12011-12014

12011  Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013  2.6 cm to 5.0 cm
12014  5.1 cm to 7.5 cm

Explanation
The dentist sutures superficial lacerations of the face, ears, eyelids, nose, lips, and/or mucous membranes. A local anesthetic is injected around the laceration and the wound is cleansed, explored, and often irrigated with a saline solution. The dentist performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissue with sutures. With multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12011 for a total length of 2.5 cm or less; 12013 for 2.6 cm to 5 cm; 12014 for 5.1 cm to 7.5 cm.

Coding Tips
Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. Suture removal is included in these procedures. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter. To report extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. When the condition is the result of an accident, the dental insurer may require that the medical insurance be billed first. When covered by the medical insurance the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form. Some payers may require that CDT codes D7910–D7912 be reported for this procedure using the ADA claim form.

Terms To Know

Irri-gate. Washing out, lavage.

Local anesthesia. Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.

Suture. Numerous stitching techniques employed in wound closure: 1) Buried suture: Continuous or interrupted suture placed under the skin for a layered closure. 2) Continuous suture: Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line. 3) Interrupted suture: Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection. 4) Purse-string suture: Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen. 5) Retention suture: Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

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Please note that this list of associated ICD-9-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.
12020-12021

12020  Treatment of superficial wound dehiscence; simple closure
12021  with packing

Explanation
There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The dentist cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips
For extensive or complicated secondary wound closure, see 13160. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168. To report extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042-11047. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. When the condition is the result of an accident, the dental insurer may require that the medical insurance be billed first. When covered by the medical insurance, the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Terms To Know
dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers. Report dehiscence with a code from ICD-9-CM subcategory 998.3.
infection. Presence of microorganisms in body tissues that may result in cellular damage.
irrigate. Washing out, lavage.
packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

HCPCS Codes
N/A

ICD-9-CM Diagnostic Codes
998.30  Disruption of wound, unspecified
998.32  Disruption of external operation (surgical) wound
998.33  Disruption of traumatic injury wound repair
998.59  Other postoperative infection — (Use additional code to identify infection)
998.83  Non-healing surgical wound

Please note that this list of associated ICD-9-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.
12051-12054

12051  Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052  2.6 cm to 5.0 cm
12053  5.1 cm to 7.5 cm
12054  7.6 cm to 12.5 cm

Explanation
The dentist performs an intermediate repair of a laceration of the face, ears, eyelids, nose, lips, and/or mucous membranes using layered closure. A local anesthetic is injected around the laceration, and the wound is cleansed, explored, and often irrigated with a saline solution. Due to deeper or more complex lacerations, deep subcutaneous or layered suturing techniques are required. The dentist closes tissue layers under the skin with dissolvable sutures before suturing the skin. Extensive cleaning or removal of foreign matter from a heavily contaminated wound that is closed with a single layer may also be reported as an intermediate repair. With multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12051 for a total length of 2.5 cm or less; 12052 for 2.6 cm to 5 cm; 12053 for 5.1 cm to 7.5 cm; and 12054 for 7.6 cm to 12.5 cm.

Coding Tips
Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter. For simple (nonlayered) closure of the face, ears, eyelids, nose, lips, and/or mucous membranes, see 12011–12018. Local anesthesia is included in this service. Surgical trays (A4550) are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. When the condition is the result of an accident, the dental insurer may require that the medical insurance be billed first. When covered by the medical insurance the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form. Some payers may require that CDT codes D7910–D7912 be reported for this procedure using the ADA claim form.

Terms To Know
suture. Numerous stitching techniques employed in wound closure: 1) Buried suture: Continuous or interrupted suture placed under the skin for a layered closure. 2) Continuous suture: Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line. 3) Interrupted suture: Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection. 4) Purse-string suture: Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen. 5) Retention suture: Secondary stitching that bridges the primary suture, providing support for the primary repair, a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

HCPCS Codes
D7911  complicated suture - up to 5 cm
D7912  complicated suture - greater than 5 cm

ICD-9-CM Diagnostic Codes
757.39  Other specified congenital anomaly of skin
873.43  Open wound of lip, without mention of complication
873.44  Open wound of jaw, without mention of complication
873.53  Open wound of lip, complicated
873.54  Open wound of jaw, complicated
873.60  Open wound of mouth, unspecified site, without mention of complication
873.61  Open wound of buccal mucosa, without mention of complication
873.69  Open wound of mouth, other and multiple sites, without mention of complication
873.70  Open wound of mouth, unspecified site, complicated
873.71  Open wound of buccal mucosa, complicated

Please note that this list of associated ICD-9-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.
21031

21031 Excision of torus mandibularis

Explanation
The dentist removes a benign outgrowth of bone (torus mandibularis) most commonly from the lingual (tongue) side of the mandible. Using an intraoral approach, the dentist makes an incision in the mucosa overlying the outgrowth of bone and reflects the tissue. The excess bone is removed with a drill or osteotome. The mucosal incision is closed with sutures.

Coding Tips
This code is used when the payer requires a CPT code to report the procedure. See also code D7473. This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. Payers may require that this service be reported using D7473 on the ADA dental claim form. Check with the payer to determine their requirements. For excision of the maxillary torus palatinus, see code 21032 or D7472.

Terms To Know
benign. Mild or nonmalignant in nature.
exostosis. Abnormal formation of a benign bony growth.
mandible. Lower jawbone giving structure to the floor of the oral cavity.
mucosa. Moist tissue lining the mouth (buccal mucosa), stomach (gastric mucosa), intestines, and respiratory tract.
osteotome. Tool used for cutting bone.
torus mandibularis. Developmental disorder of the jaw with bony projection or overgrowth of normal bone usually found on the floor of the mouth under the tongue.

HCPCS Codes
D7473 removal of torus mandibularis

ICD-9-CM Diagnostic Codes
526.81 Exostosis of jaw

Please note that this list of associated ICD-9-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.

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**21032**

**Excision of maxillary torus palatinus**

**Explanation**

The dentist excises a torus palatinus (a bony protuberance), usually found at the junction of the intermaxillary and transverse palatine structures, by making an incision through the mucosa overlying the protuberance. The torus is exposed. Drills, osteotomes, or files are used to remove and contour the bone. The tissue is sutured directly over the bone. Some soft tissue may be excised prior to closure for adaptation over the newly contoured bone.

**Coding Tips**

This procedure code is used when the payer requires the CPT code. See also D7472. This procedure includes the removal of tori, osseous tuberosities, and other osseous protuberances. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. Payers may require that this service be reported using D7472 on the ADA dental claim form. Check with the payer to determine their requirements. For biopsy only, see codes from range 20220-20245 or D7285.

**Terms To Know**

- **biopsy.** Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
- **excision.** Surgical removal of an organ or tissue.
- **local anesthesia.** Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.
- **maxilla.** Pyramidally shaped bone forming the upper jaw, part of the eye orbit, nasal cavity, and palate and lodging the upper teeth.
- **mucosa.** Moist tissue lining the mouth (buccal mucosa), stomach (gastric mucosa), intestines, and respiratory tract.
- **torus palatinus.** Developmental disorder of the jaw with bony overgrowth or projection found on the roof of the mouth (palate).

**HCPCS Codes**

D7472 removal of torus palatinus

**ICD-9-CM Diagnostic Codes**

- **526.81 Exostosis of jaw**

Please note that this list of associated ICD-9-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.

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Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)

Explanation
The dentist closes an opening between the mouth and the maxillary sinus. The communication is through the maxillary bone and this tract is lined with epithelium. Local anesthesia is injected into the mucosa. The dentist uses a scalpel to excise the epithelized tract. An incision is made into the palatal mucosa and a local mucosal flap is developed. The flap is sutured in layers, covering the oromaxillary tract. Careful postoperative instructions are given to limit sinus pressure by not allowing nose blowing which would reopen the tract and impair healing.

Coding Tips
Combine 30580 with 31030 if antrotomy is included. Local anesthesia is included in the service. For oronasal repair of the fistula, see 30600. Some payers may require that this service be reported using either D7260 or D7261 on the ADA dental claim form. Check with the payer to determine their requirements.

