Optum

Coding Guide

OMS

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

2027

optumcoding.com

Contents

Getting Started with Coding Guide

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

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

CDT and CPT Codes

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

Resequencing of CDT and CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

Some codes are presented in a less comprehensive format in the appendix. The CDT and CPT codes appropriate to the specialty are included the appendix with the official code description, followed by an easy-to-understand explanation, 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 Guide* includes the list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 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 https://www.optumcoding.com/ProductUpdates/. The 2027 edition password is: **XXXX**. Log in frequently to ensure you receive the most current updates.

Index

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

21199 Osteotomy, mandible, segmental; with genioglossus advancement

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

Advancement
Genioglossus, 21199

or **Mandible**
Osteotomy, 21198-21199

or **Osteotomy**
Mandible, 21198-21199

Telehealth/Telemedicine Services

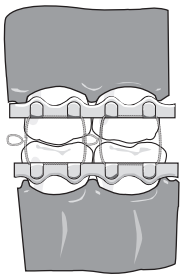
Telehealth/telemedicine services are identified by CPT with the ★ icon at the code level. The Centers for Medicare and Medicaid Services (CMS) identify services that may be performed via telehealth. These CMS-approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine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

Sample Page and Key

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

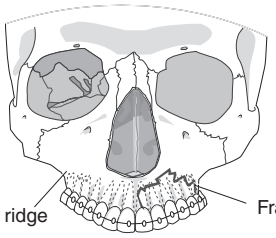
21440

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



Erich arch-type of fixation

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



Reduction, when required, is by closed manipulation

Explanation

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

Coding Tips

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

Documentation Tips

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

Reimbursement Tips

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

Associated HCPCS Codes

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

ICD-10-CM Diagnostic Codes

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

AMA: **21440** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21440	3.44	19.02	0.36	22.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
21440	3.44	14.43	0.36	18.23

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

* with documentation

Terms To Know

alveolar process. Bony part of the maxilla or mandible that supports the tooth roots and into which the teeth are implanted.
mandibular. Having to do with the lower jaw.
maxillary. Located between the eyes and the upper teeth.

1. CDT/CPT Codes and Descriptions

This edition of *Coding Guide for OMS* is updated with CDT and CPT codes for year 2027.

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

- ● This CPT code is new for 2027.
- ▲ This CPT code description is revised for 2027.
- ✚ This CPT code is an add-on code.
- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.
- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

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

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

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

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

2. Illustrations

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

3. Explanation

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

4. Coding Tips

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

5. Documentation Tips

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

6. Reimbursement Tips

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

7. Associated CPT/HCPCS Codes

The 2026 edition of the *Coding Guide for OMS* contains a crosswalk from the driver Dental or CPT code to its corresponding CPT or Dental or other associated HCPCS code. CDT codes should be reported for the majority of dental services. On occasion, coverage of trauma, injury, or neoplasm may be covered by the healthcare insurer. This heading will not appear if there is no valid crosswalk.

8. ICD-10-CM Diagnostic Codes

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

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

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

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

9. AMA References

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

10. Relative Value Units/Medicare Edits

Gap Filled Relative Value Units

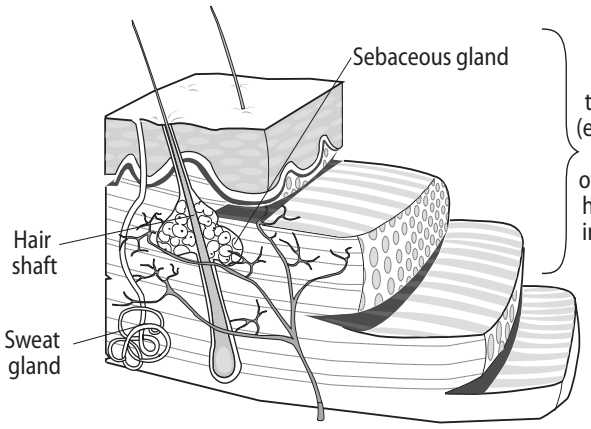
Included in this edition are 2024 gap filled relative value units (RVU) for the CDT codes. These are useful in assisting with establishing fee schedules for your practice. The gap relative value units are created by Optum using various methodologies depending on the code. For most codes, gap relative 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.

