Optum

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Partner Program

Coding Guide

OMS

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

2024

optumcoding.com

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 Optum *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

The most current ICD-10-CM codes are provided, each listed with their full official description. 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.

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, followed by an easy-to-understand explanation.

CCI Edits, RVUs, 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 28.3, 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 website address is https://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXXX**. 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

or **Mandible**
Osteotomy, 21198-21199

or **Osteotomy**
Mandible, 21198-21199

Telehealth/Telemedicine Services

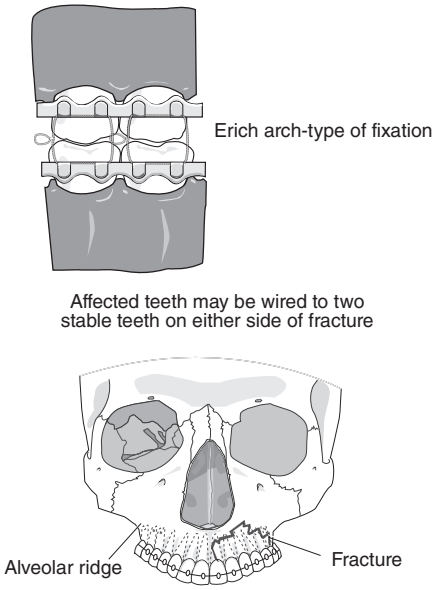
Telehealth/Telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) identify additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE) some services have been designated as temporarily 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 93 or 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

The following pages provide a sample page from the book displaying the format of *Coding Guide* with each element identified and explained.

21440

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



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** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21440	3.44	16.94	0.39	20.77
Facility RVU	**Work**	**PE**	**MP**	**Total**
21440	3.44	12.83	0.39	16.66

	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 audio-visual 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.

Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

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 Optum 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 2023 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

