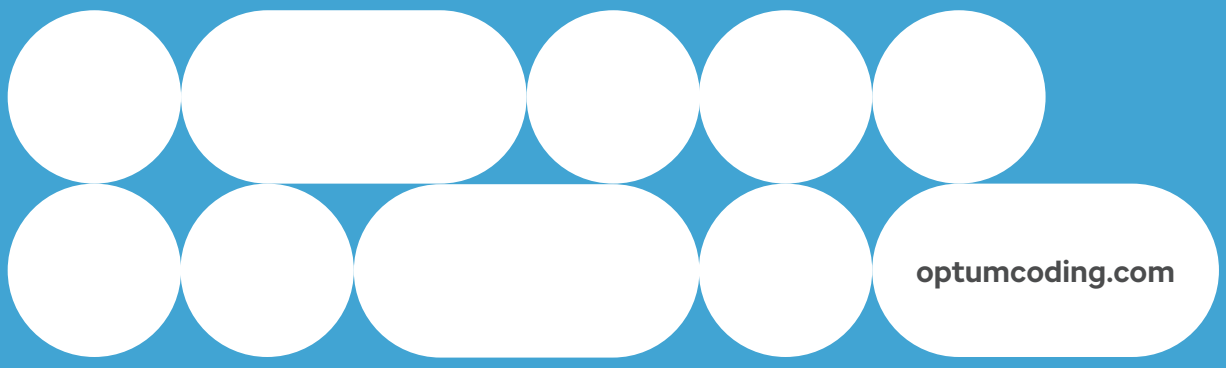
Optum

Coding &
Payment Guide

Dental Services

An essential coding, billing and reimbursement guide for dental practices

2027



optumcoding.com

Contents

Getting Started with Coding and Payment Guide

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

Resequencing of CDT and CPT Codes

The American Dental Association (ADA) and the American Medical Association (AMA) employ a resequenced numbering methodology. According to the associations, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the ADA and AMA have assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence. CPT codes within the Optum *Coding and Payment Guide* series display in their resequenced order. **Resequenced CPT 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 procedure codes are presented in a less comprehensive format in the appendix. The CDT and CPT codes appropriate to the specialty are included the appendix with the official code description, followed by an easy-to-understand explanation, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

CCI Edits, RVUs, and Other Coding Updates

This *Coding and Payment Guide* includes the a list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 32.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2027 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

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

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

General Guidelines

Providers

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

Supplies

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

Professional and Technical Component

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

Sample Page and Key

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

D1206-D1208

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

Explanation

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

Coding Tips

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

Documentation Tips

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

Reimbursement Tips

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

Associated CPT Codes

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

ICD-10-CM Diagnostic Codes

Z01.20	Encounter for dental examination and cleaning without abnormal findings
Z01.21	Encounter for dental examination and cleaning with abnormal findings
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z46.4	Encounter for fitting and adjustment of orthodontic device
Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship
Z91.128	Patient's intentional underdosing of medication regimen for other reason
Z91.141	Patient's other noncompliance with medication regimen due to financial hardship
Z91.148	Patient's other noncompliance with medication regimen for other reason
Z91.841	Risk for dental caries, low
Z91.842	Risk for dental caries, moderate
Z91.843	Risk for dental caries, high
Z98.810	Dental sealant status
Z98.811	Dental restoration status
Z98.818	Other dental procedure status

Relative Value Units/Medicare Edits

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

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

* with documentation

Terms To Know

fluoride. Compound of the gaseous element fluorine that can be incorporated into bone and teeth and provides some protection in reducing dental decay.

plaque. Accumulation of a soft sticky substance on the teeth largely composed of bacteria and its byproducts.

prophylaxis. Intervention or protective therapy intended to prevent a disease.

scaling. Removal of plaque, calculus, and stains from teeth.

1. CDT/CPT Codes and Descriptions

This edition of *Coding and Payment Guide for Dental Services* is updated with CDT and CPT codes for year 2027. The following icons are used in the *Coding and Payment Guide*:

- ● This CDT/CPT code is new for 2027.
- ▲ This CDT/CPT code description is revised for 2027.
- ✚ This CDT/CPT code is an add-on code.