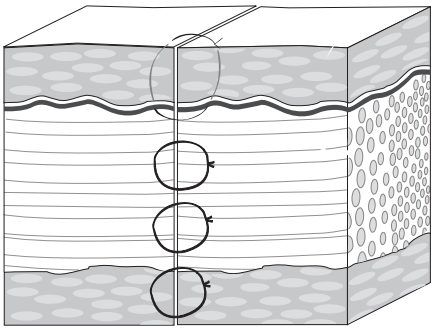
Because the Optum relative values are on a different scale than RBRVS relative values, ratios are developed relating the RBRVS and Optum scales for approximately 250 code ranges within the CPT, HCPCS, and CDT coding systems. These ratios are multiplied by the Optum relative value to create the gap value. 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:

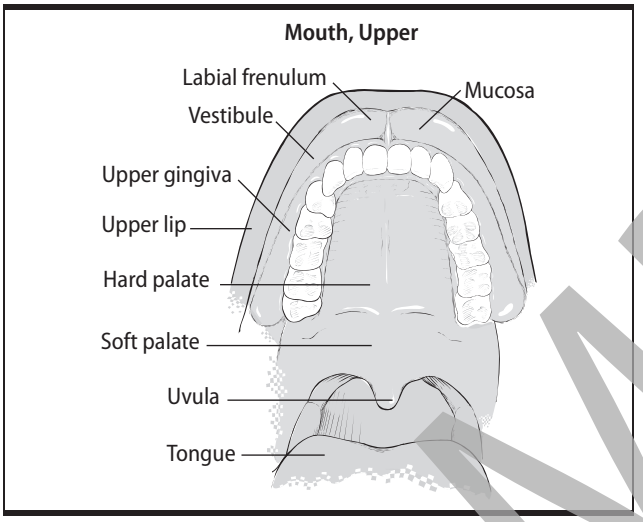
Integumentary

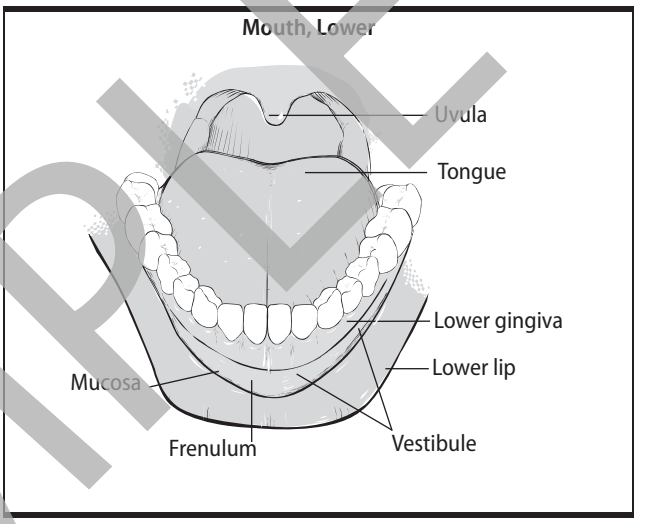


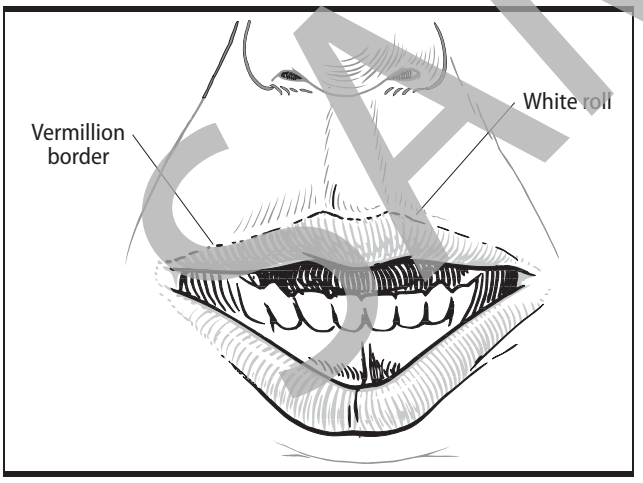


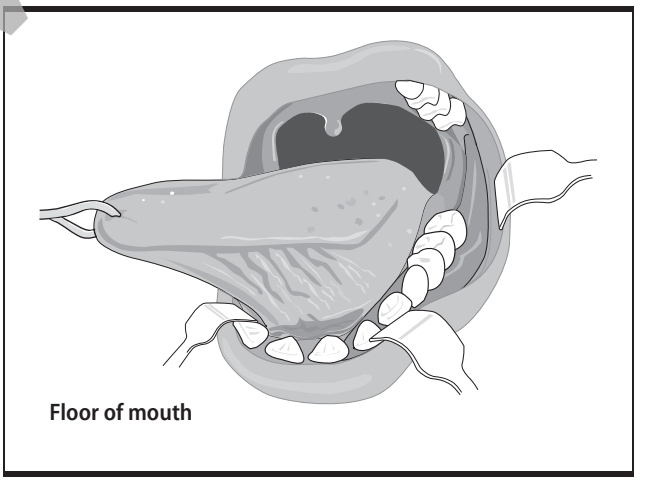
Schematic of layered suturing

Intraoral Structures









Floor of mouth

D0393

D0393 virtual treatment simulation using 3D image volume or surface scan

Virtual simulation of treatment including, but not limited to, dental implant placement, prosthetic reconstruction, orthognathic surgery and orthodontic tooth movement.

