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CODING GUIDE

OMS

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

2021

optum360coding.com

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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 resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. Codes within the Optum360 *Coding Guide* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

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. A sample is shown on page 2. The black boxes with numbers in them correspond to the information on the pages following the example.

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. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

CCI Edit Updates

The *Coding Guide* series 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 the most current version available at press time. The CCI edits are now located in a section at the back of the book. Optum360 maintains a website to accompany the *Coding Guide* series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is https:// www.optum360coding. com/ ProductUpdates/. The 2021 edition password is: XXXXXXXX. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

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

Mandible
Osteotomy, 21198-21199

Osteotomy
Mandible, 21198-21199

Sample Page and Key

On the following pages are a sample page from the book displaying the format of *Coding Guide* with each element identified and explained on the opposite page.

An additional component of the MUE edit is the MUE Adjudication Indicator (MAI). This edit is the result of an audit by the Office of Inspector General (OIG) that identified inappropriate billing practices that bypassed the MUE edits. These included inappropriate reporting of bilateral services and split billing.

There are three MUE Adjudication Indicators.

1 Line Edit
2 Date of Service Edit: Policy
3 Date of Service Edit: Clinical

The MUE will be listed following the MAI value. For example code 10140 has a MUE value of 2 and a MAI value of 3. This will display in the MUE field as "2(3)."

Modifiers

Medicare identifies some modifiers that are required or appropriate to report with the CPT code. When the modifiers are not appropriate, it will be indicated with N/A. Four modifiers are included.

51 Multiple Procedure
Medicare and other payers reduce the reimbursement of second and subsequent procedures performed at the same session to 50 percent of the allowable.

50 Bilateral Procedures
This modifier is used to identify when the same procedure is performed bilaterally. Medicare requires one line with modifier 50 and the reimbursement is 50 percent of the allowable amount. Other payers may require two lines and will reduce the second procedure.

62* Two Surgeons
Medicare identifies procedures that may be performed by cosurgeons. The reimbursement is split between both providers. Both surgeons must report the same code when using this modifier.

80* Assistant Surgeon
An assistant surgeon is allowed if modifier 80 is listed. Reimbursement is usually 20 percent of the allowable. For Medicare it is 16 percent to account for the patient's co-pay amount.

* with documentation

Medicare Official Regulatory Information

Medicare official regulatory information provides official regulatory guidelines. Also known as the CMS Online Manual System, the Internet-only Manuals (IOM) contain official CMS information pertaining to program issuances, instructions, policies, and procedures based on statutes, regulations, guidelines, models, and directives. Optum360 has provided the reference for the surgery codes. The full text of guidelines can be found online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/.

Medicare edits are provided for most codes. These 2020 Medicare edits were current as of November 2019.

11. Terms to Know

Some codes are accompanied by general information pertinent to the procedure, labeled "Terms to Know." This information is not critical to code selection, but is a useful supplement to coders hoping to expand their knowledge of the specialty.

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 physician or other qualified health care 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 physicians 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 physicians 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.

Reimbursement Issues

Reporting Dental versus Medical Claims

When selecting the name of the procedure or service that accurately identifies the service performed, practitioners must use the most accurate code. As identified in the CPT Professional manual, it is inappropriate to use a code that merely approximates the services provided. Common dental terminology (CDT) codes are specific for dental procedures and CPT codes identify medical procedures. If the CDT more accurately identifies the service, this should be used for third party payers rather than the CPT codes

Medical insurance does not typically cover dental procedures unless they are a result of current injury or trauma. While CDT codes may be submitted to medical insurance on the medical claim form, a CPT code should be reported if it adequately represents the service rendered unless otherwise directed by the payer. Healthcare, auto, or workers' compensation insurance do not normally cover dental procedures. Providers should review the patient's insurance and the certificate of coverage to determine the circumstances and specific services that should be reported to dental or medical insurance. Reporting of CPT codes must be linked to ICD-10-CM codes for the documented diagnosis and support the patient's injury or trauma.