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

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

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

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

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

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

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.

2. Explanation

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

3. Coding Tips

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

4. Documentation Tips

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

5. Reimbursement Tips

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

6. Associated CPT Codes

The 2026 edition of the *Coding and Payment Guide for Dental Services* contains a crosswalk from the driver CDT or CPT code to its corresponding CPT or CDT code. CDT codes should be reported for the majority of dental services. On occasion, coverage of trauma, injury, or neoplasm may be covered by the health care insurer. In the rare instance when reporting a medical claim, CPT codes should be reported. This heading will not appear if there is no valid crosswalk.

7. ICD-10-CM Diagnostic Codes

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

- **N** Newborn: 0
- **P** Pediatric: 0-17
- **M** Maternity: 9-64
- **A** Adult: 15-124
- ☑ Laterality

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

8. Relative Value Units/Medicare Edits

Gap Filled Relative Value Units

Included in this edition are 2024 gap filled relative value units (RVU) for the CDT codes. These are useful in assisting with establishing fee schedules for your practice.

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

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

Relative Value Units

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

Procedure Codes

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

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

HCPCS Level I or CPT Codes

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

CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. Dental 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.

HCPCS Level II Codes

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

A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update.

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

Medical and Surgical Supplies

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

A4550 **Surgical trays**

A4649 **Surgical supply; miscellaneous**

E1700 **Jaw motion rehabilitation system**

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

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

Drugs Administered Other Than Oral Method J0000–J8999

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

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

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

J0665 **Injection, bupivicaine, not otherwise specified, 0.5 mg**

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

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

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

J2401 **Injection, chloroprocaine HCL, per 1 mg**

J2402 **Injection, chloroprocaine HCL (Clorotekal), per 1 mg**

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**

D0340

D0340 2D cephalometric radiographic image - acquisition, measurement and analysis

Image of the head made using a cephalostat to standardize anatomic positioning, and with reproducible x-ray beam geometry.

Explanation

A lateral or frontal x-ray projection is taken to examine the entire skull, jaw, and related tooth positions in a cephalometric image. The machine holds the patient's head in the same position each time an image is taken so that a series of the individual cephalograms taken can be directly compared for growth and development over time.

Coding Tips

Any evaluation, prophylaxis, fluoride, restorative, or extraction service is reported separately. When reporting digit subtraction of two or more images (of the same modality), report D0394 in addition to the appropriate code for obtaining the image.

Reimbursement Tips

This procedure may be covered by the patient's medical insurance. When covered by medical insurance, the payer may require that the appropriate CPT code be reported on the CMS-1500 claim form.

Associated CPT Codes

70350 Cephalogram, orthodontic

ICD-10-CM Diagnostic Codes

K00.1 Supernumerary teeth
K00.2 Abnormalities of size and form of teeth
K00.3 Mottled teeth
K00.4 Disturbances in tooth formation
K00.5 Hereditary disturbances in tooth structure, not elsewhere classified
K00.6 Disturbances in tooth eruption
K01.0 Embedded teeth
K01.1 Impacted teeth
K03.0 Excessive attrition of teeth
K03.1 Abrasion of teeth
K03.2 Erosion of teeth
K03.3 Pathological resorption of teeth
K06.012 Localized gingival recession, moderate
K06.013 Localized gingival recession, severe
K06.022 Generalized gingival recession, moderate
K06.023 Generalized gingival recession, severe
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
K09.0 Developmental odontogenic cysts
K09.1 Developmental (nonodontogenic) cysts of oral region
M26.211 Malocclusion, Angle's class I
M26.212 Malocclusion, Angle's class II
M26.213 Malocclusion, Angle's class III
M26.220 Open anterior occlusal relationship
M26.221 Open posterior occlusal relationship
M26.23 Excessive horizontal overlap
M26.24 Reverse articulation
M26.31 Crowding of fully erupted teeth
M26.32 Excessive spacing of fully erupted teeth
M26.33 Horizontal displacement of fully erupted tooth or teeth
M26.34 Vertical displacement of fully erupted tooth or teeth
M26.35 Rotation of fully erupted tooth or teeth
M26.36 Insufficient interocclusal distance of fully erupted teeth (ridge)
M26.37 Excessive interocclusal distance of fully erupted teeth
M26.51 Abnormal jaw closure
M26.52 Limited mandibular range of motion
M26.53 Deviation in opening and closing of the mandible
M26.54 Insufficient anterior guidance
M26.55 Centric occlusion maximum intercuspation discrepancy
M26.56 Non-working side interference
M26.57 Lack of posterior occlusal support
M26.59 Other dentofacial functional abnormalities
M26.71 Alveolar maxillary hyperplasia
M26.72 Alveolar mandibular hyperplasia
M26.73 Alveolar maxillary hypoplasia
M26.74 Alveolar mandibular hypoplasia
M26.79 Other specified alveolar anomalies
M26.81 Anterior soft tissue impingement
M26.82 Posterior soft tissue impingement
S02.5XXA Fracture of tooth (traumatic), initial encounter for closed fracture
S02.5XXB Fracture of tooth (traumatic), initial encounter for open fracture
Z46.4 Encounter for fitting and adjustment of orthodontic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D0340	0.31	1.20	0.02	1.53
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0340	0.31	1.20	0.02	1.53

