2018

OMS

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

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## Contents

**Getting Started with Coding Guide** ........................................... 1  
- Sample Page and Key ................................................................. 1  
- Reimbursement Issues .............................................................. 4

**Illustrations** ........................................................................... 7  
- Facial Bones .............................................................................. 7  
- Facial Structures ...................................................................... 9  
- Integumentary ......................................................................... 11  
- Intraoral Structures .................................................................. 12  
- Jaw with TMJ .......................................................................... 14  
- LeFort Fractures ..................................................................... 15  
- Facial Nerves .......................................................................... 16

**Procedure Codes** ................................................................. 17  
- HCPCS Level I or CPT Codes ................................................... 17  
- HCPCS Level II Codes .............................................................. 17

**Appendix** ............................................................................ 679  
- Correct Coding Initiative Update 23.3 .................................... 683  
- CPT Index ............................................................................. 745  
- Evaluation and Management .................................................. 757  
- Plastic Surgery and Dermatology Specifics ............................. 775  
- Medicare Official Regulatory Information .............................. 779  
- The CMS Online Manual System ......................................... 779  
- National Coverage Determinations Manual .......................... 779  
- Medicare Benefit Policy Manual ........................................... 779  
- Pub. 100 References ................................................................. 780
**D4273, D4283**

**D4273** autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft

*There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlapping flap of gingiva and/or mucosa. The connective tissue is dissected from a separate donor site leaving an epithelialized flap for closure.*

**D4283** autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site

*Used in conjunction with D4273.*

**Explanation**

A subepithelial connective tissue graft procedure is performed to create or augment gingiva, to obtain root coverage thereby eliminating sensitivity and preventing root caries, to eliminate frenulum 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. The graft procedure utilizes two surgical sites: the recipient site where the graft will be placed and the donor site where the graft will be harvested. At the recipient site, a split thickness incision is made and the overlying flap of gingiva and mucosa retained. At the donor site, connective tissue is dissected free leaving an epithelialized flap for closure. The graft is placed on the recipient site and covered with the retained overlying flap, which is sutured into place. The donor site is also sutured closed. Report D4273 for the first tooth, implant, or edentulous tooth space and D4283 for each additional contiguous space.

**Coding Tips**

Code D4283 is an out-of-sequence code and will not display in numeric order in the CDT manual. Local anesthesia is generally considered to be part of periodontal procedures. Local anesthesia is included in these services. Any radiographs are reported separately. Preparation of recipient site is included. These codes include postoperative care.

**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. Check with payers for their specific requirements.

**Reimbursement Tips**

These codes include frenulectomy, distal wedge procedure(s), and stenting done on the same area on the same date of service.

**Terms To Know**

**autogenous transplant.** Tissue, such as bone, that is harvested from the patient and used for transplantation back into the same patient.

**chronic.** Persistent, continuing, or recurring.

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

**graft.** Tissue implant from another part of the body or another person.

**CPT Codes**

- 41870 Periodontal mucosal grafting

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**ICD-10-CM Diagnostic Codes**

- K05.10 Chronic gingivitis, plaque induced
- K05.11 Chronic gingivitis, non-plaque induced
- K06.0 Gingival recession
- K06.1 Gingival enlargement
- K06.2 Gingival and edentulous alveolar ridge lesions associated with trauma
- K08.0 Exfoliation of teeth due to systemic causes
- 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.

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* with documentation
Coronoidectomy (separate procedure)

**Explanation**
The physician removes the diseased or fractured coronoid process of the mandible, the anterior projection on the angled branch of the jaw to which the temporal muscle is attached. The physician makes an incision intraorally along the external oblique ridge of the mandible. The tissue is reflected from the bone, exposing the coronoid process. Using drills and/or osteotomes, the coronoid process is clamped and sectioned from the mandible. The muscle attachments are cut from the coronoid process and will retract, forming scar tissue. The coronoid process is removed. The mucosal incision is closed primarily.

**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. 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).

**Terms To Know**
- **Coronoidectomy.** Procedure in which a diseased or fractured coronoid process of the mandible is removed.
- **Mandible.** Lower jawbone giving structure to the floor of the oral cavity.

**CDT Codes**
D7991 coronoidectomy

**ICD-10-CM Diagnostic Codes**
- M26.03 Mandibular hyperplasia
- M26.07 Excessive tuberosity of jaw
- M26.09 Other specified anomalies of jaw size
- M26.12 Other jaw asymmetry
- M26.19 Other specified anomalies of jaw-cranial base relationship
- M26.29 Other anomalies of dental arch relationship
- M26.52 Limited mandibular range of motion
- M26.53 Deviation in opening and closing of the mandible
- M26.59 Other dentofacial functional abnormalities
- M26.89 Other dentofacial anomalies
- S02.631A Fracture of coronoid process of right mandible, initial encounter for closed fracture
- S02.631B Fracture of coronoid process of right mandible, initial encounter for open fracture
- S02.632A Fracture of coronoid process of left mandible, initial encounter for closed fracture
- S02.632B Fracture of coronoid process of left mandible, initial encounter for open fracture

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

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Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may employ when treating a given patient, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The 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 (see paragraphs 2 and 3 under “Instructions for Use of the CPT® Codebook” on page xi of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (QOHC) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable).” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient
- Emergency department services
- Critical care
- Nursing facility—initial services
- Nursing facility—subsequent services
- Nursing facility—discharge and annual assessment
- Domiciliary, rest home, or custodial care—new patient
- Domiciliary, rest home, or custodial care—established patient
- Newborn care services
- Neonatal and pediatric interfacility transport
- Neonatal and pediatric critical care—inpatient
- Neonate and infant intensive care services—initial and continuing

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending physician or other qualified health care provider may not bill a new patient code unless the attending physician or other qualified health care provider has not seen the patient for any problem within three years.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient. Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the provider “admitting” the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation