Optum

Coding &
Payment Guide

Dental Services

An essential coding, billing and reimbursement resource for dental practices

2024

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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Dental Services* is designed to be a guide to the specialty procedures classified in the CDT® and CPT® books. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book. The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

Resequencing of CDT and CPT Codes

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

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific CDT and CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some procedure codes are presented in a less comprehensive format in the appendix. The CDT and CPT codes appropriate to the specialty are included the appendix with the official code description, followed by an easy-to-understand explanation.

CCI Edits, RVUs, and Other Coding Updates

This *Coding and Payment Guide* includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

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

Debridement
endodontic, D3221
periodontal, D4355
implant
peri, D6101-D6102
single, D6081

General Guidelines

Providers

The ADA and AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. Additionally, the procedures and services listed throughout the book are for use by any qualified dentist, physician, or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow providers to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes have a technical and a professional component. When providers do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

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

D1206-D1208

D1206 topical application of fluoride varnish
D1208 topical application of fluoride - excluding varnish

Explanation

Topically applied fluoride treatments are done in the office with a variety of solutions or gels and different application protocols, excluding rinsing or "swish." The fluoride may be applied with trays or specifically to a few, isolated teeth at a time to prevent a high systemic dose from occurring. Fluoride varnish is painted directly on certain areas to help prevent further decay. The fluoride treatment reported here must be applied separately from any prophylaxis paste. Report D1206 for therapeutic application of varnish or D1208 for topical application of fluoride other than varnish.

Coding Tips

These services must be provided under direct supervision of the dental provider. Appropriate code selection is determined method used. Code D1206 should be used for the application of topical fluoride varnish only. Report D1208 for other topical applications. Any evaluation, radiograph, restorative, or extraction service is reported separately. Removal of coronal plaque is reported separately using D1110 or D1120. Report D9910 if the varnish is applied solely to desensitize the tooth. To report application of interim caries arresting medicament, see D1354.

Documentation Tips

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

Reimbursement Tips

When selecting the procedure or service that accurately identifies the service performed, dentists must use the most accurate code. If the CDT code more accurately identifies the service, this should be used rather than the CPT codes. When an oral health assessment is performed by someone other than the dentist, for example, a licensed dental hygienist, some third-party payers may require that modifier DA Oral health assessment by a licensed health professional other than a dentist, be appended to the code. Check with third-party payers for their specific requirements.

Associated CPT Codes

99188 Application of topical fluoride varnish by a physician or other qualified health care professional

ICD-10-CM Diagnostic Codes

Z01.20 Encounter for dental examination and cleaning without abnormal findings
Z01.21 Encounter for dental examination and cleaning with abnormal findings
Z41.8 Encounter for other procedures for purposes other than remedying health state
Z46.4 Encounter for fitting and adjustment of orthodontic device
Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
Z91.128 Patient's intentional underdosing of medication regimen for other reason
Z91.14 Patient's other noncompliance with medication regimen
Z91.841 Risk for dental caries, low
Z91.842 Risk for dental caries, moderate
Z91.843 Risk for dental caries, high
Z98.810 Dental sealant status
Z98.811 Dental restoration status
Z98.818 Other dental procedure status

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D1206	0.20	0.39	0.02	0.61
D1208	0.10	0.19	0.01	0.30
Facility RVU	**Work**	**PE**	**MP**	**Total**
D1206	0.20	0.39	0.02	0.61
D1208	0.10	0.19	0.01	0.30

	FUD	Status	MUE	Modifiers				IOM Reference
D1206	N/A	N	-	N/A	N/A	N/A	N/A	None
D1208	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

fluoride. Compound of the gaseous element fluorine that can be incorporated into bone and teeth and provides some protection in reducing dental decay.
plaque. Accumulation of a soft sticky substance on the teeth largely composed of bacteria and its byproducts.
prophylaxis. Intervention or protective therapy intended to prevent a disease.
scaling. Removal of plaque, calculus, and stains from teeth.

1. CDT/CPT Codes and Descriptions

This edition of *Coding and Payment Guide for Dental Services* is updated with CDT and CPT codes for year 2023. The following icons are used in the *Coding and Payment Guide*:

- ● This CDT/CPT code is new for 2023.
- ▲ This CDT/CPT code description is revised for 2023.
- ✚ This CDT/CPT code is an add-on code.