	FUD	Status	MUE	Modifiers				IOM Reference
D0340	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

Terms To Know

cephalad. Toward the head.

radiograph. Image made by an x-ray.

D2915

D2915 re-cement or re-bond indirectly fabricated or prefabricated post and core

Explanation

A prefabricated or cast post and core that becomes loose or dislodged is recemented or rebonded after first cleaning and preparing the canal. This procedure code applies to a prefabricated or an individually fitted and specially cast post (including a core and coping) that was placed into the endodontically treated canal. A prefabricated post and core is any commercial product such as a screw post, endo post, Kurer anchor, or crown saver, or any preformed post of any material or shape.

Coding Tips

For recementation or rebonding of a crown, see D2920. Code D2915 is considered an integral part of crown recementation or rebonding by most third-party payers and should not be reported in addition to D2920. Local anesthesia is generally considered to be part of restorative procedures. For recementation or rebonding of an inlay, onlay, or partial coverage restoration, see D2910.

Documentation Tips

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

ICD-10-CM Diagnostic Codes

K08.51	Open restoration margins of tooth
K08.52	Unrepairable overhanging of dental restorative materials
K08.530	Fractured dental restorative material without loss of material
K08.531	Fractured dental restorative material with loss of material
K08.54	Contour of existing restoration of tooth biologically incompatible with oral health
K08.55	Allergy to existing dental restorative material
K08.56	Poor aesthetic of existing restoration of tooth
K08.59	Other unsatisfactory restoration of tooth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D2915	0.52	0.46	0.11	1.09
Facility RVU	**Work**	**PE**	**MP**	**Total**
D2915	0.52	0.46	0.11	1.09

	FUD	Status	MUE	Modifiers				IOM Reference
D2915	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

D2920

D2920 re-cement or re-bond crown

Explanation

A crown is recemented or rebonded after becoming loose or dislodged. The crown is removed from the tooth. It is cleaned, residual cement removed, and prepared for recementing or rebonding. The tooth is also cleaned of any residual cement or foreign matter and prepared for recementing or rebonding. The crown is recemented or rebonded into place.

Coding Tips

Local anesthesia is generally considered to be part of restorative procedures. Code D2915 is considered an integral part of crown recementation or rebonding by most third-party payers and should not be reported in addition to D2920. To report recementation or rebonding of inlay, onlay, or partial coverage restorations, see D2910.

Documentation Tips

Treatment plan documentation should reflect any treatment failure or 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.

Reimbursement Tips

Most third-party payers require that the tooth number be indicated on the claim.

