CODING GUIDE

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

APPROVED BY AAOMS ASI AAOMS Services, Inc.

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Contents

Procedure Codes

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

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

Additionally documentation should:

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

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

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

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

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

HCPCS Level I or CPT Codes

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

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

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

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

HCPCS Level II Codes

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

Medical and Surgical Supplies

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

A4550 Surgical trays

A4649 Surgical supply; miscellaneous

E1700 Jaw motion rehabilitation system

E1701 Replacement cushions for jaw motion rehabilitation system, package of six

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

Drugs Administered Other Than Oral Method J0000–J8999

Drugs and biologicals are usually covered by Medicare if they:

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

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

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

Note that for Medicare purposes, special coverage instructions apply to these services:

J1790 Injection, droperidol, up to 5 mg

Pub. 100-2, chap. 15, sec. 50.4

J2250 Injection, midazolam hydrochloride, per 1 mg

Pub. 100-2, chap. 15, sec. 50.4

J2400 Injection, chloroprocaine hydrochloride, per 30 ml

Pub. 100-2, chap. 15, sec. 50.4

D4274

D4274 mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)

This procedure is performed in an edentulous area adjacent to a tooth, allowing removal of a tissue wedge to gain access for debridement, permit close flap adaptation, and reduce pocket depths.

Explanation

A mesial distal wedge procedure is performed in an edentulous area adjacent to the periodontally involved tooth. An anesthetic is administered. The provider makes a gingival incision and removes a tissue wedge to gain access to the underlying osseous defect. The osseous defect is corrected and the gingival tissue closed with sutures.

Coding Tips

Local anesthesia is generally considered to be part of periodontal procedures. Most payers feel that this procedure is included in more complex services and when performed at the time of a more complex procedure is not separately reimbursed. Check with individual payers for specific guidelines.

Documentation Tips

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

Reimbursement Tips

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

Associated CPT Codes

41870 Periodontal mucosal grafting

ICD-10-CM Diagnostic Codes

K05.00 Acute gingivitis, plaque induced
K05.01 Acute gingivitis, non-plaque induced
K05.10 Chronic gingivitis, plaque induced
K05.11 Chronic gingivitis, non-plaque induced
K05.221 Aggressive periodontitis, generalized, slight
K05.222 Aggressive periodontitis, generalized, moderate
K05.223 Aggressive periodontitis, generalized, severe
K05.229 Aggressive periodontitis, generalized, unspecified severity
K05.30 Chronic periodontitis, unspecified
K05.311 Chronic periodontitis, localized, slight
K05.312 Chronic periodontitis, localized, moderate
K05.313 Chronic periodontitis, localized, severe
K05.319 Chronic periodontitis, localized, unspecified severity
K05.321 Chronic periodontitis, generalized, slight
K05.322 Chronic periodontitis, generalized, moderate
K05.323 Chronic periodontitis, generalized, severe
K05.329 Chronic periodontitis, generalized, unspecified severity
K05.4 Periodontosis
K06.011 Localized gingival recession, minimal
K06.012 Localized gingival recession, moderate
K06.013 Localized gingival recession, severe
K06.021 Generalized gingival recession, minimal
K06.022 Generalized gingival recession, moderate
K06.023 Generalized gingival recession, severe
K06.1 Gingival enlargement
K06.2 Gingival and edentulous alveolar ridge lesions associated with trauma
S02.42XA Fracture of alveolus of maxilla, initial encounter for closed fracture
S02.42XB Fracture of alveolus of maxilla, initial encounter for open fracture
S02.5XXA Fracture of tooth (traumatic), initial encounter for closed fracture
S02.5XXB Fracture of tooth (traumatic), initial encounter for open fracture
S07.0XXA Crushing injury of face, initial encounter
S07.1XXA Crushing injury of skull, initial encounter

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D4274	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D4274	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D4274	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

acute. Sudden, severe.

chronic. Persistent, continuing, or recurring.

distal. Located farther away from a specified reference point or the trunk.

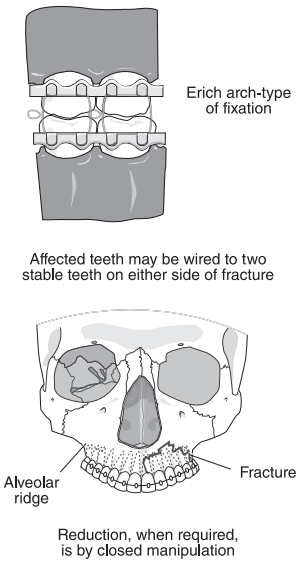
gingiva. Soft tissues surrounding the crowns of unerupted teeth and necks of erupted teeth.

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

proximal. Located closest to a specified reference point, usually the midline or trunk.

21440

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



Explanation

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

Coding Tips

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

Documentation Tips

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

Reimbursement Tips

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

Associated HCPCS Codes

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

ICD-10-CM Diagnostic Codes

S02.42XA Fracture of alveolus of maxilla, initial encounter for closed fracture
S02.671A Fracture of alveolus of right mandible, initial encounter for closed fracture
S02.672A Fracture of alveolus of left mandible, initial encounter for closed fracture

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

AMA: 21440 2002,Apr,13

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21440	3.44	12.59	0.57	16.6
Facility RVU	**Work**	**PE**	**MP**	**Total**
21440	3.44	9.46	0.57	13.47

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

* with documentation

Terms To Know

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

mandibular. Having to do with the lower jaw.

maxillary. Located between the eyes and the upper teeth.