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

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services

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

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

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

[ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Explanation

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

3. Coding Tips

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

4. Documentation Tips

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

5. Reimbursement Tips

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

6. Associated CPT Codes

The 2023 edition of the *Coding and Payment Guide for Dental Services* contains a crosswalk from the driver CDT or CPT code to its corresponding CPT or CDT code. CDT codes should be reported for the majority of dental services. On occasion, coverage of trauma, injury, or neoplasm may be covered by the health care insurer. In the rare instance when reporting a medical claim, CPT codes should be reported. This heading will not appear if there is no valid crosswalk.

7. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

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

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

8. Relative Value Units/Medicare Edits

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

Gap Filled Relative Value Units

Included in this edition are 2022 gap filled relative value units (RVU) for the CDT codes. These are useful in assisting with establishing fee schedules for your practice.

The gap relative value units are created by Optum using various methodologies depending on the code. For most codes, gap relative values are calculated by using relative value information from the Optum Relative Value Scale and adjusted to a scale similar to the Medicare physician fee schedule (MPFS) relative values (RBRVS). The Optum relative values are developed by and are proprietary to Optum, Inc. The Optum relative values are assigned when Optum has an understanding of how the procedure is typically billed by the industry and how it relates to other procedures. Relative values are based on difficulty, time, work, risk, and resources. Relative values are established by Optum employees, including an Optum medical director, clinicians, certified procedural coders, and analysts. Optum also consults with a panel of outside physicians and dentists during the relative value development process for certain codes.

Because the Optum relative values are on a different scale than RBRVS relative values, ratios are developed relating the RBRVS and Optum scales for approximately 250 code ranges within the CPT, HCPCS, and CDT coding systems. These ratios are multiplied by the Optum relative value to create the gap value. If Optum does not assign a relative value to a code, a gap value is not calculated.

Relative Value Units

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

Procedure Codes

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

- Coding and billing should be based on the service and supplies provided. Documentation should describe the patient's problems and the service provided to enable the payer to determine reasonableness and necessity of care.
- Refer to Medicare coverage reference to determine whether the care provided is a covered service. The references are noted, when they apply, on the pages following.

HCPCS Level I or CPT Codes

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

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

HCPCS Level II Codes

HCPCS Level II codes are commonly referred to as national codes or by the acronym HCPCS (pronounced "hik piks"). HCPCS codes are used for billing Medicare and Medicaid patients and have also been adopted by some third-party payers. HCPCS Level II codes published annually by CMS, are intended to supplement the CPT coding system by including codes for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); drugs; and biologicals. These Level II codes consist of one alphabetic character (A–V) followed by four numbers. In many instances, HCPCS Level II codes are developed as precursors to CPT codes.

A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.

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

Medical and Surgical Supplies A4000–A8999

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

A4550 **Surgical trays**

A4649 **Surgical supply; miscellaneous**

E1700 **Jaw motion rehabilitation system**

E1701 **Replacement cushions for jaw motion rehabilitation system, package of 6**

E1702 **Replacement measuring scales for jaw motion rehabilitation system, package of 200**

Drugs Administered Other Than Oral Method J0000–J8999

Drugs and biologicals are usually covered by Medicare if: they are of the type that cannot be self-administered; they are not excluded by being immunizations; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered; and they have not been determined by the Food and Drug Administration (FDA) to be less than effective. In addition they must meet all the general requirements for coverage of items as incident to a physician's services. Generally, prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

The following list of drugs can be injected either subcutaneously, intramuscularly, or intravenously. Third-party payers may wish to determine a threshold and pay up to a certain dollar limit for the drug.