ICD-10-CM Diagnostic Codes

K08.51	Open restoration margins of tooth
K08.52	Unrepairable overhanging of dental restorative materials
K08.530	Fractured dental restorative material without loss of material
K08.531	Fractured dental restorative material with loss of material
K08.539	Fractured dental restorative material, unspecified
K08.54	Contour of existing restoration of tooth biologically incompatible with oral health
K08.55	Allergy to existing dental restorative material
K08.56	Poor aesthetic of existing restoration of tooth
K08.59	Other unsatisfactory restoration of tooth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D2920	0.51	0.45	0.11	1.07
Facility RVU	**Work**	**PE**	**MP**	**Total**
D2920	0.51	0.45	0.11	1.07

	FUD	Status	MUE	Modifiers				IOM Reference
D2920	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

Terms To Know

artificial crown. In dentistry, a ceramic or metal restoration made to cover or replace a major part of the top of a tooth.

dental cement. Any substance used in the mouth that sets from a viscous to a hard form and functions as a restorative material, a bonding force for fabricated restorations and orthodontics, or protective filling for insulation.

D3410-D3426

D3410 apicoectomy - anterior

For surgery on root of anterior tooth. Does not include placement of retrograde filling material.

D3421 apicoectomy - premolar (first root)

For surgery on one root of a premolar. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

D3425 apicoectomy - molar (first root)

For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

D3426 apicoectomy (each additional root)

Typically used for premolar and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.

Explanation

An apicoectomy is performed. An apicoectomy involves removal of the root tip and the surrounding infected tissue of an abscessed tooth. Apicoectomy may be necessary when inflammation and infection persists in the area around the root tip following root canal therapy. The tooth is numbed and the gum is reflected (lifted) to expose the underlying bone and tooth root. The root end and all infected tissue are excised. Root end filler is used to seal the root. The gum is repositioned and repaired with dissolvable sutures. The apicectomy affects incisors or cuspids in D3410; bicuspids in D3421; or molars in D3425. Each additional root is reported using D3426.

Coding Tips

Local anesthesia is generally considered to be part of endodontic procedures. Code D3246 should be reported for each additional root treated. Payers may require that the tooth/root number be reported on the claim. Code D3426 should not be reported alone but should be reported in conjunction with D3421 or D3425.

Reimbursement Tips

When reporting code D3410, third-party payers may require clinical documentation and/or x-rays before making payment determination. Check with payers to determine their specific requirements.

ICD-10-CM Diagnostic Codes

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
K04.99	Other diseases of pulp and periapical tissues
S02.81XA	Fracture of other specified skull and facial bones, right side, initial encounter for closed fracture ☑
S02.81XB	Fracture of other specified skull and facial bones, right side, initial encounter for open fracture ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D3410	3.95	3.49	0.81	8.25
D3421	4.44	3.92	0.91	9.27
D3425	5.01	4.42	1.03	10.46
D3426	1.80	1.58	0.37	3.75
Facility RVU	**Work**	**PE**	**MP**	**Total**
D3410	3.95	3.49	0.81	8.25
D3421	4.44	3.92	0.91	9.27
D3425	5.01	4.42	1.03	10.46
D3426	1.80	1.58	0.37	3.75

	FUD	Status	MUE	Modifiers				IOM Reference
D3410	N/A	R	-	N/A	N/A	N/A	N/A	[None]
D3421	N/A	R	-	N/A	N/A	N/A	N/A	
D3425	N/A	R	-	N/A	N/A	N/A	N/A	
D3426	N/A	R	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

anterior teeth. Six upper and six lower front teeth; the upper and lower incisors and cuspids.

apex. Highest point of a root end of a tooth, or the end of any organ.

apicoectomy. In dentistry, amputation of the end of the root portion of a tooth.

endodontics. Subspecialty of dentistry that deals primarily with the pulp of the tooth or the dentine complex.

periradicular. Surrounding part of the tooth's root.

root canal. Inner soft tissue, or pulp, of the tooth containing the lymph vessels, veins, arteries, and nerves of the tooth within small channels (up to five) running from the top of the tooth down to the tip of the root. When the tooth is cracked or decayed, bacteria enter the pulp and infect it, causing damage or death to the pulpal tissue and possibly an abscess that can infect bone. Root canal therapy repairs the root canal by removing the damaged pulp and cleaning out bacteria to prevent further damage and save the tooth.

D6103-D6104

D6103 bone graft for repair of peri-implant defect - does not include flap entry and closure

Placement of a barrier membrane or biologic materials to aid in osseous regeneration, are reported separately.