Explanation

A provider uses three-dimensional (3-D) cone imaging to evaluate and simulate treatment utilizing relationships between bones, teeth, airways, nerves, and tissues to develop treatment plans for implants, prosthetics, orthodontics or surgery.

Coding Tips

For three-dimensional photographic imaging for diagnostic purposes, see D0801-D0804.

Documentation Tips

Document the simulation of dental implant placement, prosthetic reconstruction, orthognathic surgery, or orthodontic tooth movement.

Associated CPT Codes

76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation

76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation

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
D0393	1.10	4.29	0.08	5.47
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0393	1.10	4.29	0.08	5.47

	FUD	Status	MUE	Modifiers				IOM Reference
D0393	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

Terms To Know

imaging. Radiologic means of producing pictures for clinical study of the internal structures and functions of the body, such as x-ray, ultrasound, magnetic resonance, or positron emission tomography.

treatment. Management of patient.

D0394

D0394 digital subtraction of two or more images or image volumes of the same modality

To demonstrate changes that have occurred over time.

Explanation

Digital subtraction radiography (DSR) is employed to determine qualitative changes occurring over a period of time. A first baseline image is obtained. After a predetermined period of time, a second image is obtained and compared to the first by subtracting the pixel values from the first image from the pixel values of the second image. Anything that has been unchanged is removed by the process and any changes that have transpired may be observed. DSR images may be used to detect continued disease processes or to demonstrate the effectiveness of the current treatment.

Coding Tips

To report three-dimensional photographic images of the dental or maxillofacial structures for diagnostic purposes, see D0801-D0804.

Reimbursement Tips

This service may not be covered by the patient's dental insurance. However, coverage may be available through the patient's medical insurance. Check with third-party payers for specific coverage information. Services submitted to the payer of medical coverage will require that the service be reported with the appropriate CPT code on the CMS-1500 claim form. Note that when reporting this service with CPT codes, the appropriate CPT code is reported with modifier 26 Professional component, appended.

Associated CPT Codes

76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation

76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation

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
D0394	0.13	0.52	0.01	0.66
Facility RVU	**Work**	**PE**	**MP**	**Total**
D0394	0.13	0.52	0.01	0.66

	FUD	Status	MUE	Modifiers				IOM Reference
D0394	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

D5915, D5928

D5915 orbital prosthesis

A prosthesis, which artificially restores the eye, eyelids, and adjacent hard and soft tissue, lost as a result of trauma or surgery. Fabrication of an orbital prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods of time. When a new prosthesis is made from the existing mold, this procedure is termed an orbital prosthesis replacement.

D5928 orbital prosthesis, replacement

A replacement for a previously made orbital prosthesis. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age related topographical variations.

Explanation

Orbital exenteration is most often performed for malignancy or severe trauma and involves the complete removal of the orbital contents, including the intraocular muscles and perhaps the eyelids. Grafting with split-thickness grafts may be performed to ensure tolerance of an orbital l prosthesis once healing has occurred (two to four months). An orbital prosthesis is used to restore the eyelids, as well as the hard and soft tissues of the orbit, and the eyebrow, when necessary. It may or may not include the ocular prosthesis component. Steps in the process typically include fabrication of a custom impression of the orbital socket, fabrication of the mold, coloring of the iris, coloring and veining of the eyeball, and curing of the device. Report D5915 for a permanent orbital prosthesis or D5928 for a replacement orbital prosthesis.

Coding Tips

These are out-of-sequence codes and will not display in numeric order in the CDT book. For an ocular prosthesis, see D5916; for an interim ocular prosthesis, see D5923. See also codes V2623–V2629 for prosthetic eye services.