Terms To Know
antro-. Relating to a chamber or cavity.
sinus. Open space, cavity, or channel within the body or abnormal cavity, fistula, or channel created by a localized infection to allow the escape of pus.

HCPCS Codes
D7260 oroantral fistula closure — Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.
D7261 primary closure of a sinus perforation — Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.

ICD-9-CM Diagnostic Codes
473.0 Chronic maxillary sinusitis — (Use additional code to identify infectious organism)
478.19 Other diseases of nasal cavity and sinuses — (Use additional code to identify infectious organism)
526.89 Other specified disease of the jaws
528.3 Cellulitis and abscess of oral soft tissues
528.9 Other and unspecified diseases of the oral soft tissues
738.19 Other specified acquired deformity of head
748.1 Other congenital anomaly of nose
749.00 Unspecified cleft palate
749.01 Unilateral cleft palate, complete
749.02 Unilateral cleft palate, incomplete
749.03 Bilateral cleft palate, complete
749.04 Bilateral cleft palate, incomplete
749.20 Unspecified cleft palate with cleft lip
749.21 Unilateral cleft palate with cleft lip, complete
749.22 Unilateral cleft palate with cleft lip, incomplete
749.23 Bilateral cleft palate with cleft lip, complete
749.24 Bilateral cleft palate with cleft lip, incomplete
749.25 Other combinations of cleft palate with cleft lip
905.0 Late effect of fracture of skull and face bones

Please note that this list of associated ICD-9-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.
40490

Biopsy of lip

Explanation
The dentist performs a biopsy of a lesion on the lip. An incision is made in the lip and a portion of the lesion together with some normal tissue is removed. The surgical wound is closed directly.

Coding Tips
This procedure is for a biopsy of the lip. If an entire lesion is removed, use the appropriate excision code. If multiple areas are biopsied, report code 40490 for each site taken and append modifier 51 to additional codes. For resection of more than one-fourth of the lip, see code 40530. Local anesthesia is included in the service. If specimen is transported to an outside laboratory, report code 99000 for handling or conveyance. For excision of a lesion of the lip, benign, see codes from the 11440-11446 range; for malignant, see codes 11640-11646. For excision of the lip, see codes from range 40510-40527.

Terms To Know
- benign: Mild or nonmalignant in nature.
- biopsy: Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
- malignant: Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other areas in the body.

HCPCS Codes
- D7286 biopsy of oral tissue - soft — For surgical removal of an architecturally intact specimen only. This code is not used at the same time as codes for apicectomy/periradicular curettage.

ICD-9-CM Diagnostic Codes
- 149.8 Malignant neoplasm of other sites within the lip and oral cavity
- 149.9 Malignant neoplasm of ill-defined sites of lip and oral cavity
- 173.00 Unspecified malignant neoplasm of skin of lip
- 173.01 Basal cell carcinoma of skin of lip
- 173.02 Squamous cell carcinoma of skin of lip
- 210.0 Benign neoplasm of lip
- 216.0 Benign neoplasm of skin of lip
- 230.0 Carcinoma in situ of lip, oral cavity, and pharynx
- 232.0 Carcinoma in situ of skin of lip
- 235.1 Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
- 239.0 Neoplasm of unspecified nature of digestive system
- 528.6 Leukoplakia of oral mucosa, including tongue
- 528.9 Other and unspecified diseases of the oral soft tissues
- 784.2 Swelling, mass, or lump in head and neck

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Please note that this list of associated ICD-9-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.
The dentist drains an abscess, a cyst, or a hematoma within 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. The dentist makes an incision in the tissue overlying the abscess, cyst, or hematoma. Tissues are dissected and the fluid is drained. Complicated drainage for larger lesions or drainage requiring multiple incisions is done in 40801. The dentist may place a drain to facilitate healing. If a drain is placed, it is later removed. Local anesthesia is included in this service.

Coding Tips

Drain placement and removal are not reported separately. Note that 40801 is used when drainage of the abscess, cyst, or hematoma is complicated. If multiple areas are drained, report 40800 or 40801 for each incision site and append modifier 59 to additional codes. Local anesthesia is included in the service. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. Payers may require that this service be reported using the appropriate code from the D7510-D7521 range on the ADA dental claim form. Check with the payer to determine their requirements. For drainage of an abscess, a cyst, or a hematoma from dentoalveolar structures, see 41800.

Terms To Know

**abscess.** Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

**cyst.** Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

**hematoma.** Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.

### HCPCS Codes

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<td>Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) — Incision is made extraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.</td>
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Please note that this list of associated HCPCS 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.
Removal of embedded foreign body, vestibule of mouth; simple or complicated

**Explanation**
The dentist removes a foreign body embedded 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. The dentist may simply grasp the object with an instrument and remove it or incisions may be made to free the object and remove it. Complicated removal of a large foreign body or one that is difficult to access is done in 40805. Closure of the wound may be needed.

**Coding Tips**
Drain placement and removal are not reported separately. Note that 40805 is used when removal of the embedded foreign body is complicated. If multiple foreign bodies are removed, report 40804 or 40805 for each incision site and append modifier 59 to additional codes. Local anesthesia is included in the service. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For removal of an embedded foreign body from dentoalveolar structures, soft tissue, see 41805; bone, see 41806.

**Terms To Know**
- **foreign body.** Any object or substance found in an organ and tissue that does not belong under normal circumstances.
- **incision.** Act of cutting into tissue or an organ.
- **local anesthesia.** Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.
- **mucosa.** Moist tissue lining the mouth (buccal mucosa), stomach (gastric mucosa), intestines, and respiratory tract.
- **palate.** Partition that separates the nasal from the oral cavities.

**HCPCS Codes**
- D7530 removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
- D7540 removal of reaction producing foreign bodies, musculoskeletal system — May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone.

**ICD-9-CM Diagnostic Codes**
- 873.70 Open wound of mouth, unspecified site, complicated
- 873.71 Open wound of buccal mucosa, complicated
- 873.72 Open wound of gum (alveolar process), complicated
- 873.74 Open wound of tongue and floor of mouth, complicated
- 873.75 Open wound of palate, complicated
- 873.79 Open wound of mouth, other and multiple sites, complicated

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Incision of labial frenum (frenotomy)

Explanation
The dentist performs a frenotomy by incising the labial frenum. The labial frenum is a connecting fold of mucous membrane that joins the lip to the gums at the inside midcenter. This procedure is often performed to release tension on the frenum and surrounding tissues. The frenum is simply incised and not removed.

Coding Tips
When the labial frenum is attached close to the crest of the alveolar ridge, it can interfere with tooth eruption or wearing of an upper denture. Local anesthesia is included in the service. For excision of frenum (frenectomy), see 40819. Surgical trays (A4550) are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. See also code D7960. A frenotomy is often bundled into other more comprehensive dental services and, therefore, is not separately billable.

Terms To Know
frenum. Small, connected piece of skin or mucous membrane that serves to restrain, curb, or limit movement of the attached part.
hyperplasia. Abnormal proliferation in the number of normal cells in regular tissue arrangement.
labial frenum. Connecting fold of mucous membrane that joins the upper or lower lip to the gums at the inside midcenter.

HCPCS Codes
D7960 frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure — Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual that is associated with a pathological condition, or interferes with proper oral development or treatment.

ICD-9-CM Diagnostic Codes
520.8 Other specified disorders of tooth development and eruption
523.20 Gingival recession, unspecified
523.21 Gingival recession, minimal
523.22 Gingival recession, moderate
523.23 Gingival recession, severe
523.24 Gingival recession, localized
523.25 Gingival recession, generalized
524.01 Maxillary hyperplasia
524.02 Mandibular hyperplasia
524.04 Mandibular hypoplasia
524.09 Other specified major anomaly of jaw size
524.12 Other jaw asymmetry
524.39 Other anomalies of tooth position

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</table>

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Biopsy, vestibule of mouth

Explanation
The dentist performs a biopsy on 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. The dentist makes an incision in the area of the vestibule to be biopsied and removes a portion of the lesion and some surrounding tissue. The incision is closed simply.