D6104 bone graft at time of implant placement

Placement of a barrier membrane, or biologic materials to aid in osseous regeneration are reported separately.

Explanation

The provider performs a bone graft to repair a defect near an implant to stabilize or increase the level of the bone or to fill structural defects. The area is exposed; the method used is dependent upon the area where the graft will be inserted. The physician dissects tissues away and the site is exposed. The graft is placed on the site and contoured until desired shape is achieved. The graft is secured and the site is closed.

Coding Tips

These codes are out-of-sequence codes and will not display in numeric order in the CDT book. When flap entry is performed, this may be reported separately (D4240–D4245). When performed, the placement of a barrier membrane or other biologic material to aid in soft and osseous tissue regeneration may be reported separately (D4265–D4267).

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
D6103	1.79	1.58	0.37	3.74
D6104	2.41	2.13	0.50	5.04
Facility RVU	**Work**	**PE**	**MP**	**Total**
D6103	1.79	1.58	0.37	3.74
D6104	2.41	2.13	0.50	5.04

	FUD	Status	MUE	Modifiers				IOM Reference
D6103	N/A	R	-	N/A	N/A	N/A	N/A	[None]
D6104	N/A	R	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

bone graft. Bone that is removed from one part of the body and placed into another bone site without direct re-establishment of blood supply.

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

D6105

D6105 removal of implant body not requiring bone removal or flap elevation

Explanation

The implant body is the portion of the implant that is placed in the bone. If the implant body needs to be removed the dentist may gain access through a simple incision into the gums. The implant body is unscrewed and removed, leaving the bone intact. The incision is closed with sutures.

Coding Tips

For bone graft to repair a peri-implant defect, see D6103. Local anesthesia is included this service. Any evaluation, prophylaxis, or restorative service is reported separately.

Documentation Tips

The medical record should include the reason the implant body is removed.

Associated CPT Codes

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

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

ICD-10-CM Diagnostic Codes

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
K08.51 Open restoration margins of tooth
K08.52 Unrepairable overhanging of dental restorative materials
K08.530 Fractured dental restorative material without loss of material
K08.531 Fractured dental restorative material with loss of material
K08.54 Contour of existing restoration of tooth biologically incompatible with oral health
K08.55 Allergy to existing dental restorative material
K08.56 Poor aesthetic of existing restoration of tooth
M27.63 Post-osseointegration mechanical failure of dental implant
Z46.3 Encounter for fitting and adjustment of dental prosthetic device

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D6105				
Facility RVU	**Work**	**PE**	**MP**	**Total**
D6105				

	FUD	Status	MUE	Modifiers				IOM Reference
D6105	N/A		-	N/A	N/A	N/A	N/A	

* with documentation

D6780-D6784

D6780 retainer crown - 3/4 cast high noble metal
D6781 retainer crown - 3/4 cast predominantly base metal
D6782 retainer crown - 3/4 cast noble metal
D6783 retainer crown - 3/4 porcelain/ceramic
D6784 retainer crown 3/4 - titanium and titanium alloys

Explanation

A fixed partial denture retainer crown is made for a tooth that needs to be the connecting or anchoring tooth for the retainer but may be decayed or damaged enough to require restoration. The crown is made to accommodate the attachment of the retainer from impressions taken of the tooth's anatomy and the tooth with the retainer (see previous restorative crown codes D2780–D2783 for the method). Report D6780 for a cast high noble metal crown, D6781 for cast predominantly base metal, D6782 for cast noble metal, D6783 for a cast porcelain crown and D6784 for titanium and titanium alloys.