> J codes fall under the jurisdiction of the DME regional office for Medicare, unless incidental or otherwise noted. See Pub. 100-2, chap. 15, sec. 50.4

J0670 **Injection, mepivacaine HCl, per 10 ml**

J1790 **Injection, droperidol, up to 5 mg**

J2250 **Injection, midazolam HCl, per 1 mg**

J2400 **Injection, chloroprocaine HCl, per 30 ml**

J2515 **Injection, pentobarbital sodium, per 50 mg**

J2550 **Injection, promethazine HCl, up to 50 mg**

J3010 **Injection, fentanyl citrate, 0.1 mg**

J3360 **Injection, diazepam, up to 5 mg**

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

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

D0120

D0120 periodic oral evaluation - established patient

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

Explanation

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

Coding Tips

When the patient is referred by another dentist for an opinion or advice regarding a particular condition, see code D9310. When a comprehensive oral examination is performed, see code D0150. When a problem-focused limited oral evaluation is performed, see codes D0140-D0145. A detailed oral evaluation that is problem focused is reported using code D0160; a limited, problem-focused exam is reported using D0170. When the provider performs a caries risk assessment using a standardized risk assessment tool, see D0601-D0603. A comprehensive periodontal evaluation, new or established patient, is reported using D0180. Code D0180 should not be reported in addition to this code as the components of D0120 are included in the comprehensive periodic evaluation. According to the ADA, codes D0120 and D4355 may be reported on the same date of service; however, it should be noted that some third-party payer policies prohibit billing these procedures concurrently. Any radiograph, prophylaxis, fluoride, restorative, or extraction service is reported separately.

Documentation Tips

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

Reimbursement Tips

When an oral health assessment is performed by someone other than the dentist, for example, a licensed dental hygienist, some third-party payers may require that modifier DA Oral health assessment by a licensed health professional other than a dentist, be appended to the this code. Check with third-party payers for their specific requirements.

ICD-10-CM Diagnostic Codes

K00.0	Anodontia
K00.1	Supernumerary teeth
K00.2	Abnormalities of size and form of teeth
K00.3	Mottled teeth
K00.4	Disturbances in tooth formation
K00.5	Hereditary disturbances in tooth structure, not elsewhere classified
K00.6	Disturbances in tooth eruption
K00.7	Teething syndrome
K00.8	Other disorders of tooth development
K01.0	Embedded teeth
K01.1	Impacted teeth
K02.3	Arrested dental caries
K02.51	Dental caries on pit and fissure surface limited to enamel
K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K03.0	Excessive attrition of teeth
K03.1	Abrasion of teeth
K03.2	Erosion of teeth
K03.3	Pathological resorption of teeth
K03.4	Hypercementosis
K03.5	Ankylosis of teeth
K03.6	Deposits [accretions] on teeth
K03.7	Posteruptive color changes of dental hard tissues
K03.81	Cracked tooth
K04.01	Reversible pulpitis
K04.02	Irreversible pulpitis
K04.1	Necrosis of pulp
K04.2	Pulp degeneration
K04.3	Abnormal hard tissue formation in pulp
K04.4	Acute apical periodontitis of pulpal origin
K04.5	Chronic apical periodontitis
K04.6	Periapical abscess with sinus
K04.7	Periapical abscess without sinus
K04.8	Radicular cyst
K05.00	Acute gingivitis, plaque induced
K05.01	Acute gingivitis, non-plaque induced
K05.10	Chronic gingivitis, plaque induced
K05.11	Chronic gingivitis, non-plaque induced
K05.211	Aggressive periodontitis, localized, slight
K05.212	Aggressive periodontitis, localized, moderate
K05.213	Aggressive periodontitis, localized, severe
K05.222	Aggressive periodontitis, generalized, moderate
K05.223	Aggressive periodontitis, generalized, severe
K05.311	Chronic periodontitis, localized, slight
K05.312	Chronic periodontitis, localized, moderate
K05.313	Chronic periodontitis, localized, severe
K05.321	Chronic periodontitis, generalized, slight
K05.322	Chronic periodontitis, generalized, moderate
K05.323	Chronic periodontitis, generalized, severe
K05.4	Periodontosis
K05.5	Other periodontal diseases
K06.011	Localized gingival recession, minimal
K06.012	Localized gingival recession, moderate
K06.013	Localized gingival recession, severe
K06.021	Generalized gingival recession, minimal
K06.022	Generalized gingival recession, moderate
K06.023	Generalized gingival recession, severe
K06.1	Gingival enlargement
K06.2	Gingival and edentulous alveolar ridge lesions associated with trauma
K08.0	Exfoliation of teeth due to systemic causes
K08.111	Complete loss of teeth due to trauma, class I
K08.112	Complete loss of teeth due to trauma, class II

D0601-D0603

D0601 caries risk assessment and documentation, with a finding of low risk

Using recognized assessment tools.