Medicaid Coverage of Dental and Maxillofacial Services

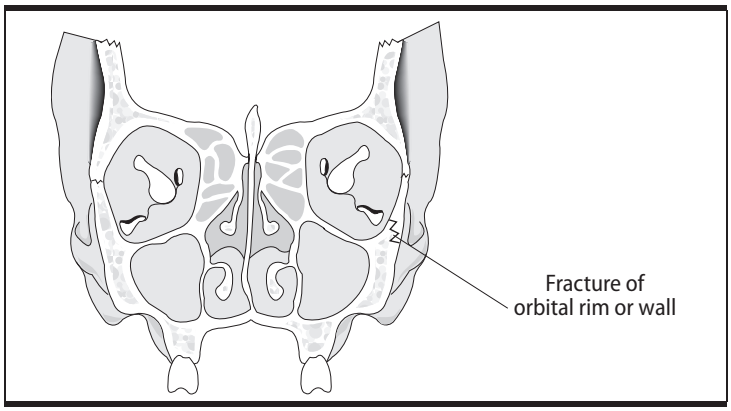
Title XIX of the Social Security Act, the Medicaid Program mandates that states provide dental services in certain specific instances.

Dental Coverage for Children

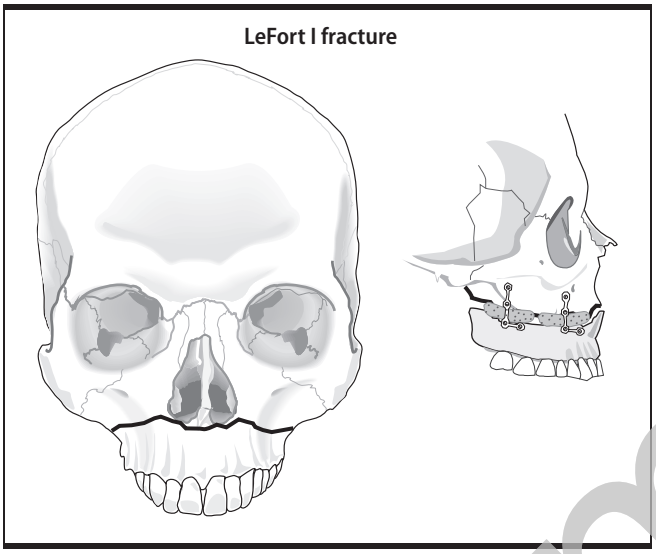
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is Medicaid's comprehensive child health program. The program's focus is on prevention, early diagnosis, and treatment of medical conditions. EPSDT is a mandatory service required to be provided under a state's Medicaid program. Dental services are covered under this program.

All state Medicaid programs must provide coverage of dental services to children at intervals that meet reasonable standards of dental practice, as determined by the state, after consultation with recognized dental organizations involved in child health, and at such other intervals, as indicated by medical necessity, to determine the existence of a suspected illness or condition.

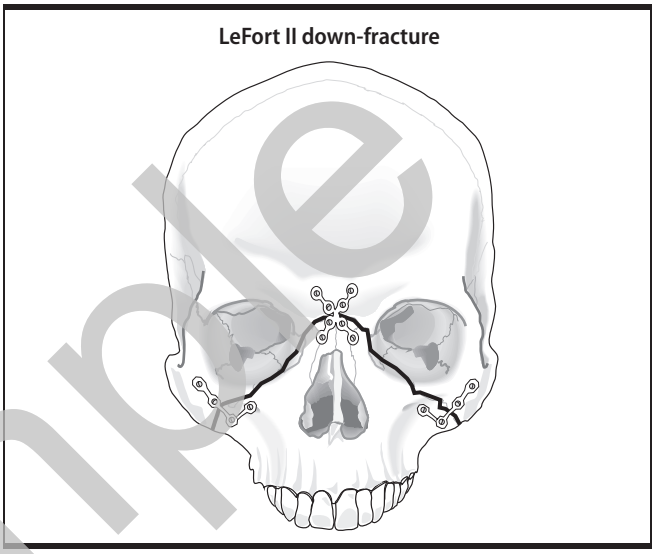
Facial Fractures



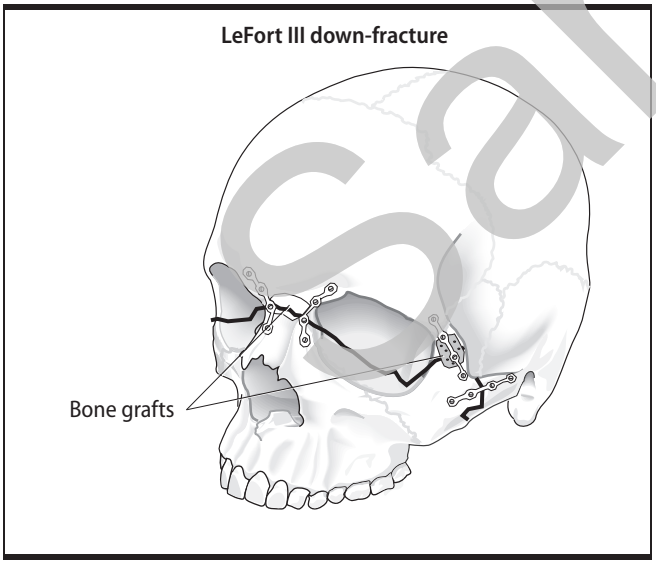
LeFort I fracture



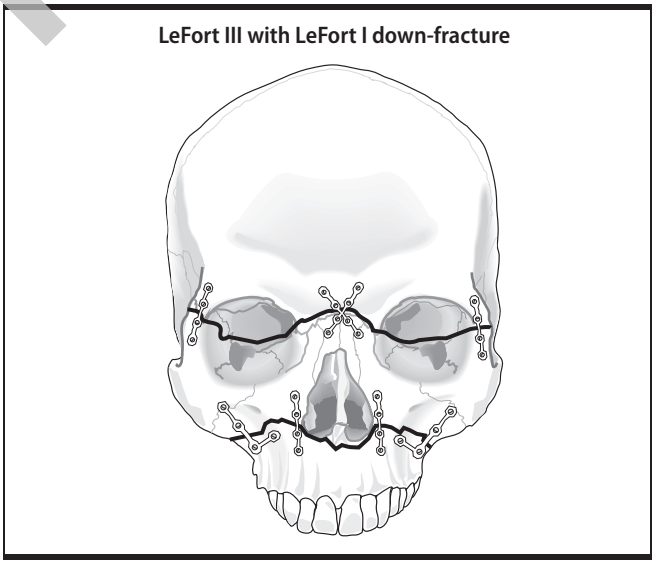
LeFort II down-fracture



LeFort III down-fracture



LeFort III with LeFort I down-fracture



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 http://www.ama-assn.org/go/cpt. 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 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:

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

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

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

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

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

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

D0160

D0160 detailed and extensive oral evaluation - problem focused, by report

A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc.

Explanation

This detailed, extensive oral evaluation focuses on a specific problem involving extensive diagnostic and cognitive skills being used, based on the findings of a comprehensive oral exam. Developing a treatment plan through integrating more extensive diagnostic faculties for the specific problem is a requirement. Thorough documentation of the condition requiring this service should be made. Examples of such conditions may include acute periprosthetic complications, temporomandibular joint (TMJ) dysfunction, pain of unknown origin, and other conditions necessitating multi-disciplinary consultation.