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

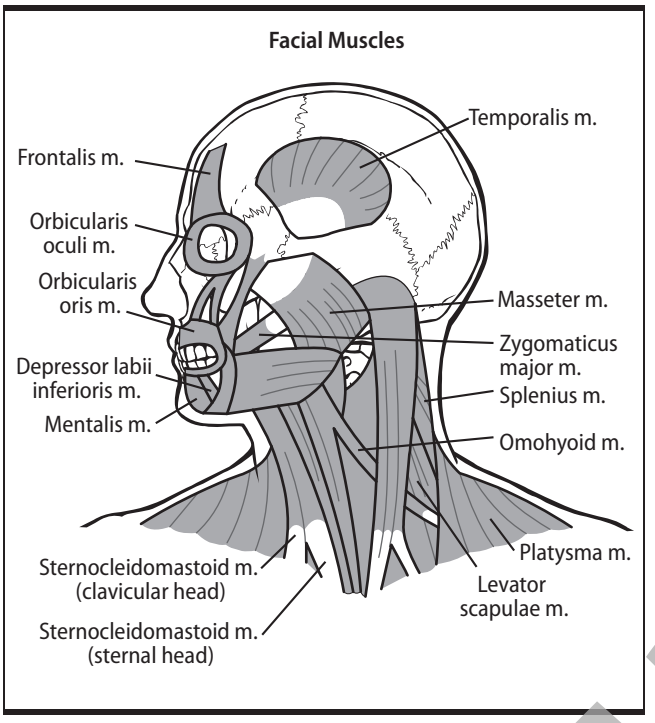
Relative Value Units

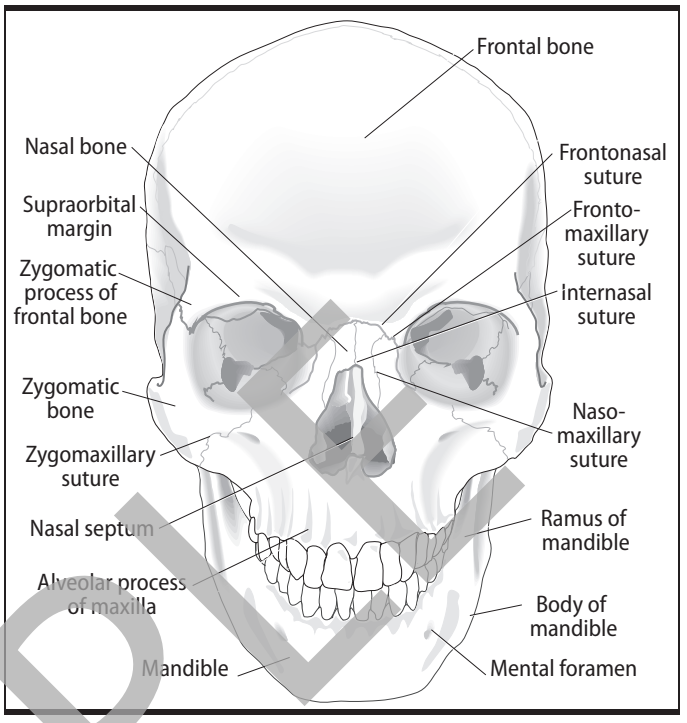
In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the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

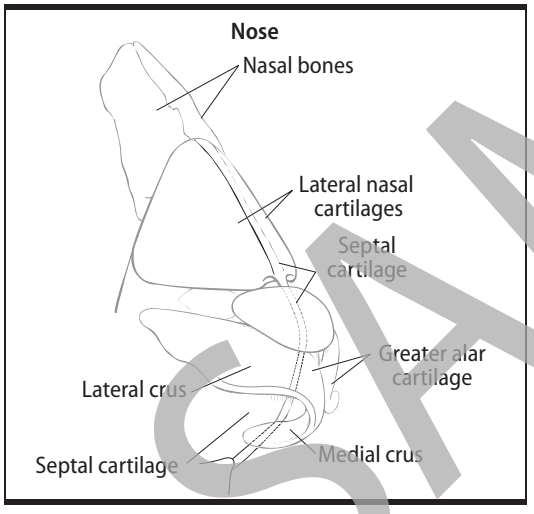
- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service

