Optum

Coding Guide

OMS

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

2025

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Getting Started with Coding Guide

The *Coding Guide for OMS* (Oral Maxillofacial Services) is designed to be a guide to the specialty procedures classified in the CDT® and CPT® books. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CDT and CPT Codes

For ease of use, evaluation and management codes related to Oral Maxillofacial Services are listed first in the CPT code section of the *Coding Guide*. All other CDT and CPT codes in *Coding Guide for OMS* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CDT code is followed by its official code description and nomenclature and each CPT code is followed by its official code description.

Resequencing of CDT and CPT Codes

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

The CDT codes print in numeric order. We have included a table that lists the resequenced code and the preceding or following code to help locate the CDT code, when you are referencing the ADA's CDT book.

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

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

CCI Edits, RVUs, and Other Coding Updates

This *Coding Guide* includes the list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is: **XXXXXX**. Log in frequently to ensure you receive the most current updates.

Index

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

21199 Osteotomy, mandible, segmental; with genioglossus advancement

could be found in the index under the following main terms:

Advancement
Genioglossus, 21199

or **Mandible**
Osteotomy, 21198-21199

or **Osteotomy**
Mandible, 21198-21199

Telehealth/Telemedicine Services

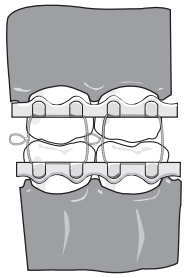
Telehealth/telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) identify services that may be performed via telehealth. These CMS-approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's home, and modifier 93 or 95 appended. If specialized equipment is used at the originating site, code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services.

Sample Page and Key

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

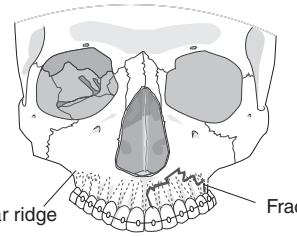
21440

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



Erich arch-type of fixation

Affected teeth may be wired to two stable teeth on either side of fracture



Reduction, when required, is by closed manipulation

Explanation

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

Coding Tips

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

Documentation Tips

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

Reimbursement Tips

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

Associated HCPCS Codes

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

ICD-10-CM Diagnostic Codes

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

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

AMA: **21440** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21440	3.44	16.9	0.37	20.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
21440	3.44	12.82	0.37	16.63

	FUD	Status	MUE	Modifiers				IOM Reference
21440	90	A	2(3)	N/A	51	N/A	80*	None

* with documentation

Terms To Know

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

mandibular. Having to do with the lower jaw.

maxillary. Located between the eyes and the upper teeth.

1. CDT/CPT Codes and Descriptions

This edition of *Coding Guide for OMS* is updated with CDT and CPT codes for year 2024.

The following icons are used in the *Coding Guide*:

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.
- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.
- **[ ]** CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

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

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

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

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

2. Illustrations

The illustrations that accompany the *Coding Guide* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most CPT pages will have an illustration, there will be some pages that do not. The pages for the CDT procedures do not have illustrations.

3. Explanation

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

4. Coding Tips

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

5. Documentation Tips

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

6. Reimbursement Tips

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

7. Associated CPT/HCPCS Codes

The 2024 edition of the *Coding Guide for OMS* contains a crosswalk from the driver Dental or CPT code to its corresponding CPT or Dental or other associated HCPCS code. CDT codes should be reported for the majority of dental services. On occasion, coverage of trauma, injury, or neoplasm may be covered by the healthcare insurer. This heading will not appear if there is no valid crosswalk.

8. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty.

Some ICD-10-CM codes are further identified with the following icons:

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

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

9. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

10. Relative Value Units/Medicare Edits

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

Relative Value Units

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

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

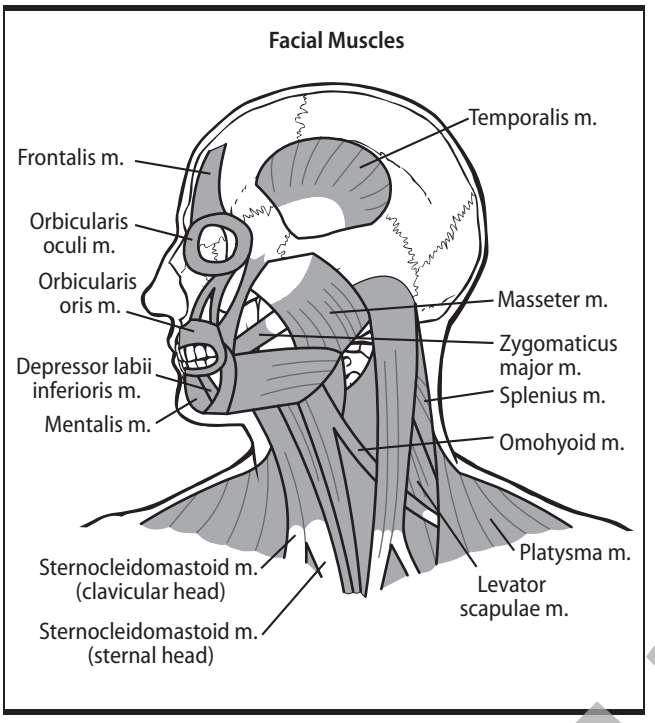
There are two groups of RVUs listed for each CPT code. The first RVU is for nonfacilities, which represents provider services performed in practitioner offices, patient's homes, or other nonhospital settings. The second RVU group is for facilities, which includes services provided by the practitioner in hospitals, ambulatory surgical centers, or skilled nursing facilities.

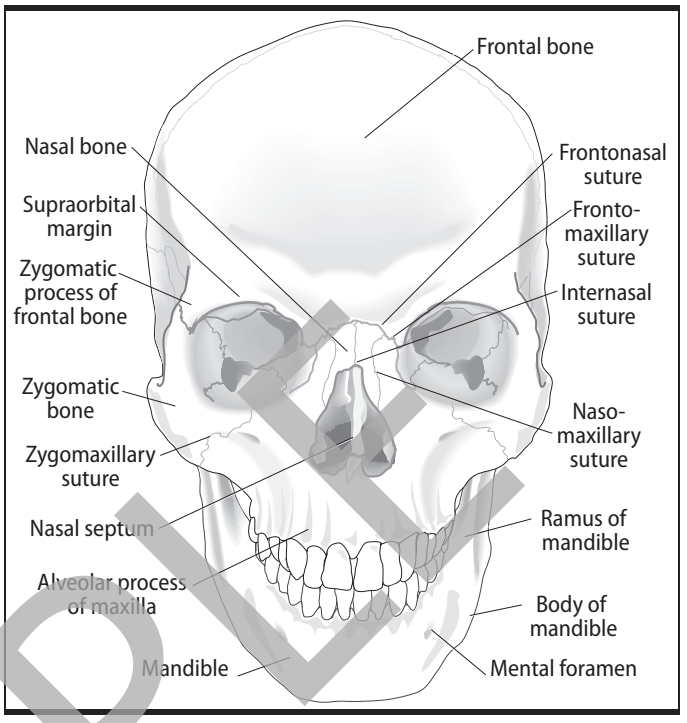
Medicare Follow-Up Days (FUD)

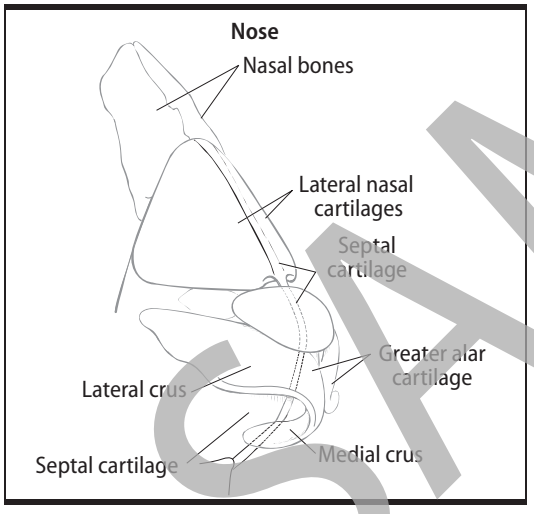
Information on the Medicare global period is provided here. The global period is the time following a surgery during which routine care by the