Coding Tips

When a comprehensive examination is performed and documented, see D0150. When the patient is referred by another dentist for an opinion or advice regarding a particular condition, see D9310. When a comprehensive periodontal evaluation is performed, report D0180. 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. Pertinent documentation to evaluate medical appropriateness should be included when this code is reported.

Documentation Tips

A tooth chart may be used to document this 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.

Associated CPT Codes

See the Evaluation and Management Section.

ICD-10-CM Diagnostic Codes

K02.7	Dental root caries
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
K05.221	Aggressive periodontitis, generalized, slight
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
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
K08.121	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
D0160	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0160	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D0160	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

D9995-D9996

D9995 teledentistry - synchronous; real-time encounter

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

D9996 teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review; Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

Explanation

The provider provides synchronous real time telemedicine services to the patient. The service involves electronic communication using interactive telecommunications equipment that includes at a minimum audio and video. Report D9995 when the telemedicine communication is provided in real-time. Report D9996 when the telemedicine communication is stored and provided for review at a subsequent time.

Coding Tips

These services are reported in addition to other services provided to the patient at the same encounter.

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.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9995	0.0	0.0	0.0	0.0
D9996	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9995	0.0	0.0	0.0	0.0
D9996	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D9995	N/A	N	-	N/A	N/A	N/A	N/A	None
D9996	N/A	N	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

telehealth service. Care by a provider with the patient at a remote site, usually rural, utilizing electronic communication to evaluate, monitor, and treat a patient.

D9997

- **D9997** dental case management - patients with special health care needs

special treatment considerations for patients/individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations, which require that modifications be made to delivery of treatment to provide comprehensive oral health care services

Explanation

The provider uses special techniques when communicating and treating patients with physical, medical, developmental or cognitive conditions.

Coding Tips

Third-party payers may not provide coverage for these services.

Documentation Tips

The provider should document the special health needs and the accommodation services provided.

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.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9997	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9997	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
D9997	N/A	N	-	N/A	N/A	N/A	N/A	None

* with documentation

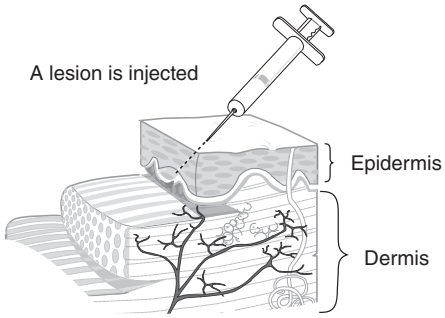
Terms To Know

cognitive. Being aware by drawing from knowledge, such as judgment, reason, perception, and memory.

developmental delay disorders. Various disorders manifested by a delay in development based on that anticipated for a certain age level or period of development. Both biological and nonbiological factors may be involved. Originating before age 18, these impairments may continue indefinitely.

11900-11901

11900 Injection, intralesional; up to and including 7 lesions
11901 more than 7 lesions



Schematic of layers of the skin

Explanation

The physician uses a syringe to inject a pharmacologic agent underneath or into seven or fewer skin lesions in 11900 and more than seven lesions in 11901. The lesions may be any diagnosed skin lesions. Steroids or anesthetics (not preoperative local anesthetic) may be injected.

Coding Tips

Codes 11900–11901 are not to be used for preoperative local anesthetic injection. Code 11901 is NOT a separate procedure and, therefore, when reporting the injection of eight or more lesions, report 11901 only. For intralesional chemotherapy administration, see 96405–96406. The drug or other substance may be reported separately with the appropriate HCPCS Level II J code. Check with the specific payer to determine coverage.

Associated HCPCS Codes

There are no direct CDT cross codes.

