
S02.621A Fracture of subcondylar process of right mandible, initial encounter for closed fracture ☑
S02.621B Fracture of subcondylar process of right mandible, initial encounter for open fracture ☑
S02.631A Fracture of coronoid process of right mandible, initial encounter for closed fracture ☑
S02.631B Fracture of coronoid process of right mandible, initial encounter for open fracture ☑
S02.641A Fracture of ramus of right mandible, initial encounter for closed fracture ☑
S02.641B Fracture of ramus of right mandible, initial encounter for open fracture ☑
S02.651A Fracture of angle of right mandible, initial encounter for closed fracture ☑
S02.651B Fracture of angle of right mandible, initial encounter for open fracture ☑
S02.66XA Fracture of symphysis of mandible, initial encounter for closed fracture
S02.66XB Fracture of symphysis of mandible, initial encounter for open fracture
S02.671A Fracture of alveolus of right mandible, initial encounter for closed fracture ☑
S02.671B Fracture of alveolus of right mandible, initial encounter for open fracture ☑
S02.69XA Fracture of mandible of other specified site, initial encounter for closed fracture
S02.69XB Fracture of mandible of other specified site, initial encounter for open fracture

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: **21461** 2018,Sep,7 **21462** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21461	9.31	47.83	1.2	58.34
21462	11.01	51.39	1.34	63.74
Facility RVU	**Work**	**PE**	**MP**	**Total**
21461	9.31	20.64	1.2	31.15
21462	11.01	22.46	1.34	34.81

	FUD	Status	MUE	Modifiers				IOM Reference
21461	90	A	1(2)	N/A	51	62*	N/A	None
21462	90	A	1(2)	N/A	51	62*	80	

* with documentation