Coding Tips
This procedure is for a biopsy of the vestibule of the mouth. If an entire lesion is removed, use the appropriate excision code. If multiple areas are biopsied, report code 40808 for each site taken and append modifier 51 to additional codes. Local anesthesia is included in the service. For excision of a lesion of the mucosa and submucosa, vestibule of mouth, see codes 40810-40818. For excision of lesions from the lips and mucous membranes, see codes 11440-11446. Payers may require that this service be reported using D7286 on the ADA dental claim form. Surgical trays (A4550) may be separately reimbursed by third-party payers. Check with the specific payer to determine coverage. Check with the payer to determine their requirements. Local anesthesia is generally considered part of the procedure.

Terms To Know
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

HCPCS Codes
biopsy of oral tissue - soft — For surgical removal of an architecturally intact specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage.

ICD-9-CM Diagnostic Codes
140.3 Malignant neoplasm of upper lip, inner aspect
140.4 Malignant neoplasm of lower lip, inner aspect
140.5 Malignant neoplasm of lip, inner aspect, unspecified as to upper or lower
140.6 Malignant neoplasm of commissure of lip
140.8 Malignant neoplasm of other sites of lip
140.9 Malignant neoplasm of lip, vermilion border, unspecified as to upper or lower
144.8 Malignant neoplasm of other sites of floor of mouth
144.9 Malignant neoplasm of floor of mouth, part unspecified
145.1 Malignant neoplasm of vestibule of mouth
145.8 Malignant neoplasm of other specified parts of mouth
145.9 Malignant neoplasm of mouth, unspecified site
198.89 Secondary malignant neoplasm of other specified sites
210.4 Benign neoplasm of other and unspecified parts of mouth

Carcinoma in situ of lip, oral cavity, and pharynx
Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
Neoplasm of unspecified nature of digestive system
Neoplasm of unspecified nature, site unspecified
Radicular cyst of dental pulp
Stomatitis and mucositis, unspecified
Other stomatitis and mucositis (ulcerative)
Cellulitis and abscess of oral soft tissues
Leukoplakia of oral mucosa, including tongue
Other disturbances of oral epithelium, including tongue
Oral submucosal fibrosis, including of tongue
Other and unspecified diseases of the oral soft tissues
Lichen planus

Please note that this list of associated ICD-9-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.
The dentist 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. The dentist makes an incision around the lesion and through submucosal tissue, removing the lesion. No repair of the wound is done in 40810. Simple repair of the wound is done in 40812, such as a sutured closure. Payers may require that this service be reported using the appropriate code from the D7410-D7414 range on the ADA dental claim form. Check with payers to determine their requirements. Local anesthesia is generally considered part of the procedure.

**Coding Tips**

If only a portion of the lesion is removed, report code 40808 for biopsy of the vestibule of the mouth. An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. Note that 40812 is identified when a lesion of the mucosa or submucosa, vestibule of mouth is excised with a simple repair. For the excision of a lesion of the vestibule of the mouth with complex repair, see 40814. To report an excision of a lesion of the mucosa and submucosa, vestibule of the mouth, complex, with an excision of the underlying muscle, see code 40816. For excision of lesions from the lips and mucous membranes, see codes 11440–11446. Surgical trays (A4550) may be separately reimbursed by third-party payers. Check with the specific payer to determine coverage.

**Terms To Know**

**excision.** Surgical removal of an organ or tissue.

**HCPCS Codes**

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<th>Code</th>
<th>Description</th>
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<tr>
<td>D7410</td>
<td>excision of benign lesion up to 1.25 cm</td>
</tr>
<tr>
<td>D7411</td>
<td>excision of benign lesion greater than 1.25 cm</td>
</tr>
<tr>
<td>D7413</td>
<td>excision of malignant lesion up to 1.25 cm</td>
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<tr>
<td>D7414</td>
<td>excision of malignant lesion greater than 1.25 cm</td>
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**ICD-9-CM Diagnostic Codes**

- 214.8 Lipoma of other specified sites
- 214.9 Lipoma of unspecified site
- 215.0 Other benign neoplasm of connective and other soft tissue of head, face, and neck
- 230.0 Carcinoma in situ of lip, oral cavity, and pharynx
- 235.1 Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
- 239.0 Neoplasm of unspecified nature of digestive system
- 239.9 Neoplasm of unspecified nature, site unspecified

Please note that this list of associated ICD-9-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.
Excision of frenum, labial or buccal (frenulectomy, frenulectomy, frenectomy)

Explanation
The dentist removes the labial or buccal frenum. 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 midcenter. Incisions are made around the frenum and through the mucosa and submucosa. The underlying muscle is removed as well. The excision may extend to the interincisal papilla. The mucosa is closed simply, or the dentist may rearrange the tissue as in a Z-plasty technique.

Coding Tips
When the labial frenum is attached close to the crest of the alveolar ridge, it can interfere with tooth eruption or wearing of an upper denture. Local anesthesia is included in the service. For incision of labial frenum (frenotomy), see 40806. For incision or excision of lingual frenum, see 41010 or 41115, respectively. This service may also be reported using HCPCS Level II code D7960. This procedure is often included in a more comprehensive service and, therefore, should not be billed separately. Check with third-party payers for their specific guidelines.

Terms To Know
buccal. Relating to or toward the cheek. b. frenum Band of mucosal membrane that connects the alveolar (dental) ridge to the cheek, separating the lip vestibule from the cheek vestibule. b. mucosa Tissue from the mucous membrane on the inside of the cheek. b. vestibule Space in the mouth between the cheek and the teeth and gums.

frenulectomy. Excision of the labial, buccal, or lingual frenum, reported with CPT codes 40819 and 41115 or HCPCS Level II code D7960. Synonym(s): frenectomy.
frenum. Small, connected piece of skin or mucous membrane that serves to restrain, curb, or limit movement of the attached part.
labial frenum. Connecting fold of mucous membrane that joins the upper or lower lip to the gums at the inside midcenter.

HCPCS Codes
D7960 frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure — Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual that is associated with a pathological condition, or interferes with proper oral development or treatment.

ICD-9-CM Diagnostic Codes
140.3 Malignant neoplasm of upper lip, inner aspect
140.4 Malignant neoplasm of lower lip, inner aspect
140.5 Malignant neoplasm of lip, inner aspect, unspecified as to upper or lower

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40830-40831

40830 Closure of laceration, vestibule of mouth; 2.5 cm or less
40831 Closure of laceration, vestibule of mouth; over 2.5 cm or complex

Explanation
The dentist sutures a laceration of the vestibule of the mouth measuring 2.5 cm or less in length. The dentist performs a simple closure without submucosal sutures or tissue rearrangement in 40830. Extensive tissue damage or crushing, requiring complex closure, such as retention sutures, or the closure of a laceration more than 2.5 cm is done in 40831.

Coding Tips
When 40830 or 40831 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. Local anesthesia is included in the service. For complex closure of a laceration, vestibule of mouth, see 40831. For vestibuloplasty, see 40840-40845. For repair of a laceration of lips and/or mucous membranes, simple, see 12011; intermediate, see 2051. Surgical trays (A4550) are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. Payers may require that this service be reported using the appropriate code from range D7910-D7912 on the ADA dental claim form. Check with payers to determine their requirements.

Terms To Know
laceration. Tearing injury; a torn, ragged-edged wound.