ICD-10-CM Diagnostic Codes

B07.8	Other viral warts
H00.021	Hordeolum internum right upper eyelid ☑
H00.022	Hordeolum internum right lower eyelid ☑
H00.11	Chalazion right upper eyelid ☑
H00.12	Chalazion right lower eyelid ☑
L28.0	Lichen simplex chronicus
L28.1	Prurigo nodularis
L30.0	Nummular dermatitis
L30.8	Other specified dermatitis
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis
L40.2	Acrodermatitis continua
L40.3	Pustulosis palmaris et plantaris
L40.4	Guttate psoriasis
L40.8	Other psoriasis
L43.0	Hypertrophic lichen planus
L43.1	Bullous lichen planus
L43.2	Lichenoid drug reaction
L43.3	Subacute (active) lichen planus
L43.8	Other lichen planus
L52	Erythema nodosum
L63.2	Ophiasis
L66.1	Lichen planopilaris
L91.0	Hypertrophic scar
L92.0	Granuloma annulare
L92.1	Necrobiosis lipoidica, not elsewhere classified
L92.2	Granuloma faciale [eosinophilic granuloma of skin]
L93.0	Discoid lupus erythematosus
L93.1	Subacute cutaneous lupus erythematosus
L93.2	Other local lupus erythematosus

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: **11900** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11; 2013,Nov,14 **11901** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11900	0.52	0.99	0.05	1.56
11901	0.8	1.08	0.09	1.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
11900	0.52	0.3	0.05	0.87
11901	0.8	0.47	0.09	1.36

	FUD	Status	MUE	Modifiers				IOM Reference
11900	0	A	1(2)	N/A	51	N/A	N/A	None
11901	0	A	1(2)	N/A	51	N/A	N/A	

* with documentation

Terms To Know

injection. Forcing a liquid substance into a body part such as a joint or muscle.

intralesional injection. Medication delivered through a syringe and needle directly into a localized lesion.

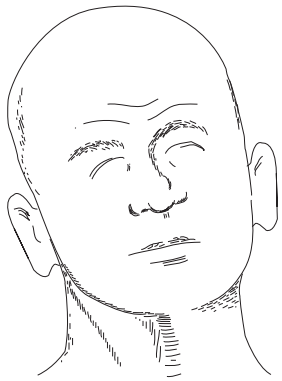
pharmacological agent. Drug used to produce a chemical effect.

steroids. Hormonal substances with a similar basic chemical structure, produced mainly in the adrenal cortex and gonads.

20670-20680

20670 Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)

20680 deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)



A small incision is used to remove implant

Explanation

The physician makes a small incision overlying the site of the implant. The implant is located. The physician removes the implant by pulling or unscrewing it. The incision is closed with sutures and/or Steri-strips.

Coding Tips

Note that 20670, a separate procedure by definition, 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.

Reimbursement Tips

Code 20670 may be used to report the removal of interdental fixation, such as arch bars; however, third-party payers may require modifier 58 or 78 to be appended, especially when performed during the global period of the placement procedure. Note that some payers may consider the removal to be included in the initial surgery and, therefore, will not reimburse this procedure separately. Check with third-party payers to determine their specific policy.

Associated HCPCS Codes

D6100 implant removal, by report

D7540 removal of reaction producing foreign bodies, musculoskeletal system

D7997 appliance removal (not by dentist who placed appliance), includes removal of archbar

ICD-10-CM Diagnostic Codes

T84.310A Breakdown (mechanical) of electronic bone stimulator, initial encounter

T84.318A Breakdown (mechanical) of other bone devices, implants and grafts, initial encounter

T84.320A Displacement of electronic bone stimulator, initial encounter

T84.328A Displacement of other bone devices, implants and grafts, initial encounter

T84.390A Other mechanical complication of electronic bone stimulator, initial encounter

T84.398A Other mechanical complication of other bone devices, implants and grafts, initial encounter

T84.410A Breakdown (mechanical) of muscle and tendon graft, initial encounter

T84.418A Breakdown (mechanical) of other internal orthopedic devices, implants and grafts, initial encounter

T84.420A Displacement of muscle and tendon graft, initial encounter

T84.428A Displacement of other internal orthopedic devices, implants and grafts, initial encounter