Coding Tips

Local anesthesia is included in these services. Any evaluation or radiograph, core buildup, or post or preparation service is reported separately. For individual restorations, see D2710-D2799. Prefabricated crowns are reported using the appropriate code from the D2930-D2934 range; for abutment supported, see D6058-D6064 or D6094. Implant supported crowns are reported with a code from the D6065-D6067 range. Code D6710 should not be used to report a temporary or provisional prosthesis; see D6793. For crowns used as a fixed partial denture retainer fabricated using porcelain or ceramic, see codes D6740-D6752; for crowns used as a fixed partial denture retainer fabricated using resin-based materials, see D6710-D6722. Full crowns used for partial denture retainers are reported with the appropriate code in the D6790-D6792 range. A titanium fixed partial denture retainer crown is reported with D6794. High noble metals include gold, palladium, and platinum. The content must be ≥ 60 percent gold plus platinum and a minimum of ≥ 40 percent gold. Noble metals include 25 percent or less gold plus platinum group. Predominantly base alloys contain a noble metal content of < 25 percent gold plus platinum group. The metals of the platinum group include platinum, palladium, rhodium, iridium, osmium, and ruthenium. Porcelain/ceramic refers to pressed, fired, polished, or milled substances, which predominantly contain inorganic refractory compounds such as porcelains, glasses, ceramics, and glass-ceramics.

Documentation Tips

Documentation should indicate the location and number of missing teeth.

Reimbursement Tips

Payers may require documentation including the tooth number and preoperative periapical x-rays showing the entire treatment site.

ICD-10-CM Diagnostic Codes

K02.3 Arrested dental caries
K02.51 Dental caries on pit and fissure surface limited to enamel
K02.52 Dental caries on pit and fissure surface penetrating into dentin
K02.53 Dental caries on pit and fissure surface penetrating into pulp
K02.61 Dental caries on smooth surface limited to enamel
K02.62 Dental caries on smooth surface penetrating into dentin
K02.63 Dental caries on smooth surface penetrating into pulp
K02.7 Dental root caries
K03.0 Excessive attrition of teeth
K03.1 Abrasion of teeth
K03.2 Erosion of teeth
K03.3 Pathological resorption of teeth
K03.4 Hypercementosis
K03.5 Ankylosis of teeth
K03.6 Deposits [accretions] on teeth
K03.7 Posteruptive color changes of dental hard tissues
K03.81 Cracked tooth
K03.89 Other specified diseases of hard tissues of teeth

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D6780	6.05	5.34	1.25	12.64
D6781	5.77	5.09	1.19	12.05
D6782	5.46	4.82	1.12	11.40
D6783	5.92	5.22	1.22	12.36
D6784	3.75	3.31	0.77	7.83
Facility RVU	**Work**	**PE**	**MP**	**Total**
D6780	6.05	5.34	1.25	12.64
D6781	5.77	5.09	1.19	12.05
D6782	5.46	4.82	1.12	11.40
D6783	5.92	5.22	1.22	12.36
D6784	3.75	3.31	0.77	7.83

	FUD	Status	MUE	Modifiers				IOM Reference
D6780	N/A	R	-	N/A	N/A	N/A	N/A	[None]
D6781	N/A	R	-	N/A	N/A	N/A	N/A	
D6782	N/A	R	-	N/A	N/A	N/A	N/A	
D6783	N/A	R	-	N/A	N/A	N/A	N/A	
D6784	N/A	R	-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

abutment crown. Artificial tooth cap for the retention and/or support of a dental prosthesis.

artificial crown. In dentistry, a ceramic or metal restoration made to cover or replace a major part of the top of a tooth.

composite. In dentistry, synthetic material such as acrylic resin and quartz particles used in tooth restoration.

coping. Thin covering that is placed over a tooth before attaching a crown or overdenture.

denture. Manmade substitution of natural teeth and neighboring structures.

moulage. Model of an anatomical structure formed via a negative impression in wax or plaster.

D9932-D9933

D9932 cleaning and inspection of removable complete denture, maxillary

This procedure does not include any adjustments.

D9933 cleaning and inspection of removable complete denture, mandibular

This procedure does not include any adjustments.

Explanation

A removable complete denture is cleaned and inspected. The denture is cleaned using ultrasound, and stubborn stains and/or calculus are removed. The dentist examines the denture to determine any wear or damage to the denture. Report D9932 for upper denture, D9933 for lower denture.

Coding Tips

To report the cleaning and inspection of a partial denture, see D9934–D9935. Correct code selection is dependent upon the type of denture. Any adjustments are reported separately.

Documentation Tips

Documentation should include notation that the dentures are cleaned and inspected, and any findings such as abrasions or wear should be noted. Also document any adjustments that are required.

Reimbursement Tips

Coverage guidelines vary by payer and by patient contract. Check with the payer to determine coverage policies.