HCPCS Codes
D7910 suture of recent small wounds up to 5 cm
D7911 complicated suture - up to 5 cm
D7912 complicated suture - greater than 5 cm

ICD-9-CM Diagnostic Codes
873.43 Open wound of lip, without mention of complication
873.49 Open wound of face, other and multiple sites, without mention of complication
873.53 Open wound of lip, complicated
873.59 Open wound of face, other and multiple sites, complicated
873.60 Open wound of mouth, unspecified site, without mention of complication
873.61 Open wound of buccal mucosa, without mention of complication
873.62 Open wound of gum (alveolar process), without mention of complication
873.63 Open wound of tongue and floor of mouth, without mention of complication
873.65 Open wound of palate, without mention of complication
873.69 Open wound of mouth, other and multiple sites, without mention of complication

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<td>Closure of laceration, vestibule of mouth; over 2.5 cm or complex</td>
<td>2.57</td>
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<td>0.40</td>
<td>9.82</td>
<td>6.57</td>
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Vestibuloplasty; anterior
40840
posterior, unilateral
40842
posterior, bilateral
40843

Explanation
The dentist performs a vestibuloplasty and deepens the vestibule of the mouth by any series of surgical procedures for the purpose of increasing the height of the alveolar ridge, allowing a complete denture to be worn. The vestibule refers to the mucosal and submucosal tissue of the inner lips and cheeks, the part of the oral cavity outside of the dentoalveolar structures. This procedure may be performed in several ways. The dentist may rearrange the patient's own tissue or the submucosal tissue may be dissected and freed from the bone. The mucosa is moved deeper into the vestibule. Soft tissues may also be grafted into the mouth. An anterior procedure is performed in 40840; a one-sided procedure is done on the posterior portion of the mouth in 40842; and a posterior procedure is done on both sides of the mouth in 40843.

Coding Tips
When 40840 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. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. Local anesthesia is included in the service. This service may also be reported using D7340. For vestibuloplasty of the entire arch, see 40844 or D7340; complex (including ridge extension, muscle repositioning), see 40845 or D7350.

Terms To Know
vestibuloplasty. Surgical procedure in which the vestibule of the mouth is deepened for the purpose of increasing the height of the alveolar ridge.

HCPCS Codes
D7340  vestibuloplasty - ridge extension (secondary epithelialization)

ICD-9-CM Diagnostic Codes
386.12  Vestibular neuronitis
525.11  Loss of teeth due to trauma — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.12  Loss of teeth due to periodontal disease — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.13  Loss of teeth due to caries — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.19  Other loss of teeth — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.40  Complete edentulism, unspecified — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.41  Complete edentulism, class I — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.42  Complete edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.43  Complete edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.44  Complete edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.50  Partial edentulism, unspecified — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.51  Partial edentulism, class I — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.52  Partial edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.53  Partial edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.54  Partial edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.8  Other specified disorders of the teeth and supporting structures
528.9  Other and unspecified diseases of the oral soft tissues
733.7  Aloigneurodystrophy
873.59  Open wound of face, other and multiple sites, complicated
905.0  Late effect of fracture of skull and face bones
906.0  Late effect of open wound of head, neck, and trunk
906.5  Late effect of burn of eye, face, head, and neck
909.3  Late effect of complications of surgical and medical care
947.0  Burn of mouth and pharynx
V41.6  Problems with swallowing and mastication

Please note that this list of associated ICD-9-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.
40844

Vestibuloplasty; entire arch

Explanation
The dentist performs a vestibuloplasty and deepens the vestibule of the mouth by any series of surgical procedures for the purpose of increasing the height of the alveolar ridge, allowing a complete denture to be worn. The vestibule refers to the mucosal and submucosal tissue of the inner lips and cheeks, the part of the oral cavity outside of the dentoalveolar structures. This procedure may be performed in several ways. The dentist may rearrange the patient's own tissue or the submucosal tissue may be dissected and freed from the bone. The mucosa is moved deeper into the vestibule. Soft tissues may also be grafted into the mouth. Report 40844 when this procedure is done over the arch of the mouth.

Coding Tips
When 40844 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. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. Local anesthesia is included in the service. For posterior vestibuloplasty, unilateral, see 40842; bilateral, see 40843. Some payers may require code D7340.

Terms To Know
vestibuloplasty. Surgical procedure in which the vestibule of the mouth is deepened for the purpose of increasing the height of the alveolar ridge.

HCPCS Codes
D7340 vestibuloplasty - ridge extension (secondary epithelialization)

ICD-9-CM Diagnostic Codes
386.12 Vestibular neuronitis
525.10 Unspecified acquired absence of teeth — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.11 Loss of teeth due to trauma — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.12 Loss of teeth due to periodontal disease — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.13 Loss of teeth due to caries — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.19 Other loss of teeth — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.20 Unspecified atrophy of edentulous alveolar ridge
525.40 Complete edentulism, unspecified — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.41 Complete edentulism, class I — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.42 Complete edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.43 Complete edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.44 Complete edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.50 Partial edentulism, unspecified — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.51 Partial edentulism, class I — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.52 Partial edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.53 Partial edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.54 Partial edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.55 Other specified disorders of the teeth and supporting structures
525.8 Other and unspecified diseases of the oral soft tissues
733.7 Algoneurodystrophy
750.26 Other specified congenital anomalies of mouth
873.59 Open wound of face, other and multiple sites, complicated
905.0 Late effect of fracture of skull and face bones
906.0 Late effect of open wound of head, neck, and trunk
906.5 Late effect of burn of eye, face, head, and neck
908.9 Late effect of unspecified injury
909.3 Late effect of complications of surgical and medical care
925.1 Crushing injury of face and scalp — (Use additional code to identify any associated injuries, such as: 800-829, 850.0-854.1, 860.0-869.1)
947.0 Burn of mouth and pharynx
959.09 Injury of face and neck, other and unspecified
959.9 Injury, other and unspecified, unspecified site
V41.6 Problems with swallowing and mastication

Please note that this list of associated ICD-9-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.

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Vestibuloplasty; complex (including ridge extension, muscle repositioning)

Explanation
The dentist performs a vestibuloplasty and deepens the vestibule of the mouth by any series of surgical procedures for the purpose of increasing the height of the alveolar ridge, allowing a complete denture to be worn. The vestibule refers to the mucosal and submucosal tissue of the inner lips and cheeks, the part of the oral cavity outside of the dentoalveolar structures. This procedure is performed for complex cases, such as those in which the dentist must lower muscle attachments to provide enough space for deepening the vestibule. Soft tissue grafting from other areas of the body into the mouth is often required. Hypertrophied and hyperplastic tissue may need to be trimmed and soft tissue revised by dissecting it from the alveolar ridge and rearranging its attachment.

Coding Tips
Some payers may require that this procedure be reported using D7350. When 40845 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. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. Report any free grafts or flaps separately, see 15004, 15120, and 15240. Local anesthesia is included in the service. For anterior vestibuloplasty, see 40840. For posterior vestibuloplasty, unilateral, see 40842; bilateral, see 40843. For vestibuloplasty of the entire arch, see 40844.

Terms To Know
vestibuloplasty. Surgical procedure in which the vestibule of the mouth is deepened for the purpose of increasing the height of the alveolar ridge.

HCPCS Codes
D7350 vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

ICD-9-CM Diagnostic Codes
230.0 Carcinoma in situ of lip, oral cavity, and pharynx
525.10 Unspecified acquired absence of teeth — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.11 Loss of teeth due to trauma — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.12 Loss of teeth due to periodontal disease — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.13 Loss of teeth due to caries — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.19 Other loss of teeth — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
525.20 Unspecified atrophy of edentulous alveolar ridge
525.40 Complete edentulism, unspecified — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.41 Complete edentulism, class I — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.42 Complete edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.43 Complete edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.44 Complete edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.50 Partial edentulism, unspecified — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.51 Partial edentulism, class I — (Use additional code to identify cause of edentulism: 525.10-525.19)
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525.53 Partial edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
525.54 Partial edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)
905.0 Late effect of fracture of skull and face bones
906.0 Late effect of open wound of head, neck, and trunk
906.8 Late effect of burns of other specified sites
947.0 Burn of mouth and pharynx
V10.02 Personal history of malignant neoplasm of other and unspecified parts of oral cavity and pharynx
V41.6 Problems with swallowing and mastication
V50.1 Other plastic surgery for unacceptable cosmetic appearance
V51.8 Other aftercare involving the use of plastic surgery

Please note that this list of associated ICD-9-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.

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**41000-41007**

**41000** Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual

**41005** sublingual, superficial

**41006** sublingual, deep, supramylohyoid

**41007** submental space

**Explanation**

The dentist makes a small intraoral incision through the mucosa of the tongue or floor of the mouth overlying an abscess, cyst, or hematoma. The abscess, hematoma, or cyst is opened with a surgical instrument and the fluid is drained.