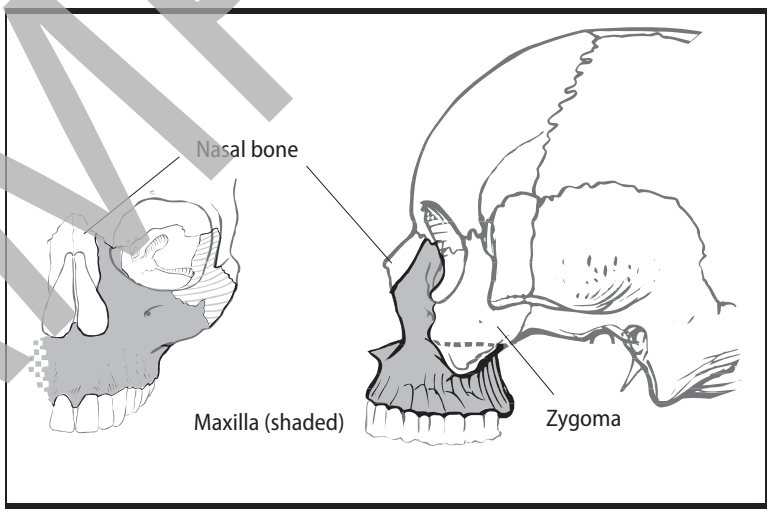
Illustrations

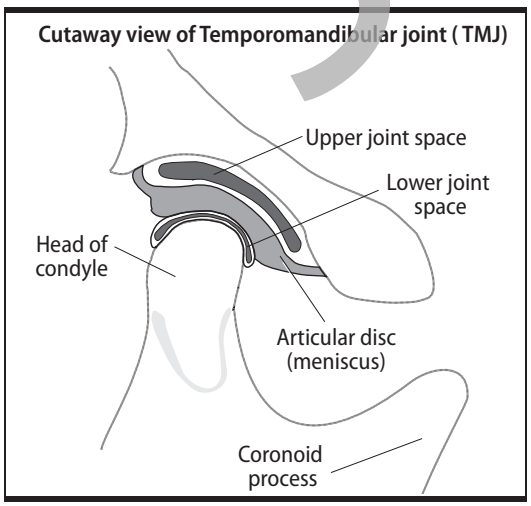
Facial Muscles and Bones

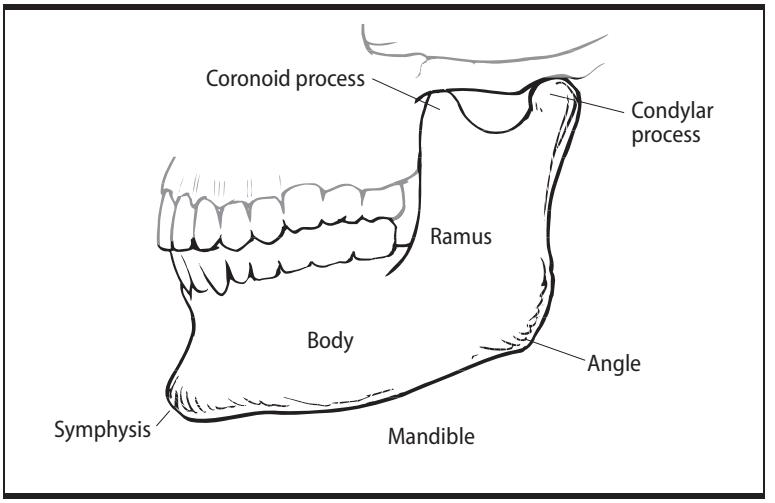












Procedure Codes

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 www.ama-assn.org/practice-management/cpt/category-ii-codes.

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 usually 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**

D0150

D0150 comprehensive oral evaluation - new or established patient

Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This includes an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

Explanation

The comprehensive oral evaluation on a new or established patient who has had a significant change in health or has not been seen for active treatment in three or more years including a thorough intra- and extra-oral examination of all hard and soft tissues with evaluation and recording of findings. A comprehensive oral evaluation includes the patient's dental and medical history, typically recording things such as anomalies, caries, missing or unerupted teeth, restorations, occlusal relationships, existing prostheses, evaluation for oral cancer, and periodontal evaluation.

Coding Tips

This service may require interpretation of information acquired by other diagnostic procedures that should be reported separately. To report a periodic evaluation, see D0120. A detailed and extensive, problem focused oral evaluation is reported using D0160. When the patient is referred by another provider for an opinion and/or advice regarding a particular condition, see D9310. If the service provided is medical, and not dental in nature, see the appropriate CPT evaluation and management codes. This code does not distinguish between an established or new patient. Any radiograph, prophylaxis, fluoride, restorative, or extraction service is reported separately. This procedure is a Medicare-covered service when the purpose is to identify a patient's existing infections prior to kidney transplantation.

Documentation Tips

Documentation supporting an evaluation must indicate if the evaluation was complete, periodic, or limited. Any diagnostic studies performed elsewhere but reviewed should be recorded in the documentation. If the patient is established, the time interval between encounters should be recorded as well. Treatment plan documentation should reflect any treatment failure, change in diagnosis, and/or a change in treatment plan. There should also be evidence of any initiation or reinstatement of a drug regime, which requires close and continuous skilled medical observation. Providers should include sufficient documentation in the medical record to accurately describe and verify the services rendered. Additionally, records should be legible and signed with the appropriate name and title of the provider of the service. The following information should 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.

Associated CPT Codes

See the Evaluation and Management Section.

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
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
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
K08.3	Retained dental root
K08.421	Partial loss of teeth due to periodontal diseases, class I
K08.422	Partial loss of teeth due to periodontal diseases, class II
K08.423	Partial loss of teeth due to periodontal diseases, class III
K08.424	Partial loss of teeth due to periodontal diseases, class IV
K08.431	Partial loss of teeth due to caries, class I
K08.432	Partial loss of teeth due to caries, class II
K08.433	Partial loss of teeth due to caries, class III
K08.434	Partial loss of teeth due to caries, class IV

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
D0150	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0150	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D0150	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

D4210-D4211

D4210 gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant

It is performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

D4211 gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant

It is performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

Explanation

The provider performs a gingivectomy or gingivoplasty to reshape damaged gingivae or excise excess tissue into a better contour for restorative treatment and/or a more esthetic look. Pockets of gingiva are marked for the line of incision, which is then made with the blade angled to the long axis of the tooth. Supragingival pockets are thereby excised and recontouring of the gums is accomplished using the beveled incision. The strip of remaining gingiva is released, the root surfaces are curetted, and the area is packed and left to heal by granulation. Report code D4210 for a gingivectomy or gingivoplasty performed in each quadrant on four or more contiguous teeth or bounded teeth spaces. Report code D4211 for one to three teeth per quadrant.