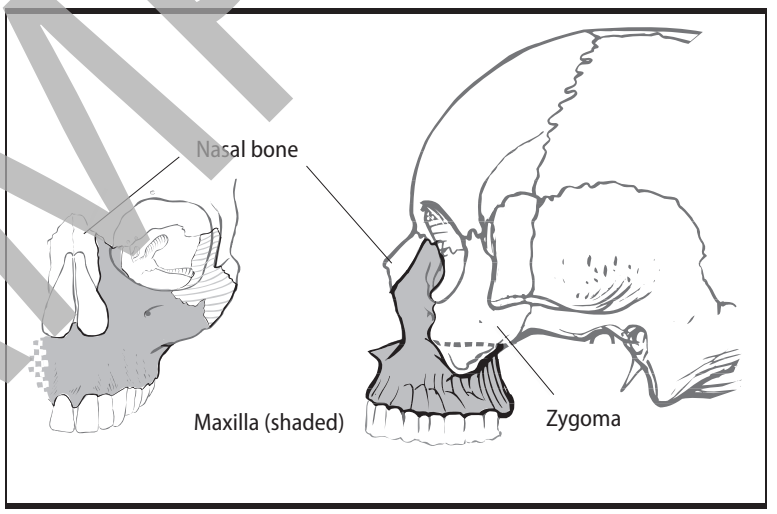
Illustrations

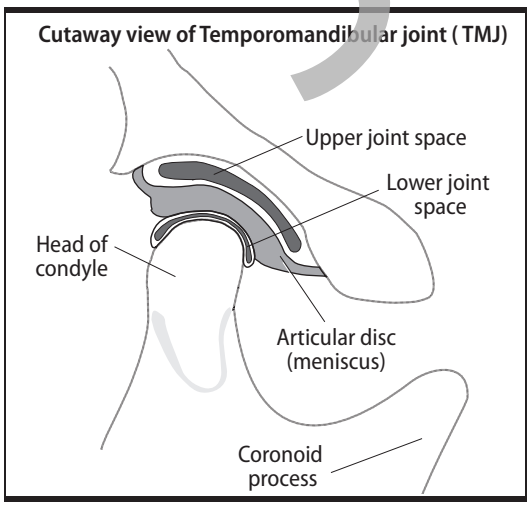
Facial Muscles and Bones

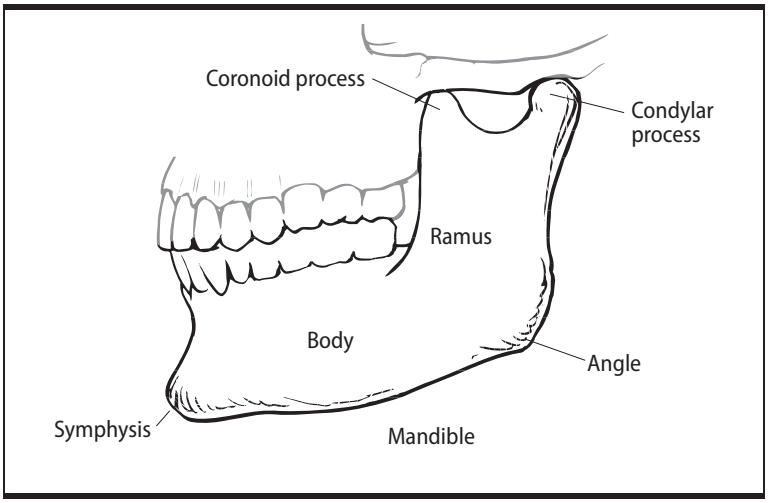












Procedure Codes

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

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

Additionally documentation should:

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

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

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

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

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

HCPCS Level I or CPT Codes

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

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

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

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

HCPCS Level II Codes

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

Medical and Surgical Supplies

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

A4649 **Surgical supply; miscellaneous**
A4550 **Surgical trays**
E1700 **Jaw motion rehabilitation system**
E1701 **Replacement cushions for jaw motion rehabilitation system, package of six**
E1702 **Replacement measuring scales for jaw motion rehabilitation system, package of 200**

Drugs Administered Other Than Oral Method J0000–J8999

Drugs and biologicals are usually covered by Medicare if they:

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

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

The following list of drugs can be injected either subcutaneously, intramuscularly, or intravenously. Third-party payers may wish to determine a threshold and pay up to a certain dollar limit for the drug. Note that for Medicare purposes, special coverage instructions apply to these services—*see* Pub. 100-2, chap. 15, sec. 50.4.