D0602 caries risk assessment and documentation, with a finding of moderate risk

Using recognized assessment tools.

D0603 caries risk assessment and documentation, with a finding of high risk

Using recognized assessment tools.

Explanation

Using a standardized risk assessment tool, the provider evaluates the patient's level of risk for developing caries. Assessments and level of risk vary based on the age of the patient but include such factors as fluoride exposure, dietary risks, general health conditions, and dental clinical conditions including but not limited to visible plaque, xerostomia, dental/orthodontic appliances, and unusual tooth morphology. Report D0601 when the level of risk is low, D0602 when the level of risk is moderate, and D0603 when the level of risk is determined to be high.

Coding Tips

These are out of sequence codes and will not display in numeric order in the CDT manual. After review of the assessment tool, the level of risk may be increased or decreased dependent upon clinical judgment and the review of other pertinent information. Documentation as to the reason for the revised level of risk should be recorded in the medical record. To report nutritional counseling, see D1310. To report oral hygiene counseling, see D1330. To report caries susceptibility testing, see D0425. Coverage of this procedure varies by payer. Check with payers for their specific coverage guidelines.

Documentation Tips

After review of the assessment tool, the level of risk may be increased or decreased dependent upon clinical judgment and the review of other pertinent information. Documentation as to the reason for the revised level of risk should be recorded in the medical record.

Reimbursement Tips

Coverage of this procedure varies by payer. Check with the payer for specific coverage guidelines.

ICD-10-CM Diagnostic Codes

Z01.20	Encounter for dental examination and cleaning without abnormal findings
Z01.21	Encounter for dental examination and cleaning with abnormal findings
Z71.3	Dietary counseling and surveillance
Z91.841	Risk for dental caries, low
Z91.842	Risk for dental caries, moderate
Z91.843	Risk for dental caries, high

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D0601	0.00	0.16	0.00	0.16
D0602	0.00	0.16	0.00	0.16
D0603	0.00	0.16	0.00	0.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0601	0.00	0.16	0.00	0.16
D0602	0.00	0.16	0.00	0.16
D0603	0.00	0.16	0.00	0.16

	FUD	Status	MUE	Modifiers				IOM Reference
D0601	N/A	R	-	N/A	N/A	N/A	N/A	None
D0602	N/A	R	-	N/A	N/A	N/A	N/A	
D0603	N/A	R	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

caries. Localized section of tooth decay that begins on the tooth surface with destruction of the calcified enamel, allowing bacterial destruction to continue and form cavities and may extend to the dentin and pulp.

morphological. Pertaining to structure and function.

xerostomia. Dry mouth due to lack of saliva.

D2981-D2983

D2981 inlay repair necessitated by restorative material failure
D2982 onlay repair necessitated by restorative material failure
D2983 veneer repair necessitated by restorative material failure

Explanation

The provider repairs a previous restoration due to marginal defects. The repair of limited defects allows the previous restoration to be left undisturbed for several years or more. In D2981 the provider creates a fixed restoration outside of the mouth, which is then luted onto the tooth with the failed restorative material. In D2982 the repair restores one or more cusps and adjoining occlusal surfaces and is then retained by adhesive means. In D2983 a thin covering is placed over the damaged restorative material.

Coding Tips

When the failed restoration is replaced, see the appropriate code for the type of procedure performed.

Reimbursement Tips

The tooth/root number should be indicated on the claim.