Coding Tips

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. These codes include frenulectomy. This procedure may be covered by medical insurances. When covered by medical insurance the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Documentation Tips

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

41820 Gingivectomy, excision gingiva, each quadrant
41872 Gingivoplasty, each quadrant (specify)

ICD-10-CM Diagnostic Codes

K06.010 Localized gingival recession, unspecified
K06.011 Localized gingival recession, minimal
K06.012 Localized gingival recession, moderate
K06.013 Localized gingival recession, severe
K06.020 Generalized gingival recession, unspecified
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
D4210	0.0	0.0	0.0	0.0
D4211	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D4210	0.0	0.0	0.0	0.0
D4211	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D4210	N/A	N	-	N/A	N/A	N/A	N/A	None
D4211	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

edentulous. Loss of all or some of the natural teeth.

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.

D7951

D7951 sinus augmentation with bone or bone substitutes via a lateral open approach

The augmentation of the sinus cavity to increase alveolar height for reconstruction of edentulous portions of the maxilla. This procedure is performed via a lateral open approach. This includes obtaining the bone or bone substitutes. Placement of a barrier membrane if used should be reported separately.

Explanation

This procedure is performed to increase the alveolar height when reconstructing portions of the maxilla usually to support dental implants. There are several ways in which the procedure may be performed. Regardless of the method used the provider makes an incision into the gum exposing the lateral boney wall of the sinus. A window is cut into the thin membrane that covers the sinus and bone graft material is placed into the space. Bone substitutes may also be used. During a less invasive technique, the sinus membranes are lifted by gentle tapping of the sinus floor with the use of osteotomes. The amount of augmentation achieved with the osteotome technique is usually less than what can be achieved with the lateral window. The goal of this procedure is to stimulate bone growth and form a thicker sinus floor, in order to support dental implants.

Coding Tips

This code includes obtaining bone or placement of bone substitute. When the physician places a barrier membrane, report code D4266 or D4267 in addition to this code. To report crestal sinus lift, crestal window maxillary sinus augmentation, or crestal sinus augmentation, see D7952. When reporting CPT code 21210 without graft harvesting or using a nonautogenous graft, append modifier 52 for reduced services.

Documentation Tips

This procedure may also be documented as a "sinus lift."

Reimbursement Tips

This service may be covered by the patient's medical insurance. When covered by the patient's medical insurance, report the appropriate CPT code on the CMS-1500 claim form.

Associated CPT Codes

21210 Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)

ICD-10-CM Diagnostic Codes

K08.0 Exfoliation of teeth due to systemic causes
K08.111 Complete loss of teeth due to trauma, class I
K08.112 Complete loss of teeth due to trauma, class II
K08.113 Complete loss of teeth due to trauma, class III
K08.114 Complete loss of teeth due to trauma, class IV
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
K08.191 Complete loss of teeth due to other specified cause, class I
K08.192 Complete loss of teeth due to other specified cause, class II
K08.193 Complete loss of teeth due to other specified cause, class III
K08.194 Complete loss of teeth due to other specified cause, class IV
K08.411 Partial loss of teeth due to trauma, class I
K08.412 Partial loss of teeth due to trauma, class II
K08.413 Partial loss of teeth due to trauma, class III
K08.414 Partial loss of teeth due to trauma, 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
K08.423 Partial loss of teeth due to periodontal diseases, class III
K08.424 Partial loss of teeth due to periodontal diseases, class IV
K08.431 Partial loss of teeth due to caries, class I
K08.432 Partial loss of teeth due to caries, class II
K08.433 Partial loss of teeth due to caries, class III
K08.434 Partial loss of teeth due to caries, class IV
K08.491 Partial loss of teeth due to other specified cause, class I
K08.492 Partial loss of teeth due to other specified cause, class II
K08.493 Partial loss of teeth due to other specified cause, class III
K08.494 Partial loss of teeth due to other specified cause, class IV
M26.01 Maxillary hyperplasia
M26.02 Maxillary hypoplasia