Reimbursement Tips

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

Associated CPT Codes

21077 Impression and custom preparation; orbital prosthesis

ICD-10-CM Diagnostic Codes

C41.0 Malignant neoplasm of bones of skull and face
S01.111A Laceration without foreign body of right eyelid and periocular area, initial encounter ☑
S01.112A Laceration without foreign body of left eyelid and periocular area, initial encounter ☑
S01.121A Laceration with foreign body of right eyelid and periocular area, initial encounter ☑
S01.122A Laceration with foreign body of left eyelid and periocular area, initial encounter ☑
S01.131A Puncture wound without foreign body of right eyelid and periocular area, initial encounter ☑
S01.132A Puncture wound without foreign body of left eyelid and periocular area, initial encounter ☑
S01.141A Puncture wound with foreign body of right eyelid and periocular area, initial encounter ☑
S01.142A Puncture wound with foreign body of left eyelid and periocular area, initial encounter ☑
S01.151A Open bite of right eyelid and periocular area, initial encounter ☑
S01.152A Open bite of left eyelid and periocular area, initial encounter ☑
S02.411A LeFort I fracture, initial encounter for closed fracture
S02.411B LeFort I fracture, initial encounter for open fracture
S02.412A LeFort II fracture, initial encounter for closed fracture
S02.412B LeFort II fracture, initial encounter for open fracture
S02.413A LeFort III fracture, initial encounter for closed fracture
S02.413B LeFort III fracture, initial encounter for open fracture
S02.42XA Fracture of alveolus of maxilla, initial encounter for closed fracture
S02.42XB Fracture of alveolus of maxilla, initial encounter for open fracture
S05.21XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, right eye, initial encounter ☑
S05.31XA Ocular laceration without prolapse or loss of intraocular tissue, right eye, initial encounter ☑
S05.32XA Ocular laceration without prolapse or loss of intraocular tissue, left eye, initial encounter ☑
S05.41XA Penetrating wound of orbit with or without foreign body, right eye, initial encounter ☑
S05.42XA Penetrating wound of orbit with or without foreign body, left eye, initial encounter ☑
S05.51XA Penetrating wound with foreign body of right eyeball, initial encounter ☑
S05.52XA Penetrating wound with foreign body of left eyeball, initial encounter ☑
S05.61XA Penetrating wound without foreign body of right eyeball, initial encounter ☑
S05.62XA Penetrating wound without foreign body of left eyeball, initial encounter ☑
S05.71XA Avulsion of right eye, initial encounter ☑
S05.72XA Avulsion of left eye, initial encounter ☑
S07.0XXA Crushing injury of face, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D5915	55.84	49.29	11.50	116.63
D5928	22.84	20.16	4.70	47.70
Facility RVU	**Work**	**PE**	**MP**	**Total**
D5915	55.84	49.29	11.50	116.63
D5928	22.84	20.16	4.70	47.70

	FUD	Status	MUE	Modifiers				IOM Reference
D5915	N/A	R	-	N/A	N/A	N/A	80*	[None]
D5928	N/A	R	-	N/A	N/A	N/A	80*	

* with documentation

D7880

D7880 occlusal orthotic device, by report

Presently includes splints provided for treatment of temporomandibular joint dysfunction.

Explanation

The physician fits the patient for an occlusal orthotic device including a splint.

Coding Tips

This should be used to report occlusal orthotic devices that are used to treat disorders of the temporomandibular joint only.

Documentation Tips

Documentation should clearly indicate the type of temporomandibular joint dysfunction the patient has.

Associated CPT Codes

There are no direct CPT cross codes.

ICD-10-CM Diagnostic Codes

M26.611 Adhesions and ankylosis of right temporomandibular joint ☑
M26.612 Adhesions and ankylosis of left temporomandibular joint ☑
M26.613 Adhesions and ankylosis of bilateral temporomandibular joint ☑
M26.621 Arthralgia of right temporomandibular joint ☑
M26.622 Arthralgia of left temporomandibular joint ☑
M26.623 Arthralgia of bilateral temporomandibular joint ☑
M26.631 Articular disc disorder of right temporomandibular joint ☑
M26.632 Articular disc disorder of left temporomandibular joint ☑
M26.633 Articular disc disorder of bilateral temporomandibular joint ☑
M26.641 Arthritis of right temporomandibular joint ☑
M26.643 Arthritis of bilateral temporomandibular joint ☑
M26.649 Arthritis of unspecified temporomandibular joint
M26.651 Arthropathy of right temporomandibular joint ☑
M26.653 Arthropathy of bilateral temporomandibular joint ☑
M26.659 Arthropathy of unspecified temporomandibular joint

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D7880	4.49	3.96	0.92	9.37
Facility RVU	**Work**	**PE**	**MP**	**Total**
D7880	4.49	3.96	0.92	9.37

	FUD	Status	MUE	Modifiers				IOM Reference
D7880	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

Terms To Know

temporomandibular joint. Joint or hinge formed by the connection of the lower jaw to the temporal bone of the cranium, located in front of the ear on both sides of the face.

D7881

D7881 occlusal orthotic device adjustment

Explanation

The provider makes adjustments to a previously provided occlusal orthotic device. An occlusal orthotic device or splint is a device specifically fitted for people who have a history of temporomandibular joint pain or other conditions. Usually made of an acrylic resin, the provider may need to make adjustments to the device for a better fit by heating, filing, or other methods.

Coding Tips

Use this code to report the adjustment of a TMJ appliance. See D9943 for the adjustment of an occlusal guard. See code D7880 to report the provision of the occlusal orthotic device.

Documentation Tips

Documentation should clearly identify the condition necessitating the occlusal orthotic device. It should also identify the type of adjustment that was needed.

Associated CPT Codes

There are no direct CPT cross codes.