J1790 **Injection, droperidol, up to 5 mg**
J2250 **Injection, midazolam HCl, per 1 mg**
J2400 **Injection, chloroprocaine HCl, per 30 ml**
J2515 **Injection, pentobarbital sodium, per 50 mg**
J2550 **Injection, promethazine HCl, up to 50 mg**
J3010 **Injection, fentanyl citrate, 0.1 mg**
J3360 **Injection, diazepam, up to 5 mg**

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

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

D0150

D0150 comprehensive oral evaluation - new or established patient

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

Explanation

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

Coding Tips

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

Documentation Tips

Documentation supporting an evaluation must indicate if the evaluation was complete, periodic, or limited. Any diagnostic studies performed elsewhere but reviewed should be recorded in the documentation. If the patient is established, the time interval between encounters should be recorded as well. Treatment plan documentation should reflect any treatment failure, change in diagnosis, and/or a change in treatment plan. There should also be evidence of any initiation or reinstatement of a drug regime, which requires close and continuous skilled medical observation. Providers should include sufficient documentation in the medical record to accurately describe and verify the services rendered. Additionally, records should be legible and signed with the appropriate name and title of the provider of the service. The following information should be documented on a tooth chart: treatment/location of caries, endodontic procedures, prosthetic services, preventive services, treatment of lesions and dental disease, or other special procedures. A tooth chart may also be used to identify structure and rationale of disease process, and the type of service performed on intraoral structures other than teeth.

Associated CPT Codes

See the Evaluation and Management Section.

ICD-10-CM Diagnostic Codes

K05.00	Acute gingivitis, plaque induced
K05.01	Acute gingivitis, non-plaque induced
K05.10	Chronic gingivitis, plaque induced
K05.11	Chronic gingivitis, non-plaque induced
K05.311	Chronic periodontitis, localized, slight
K05.312	Chronic periodontitis, localized, moderate
K05.313	Chronic periodontitis, localized, severe
K05.321	Chronic periodontitis, generalized, slight
K05.322	Chronic periodontitis, generalized, moderate
K05.323	Chronic periodontitis, generalized, severe
K05.4	Periodontosis
K06.011	Localized gingival recession, minimal
K06.012	Localized gingival recession, moderate
K06.013	Localized gingival recession, severe
K06.021	Generalized gingival recession, minimal
K06.022	Generalized gingival recession, moderate
K06.023	Generalized gingival recession, severe
K06.1	Gingival enlargement
K08.0	Exfoliation of teeth due to systemic causes
K08.121	Complete loss of teeth due to periodontal diseases, class I
K08.122	Complete loss of teeth due to periodontal diseases, class II
K08.123	Complete loss of teeth due to periodontal diseases, class III
K08.124	Complete loss of teeth due to periodontal diseases, class IV
K08.131	Complete loss of teeth due to caries, class I
K08.132	Complete loss of teeth due to caries, class II
K08.133	Complete loss of teeth due to caries, class III
K08.134	Complete loss of teeth due to caries, class IV
K08.3	Retained dental root
K08.421	Partial loss of teeth due to periodontal diseases, class I
K08.422	Partial loss of teeth due to periodontal diseases, class II
K08.423	Partial loss of teeth due to periodontal diseases, class III
K08.424	Partial loss of teeth due to periodontal diseases, class IV
K08.431	Partial loss of teeth due to caries, class I
K08.432	Partial loss of teeth due to caries, class II
K08.433	Partial loss of teeth due to caries, class III
K08.434	Partial loss of teeth due to caries, class IV

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

Relative Value Units/Medicare Edits

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

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

* with documentation

D4230-D4231

D4230 anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant

This procedure is utilized in an otherwise periodontally healthy area to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship.

D4231 anatomical crown exposure - one to three teeth or tooth bounded spaces per quadrant

This procedure is utilized in an otherwise periodontally healthy area to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship.