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
D7951	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D7951	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D7951	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

augmentation. Add to or increase the substance of a body site, usually performed as plastic reconstructive measures. Augmentation may involve the use of an implant or prosthesis, especially within soft tissue or grafting procedures, such as bone tissue.

implant. Material or device inserted or placed within the body for therapeutic, reconstructive, or diagnostic purposes.

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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 codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶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 evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

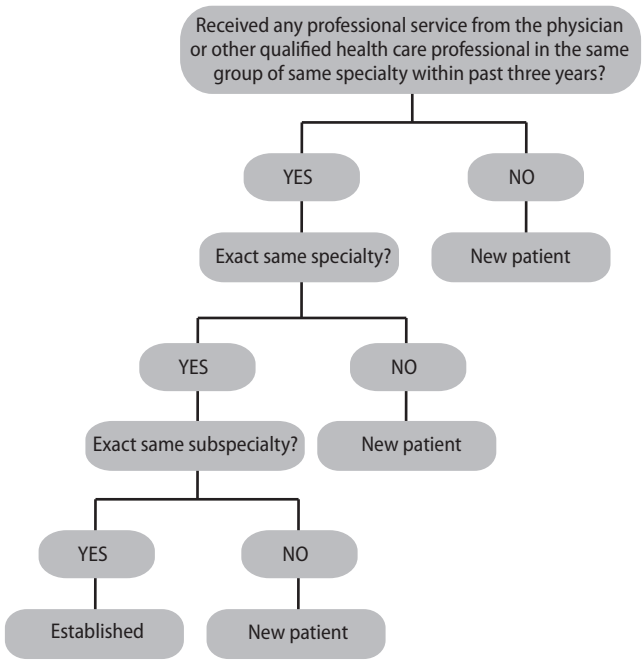
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other 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 subspecialty** 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 for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



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▶ ◀ = Contains new or revised text

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 and 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 not considered 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 patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines.

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, 22 designating an outpatient setting, or 23 indicating service provided in an emergency department. 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.

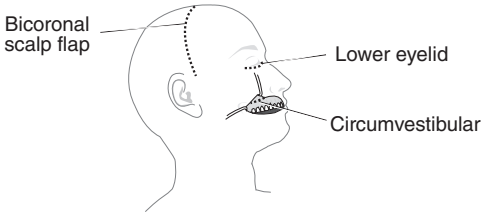
ICD-10-CM Diagnostic Codes

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.

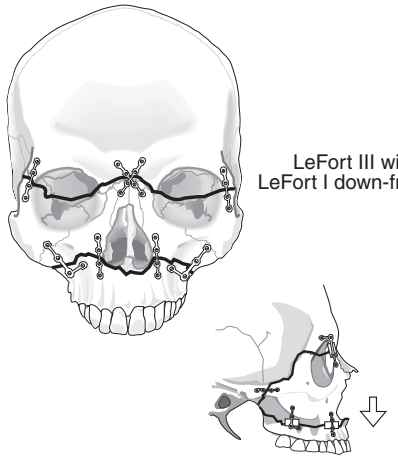
AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

21155

21155 Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I



Typical transcutaneous and transoral incisions



Explanation

The physician reconstructs both the midface and the maxilla to correct developmental or acquired skeletal deformities. The physician uses a variety of incisions, including a bicoronal scalp flap, lower eyelid, and transoral incisions. Complete separation of the midface (LeFort III) from the cranial base is necessary. Additionally, horizontal down-fracture of the maxilla is necessary to correct alignment of the teeth. Surgical fractures are made through the zygomas, orbits, and bones of the nasofrontal region with saws, burrs, or osteotomes. The physician also makes a horizontal osteotomy, separating the maxilla from the midface. The midface is down-fractured from the stable cranial base and the maxilla is down-fractured from the midface segment. Both the midface and the maxilla are placed into new positions and reduced with wires, plates, and/or screws. The physician harvests bone grafts from the patient's hip, rib, or skull, and closes the surgically created wound. The interpositional bone grafts are placed between the bony interfaces of the maxilla and the midface. The transoral incisions are closed in a single layer. Lower eyelid and scalp incisions are closed in layers. Intermaxillary fixation may be applied.