ICD-10-CM Diagnostic Codes

M26.611 Adhesions and ankylosis of right temporomandibular joint ☑
M26.612 Adhesions and ankylosis of left temporomandibular joint ☑
M26.613 Adhesions and ankylosis of bilateral temporomandibular joint ☑
M26.621 Arthralgia of right temporomandibular joint ☑
M26.622 Arthralgia of left temporomandibular joint ☑
M26.623 Arthralgia of bilateral temporomandibular joint ☑
M26.631 Articular disc disorder of right temporomandibular joint ☑
M26.632 Articular disc disorder of left temporomandibular joint ☑
M26.633 Articular disc disorder of bilateral temporomandibular joint ☑
M26.641 Arthritis of right temporomandibular joint ☑
M26.643 Arthritis of bilateral temporomandibular joint ☑
M26.649 Arthritis of unspecified temporomandibular joint
M26.651 Arthropathy of right temporomandibular joint ☑
M26.653 Arthropathy of bilateral temporomandibular joint ☑
M26.659 Arthropathy of unspecified temporomandibular joint

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
D7881	1.68	1.48	0.35	3.51
Facility RVU	**Work**	**PE**	**MP**	**Total**
D7881	1.68	1.48	0.35	3.51

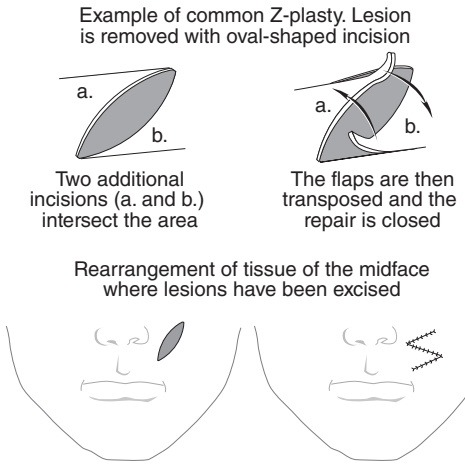
	FUD	Status	MUE	Modifiers				IOM Reference
D7881	N/A	R	-	N/A	N/A	N/A	80*	[None]

* with documentation

14040-14041

14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

14041 defect 10.1 sq cm to 30.0 sq cm



Explanation

The physician transfers or rearranges adjacent tissue to repair traumatic or surgical wounds on the forehead, cheeks, chin, mouth, and/or neck. This includes, but is not limited to, such rearrangement procedures as Z-plasty, W-plasty, ZY-plasty, or tissue transfers such as rotational flaps or advancement flaps. Report code 14040 for defects that are 10 sq cm or less and code 14041 for defects that are 10.1 sq cm to 30 sq cm.

Coding Tips

When these codes are used for the repair of traumatic wounds, the procedure must have been previously planned and developed by the physician to effect this particular repair. These codes do not apply when direct closure or rearrangement of traumatized tissue incidentally results in these configurations. Any skin graft necessary to close the defect is considered an additional procedure and is reported separately. The total square centimeter area can be calculated by adding together the areas of the primary and secondary defects. For separate wounds in the same anatomical location that are repaired with one adjacent tissue transfer or rearrangement, report one code for the total sum of the defects. If more than one adjacent tissue repair is performed in the same anatomical location, report the appropriate code for each site and append modifier 59 to additional codes.

Associated HCPCS Codes

D4245 apically positioned flap
D7911 complicated suture - up to 5 cm
D7912 complicated suture - greater than 5 cm

ICD-10-CM Diagnostic Codes

C49.0 Malignant neoplasm of connective and soft tissue of head, face and neck
C76.0 Malignant neoplasm of head, face and neck
D17.0 Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck
D21.0 Benign neoplasm of connective and other soft tissue of head, face and neck
S01.411A Laceration without foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.421A Laceration with foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.431A Puncture wound without foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.441A Puncture wound with foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.451A Open bite of right cheek and temporomandibular area, initial encounter ☑
S01.81XA Laceration without foreign body of other part of head, initial encounter
S01.82XA Laceration with foreign body of other part of head, initial encounter
S01.83XA Puncture wound without foreign body of other part of head, initial encounter
S01.84XA Puncture wound with foreign body of other part of head, initial encounter
S01.85XA Open bite of other part of head, initial encounter
T20.36XA Burn of third degree of forehead and cheek, initial encounter
T20.39XA Burn of third degree of multiple sites of head, face, and neck, initial encounter
T20.73XA Corrosion of third degree of chin, initial encounter
T20.76XA Corrosion of third degree of forehead and cheek, initial encounter
T20.79XA Corrosion of third degree of multiple sites of head, face, and neck, initial encounter

AMA: **14040** 2024,Jul; 2024,Jan; 2023,Apr; 2023,Mar; 2022,Nov; 2022,Feb; 2021,Aug; 2021,Apr; 2021,Mar **14041** 2024,Jul; 2024,Jan; 2023,Apr; 2023,Mar; 2022,Nov; 2022,Feb; 2021,Aug; 2021,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
14040	8.6	13.2	1.12	22.92
14041	10.83	15.65	1.34	27.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
14040	8.6	9.01	1.12	18.73
14041	10.83	10.67	1.34	22.84