**Coding Tips**

Local anesthesia is included in these services. For incision and drainage of a sublingual cyst, see 41005 or 41006. Payers may require that these services be reported using D7510 or D7511 on the ADA dental claim form. Check with payers to determine their requirements.

**Terms To Know**

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

cellulitis. Sudden, severe, suppurative inflammation and edema in subcutaneous tissue or muscle, most often caused by bacterial infection secondary to a cutaneous lesion.

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

hematoma. Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.

incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity. Incision and drainage of specified lesions or wounds is reported in the Integumentary chapter of CPT. Synonym(s): I & D.

**HCPCS Codes**

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<td>D7511</td>
<td>Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) — Incision is made intraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.</td>
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**ICD-9-CM Diagnostic Codes**

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<td>Cysts of oral soft tissues</td>
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<td>Other congenital anomaly of tongue</td>
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Postprocedural fever: 780.62
Swelling, mass, or lump in head and neck: 784.2
Contusion of face, scalp, and neck except eye(s): 920
Posttraumatic wound infection not elsewhere classified: 958.3
Hematoma complicating a procedure: 998.12
Other postoperative infection: 998.59

Please note that this list of associated ICD-9-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.
Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space

**Explanation**

The dentist makes a small intraoral incision through the mucosa of the tongue or floor of the mouth overlying an abscess, cyst, or hematoma and drains the fluid. The dentist incises through the mucosa of the floor of the mouth to the supramylohyoid muscle and carries the dissection deeper into the tissue to reach the submandibular space. The abscess, hematoma, or cyst is opened with a surgical instrument and the fluid is drained. An artificial drain may be placed.

**Coding Tips**

Placement and removal of drain are not reported separately. Local anesthesia is included in the service. Payers may require that this service be reported using D7510 or D7511 on the ADA dental claim form. Check with payers to determine their requirements.

**Terms To Know**

- **abscess.** Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
- **cellulitis.** Sudden, severe, suppurative inflammation and edema in subcutaneous tissue or muscle, most often caused by bacterial infection secondary to a cutaneous lesion.
- **cyst.** Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.
- **hematoma.** Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.
- **incision and drainage.** Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

**HCPCS Codes**

D7510 incision and drainage of abscess - intraoral soft tissue — Involves incision through mucosa, including periodontal origins.

D7511 incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) — Incision is made intraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.

**ICD-9-CM Diagnostic Codes**

- 526.4 Inflammatory conditions of jaw
- 528.3 Cellulitis and abscess of oral soft tissues
- 528.4 Cysts of oral soft tissues
- 528.9 Other and unspecified diseases of the oral soft tissues
- 529.6 Glossodynia
- 529.8 Other specified conditions of the tongue
- 682.0 Cellulitis and abscess of face — (Use additional code to identify organism, such as 041.1, etc.)

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Please note that this list of associated ICD-9-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.
Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space

Explanation
The dentist makes a small intraoral incision through the mucosa of the tongue or floor of the mouth overlying an abscess, cyst, or hematoma and drains the fluid. The dentist dissects down through the mucosa in the posterior floor of the mouth and into the masticator space, containing the ramus, the posterior part of the mandible, and the masticator muscles to drain the abscess. The abscess, hematoma, or cyst is opened with a surgical instrument and the fluid is drained. An artificial drain may be placed.

Coding Tips
Placement and removal of drain are not reported separately. Local anesthesia is included in the service. Payers may require that this service be reported using D7510 or D7511 on the ADA dental claim form. Check with payers to determine their requirements. For extraoral approach, see code 41018.

Terms To Know
abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

HCPCS Codes
D7510 incision and drainage of abscess - intraoral soft tissue — Involves incision through mucosa, including periodontal origins.
D7511 incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) — Incision is made intraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.

ICD-9-CM Diagnostic Codes
522.5 Periapical abscess without sinus
522.7 Periapical abscess with sinus
523.30 Aggressive periodontitis, unspecified
523.31 Aggressive periodontitis, localized
523.32 Aggressive periodontitis, generalized
523.33 Acute periodontitis
528.3 Cellulitis and abscess of oral soft tissues
528.4 Cysts of oral soft tissues
528.9 Other and unspecified diseases of the oral soft tissues
529.6 Glossodynia
529.8 Other specified conditions of the tongue
682.0 Cellulitis and abscess of face — (Use additional code to identify organism, such as 041.1, etc.)
**41010**

41010 Incision of lingual frenum (frenotomy)

**Explanation**
The dentist makes an incision in the lingual frenum, freeing the tongue and allowing greater range of motion. The lingual frenum is the connecting fold or membrane under the tongue that attaches it to the floor of the mouth. Sutures may be placed. The frenum is simply incised and not removed.

**Coding Tips**
Suturing is not reported separately. Local anesthesia is included in the service. For frenoplasty, see 41520. For lingual frenectomy, see 41115. This procedure is often included in a more comprehensive service when performed during the same encounter and, therefore, is not billed separately. Check with third-party payers for their specific guidelines. See also code D7960.

**Terms To Know**
adhesion. Abnormal fibrous connection between two structures, soft tissue or bony structures, that may occur as the result of surgery, infection, or trauma.

frenum. Small, connected piece of skin or mucous membrane that serves to restrain, curb, or limit movement of the attached part.

hyperplasia. Abnormal proliferation in the number of normal cells in regular tissue arrangement.

hypoplasia. Condition in which there is underdevelopment of an organ or tissue.

incision. Act of cutting into tissue or an organ.

lingual. Surface of the tooth closest to the tongue or relating to the tongue and its surrounding areas.

local anesthesia. Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.

**HCPCS Codes**
D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure — Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual that is associated with a pathological condition, or interferes with proper oral development or treatment.

**ICD-9-CM Diagnostic Codes**
524.02 Mandibular hyperplasia
524.74 Alveolar mandibular hypoplasia
750.0 Tongue tie
750.12 Congenital adhesions of tongue

Please note that this list of associated ICD-9-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.

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**41015-41016**

**41015** Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual

**41016** submental

**Explanation**

The dentist drains an abscess, a cyst, or a hematoma from the floor of the mouth by making an extraoral incision in the skin below the inferior border of the mandible and dissecting through the tissue to reach the affected space. In 41015, the dentist dissects through the supramylohyoid muscle and submental space into the sublingual space below the tongue to drain the abscess. In 41016, dissection is taken to the supramylohyoid muscle to drain an abscess in the submental space.

**Coding Tips**

Placement and removal of drain are not reported separately. Local anesthesia is included in these services. Payers may require that these services be reported using D7520 or D7521 on the ADA dental claim form. Check with payers to determine their requirements.

**Terms To Know**

**abscess.** Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

**cyst.** Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

**glossitis.** Inflammation and swelling of the tongue that may be associated with infection, adverse drug reactions, smoking, or injury.

**hematoma.** Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.

**incision and drainage.** Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

**HCPCS Codes**

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**ICD-9-CM Diagnostic Codes**

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Please note that this list of associated ICD-9-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.
Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular

Explanation
The dentist drains an abscess, a cyst, or a hematoma from the floor of the mouth in the submandibular space. The dentist makes an incision under the angle of the mandible, or between the angle and the chin and below the inferior border of the mandible. Dissection is limited to the submandibular space. The fluid is then drained and an artificial drain may be placed. If placed, the drain is later removed.

Coding Tips
Placement and removal of drain are not reported separately. Local anesthesia is included in the service. Payers may require that this service be reported using D7520 or D7521 on the ADA dental claim form. Check with payers to determine their requirements.

Terms To Know
- **abscess**: Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
- **cellulitis**: Sudden, severe, suppurative inflammation and edema in subcutaneous tissue or muscle, most often caused by bacterial infection secondary to a cutaneous lesion.
- **cyst**: Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.
- **dissection**: Separating by cutting tissue or body structures apart.
- **hematoma**: Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.
- **incision and drainage**: Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

HCPCS Codes
- D7520 incision and drainage of abscess - extraoral soft tissue — Involves incision through skin.
- D7521 incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) — Incision is made extraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.