ICD-10-CM Diagnostic Codes

K08.530 Fractured dental restorative material without loss of material
K08.531 Fractured dental restorative material with loss of material
K08.539 Fractured dental restorative material, unspecified
K08.54 Contour of existing restoration of tooth biologically incompatible with oral health
K08.55 Allergy to existing dental restorative material
K08.56 Poor aesthetic of existing restoration of tooth
K08.59 Other unsatisfactory restoration of tooth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D2981	0.00	0.00	0.00	0.00
D2982	0.00	0.00	0.00	0.00
D2983	0.00	0.00	0.00	0.00
Facility RVU	**Work**	**PE**	**MP**	**Total**
D2981	0.00	0.00	0.00	0.00
D2982	0.00	0.00	0.00	0.00
D2983	0.00	0.00	0.00	0.00

	FUD	Status	MUE	Modifiers				IOM Reference
D2981	N/A	N	-	N/A	N/A	N/A	N/A	None
D2982	N/A	N	-	N/A	N/A	N/A	N/A	
D2983	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

inlay. Restoration made outside of the mouth to fit a prepared cavity and placed on the tooth.

onlay. In dentistry, restoration made outside of the mouth that is cemented over a cusp or cusps of the tooth.

D2990

D2990 resin infiltration of incipient smooth surface lesions

Placement of an infiltrating resin restoration for strengthening, stabilizing and/or limiting the progression of the lesion.

Explanation

The provider applies a resin infiltrant to a caries lesion to stop lesion progression. Low viscosity resins are drawn deep into the pore system of the lesion replacing lost tooth structure and stopping caries progression by blocking nutrients from entering into the pore system while stabilizing the anatomical shape and color of the tooth. A rubber dam is placed to protect the gingiva. The tooth surface is etched with a hydrochloric acid solution. The resin infiltrant is applied. Excessive materials are removed and the area is light cured. Application of the infiltrant may be repeated to ensure coverage.

Coding Tips

This is an out of sequence code and will not display in numeric order in the CDT manual. When done at the same time a topical application of fluoride varnish, code D1206 may also be reported.

Reimbursement Tips

Coverage of this procedure varies by payer. Check with payers for their specific coverage guidelines.

ICD-10-CM Diagnostic Codes

K02.3 Arrested dental caries
K02.51 Dental caries on pit and fissure surface limited to enamel
K02.52 Dental caries on pit and fissure surface penetrating into dentin
K02.53 Dental caries on pit and fissure surface penetrating into pulp
K02.61 Dental caries on smooth surface limited to enamel
K02.62 Dental caries on smooth surface penetrating into dentin
K02.63 Dental caries on smooth surface penetrating into pulp
K02.7 Dental root caries
K08.530 Fractured dental restorative material without loss of material
K08.531 Fractured dental restorative material with loss of material
K08.54 Contour of existing restoration of tooth biologically incompatible with oral health
K08.55 Allergy to existing dental restorative material
K08.56 Poor aesthetic of existing restoration of tooth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D2990	0.24	0.21	0.05	0.50
Facility RVU	**Work**	**PE**	**MP**	**Total**
D2990	0.24	0.21	0.05	0.50

	FUD	Status	MUE	Modifiers				IOM Reference
D2990	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

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

D5640-D5650

D5640 replace broken teeth - per tooth
D5650 add tooth to existing partial denture

Explanation

Partial dentures are composed of a metal framework with plastic teeth and gum areas. The framework contains metal clasps or other attachments that hold the denture in place. Two types of attachments are available: metal clasps and precision attachments. Metal clasps consist of C-shaped pieces of denture framework that fit around adjacent natural teeth. A precision attachment uses a receptacle created within a remaining tooth. The receptacle typically is covered with a crown. The precision attachment extends into the receptacle securing the partial denture. If the framework, clasps, or precision attachments break they are repaired in the dentist's office or sent to a dental laboratory. To repair cast framework or replace a fractured clasp or precision attachment, an alginate impression in a stock tray is made of the denture with the patient wearing the denture. Care must be taken to ensure the impression material does not displace the denture from its correct position. The new framework, clasp, or precision attachment is fabricated and attached to the existing denture using the impression to correctly align and place the required part. Repair of the cast framework is reported with D5621 (mandibular or upper) or D5622 (maxillary or lower). Repair of a metal clasp or precision attachment is reported with D5630.

Coding Tips

Local anesthesia is generally considered to be part of removable prosthodontic procedures.

Reimbursement Tips

Third-party payers may not reimburse separately for this service. Check with the payer for specific guidelines.