T84.490A Other mechanical complication of muscle and tendon graft, initial encounter

T84.498A Other mechanical complication of other internal orthopedic devices, implants and grafts, initial encounter

T84.69XA Infection and inflammatory reaction due to internal fixation device of other site, initial encounter

T84.7XXA Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter

Z47.1 Aftercare following joint replacement surgery

Z47.2 Encounter for removal of internal fixation device

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: **20670** 2018,Jan,3; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11 **20680** 2018,Jan,3; 2018,Jan,8; 2017,Jan,8; 2016,Nov,9; 2016,Jan,13; 2015,Nov,10; 2015,Jan,16; 2014,Mar,4; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20670	1.79	8.46	0.28	10.53
20680	5.96	10.63	1.0	17.59
Facility RVU	**Work**	**PE**	**MP**	**Total**
20670	1.79	2.11	0.28	4.18
20680	5.96	5.17	1.0	12.13

	FUD	Status	MUE	Modifiers				IOM Reference
20670	10	A	3(3)	N/A	51	N/A	N/A	None
20680	90	A	3(3)	N/A	51	N/A	80*	

* with documentation

Terms To Know

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

superficial. On the skin surface or near the surface of any involved structure or field of interest.

D8999

D8999 unspecified orthodontic procedure, by report

Explanation

This code is used to report orthodontic procedures for which there is no code which specifically describes the procedure.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D8999	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D8999	0.0	0.0	0.0	0.0

D9430

D9430 office visit for observation (during regularly scheduled hours) - no other services performed

Explanation

This code reports office visits. It is used for an office visit for observation only when no other identifiable services are performed during the regularly scheduled office hours.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9430	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9430	0.0	0.0	0.0	0.0

D9440

D9440 office visit - after regularly scheduled hours

Explanation

This code reports office visits. It is used for an office visit occurring after the regularly scheduled hours. If the service provided is medical and not dental in nature, see the appropriate CPT evaluation and management codes and the Special Services, Procedures and Reports (99000-99091) section.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9440	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9440	0.0	0.0	0.0	0.0

D9450

D9450 case presentation, detailed and extensive treatment planning

Explanation

This code is reported for a detailed and extensive treatment plan case presentation of an established patient when the case presentation is not performed on the same day that the evaluation is done.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9450	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9450	0.0	0.0	0.0	0.0

D9950

D9950 occlusion analysis - mounted case

Explanation

Primarily performed to evaluate malocclusion or abnormal bite forces, there are two methods that can be employed to accomplish this procedure. In the first method, the provider takes casts of both the maxillary and mandibular bite. These casts are then transferred to an articulator. The articulator is used to record and map the bite looking for abnormal forces or malocclusion. The second method employs a computerized system. After placing electrodes in the appropriate positions on the face and jaw, the patient is instructed to bite on a sensor. The information received by the sensor is transferred to a computerized program, which maps the forces of the bite, identifies malocclusion, and generates a three-dimensional model.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9950	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9950	0.0	0.0	0.0	0.0

D9951-D9952

D9951 occlusal adjustment - limited

D9952 occlusal adjustment - complete

Explanation

Occlusal adjustment is making corrections in the bite from loose or shifting teeth, or teeth that are biting too hard against each other. Occlusal adjustment redistributes the forces applied to teeth in biting and chewing and relieves the excessive pressures on gums and other supporting tissues. The provider determines which points on which teeth are to be adjusted. The teeth are marked with indicator tape while biting and grinding and then reshaping is done with carbide or diamond tips and a hand drill instrument. Report code D9951 for limited occlusal adjustment, done in one area of the mouth, and code D9952 for complete occlusal adjustment of the entire mouth.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9951	0.0	0.0	0.0	0.0
D9952	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9951	0.0	0.0	0.0	0.0
D9952	0.0	0.0	0.0	0.0

● New ▲ Revised + Add On [Resequenced]

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