ICD-9-CM Diagnostic Codes
- 526.4 Inflammatory conditions of jaw
- 528.3 Cellulitis and abscess of oral soft tissues
- 528.4 Cysts of oral soft tissues
- 528.9 Other and unspecified diseases of the oral soft tissues
- 682.0 Cellulitis and abscess of face — (Use additional code to identify organism, such as 041.1, etc.)
- 750.26 Other specified congenital anomalies of mouth
- 784.2 Swelling, mass, or lump in head and neck
- 920 Contusion of face, scalp, and neck except eye(s)

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Please note that this list of associated ICD-9-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.
41018
Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space

Explanation
The dentist drains an abscess, a cyst, or a hematoma from the floor of the mouth by making an extraoral incision in the skin below the inferior border of the mandible and dissecting up through the tissue to reach the affected space. An incision is made just below the angle of the ramus of the mandible, the posterior part of the mandible, and into the masticator space containing the masticator muscles to drain the abscess, cyst, or hematoma. A drain may be placed to facilitate healing, which is later removed.

Coding Tips
Placement and removal of drain are not reported separately. Local anesthesia is included in the service. Payers may require that this service be reported using D7520 or D7521 on the ADA dental claim form. Check with payers to determine their requirements.

Terms To Know
abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

HCPCS Codes
D7520 incision and drainage of abscess - extraoral soft tissue — Involves incision through skin.
D7521 incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) — Incision is made extraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.

ICD-9-CM Diagnostic Codes
522.5 Periapical abscess without sinus
522.7 Periapical abscess with sinus
523.30 Aggressive periodontitis, unspecified
523.31 Aggressive periodontitis, localized
523.32 Aggressive periodontitis, generalized
523.33 Acute periodontitis
528.3 Cellulitis and abscess of oral soft tissues
528.4 Cysts of oral soft tissues
528.9 Other and unspecified diseases of the oral soft tissues
682.0 Cellulitis and abscess of face — (Use additional code to identify organism, such as 041.1, etc.)
750.26 Other specified congenital anomalies of mouth
784.2 Swelling, mass, or lump in head and neck
906.0 Late effect of open wound of head, neck, and trunk

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Please note that this list of associated ICD-9-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.
Excision of lingual frenum (frenectomy)

Explanation
The dentist removes a tight or short lingual frenum to free the tongue and allow greater range of motion. The lingual frenum is the connecting fold or membrane under the tongue that attaches it to the floor of the mouth. The dentist makes incisions in the frenum both near the tongue and near the mandible, which ultimately connect as they move posteriorly. The frenum is excised. The surgical wound may be sutured.

Coding Tips
This procedure differs from 41010 in that the frenum is removed (excised) rather than just cut (incised). Suturing is not reported separately. Local anesthesia is included in the service. This service is often included in a more comprehensive service when performed at the same time and, therefore, is not separately billable. Check with third-party payers for their specific guidelines. See also code D7960.

Terms To Know
- **adhesion.** Abnormal fibrous connection between two structures, soft tissue or bony structures, that may occur as the result of surgery, infection, or trauma.
- **excision.** Surgical removal of an organ or tissue.
- **frenulectomy.** Excision of the labial, buccal, or lingual frenum, reported with CPT codes 40819 and 41115 or HCPCS Level II code D7960. Synonym(s): frenectomy.
- **frenum.** Small, connected piece of skin or mucous membrane that serves to restrain, curb, or limit movement of the attached part.
- **lingual.** Surface of the tooth closest to the tongue or relating to the tongue and its surrounding areas.
- **neoplasm.** New abnormal growth, tumor.

HCPCS Codes
- **D7960** frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure — Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual that is associated with a pathological condition, or interferes with proper oral development or treatment.

ICD-9-CM Diagnostic Codes
- 141.3 Malignant neoplasm of ventral surface of tongue
- 145.1 Malignant neoplasm of vestibule of mouth
- 210.0 Benign neoplasm of lip
- 230.0 Carcinoma in situ of lip, oral cavity, and pharynx
- 235.1 Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
- 528.9 Other and unspecified diseases of the oral soft tissues
- 529.6 Glossodynia
- 750.0 Tongue tie
- 750.12 Congenital adhesions of tongue

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Explanation
The dentist performs a frenoplasty and surgically alters the frenum by rearranging the tissue, usually with a Z-plasty technique. The lingual frenum is the connecting fold or membrane under the tongue that attaches it to the floor of the mouth. An incision in the shape of a "Z" is made through the frenum and the tissues are reapproximated in a different position and sutured.

Coding Tips
Some payers may require that this service be reported using D7963. When performed at the time of other, more comprehensive services the frenuloplasty is considered to be an integral part of the more comprehensive service and not separately billable. Check with third-party payers for their specific guidelines. Local anesthesia is included in the service. For frenotomy, see 40806 and 41010 or D7960.

Terms To Know
- adhesion. Abnormal fibrous connection between two structures, soft tissue or bony structures, that may occur as the result of surgery, infection, or trauma.
- congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
- frenum. Small, connected piece of skin or mucous membrane that serves to restrain, curb, or limit movement of the attached part.
- hyperplasia. Abnormal proliferation in the number of normal cells in regular tissue arrangement.
- hypoplasia. Condition in which there is underdevelopment of an organ or tissue.
- z-plasty. Plastic surgery technique used primarily to release tension or elongate contractured scar tissue in which a Z-shaped incision is made with the middle line of the Z crossing the area of greatest tension. The triangular flaps are then rotated so that they cross the incision line in the opposite direction, creating a reversed Z.

HCPCS Codes
D7963 frenuloplasty — Excision of frenum with accompanying excision or repositioning of aberrant muscle and z-plasty or other local flap closure.

ICD-9-CM Diagnostic Codes
- 524.02 Mandibular hyperplasia
- 524.04 Mandibular hypoplasia
- 529.8 Other specified conditions of the tongue
- 750.0 Tongue tie
- 750.10 Congenital anomaly of tongue, unspecified
- 750.12 Congenital adhesions of tongue
- 906.0 Late effect of open wound of head, neck, and trunk

Please note that this list of associated ICD-9-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.
Gingivectomy, excision gingiva, each quadrant

**Explanation**
The dentist excises or trims hypertrophic (overgrown) gingiva to normal contours. The dentist excises the overgrown gingiva using a scalpel, electrocautery, or a laser. Periodontal dressing or packing is often placed. Use this code for each quadrant of the mouth where gingivectomy is performed.

**Coding Tips**
Excision of gingiva from the second, third, or fourth quadrant of the dentition may be reported separately. When 41820 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. Local anesthesia is included in the service. For gingivoplasty, each quadrant, see code 41872 or codes from range D4210-D4211.

**Terms To Know**
- **Gingivectomy.** Surgical excision or trimming of overgrown gum tissue back to normal contours using a scalpel, electrocautery, or a laser. CPT code 41820 or HCPCS Level II code D4210 or D4211 is reported for each quadrant of the mouth in which gingivectomy is performed.
- **Gingivitis.** Inflamed gingiva (oral mucosa) that surrounds the teeth. Report gingivitis with a code from ICD-9-CM category 523 or ICD-10-CM category K05.-; codes are selected based on whether the condition is documented as acute, chronic, or plaque induced.
- **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.

**HCPCS Codes**
- **Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant** — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

- **Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant** — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

**ICD-9-CM Diagnostic Codes**
- 143.0 Malignant neoplasm of upper gum
- 143.1 Malignant neoplasm of lower gum
- 143.8 Malignant neoplasm of other sites of gum
- 143.9 Malignant neoplasm of gum, unspecified site
- 198.89 Secondary malignant neoplasm of other specified sites
- 210.4 Benign neoplasm of other and unspecified parts of mouth
- 230.0 Carcinoma in situ of lip, oral cavity, and pharynx
- 235.1 Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
- 239.0 Neoplasm of unspecified nature of digestive system
- 523.00 Acute gingivitis, plaque induced
- 523.01 Acute gingivitis, non-plaque induced
- 523.10 Chronic gingivitis, plaque induced
- 523.11 Chronic gingivitis, non-plaque induced
- 523.30 Aggressive periodontitis, unspecified
- 523.31 Aggressive periodontitis, localized
- 523.32 Aggressive periodontitis, generalized
- 523.33 Acute periodontitis
- 523.40 Chronic periodontitis, unspecified
- 523.41 Chronic periodontitis, localized
- 523.42 Chronic periodontitis, generalized
- 523.8 Other specified periodontal diseases
- 996.67 Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft — (Use additional code to identify specified infections)

Please note that this list of associated ICD-9-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.