	FUD	Status	MUE	Modifiers				IOM Reference
14040	90	A	2(3)	N/A	51	N/A	N/A	None
14041	90	A	3(3)	N/A	51	N/A	N/A	

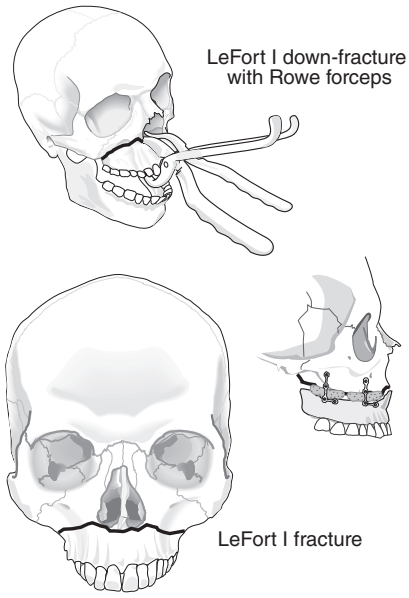
* with documentation

21141-21143

21141 Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft

21142 2 pieces, segment movement in any direction, without bone graft

21143 3 or more pieces, segment movement in any direction, without bone graft



The maxilla is down-fractured from the stable bone and reduced with wires, plates, and/ or screws

Explanation

The physician performs a LeFort I osteotomy to repair congenital malformations or acquired deformities of the facial bones, without using a bone graft. With the patient under anesthesia, the physician makes a horizontal cut through the maxillary sinuses and nasal septum through an intraoral incision, and into the pterygoid fissure. Surgical instruments are used to complete the separation of the maxilla from the skull base. The maxilla is down-fractured to mobilize it and can be moved into the proper predetermined position. If segmental surgery in the maxilla was necessary, the mobilized segments are held in position by a template secured to the upper teeth. Maxillary malpositioning is corrected and the maxilla is wired to the mandible, which is positioned as a whole unit. Rigid fixation of the maxilla is achieved with miniplates or intermaxillary wires. The operative site is irrigated with antibiotic solution and the oral mucosa is closed as needed. Report 21141 if a single piece segment if repositioned; 21142 for lower maxillary midface reconstruction with two piece segmental movement; and 21143 if multiple piece (three or more) osteotomies are performed.

Coding Tips

These procedures modify or change the configuration of the bone. The amount of bone removed is determined prior to surgery based on preoperative radiographs and clinical examination. The surgical portion of the procedure includes extensive debridement, bone cuts and fracturing, fixation, wound closure, and normal postoperative follow-up care. Dental deformities are often corrected as a result of these procedures by aligning the maxillary and mandibular dentition. Report radiology services separately. For cranioplasty, see 21179, 21180, 62120, and 62140–62147.

Reimbursement Tips

Some payers may require that these services be reported using the appropriate CDT code.

Associated HCPCS Codes

D7946 LeFort I (maxilla - total)

D7947 LeFort I (maxilla - segmented)

ICD-10-CM Diagnostic Codes

G47.14 Hypersomnia due to medical condition

G47.31 Primary central sleep apnea

G47.33 Obstructive sleep apnea (adult) (pediatric)

G47.34 Idiopathic sleep related nonobstructive alveolar hypoventilation

G47.35 Congenital central alveolar hypoventilation syndrome

G47.36 Sleep related hypoventilation in conditions classified elsewhere

M26.01 Maxillary hyperplasia

M26.02 Maxillary hypoplasia

M26.11 Maxillary asymmetry

M26.72 Alveolar mandibular hyperplasia

Q75.052 Pansynostosis

Q75.058 Other multi-suture craniosynostosis

Q75.1 Craniofacial dysostosis

Q75.2 Hypertelorism

Q75.3 Macrocephaly

Q75.4 Mandibulofacial dysostosis

Q75.5 Oculomandibular dysostosis

Q87.0 Congenital malformation syndromes predominantly affecting facial appearance

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21141	19.57	18.17	2.01	39.75
21142	20.28	18.42	2.09	40.79
21143	21.05	18.82	2.17	42.04
Facility RVU	**Work**	**PE**	**MP**	**Total**
21141	19.57	18.17	2.01	39.75
21142	20.28	18.42	2.09	40.79
21143	21.05	18.82	2.17	42.04

	FUD	Status	MUE	Modifiers				IOM Reference
21141	90	A	1(2)	N/A	51	62*	80	100-02,16,10;
21142	90	A	1(2)	N/A	51	62*	80	100-02,16,120;
21143	90	A	1(2)	N/A	51	62*	80	100-02,16,180

* with documentation

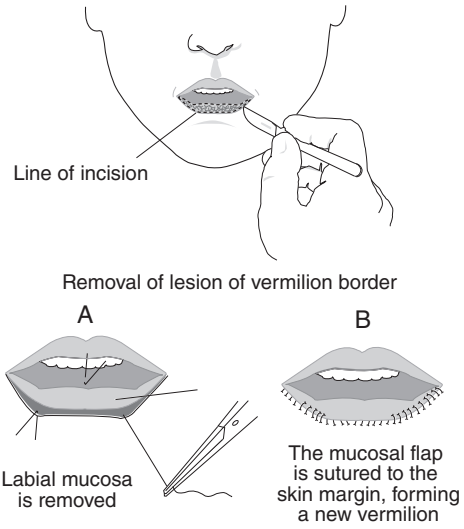
Terms To Know

LeFort I type fracture. Horizontal fracture of the maxilla in which a segment of the alveolar process containing teeth becomes detached.

reconstruction. Recreating, restoring, or rebuilding a body part or organ.

40500

40500 Vermilionectomy (lip shave), with mucosal advancement



Explanation

The physician removes the diseased vermilion border of the lip. The mucosa from the skin to the labial mucosa is separated from the underlying muscle and removed. The remaining labial mucosa is advanced and sutured to the skin, covering the exposed muscle and forming a new vermilion.

Coding Tips

If only a portion of the lesion is removed, report code 40490 for biopsy of the lip. An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For excision of a lesion of the lip, benign, see 11440–11446; for malignant, see 11640–11646. For wedge excision of the lip, see 40510–40527. For resection of more than one-fourth of the lip, see 40530.

Documentation Tips

When this procedure is not done for a cosmetic reason, the medical necessity of the service should be clearly and concisely indicated in the medical record.

Reimbursement Tips

If significant additional time and effort are documented, append modifier 22 and submit a cover letter and operative report.

Associated HCPCS Codes

D7412	excision of benign lesion, complicated
D7413	excision of malignant lesion up to 1.25 cm
D7414	excision of malignant lesion greater than 1.25 cm
D7415	excision of malignant lesion, complicated

ICD-10-CM Diagnostic Codes

C00.0	Malignant neoplasm of external upper lip
C00.1	Malignant neoplasm of external lower lip
C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C00.8	Malignant neoplasm of overlapping sites of lip
C43.0	Malignant melanoma of lip
C44.01	Basal cell carcinoma of skin of lip
C44.02	Squamous cell carcinoma of skin of lip
C4A.0	Merkel cell carcinoma of lip
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D03.0	Melanoma in situ of lip
D04.0	Carcinoma in situ of skin of lip
D10.0	Benign neoplasm of lip
D22.0	Melanocytic nevi of lip
K13.0	Diseases of lips
K13.21	Leukoplakia of oral mucosa, including tongue
Q18.6	Macrocheilia
Q38.0	Congenital malformations of lips, not elsewhere classified
S00.521A	Blister (nonthermal) of lip, initial encounter
S00.531A	Contusion of lip, initial encounter
S00.541A	External constriction of lip, initial encounter
S01.511A	Laceration without foreign body of lip, initial encounter
S01.521A	Laceration with foreign body of lip, initial encounter
S01.531A	Puncture wound without foreign body of lip, initial encounter
S01.541A	Puncture wound with foreign body of lip, initial encounter
T20.22XA	Burn of second degree of lip(s), initial encounter
T20.32XA	Burn of third degree of lip(s), initial encounter
T20.62XA	Corrosion of second degree of lip(s), initial encounter
T20.72XA	Corrosion of third degree of lip(s), initial encounter
Z41.1	Encounter for cosmetic surgery
Z42.8	Encounter for other plastic and reconstructive surgery following medical procedure or healed injury

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
40500	4.47	10.94	0.59	16.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
40500	4.47	6.17	0.59	11.23

	FUD	Status	MUE	Modifiers				IOM Reference
40500	90	A	2(3)	N/A	51	N/A	N/A	None

* with documentation

Terms To Know

vermilion border. Red margin of the upper and lower lip that commences at the exterior edge of the intraoral labial mucosa, and extends outward, terminating at the extraoral labial cutaneous junction.

96372-96376

96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

96373 intra-arterial

96374 intravenous push, single or initial substance/drug

\+ **96375** each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)

\+ **96376** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)

Explanation

The physician or an assistant under direct physician supervision administers a therapeutic, prophylactic, or diagnostic substance by subcutaneous or intramuscular injection (96372), intra-arterial injection (96373), or by push into an intravenous catheter or intravascular access device (96374 for a single or initial substance, 96375 for each additional sequential IV push of a new substance, and 96376 for each additional sequential IV push of the same substance after 30 minutes have elapsed). The push technique involves an infusion of 15 minutes or less, or one in which the physician or supervised assistant is continuously present to administer the injection and observe the patient. Code 96376 may be reported only by facilities.