Coding Tips

This procedure includes debridement, bone cuts, down-fracturing, segmentation of maxilla, repositioning, fixation, wound closure, and normal postoperative follow-up care. Harvest of autografts is not reported separately.

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

D7949	LeFort II or LeFort III - with bone graft

ICD-10-CM Diagnostic Codes

H05.321	Deformity of right orbit due to bone disease ☑
H05.331	Deformity of right orbit due to trauma or surgery ☑
H05.351	Exostosis of right orbit ☑
H05.89	Other disorders of orbit
M26.01	Maxillary hyperplasia
M26.02	Maxillary hypoplasia
M26.09	Other specified anomalies of jaw size
M26.11	Maxillary asymmetry
M26.12	Other jaw asymmetry
M26.19	Other specified anomalies of jaw-cranial base relationship
M26.59	Other dentofacial functional abnormalities
M26.72	Alveolar mandibular hyperplasia
M26.89	Other dentofacial anomalies
M87.08	Idiopathic aseptic necrosis of bone, other site
M87.180	Osteonecrosis due to drugs, jaw
M95.2	Other acquired deformity of head
M99.80	Other biomechanical lesions of head region
Q10.7	Congenital malformation of orbit
Q75.0	Craniosynostosis
Q75.1	Craniofacial dysostosis
Q75.2	Hypertelorism
Q75.3	Macrocephaly
Q75.4	Mandibulofacial dysostosis
Q75.5	Oculomandibular dysostosis
Q75.8	Other specified congenital malformations of skull and face bones
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
S02.413A	LeFort III fracture, initial encounter for closed fracture
S02.413B	LeFort III fracture, initial encounter for open fracture
S02.81XA	Fracture of other specified skull and facial bones, right side, initial encounter for closed fracture ☑
S02.81XB	Fracture of other specified skull and facial bones, right side, 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.

Relative Value Units/Medicare Edits

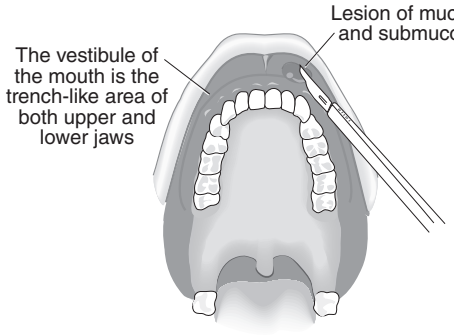
Non-Facility RVU	Work	PE	MP	Total
21155	35.22	23.64	5.0	63.86
Facility RVU	**Work**	**PE**	**MP**	**Total**
21155	35.22	23.64	5.0	63.86

	FUD	Status	MUE	Modifiers				IOM Reference
21155	90	A	1(2)	N/A	51	N/A	80	None

* with documentation

40816

40816 Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle



Explanation

The physician removes a lesion in the vestibule of the mouth. 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 the submucosal tissue, removing the lesion, along with the excision of underlying muscle as well. Complex repair of the surgical wound is required after excision of the lesion. 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. For excision of lesions from the lips and mucous membranes, see 11440–11446. Local anesthesia is included in the service. For the excision of a lesion of the vestibule of the mouth, with complex repair, see 40814. For excision of mucosa of the vestibule of the mouth, as donor graft, see 40818. For anterior vestibuloplasty, see 40840.

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
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.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
40816	3.77	7.77	0.42	11.96
Facility RVU	**Work**	**PE**	**MP**	**Total**
40816	3.77	4.73	0.42	8.92

	FUD	Status	MUE	Modifiers				IOM Reference
40816	90	A	2(3)	N/A	51	N/A	N/A	None

* with documentation

Terms To Know

excision. Surgical removal of an organ or tissue.

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.