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<td>Gingivectomy, excision gingiva, each quadrant</td>
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**Coding and Payment Guide for Dental Services**

<table>
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<th>Code</th>
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<tbody>
<tr>
<td>41820</td>
<td>Gingivectomy, excision gingiva, each quadrant</td>
</tr>
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</table>

**HCPCS Codes**
- **Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant** — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

- **Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant** — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

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41821
Explanation
The dentist removes a small piece of gingiva from the back or top of a
tooth. A scalpel, a laser, or electrocautery is used to excise the tissue
and establish normal gingival contours around the tooth. A periodontal
dressing may be applied.

Coding Tips
Some third-party payers may require that this service be reported using
D7971. When 41821 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.
Local anesthesia is included in the service. For excision of a lesion or
tumor, other than those procedures listed in 41820-41823, see
41825-41827. For destruction of a lesion (except excision),
dentoalveolar structures, see 41850.

Terms To Know
coronal. Relating to the top of a tooth or the crown of the head.
gingiva. Soft tissues surrounding the crowns of unerupted teeth and necks
of erupted teeth.
hypertrophy. Overgrowth or enlargement of normal cells in tissue.
leukoplakia. Thickened white patches or lesions appearing on a mucous
membrane.
periodontal. Relating to the tissues that support and surround the teeth.

HCPCS Codes
D7971 excision of pericoronal gingiva — Surgical removal of
inflammatory or hypertrophied tissues surrounding partially
erupted/impacted teeth.

ICD-9-CM Diagnostic Codes
520.6 Disturbances in tooth eruption
520.8 Other specified disorders of tooth development and
eruption
521.6 Ankylosis of teeth
523.00 Acute gingivitis, plaque induced
523.01 Acute gingivitis, non-plaque induced
523.10 Chronic gingivitis, plaque induced
523.11 Chronic gingivitis, non-plaque induced
523.20 Gingival recession, unspecified
523.22 Gingival recession, moderate
523.23 Gingival recession, severe
523.24 Gingival recession, localized
523.25 Gingival recession, generalized
523.30 Aggressive periodontitis, unspecified
523.31 Aggressive periodontitis, localized
523.32 Aggressive periodontitis, generalized
523.33 Acute periodontitis
523.40 Chronic periodontitis, unspecified
523.41 Chronic periodontitis, localized
523.42 Chronic periodontitis, generalized
523.5 Periodontosis
528.6 Leukoplakia of oral mucosa, including tongue
528.9 Other and unspecified diseases of the oral soft tissues

Please note that this list of associated ICD-9-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.
Excision of fibrous tuberosities, dentoalveolar structures

Explanation
The dentist excises fibrous soft tissue overlying the tuberosities of dentoalveolar structures, reducing the size of the tuberosity. The dentist makes wedged or elliptically shaped incisions through the soft tissue of the tuberosity. The tissue is removed and the surgical wound is sutured directly.

Coding Tips
This procedure includes the removal of overlying soft tissue and sufficient bone to provide an acceptable tissue contour. Local anesthesia is included in the service. Third-party payers may require that this service be reported using D7972. Additionally, payers may bundle this service into gingivectomy or other osseous surgical procedures.

Terms To Know
- anomaly. Irregularity in the structure or position of an organ or tissue.
- gingivitis. Inflamed gingiva (oral mucosa) that surrounds the teeth.
- incision. Act of cutting into tissue or an organ.
- periodontitis. Inflammation of the tissue structures supporting the teeth leading to a loss of connective tissue attachments.
- tubercle. Small rough prominence or rounded nodule on a bone.

HCPCS Codes
- D7972 surgical reduction of fibrous tuberosity

ICD-9-CM Diagnostic Codes
- 523.30 Aggressive periodontitis, unspecified
- 523.31 Aggressive periodontitis, localized
- 523.32 Aggressive periodontitis, generalized
- 523.33 Acute periodontitis
- 523.40 Chronic periodontitis, unspecified
- 523.41 Chronic periodontitis, localized
- 523.42 Chronic periodontitis, generalized
- 523.8 Other specified periodontal diseases
- 524.70 Unspecified alveolar anomaly
- 524.71 Alveolar maxillary hyperplasia
- 524.72 Alveolar mandibular hyperplasia
- 524.79 Other specified alveolar anomaly
- 524.89 Other specified dentofacial anomalies
- 524.9 Unspecified dentofacial anomalies
- 525.8 Other specified disorders of the teeth and supporting structures
- 525.9 Unspecified disorder of the teeth and supporting structures
- 526.89 Other specified disease of the jaws

Please note that this list of associated ICD-9-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.

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Excision of osseous tuberosities, dentoalveolar structures

Explanation
The dentist removes the osseous tissue from the tuberosities of dentoalveolar structures, producing more favorable bone contours. The dentist makes an incision through the mucosa of the tuberosity and exposes the underlying bone. Drills, osteotomes, or files are used to remove and contour the bone. The tissue is sutured directly over the bone. Some soft tissue may be excised prior to closure for adaptation over the newly contoured bone.

Coding Tips
This procedure includes the removal of tori, osseous tuberosities, and other osseous protuberances. The overlying soft tissue is reflected and sufficient bone is removed to provide an acceptable tissue contour. If there is a fibrous component to the tuberosity and simultaneous reduction of the fibrous portion is performed, the procedure is not reported separately. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. Local anesthesia is included in the service. Some payers may require that this procedure be reported using either D7471 or D7485.

Terms To Know
- exostosis: Abnormal formation of a benign bony growth.
- osseous: Related to, consisting of, or resembling bone.
- osteotome: Tool used for cutting bone.
- periodontitis: Inflammation of the tissue structures supporting the teeth leading to a loss of connective tissue attachments.
- tubercle: Small rough prominence or rounded nodule on a bone.

HCPCS Codes
- D7471 removal of lateral exostosis (maxilla or mandible)
- D7485 surgical reduction of osseous tuberosity

ICD-9-CM Diagnostic Codes
- 210.4 Benign neoplasm of other and unspecified parts of mouth
- 213.0 Benign neoplasm of bones of skull and face
- 520.6 Disturbances in tooth eruption
- 523.30 Aggressive periodontitis, unspecified
- 523.31 Aggressive periodontitis, localized
- 523.32 Aggressive periodontitis, generalized
- 523.33 Acute periodontitis
- 523.40 Chronic periodontitis, unspecified
- 523.41 Chronic periodontitis, localized
- 523.42 Chronic periodontitis, generalized
- 523.8 Other specified periodontal diseases
- 523.9 Unspecified gingival and periodontal disease
- 524.70 Unspecified alveolar anomaly
- 524.71 Alveolar maxillary hyperplasia
- 524.72 Alveolar mandibular hyperplasia
- 524.79 Other specified alveolar anomaly
- 524.89 Other specified dentofacial anomalies
- 524.9 Unspecified dentofacial anomalies
- 525.8 Other specified disorders of the teeth and supporting structures
- 525.9 Unspecified disorder of the teeth and supporting structures
- 526.0 Developmental odontogenic cysts
- 526.81 Exostosis of jaw
- 526.89 Other specified disease of the jaws
- 528.9 Other and unspecified diseases of the oral soft tissues
- 730.88 Other infections involving bone diseases classified elsewhere, other specified sites — (Use additional code to identify organism: 041.1. Code first underlying disease: 002.0, 015.0-015.9)

Please note that this list of associated ICD-9-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.

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Excision of hyperplastic alveolar mucosa, each quadrant (specify)

**Explanation**
The dentist excises hyperplastic or excessive mucosa from the alveolus. Incisions are made in the hyperplastic tissue, separating it from the normal mucosa. The excessive tissue is removed. The resultant defect may be directly sutured or left to heal without suturing. With large amounts of excess tissue, more than one surgical session may be required to eliminate all of the tissue. Use this code for each specified quadrant excised.