Explanation

The provider removes enlarged gingival tissue and supporting bone to improve the health and cosmetic appearance of the teeth and gums. Incisions are made that allow the gums to be retracted from around the teeth. Some bone may be removed using a combination of hand instruments or rotary burrs. The retracted flap is sutured back in place after some soft tissue has been removed. This will result in more tooth or teeth being exposed once the gum incisions have healed. Report D4230 when four our more contiguous teeth are treated or D4231 for up to three teeth in a single quadrant.

Coding Tips

Local anesthesia is generally considered part of restorative procedures. For crown lengthening focused upon hard tissue, see code D4249.

Reimbursement Tips

Payers often require documentation before covering these procedures. Check with the specific payer to determine coverage. These procedures are often performed for cosmetic reasons and may not be covered by third-party payers. Many payers will not separately reimburse the following services when performed by the same provider, on the same date of service, and at the same surgical site: biopsy (D7285–D7286), frenulectomy (D7960), and/or excision of hard and soft tissue lesions (D7410–D7411, D7450–D7451). When one or more of the above services are provided on a different date of service, a narrative indicating the medical necessity of separating the services should be provided; otherwise, payers may deny those services.

Associated CPT Codes

41820 Gingivectomy, excision gingiva, each quadrant
41821 Operculectomy, excision pericoronal tissues

ICD-10-CM Diagnostic Codes

K06.1 Gingival enlargement
K06.2 Gingival and edentulous alveolar ridge lesions associated with trauma
K06.8 Other specified disorders of gingiva and edentulous alveolar ridge
K06.9 Disorder of gingiva and edentulous alveolar ridge, unspecified

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
D4230	0.0	0.0	0.0	0.0
D4231	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D4230	0.0	0.0	0.0	0.0
D4231	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D4230	N/A	N	-	N/A	N/A	N/A	N/A	None
D4231	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

clinical crown. Part of the tooth that is not covered by any supporting structures such as the gums.

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

ostectomy. Excision of bone.

D6116-D6117

D6116 implant /abutment supported fixed denture for partially edentulous arch - maxillary

D6117 implant /abutment supported fixed denture for partially edentulous arch - mandibular

Explanation

The physician provides an implant/abutment supported fixed denture for the upper (D6116) or lower jaw (D6117) replacing missing teeth from a partially edentulous jaw. Following the drawing up of a dental plan and preparation for the denture, including the placement of the abutments and/or implants (see codes D6010–D6050) and supporting structures (D6055–D6052) previously performed, the patient receives the fixed denture. The fit and comfort of the denture is determined and minor adjustments may be made if required. The denture is fastened using screws (screw-retained) or clips (bar-retained). The patient is instructed as to the care of the denture.

Coding Tips

To report implant/abutment supported removable denture for a partially edentulous arch, see D6112–D6113. To report implant/abutment supported fixed denture for completely edentulous arch, see D6114–D6115.

Associated CPT Codes

There are no direct CPT cross codes.

ICD-10-CM Diagnostic Codes

K08.411 Partial loss of teeth due to trauma, class I
K08.412 Partial loss of teeth due to trauma, class II
K08.413 Partial loss of teeth due to trauma, class III
K08.414 Partial loss of teeth due to trauma, class IV
K08.421 Partial loss of teeth due to periodontal diseases, class I
K08.422 Partial loss of teeth due to periodontal diseases, class II
K08.423 Partial loss of teeth due to periodontal diseases, class III
K08.424 Partial loss of teeth due to periodontal diseases, class IV
K08.431 Partial loss of teeth due to caries, class I
K08.432 Partial loss of teeth due to caries, class II
K08.433 Partial loss of teeth due to caries, class III
K08.434 Partial loss of teeth due to caries, class IV
K08.491 Partial loss of teeth due to other specified cause, class I
K08.492 Partial loss of teeth due to other specified cause, class II
K08.493 Partial loss of teeth due to other specified cause, class III
K08.494 Partial loss of teeth due to other specified cause, class IV

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
D6116	0.0	0.0	0.0	0.0
D6117	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D6116	0.0	0.0	0.0	0.0
D6117	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D6116	N/A	N	-	N/A	N/A	N/A	N/A	None
D6117	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

abutment. Tooth or implant fixture supporting a prosthesis.