Coding Tips

Do not report 96372–96376 with codes for which IV push or infusion is an integral part of the procedure. Direct physician supervision is required for 96372 when reported by the provider. Code 96376 is to be reported by the facility only. Do not report a push performed within 30 minutes of a reported push of the same substance or drug. For declotting of a catheter or port, see 36593. Some payers may require HCPCS Level II codes D9610–D9612 be reported for these services.

Reimbursement Tips

As add-on codes, 96375 and 96376 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code.

Do not report codes 96365–96379 in conjunction with codes where the IV push or infusion is an inherent component of the procedure; for example, administration of contrast material for a diagnostic imaging study.

Only **one** initial service code is to be reported other than in cases where either protocol or patient condition necessitates the use of two distinct IV sites be used. Reporting of the service must include appending modifier 59 to the *initial* service code in order to denote the distinction in both time and effort in providing the secondary IV access site.

All sequential infusions are described as any infusion or IV push of a new substance that follows the initial or primary service. In order to qualify as a sequential service, a new substance or drug must be introduced with one exception: facilities are permitted to report a sequential IV push of the same drug using CPT code 96376.

Concurrent infusions are those in which a new substance or drug is infused at the same time as another substance or drug. These services are not time based and should only be reported once daily regardless of whether an additional new substance or drug is being administered at the same time. Do not report hydration services with any other services.

Determining which service should be reported when more than one type of service is provided is done using hierarchies; these hierarchies are different depending on whether the service is reported by a clinician or a facility. When reported by a clinician, the initial service code selected should be based on key or primary reason for the encounter, regardless of the order in which the infusions/injections occur. Facility reporting is based on a structural algorithm and the initial code should be chosen following a hierarchy that states chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services, which are primary to hydration services. Infusions are primary to pushes, which are primary to injections. This ranking is followed by facilities and replaces any CPT parenthetical instructions for add-on codes that might refer an add-on code of a higher hierarchical position be reported with a base code of a lower position. For example, hierarchy would not allow the reporting of CPT code 96376 with 96360; 96376 is a higher order service. (IV push is primary to hydration.)

Associated HCPCS Codes

D9610 therapeutic parenteral drug, single administration

D9612 therapeutic parenteral drugs, two or more administrations, different medications

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: 96372 2024,Feb; 2022,May; 2021,Mar; 2020,Nov; 2018,Dec; 2018,Sep **96373** 2021,Mar; 2020,Nov; 2018,Sep **96374** 2022,Sep; 2021,Mar; 2020,Nov; 2019,Sep; 2019,Jun; 2018,Sep **96375** 2021,Mar; 2019,Sep; 2018,Sep **96376** 2022,Sep; 2021,Mar; 2018,Dec; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96372	0.17	0.25	0.01	0.43
96373	0.17	0.38	0.01	0.56
96374	0.18	0.9	0.02	1.1
96375	0.1	0.35	0.01	0.46
96376	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
96372	0.17	0.25	0.01	0.43
96373	0.17	0.38	0.01	0.56
96374	0.18	0.9	0.02	1.1
96375	0.1	0.35	0.01	0.46
96376	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
96372	N/A	A	4(3)	N/A	N/A	N/A	80*	100-04,4,230.2
96373	N/A	A	2(3)	N/A	N/A	N/A	80*	
96374	N/A	A	1(3)	N/A	N/A	N/A	80*	
96375	N/A	A	6(3)	N/A	N/A	N/A	80*	
96376	N/A	X	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

prophylactic. Treatment measure intended to prevent or ward off a disease or condition.

therapeutic. Act meant to alleviate a medical or mental condition.

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

0792T 36591-36592, 96523

00100 01996, 0213T, 0216T, 0632T, 0708T-0709T, 31505, 31515, 31527, 31622, 31634, 31645, 31647, 36000, 36010-36015, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752-43754, 61026, 61055, 62280-62284, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 64553-64555, 67500, 76000, 76998, 77002, 81000, 81002-81003, 81005, 81015, 82013, 90865, 92511-92516, 92520, 92537-92538, 92950-92961, 93000-93010, 93040-93042, 93050, 93303-93304, 93306-93308, 93312-93318, 93351, 93355, 93451, 93456-93457, 93598, 93701, 93922-93931, 93970-93981, 93985-93986, 94002, 94004, 94200, 94640, 94644, 94660-94662, 94680-94690, 94760-94762, 95700-95726, 95812-95816, 95819, 95822, 95829, 95955, 95957, 96360, 96365, 96372-96377, 96523, 99151, 99152, 99153, 99155, 99156, 99157, 99202-99215, 99221-99223, 99231-99239, 99281-99285, 99304-99310, 99315, 99341-99342, 99347-99349, 99358-99359, 99415-99416, 99418, 99446-99449, 99451-99452, 99466, 99468-99472, 99475-99480, 99483, 99485, 99497, C8921-C8927, C8929-C8930, G0380-G0384, G0406-G0408, G0425-G0427, G0463, G0500, G0508-G0509

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