ICD-10-CM Diagnostic Codes

Z46.3 Encounter for fitting and adjustment of dental prosthetic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D5640	0.89	0.79	0.18	1.86
D5650	1.10	0.97	0.23	2.30
Facility RVU	**Work**	**PE**	**MP**	**Total**
D5640	0.89	0.79	0.18	1.86
D5650	1.10	0.97	0.23	2.30

	FUD	Status	MUE	Modifiers				IOM Reference
D5640	N/A	N	-	N/A	N/A	N/A	N/A	None
D5650	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

denture base. Portion of the artificial substitute for natural teeth that makes contact with the soft tissue of the mouth and serves as the anchor for the artificial teeth.

partial dentures. In dentistry, artificial teeth composed of a framework with plastic teeth and gum area replacing part but not all of the natural teeth. The framework can either be formed from an acrylic resin base, cast metal or may be made more flexible using thermoplastics.

D5660

D5660 add clasp to existing partial denture - per tooth

Explanation

A clasp is added to an existing partial denture. To add a clasp to a denture, an alginate impression in a stock tray is made of the denture with the patient wearing the denture. Care must be taken to ensure that the impression material does not displace the denture from its correct position. An impression of the opposing dentition is also made if the component to be added is affected by the occlusion (bite), as this will influence the design and position of the component. If the casts cannot be placed by hand into the intercuspal position, an interocclusal record will be obtained to allow the casts to be mounted on an articulator. A new clasp arm is then produced by adapting a wrought stainless steel wire to the tooth on the cast and attaching the wire to the existing denture base.

Coding Tips

Local anesthesia is generally considered to be part of removable prosthodontic procedures.

Reimbursement Tips

Third-party payers may not reimburse separately for this service. Check with the payer for specific guidelines.

ICD-10-CM Diagnostic Codes

Z46.3 Encounter for fitting and adjustment of dental prosthetic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D5660	1.47	1.30	0.30	3.07
Facility RVU	**Work**	**PE**	**MP**	**Total**
D5660	1.47	1.30	0.30	3.07

	FUD	Status	MUE	Modifiers				IOM Reference
D5660	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

partial dentures. In dentistry, artificial teeth composed of a framework with plastic teeth and gum area replacing part but not all of the natural teeth. The framework can either be formed from an acrylic resin base, cast metal or may be made more flexible using thermoplastics.

prosthodontics. Branch of dentistry that specializes in the replacement of missing or damaged teeth.

D7510-D7521

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.

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.

Explanation

Incision of the abscess and drainage of the accumulated pus and bacteria are primary in managing odontogenic infections, which most commonly take the form of a necrotic pulp or deep periodontal pocket. Once the area has been anesthetized with a regional block or local infiltration, the dentist inserts a large gauge needle into the abscess cavity to collect a specimen for laboratory analysis. The subsequent incision into the cavity to drain the pus from the infection is made through the mucosa and submucosa; pus remaining in the cavity is removed. Once all areas of the abscess cavity have been emptied and the pus is aspirated through suction from the patient's mouth, a small drain is prepared and sutured into viable tissue to prevent its loss; the drain remains in place, from two to five days, and removal is done by cutting the suture and slipping the drain from the wound. Report D7511 or D7521 for an incision and a drainage that involves multiple fascial spaces. Report D7520 or D7521 when the drainage incision is made through the skin of the face or neck rather than through oral mucosa.

Coding Tips

Any evaluation of specimen or radiograph is reported separately. Local anesthesia is generally considered part of these services.

Documentation Tips

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

Reimbursement Tips

When selecting the procedure or service that accurately identifies the service performed, dentists must use the most accurate code. If the CDT code more accurately identifies the service, this should be used rather than the CPT codes. This procedure may be covered by the patient's medical insurance. When covered by medical insurance, the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Associated CPT Codes

10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)
10009	Fine needle aspiration biopsy, including CT guidance; first lesion
10010	Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)
10011	Fine needle aspiration biopsy, including MR guidance; first lesion
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)
11102	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
11103	Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)
11104	Punch biopsy of skin (including simple closure, when performed); single lesion
11105	Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)
11106	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion
11107	Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)
38300	Drainage of lymph node abscess or lymphadenitis; simple
38305	Drainage of lymph node abscess or lymphadenitis; extensive
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial
41006	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid
41007	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space
41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space
41010	Incision of lingual frenum (frenotomy)
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures

ICD-10-CM Diagnostic Codes

K12.2	Cellulitis and abscess of mouth
K12.30	Oral mucositis (ulcerative), unspecified
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.32	Oral mucositis (ulcerative) due to other drugs
K12.33	Oral mucositis (ulcerative) due to radiation
K12.39	Other oral mucositis (ulcerative)

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

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

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

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

Classification of Evaluation and Management (E/M) Services

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

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

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

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New and Established Patients

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

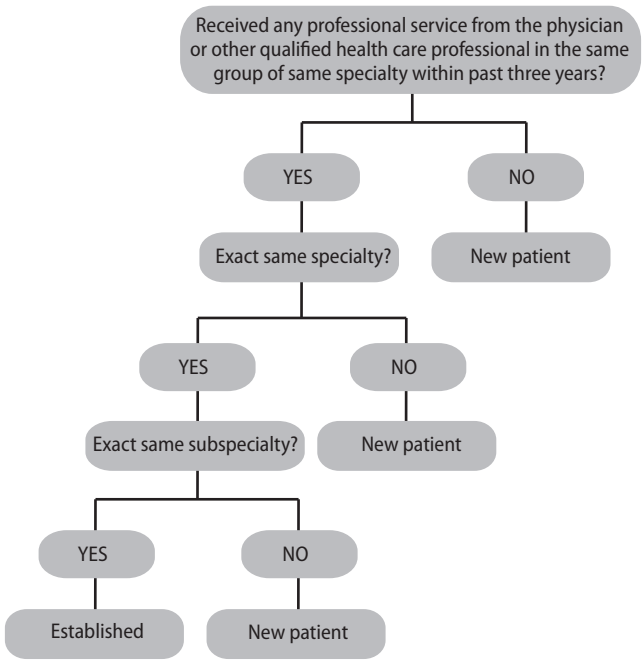
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

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

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

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



▶◀ = Contains new or revised text

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

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

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

Documentation Tips

Documentation should include the history and exam performed in addition to the medical decision making performed. When time is the determinant for code selection, total time should be documented. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

The place-of-service (POS) codes used for reporting these services are the same as those for a new patient: POS code 11 represents the clinician's office environment and POS code 22 represents the outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service is distinct from the other service performed.

ICD-10-CM Diagnostic Codes

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

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

41017

41017 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.

Documentation Tips

The infectious agent, if known, should be documented in the medical record.

Reimbursement Tips

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

Associated HCPCS Codes

D7520 incision and drainage of abscess - extraoral soft tissue
D7521 incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)

ICD-10-CM Diagnostic Codes

K09.8 Other cysts of oral region, not elsewhere classified
K12.2 Cellulitis and abscess of mouth
K13.29 Other disturbances of oral epithelium, including tongue
K14.0 Glossitis
K14.8 Other diseases of tongue

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
41017	4.19	9.29	0.42	13.90
Facility RVU	**Work**	**PE**	**MP**	**Total**
41017	4.19	5.49	0.42	10.10

	FUD	Status	MUE	Modifiers				IOM Reference
41017	90	A	2(3)	N/A	51	N/A	80*	100-04,12,90.4.5

* with documentation

Terms To Know

dissection. Separating by cutting tissue or body structures apart.

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

41018

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.

Documentation Tips

The infectious agent, if known, should be documented in the medical record.

Reimbursement Tips

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

Associated HCPCS Codes

D7520 incision and drainage of abscess - extraoral soft tissue
D7521 incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)

ICD-10-CM Diagnostic Codes

K09.8 Other cysts of oral region, not elsewhere classified
K12.2 Cellulitis and abscess of mouth
K13.29 Other disturbances of oral epithelium, including tongue
K14.0 Glossitis
K14.8 Other diseases of tongue

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
41018	5.22	9.79	0.56	15.57
Facility RVU	**Work**	**PE**	**MP**	**Total**
41018	5.22	5.97	0.56	11.75

	FUD	Status	MUE	Modifiers				IOM Reference
41018	90	A	2(3)	N/A	51	N/A	80*	100-04,12,90.4.5

* with documentation