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

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

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

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

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

Classification of Evaluation and Management (E/M) Services

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

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

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

New and Established Patients

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

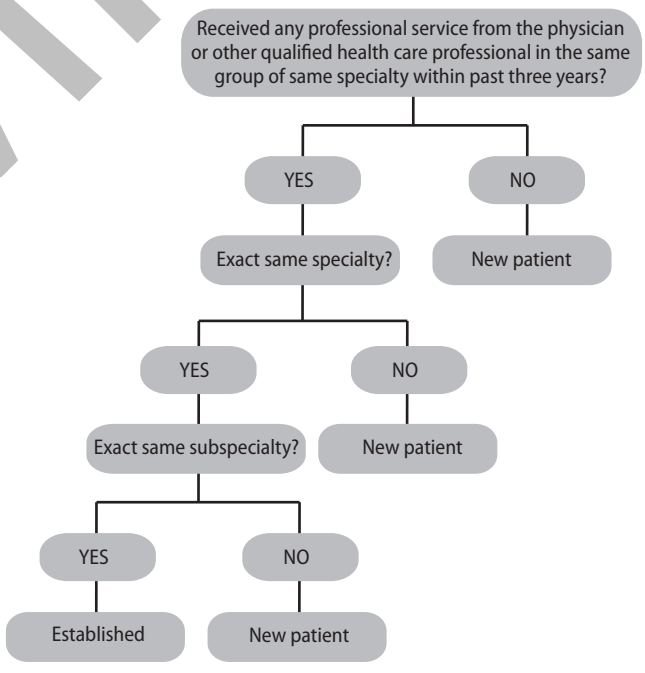
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

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

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

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

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

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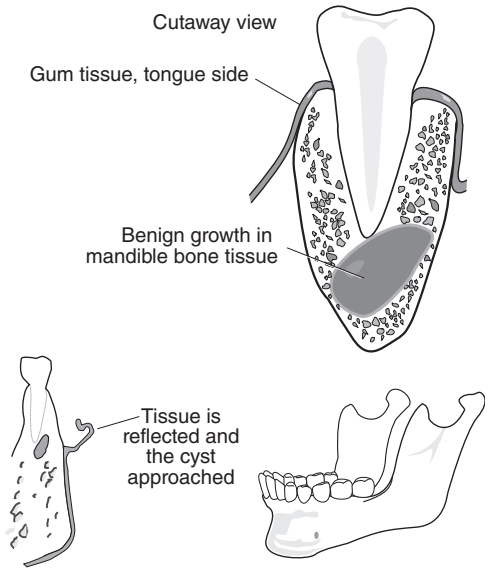
▶ ◀ = Contains new or revised text

21040

21040 Excision of benign tumor or cyst of mandible, by enucleation and/or curettage



Explanation

The physician removes a cyst or benign tumor from the mandible by enucleation and/or curettage, not requiring osteotomy. Using an intraoral approach, the physician incises and reflects a mucosal flap of tissue inside the mouth overlying the tumor. In an extraoral approach, the physician approaches the defect through an external skin incision. The tumor is identified and removed from the mandible by scraping with a curette or by cutting the tumor out in such a way as to leave it intact and remove it whole. The mucosal flap is sutured primarily or subcutaneous tissue and skin incisions on the face are closed with layered sutures.

Coding Tips

When 21040 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 are documented, append modifier 22 and submit a cover letter and an operative report. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. Report any free grafts or flaps separately. For biopsy of bone, see codes 20220 and 20240. For excision of a malignant tumor of the mandible, see 21044.

Associated HCPCS Codes

D7410	excision of benign lesion up to 1.25 cm
D7411	excision of benign lesion greater than 1.25 cm
D7412	excision of benign lesion, complicated
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm

ICD-10-CM Diagnostic Codes

D16.5	Benign neoplasm of lower jaw bone
K09.0	Developmental odontogenic cysts
K09.1	Developmental (nonodontogenic) cysts of oral region
M27.49	Other cysts of jaw
M27.8	Other specified diseases of jaws

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: 21040 2021,Dec; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21040	4.91	8.55	0.49	13.95
Facility RVU	**Work**	**PE**	**MP**	**Total**
21040	4.91	5.46	0.49	10.86

	FUD	Status	MUE	Modifiers				IOM Reference
21040	90	A	2(3)	N/A	51	N/A	N/A	None

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

curettage. Removal of tissue by scraping.