ICD-10-CM Diagnostic Codes

Z01.20 Encounter for dental examination and cleaning without abnormal findings

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9932	0.09	0.17	0.01	0.27
D9933	0.09	0.17	0.01	0.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9932	0.09	0.17	0.01	0.27
D9933	0.09	0.17	0.01	0.27

	FUD	Status	MUE	Modifiers				IOM Reference
D9932	N/A	R	-	N/A	N/A	N/A	80*	[None]
D9933	N/A	R	-	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

denture. Manmade substitution of natural teeth and neighboring structures.

D9934-D9935

D9934 cleaning and inspection of removable partial denture, maxillary

This procedure does not include any adjustments.

D9935 cleaning and inspection of removable partial denture, mandibular

This procedure does not include any adjustments.

Explanation

A removable partial denture is cleaned and inspected. The denture is cleaned using ultrasound and stubborn stains and/or calculus are removed. The dentist examines the denture to determine any wear or damage to the denture. Report D9934 for upper denture, D9935 for lower denture.

Coding Tips

To report the cleaning and inspection of a complete denture, see D9932–D9933. Correct code selection is dependent upon the type of denture. Any adjustments are reported separately.

Documentation Tips

Documentation should include notation that the dentures are cleaned and inspected, and any findings such as abrasions or wear should be noted. Also document any adjustments that are required or repairs to framework or clasps.

Reimbursement Tips

Coverage guidelines vary by payer and by patient contract. Check with the payer to determine coverage policies.

ICD-10-CM Diagnostic Codes

Z01.20 Encounter for dental examination and cleaning without abnormal findings

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D9934	0.09	0.17	0.01	0.27
D9935	0.09	0.17	0.01	0.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
D9934	0.09	0.17	0.01	0.27
D9935	0.09	0.17	0.01	0.27

	FUD	Status	MUE	Modifiers				IOM Reference
D9934	N/A	R	-	N/A	N/A	N/A	80*	[None]
D9935	N/A	R	-	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

denture. Manmade substitution of natural teeth and neighboring structures.

99202-99205

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

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

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

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

Explanation

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

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211–99215.

Documentation Tips

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

Reimbursement Tips

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

ICD-10-CM Diagnostic Codes

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

AMA: **99202** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

41017

41017 Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular

Explanation

The dentist drains an abscess, a cyst, or a hematoma from the floor of the mouth in the submandibular space. The dentist makes an incision under the angle of the mandible, or between the angle and the chin and below the inferior border of the mandible. Dissection is limited to the submandibular space. The fluid is then drained and an artificial drain may be placed. If placed, the drain is later removed.

Coding Tips

Placement and removal of drain are not reported separately. Local anesthesia is included in the service. Payers may require that this service be reported using D7520 or D7521 on the ADA dental claim form. Check with payers to determine their requirements.

Documentation Tips

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

Reimbursement Tips

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

Associated HCPCS Codes

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

ICD-10-CM Diagnostic Codes

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
41017	4.19	9.33	0.45	13.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
41017	4.19	5.66	0.45	10.30

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

* with documentation

Terms To Know

dissection. Separating by cutting tissue or body structures apart.

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

41018

41018 Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space

Explanation

The dentist drains an abscess, a cyst, or a hematoma from the floor of the mouth by making an extraoral incision in the skin below the inferior border of the mandible and dissecting up through the tissue to reach the affected space. An incision is made just below the angle of the ramus of the mandible, the posterior part of the mandible, and into the masticator space containing the masticator muscles to drain the abscess, cyst, or hematoma. A drain may be placed to facilitate healing, which is later removed.

Coding Tips

Placement and removal of drain are not reported separately. Local anesthesia is included in the service. Payers may require that this service be reported using D7520 or D7521 on the ADA dental claim form. Check with payers to determine their requirements.

Documentation Tips

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

Reimbursement Tips

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

Associated HCPCS Codes

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

ICD-10-CM Diagnostic Codes

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
41018	5.22	9.94	0.59	15.75
Facility RVU	**Work**	**PE**	**MP**	**Total**
41018	5.22	6.20	0.59	12.01

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

* with documentation