**Coding Tips**
Each session required to complete the procedure and tissue grafts is reported separately. Specify the quadrant where the procedure was performed. When 41828 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. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. Some payers may require that this service be reported using D7970. Check with payers for their specific guidelines.

**Terms To Know**
- **alveolar process.** Bony part of the maxilla or mandible that supports the tooth roots and into which the teeth are implanted.
- **excision.** Surgical removal of an organ or tissue.
- **hyperplasia.** Abnormal proliferation in the number of normal cells in regular tissue arrangement.
- **local anesthesia.** Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.
- **mucosa.** Moist tissue lining the mouth (buccal mucosa), stomach (gastric mucosa), intestines, and respiratory tract.
- **periodontal.** Relating to the tissues that support and surround the teeth.

**HCPCS Codes**
- D7970 excision of hyperplastic tissue - per arch

**ICD-9-CM Diagnostic Codes**
- 210.4 Benign neoplasm of other and unspecified parts of mouth
- 523.8 Other specified periodontal diseases
- 528.9 Other and unspecified diseases of the oral soft tissues
- VS4.89 Other orthopedic aftercare

Please note that this list of associated ICD-9-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.

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Periodontal mucosal grafting

Explanation
The dentist takes mucosa from one area of the mouth and grafts it around the teeth to repair areas of gingival recession. The dentist uses a scalpel to remove a small piece of mucosa, usually from the hard palate. After preparing the recipient site, the dentist sutures the graft in the area of gingival recession.

Coping Tips
When 41870 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. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. Local anesthesia is included in the service. See 40818 for excision of the mucosa of the vestibule of the mouth as a donor graft. Soft tissue grafting may also be reported using D4270-D4273 and D4275-D4276.

Terms To Know
allograft. Graft from one individual to another of the same species.
graft. Tissue implant from another part of the body or another person.
mucosa. Moist tissue lining the mouth (buccal mucosa), stomach (gastric mucosa), intestines, and respiratory tract.
pedicle graft. Mass of flesh and skin partially excised from the donor location, retaining its blood supply through intact blood vessels, and grafted onto another site to repair adjacent or distant defects.

HCPCS Codes
D4270 pedicle soft tissue graft procedure — A pedicle flap of gingiva can be raised from an edentulous ridge, adjacent teeth, or from the existing gingiva on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.
D4273 subepithelial connective tissue graft procedures, per tooth — This procedure is performed to create or augment gingiva, to obtain root coverage to eliminate sensitivity and to prevent root caries, to eliminate frenum pull, to extend the vestibular fornix, to augment collapsed ridges, to provide an adequate gingival interface with a restoration or to cover bone or ridge regeneration sites when adequate gingival tissues are not available for effective closure. There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlying flap of gingiva and/or mucosa. The connective tissue is dissected from the donor site leaving an epithelialized flap for closure. After the graft is placed on the recipient site, it is covered with the retained overlying flap.

ICD-9-CM Diagnostic Codes
143.0 Malignant neoplasm of upper gum
143.1 Malignant neoplasm of lower gum
210.4 Benign neoplasm of other and unspecified parts of mouth
230.0 Carcinoma in situ of lip, oral cavity, and pharynx
520.6 Disturbances in tooth eruption
523.10 Chronic gingivitis, plaque induced
523.11 Chronic gingivitis, non-plaque induced
523.20 Gingival recession, unspecified
523.21 Gingival recession, minimal
523.22 Gingival recession, moderate
523.23 Gingival recession, severe
523.24 Gingival recession, localized
523.25 Gingival recession, generalized
523.40 Chronic periodontitis, unspecified
523.41 Chronic periodontitis, localized
523.42 Chronic periodontitis, generalized
523.5 Periodontosis
523.8 Other specified periodontal diseases
528.6 Leukoplakia of oral mucosa, including tongue
V10.02 Personal history of malignant neoplasm of other and unspecified parts of oral cavity and pharynx
V51.8 Other aftercare involving the use of plastic surgery

Please note that this list of associated ICD-9-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.
Gingivoplasty, each quadrant (specify)

Explanation
The dentist alters the contours of the gums by performing gingivoplasty. Areas of gingiva may be excised or incisions may be made through the gingiva to create a gingival flap. The flap may be sutured in a different position, trimmed, or both. Any incisions made are closed with sutures.

Coding Tips
Gingivoplasty on the second, third, or fourth quadrant of the dentition may be reported separately. If gingivoplasty is completed, per quadrant, during separate sessions, report one quadrant per session. When 41872 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. Local anesthesia is included in the service. For gingivectomy, each quadrant, see 41820 or D4210-D4211.

Terms To Know
- **gingiva**: Soft tissues surrounding the crowns of unerupted teeth and necks of erupted teeth.
- **gingivectomy**: Surgical excision or trimming of overgrown gum tissue back to normal contours using a scalpel, electrocautery, or a laser. CPT code 41820 or HCPCS Level II code D4210 or D4211 is reported for each quadrant of the mouth in which gingivectomy is performed.
- **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.

HCPCS Codes
- **D4210** gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of 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 — Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

ICD-9-CM Diagnostic Codes
- S20.6 Disturbances in tooth eruption
- S23.00 Acute gingivitis, plaque induced
- S23.01 Acute gingivitis, non-plaque induced
- S23.10 Chronic gingivitis, plaque induced
- S23.11 Chronic gingivitis, non-plaque induced
- S23.20 Gingival recession, unspecified
- S23.21 Gingival recession, minimal
- S23.22 Gingival recession, moderate
- S23.23 Gingival recession, severe
- S23.24 Gingival recession, localized
- S23.25 Gingival recession, generalized
- S23.5 Periodontosis
- S23.8 Other specified periodontal diseases
- B73.62 Open wound of gum (alveolar process), without mention of complication
- B73.72 Open wound of gum (alveolar process), complicated
- 906.0 Late effect of open wound of head, neck, and trunk
- 996.60 Infection and inflammatory reaction due to unspecified device, implant, and graft — (Use additional code to identify specified infections)

Please note that this list of associated ICD-9-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.

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HCPCS Codes

**D7310**  
alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant — The alveoplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

**D7311**  
alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant — The alveoplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

**D7320**  
alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant — No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

**D7321**  
alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant — No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

**ICD-9-CM Diagnostic Codes**

- **143.0** Malignant neoplasm of upper gum
- **143.1** Malignant neoplasm of lower gum
- **170.1** Malignant neoplasm of mandible
- **198.89** Secondary malignant neoplasm of other specified sites
- **210.4** Benign neoplasm of other and unspecified parts of mouth
- **213.1** Benign neoplasm of lower jaw bone
- **230.0** Carcinoma in situ of lip, oral cavity, and pharynx
- **235.1** Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
- **238.0** Neoplasm of uncertain behavior of bone and articular cartilage
- **522.4** Acute apical periodontitis of pulpal origin
- **523.20** Gingival recession, unspecified
- **523.21** Gingival recession, minimal
- **523.22** Gingival recession, moderate
- **523.23** Gingival recession, severe
- **523.24** Gingival recession, localized
- **523.25** Gingival recession, generalized
- **523.41** Chronic periodontitis, localized
- **523.42** Chronic periodontitis, generalized
- **524.72** Alveolar mandibular hyperplasia
- **524.74** Alveolar mandibular hypoplasia
- **525.11** Loss of teeth due to trauma — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
- **525.12** Loss of teeth due to periodontal disease — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
- **525.13** Loss of teeth due to caries — (Code first class of edentulism: 525.40-525.44, 525.50-525.54)
- **525.42** Complete edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)
- **525.43** Complete edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
- **525.44** Complete edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)
- **525.52** Partial edentulism, class II — (Use additional code to identify cause of edentulism: 525.10-525.19)
- **525.53** Partial edentulism, class III — (Use additional code to identify cause of edentulism: 525.10-525.19)
- **525.54** Partial edentulism, class IV — (Use additional code to identify cause of edentulism: 525.10-525.19)

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