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

enucleation. Removal of a growth or organ cleanly so as to extract it in one piece.

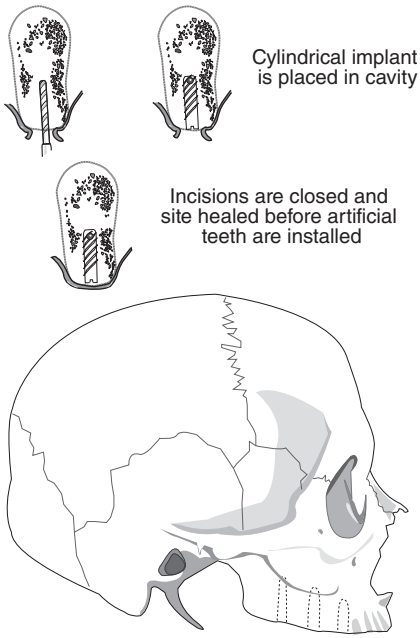
mandible. Lower jawbone giving structure to the floor of the oral cavity.

tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

21248-21249

21248 Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial

21249 complete



Explanation

The physician places metal implants into the bone of the maxilla or mandible. Metal posts attached to the implants protrude through the mucosa into the mouth. Artificial teeth or dentures are attached to the roots to replace missing teeth. These implants may be cylindrical or thin blades. The physician makes incisions through the mucosa to expose the bone using an intraoral approach. Precision holes are drilled in the bone where the implants are to be placed. With blade style implants, the posts are already attached to the implant and the mucosa is sutured simply around the post. With cylindrical implants, the mucosa is sutured over the top of the implant and is allowed to heal while buried under the mucosa. The incisions are closed simply. A second procedure is performed three to eight months later. The implant is exposed again and the abutment connectors are attached. Report 21248 for partial reconstruction. Report 21249 for complete reconstruction.

Coding Tips

These procedures include the surgical placement of the implant device; the second procedure is performed to expose the integrated implant and the abutment posts. If abutment posts are not provided, use modifier 52 Reduced service, when reporting the initial procedure. Local anesthesia is included in the service.

Associated HCPCS Codes

D6010 surgical placement of implant body: endosteal implant

D6012 surgical placement of interim implant body for transitional prosthesis: endosteal implant

ICD-10-CM Diagnostic Codes

C41.0 Malignant neoplasm of bones of skull and face

C41.1 Malignant neoplasm of mandible

C79.51 Secondary malignant neoplasm of bone

D16.5 Benign neoplasm of lower jaw bone

D48.0 Neoplasm of uncertain behavior of bone and articular cartilage

D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin

K08.21 Minimal atrophy of the mandible

K08.22 Moderate atrophy of the mandible

K08.23 Severe atrophy of the mandible

K08.24 Minimal atrophy of maxilla

K08.25 Moderate atrophy of the maxilla

K08.26 Severe atrophy of the maxilla

K08.81 Primary occlusal trauma

K08.82 Secondary occlusal trauma

K08.89 Other specified disorders of teeth and supporting structures

M26.03 Mandibular hyperplasia

M26.04 Mandibular hypoplasia

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

M26.72 Alveolar mandibular hyperplasia

M26.73 Alveolar maxillary hypoplasia

M26.74 Alveolar mandibular hypoplasia

M26.79 Other specified alveolar anomalies

M26.89 Other dentofacial anomalies

M27.2 Inflammatory conditions of jaws

M27.8 Other specified diseases of jaws

M87.180 Osteonecrosis due to drugs, jaw

M95.2 Other acquired deformity of head

M99.80 Other biomechanical lesions of head region

Q67.0 Congenital facial asymmetry

Q67.1 Congenital compression facies

Q67.4 Other congenital deformities of skull, face and jaw

S02.40CA Maxillary fracture, right side, initial encounter for closed fracture ☑

S02.40CB Maxillary fracture, right side, initial encounter for open fracture ☑

S02.411A LeFort I fracture, initial encounter for closed fracture

S02.411B LeFort I fracture, initial encounter for open fracture

S02.412A LeFort II fracture, initial encounter for closed fracture

S02.412B LeFort II fracture, initial encounter for open fracture

S02.413A LeFort III fracture, initial encounter for closed fracture

S02.413B LeFort III fracture, initial encounter for open fracture

S02.42XA Fracture of alveolus of maxilla, initial encounter for closed fracture

S02.42XB Fracture of alveolus of maxilla, initial encounter for open fracture

S02.611A Fracture of condylar process of right mandible, initial encounter for closed fracture ☑

S02.611B Fracture of condylar process of right mandible, initial encounter for open fracture ☑

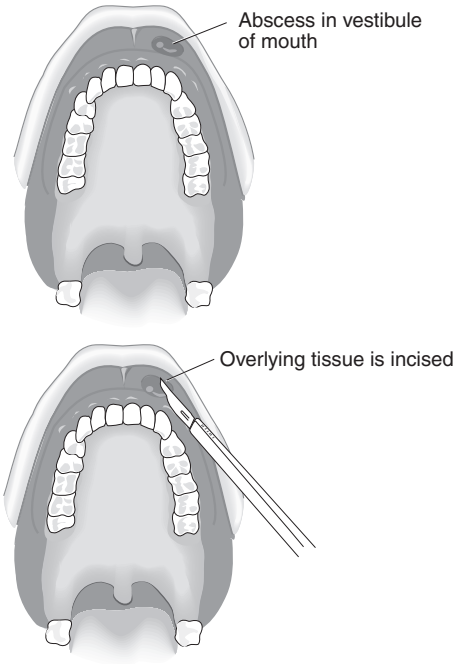
S02.621A Fracture of subcondylar process of right mandible, initial encounter for closed fracture ☑

S02.621B Fracture of subcondylar process of right mandible, initial encounter for open fracture ☑

S02.631A Fracture of coronoid process of right mandible, initial encounter for closed fracture ☑

40800-40801

40800 Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801 complicated



Explanation

The physician 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 physician 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 physician may place a drain to facilitate healing. If a drain is placed, it is later removed.

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 or an X{EPSU} modifier to additional codes. Local anesthesia is included in the service. For drainage of an abscess, a cyst, or a hematoma from dentoalveolar structures, see 41800.

Documentation Tips

The size of the abscess as well as the infectious agent, if known, should be documented in the medical record.

Reimbursement Tips

These services may be subject to patient deductible and copayments. Some payers may require that these services be reported using the appropriate CDT code.

Associated HCPCS Codes

D7510 incision and drainage of abscess - intraoral soft tissue
D7511 incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)

ICD-10-CM Diagnostic Codes

C06.1 Malignant neoplasm of vestibule of mouth
K00.6 Disturbances in tooth eruption
K01.0 Embedded teeth
K01.1 Impacted teeth
K04.01 Reversible pulpitis
K04.02 Irreversible pulpitis
K05.10 Chronic gingivitis, plaque induced
K09.0 Developmental odontogenic cysts
K09.1 Developmental (nonodontogenic) cysts of oral region
K09.8 Other cysts of oral region, not elsewhere classified
K12.1 Other forms of stomatitis
K12.2 Cellulitis and abscess of mouth
K13.0 Diseases of lips
Q38.6 Other congenital malformations of mouth
S00.521A Blister (nonthermal) of lip, initial encounter
S00.531A Contusion of lip, initial encounter
T20.22XA Burn of second degree of lip(s), initial encounter
T20.32XA Burn of third degree of lip(s), initial encounter
T20.62XA Corrosion of second degree of lip(s), initial encounter
T20.72XA Corrosion of third degree of lip(s), initial encounter
T28.0XXA Burn of mouth and pharynx, initial encounter
T28.5XXA Corrosion of mouth and pharynx, 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
40800	1.23	4.73	0.12	6.08
40801	2.63	5.81	0.26	8.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
40800	1.23	2.19	0.12	3.54
40801	2.63	3.0	0.26	5.89

	FUD	Status	MUE	Modifiers				IOM Reference
40800	10	A	2(3)	N/A	51	N/A	N/A	None
40801	10	A	2(3)	N/A	51	N/A	N/A	

* with documentation

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.

vestibule of the mouth. Mucosal and submucosal tissue of the lips and cheeks within the oral cavity, not including the dentoalveolar structures.

Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

0792T No CCI edits apply to this code.

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