



Coding Guide for OMS

2016

Contents

Introduction	1	Illustrations	61
Coding Systems	1	Dental Codes	71
ICD-9-CM to ICD-10 Transition	2	CPT Codes	349
Claim Forms	2	Unlisted Codes: Medical and Dental	744
Contents and Format of This Guide	3	Correct Coding Initiative Update (20.3)	747
CCI Edits	3	CPT Index	805
How to Use This Guide	3	Evaluation and Management	817
The Reimbursement Process	5	Providers	817
Coverage Issues	5	Types of E/M Services	817
Payment Methodologies	6	Levels of E/M Services	826
Modifier Use	7	Documentation Guidelines for Evaluation and	
Tooth Number and Surface	7	Management Services	826
Other Factors Influencing Payment	8	Plastic Surgery and Dermatology Specifics	836
Participation in Medicare Plans	14	ICD-9-CM Index	839
Collection Policies	17	ICD-9-CM Coding Conventions	839
Documentation—An Overview	19	Coding Neoplasms	839
Methods of Documentation	19	Manifestation Codes	840
General Guidelines for Documentation	20	Official ICD-9-CM Guidelines for Coding and Reporting ...	840
Principles of Documentation	20	ICD-9-CM Codes	841
Waste, Fraud, and Abuse	23	Alphabetic Index to External Causes of Injury and	
Claims Processing	31	Poisoning (E Code)	863
What to Include on Claims	31	Procedure Codes	59
Determining Coverage	31	HCPCS Level I or CPT Codes	59
Clean Claims	31	HCPCS Level II Codes	59
The Health Insurance Portability and Accountability Act	32		
Processing the Claim	35		
Appeals Process	35		
The CMS-1500 Claim Form	37		
Dental Claim Form	50		

Dental Billing Forms

The ADA revised the dental claim form that is used by most dental third-party payers. These revisions allow the reporting of diagnosis and place of service information. The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan and has been revised to meet HIPAA requirements. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim Form by providers and payers.

There are significant numbers of claims that are filed using forms customized by the provider. These "superbills" typically are multipart check-off forms. While these bills improve the efficiency of the provider's office, they may create difficulties in the payer's claims flow and can result in delayed reimbursement. The most recent revisions to this claim form were made in July 2012.

Contents and Format of This Guide

Coding Guide for OMS has three primary sections: reimbursement, procedure code definitions and guidelines, and diagnosis code guidelines and index.

Reimbursement

The first section of the guide provides comprehensive information about the coding and reimbursement process. It has four chapters: "Introduction," "The Reimbursement Process," "Documentation—An Overview," and "Claims Processing."

Definitions and Guidelines

The second section provides the definitions and guidelines for using the 2014 CDT and CPT codes, as well as the ICD-9-CM codes that most commonly support medical necessity of the service, any associated HCPCS Level II codes, and reimbursement information.

Procedure Code Definitions and Guidelines

This section begins with the standard coding definitions and guidelines for CDT and CPT codes. In addition, immediately following the coding definitions and guidelines, are illustrations that assist in correct procedure code assignment.

Following the illustrations section is a listing of the most common CDT and CPT codes applicable to oral maxillofacial surgery (OMS) services presented in numeric order. At the top of each page is a code or code range with its official description, followed by an explanation of the procedure or supply.

These references can be used to locate the appropriate citation in the Internet-Only Manuals (IOM) that may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. This information is designed to allow the user to appropriately code and bill for services. Those pages that discuss CPT codes also include an illustration representing the procedure(s) discussed on that page.

The explanations and coding tips found in the sections titled "Definitions and Guidelines" and "Procedure Code Definitions and Guidelines" sections are researched and written by Optum technical staff. The coding tips are based upon information found in CPT, CDT, CMS, and other appropriate specialty societies, as well as information based on third-party payer policies. This information has been reviewed by the American Association of Oral and Maxillofacial Surgeons (AAOMS).

CDT codes are cross-walked to the corresponding CPT code likewise, the CPT codes are cross-walked to the corresponding CDT code. The code set pages also contain a list of the ICD-9-CM codes describing those conditions for which the procedure is commonly performed as well as coding tips and terms to know.

Note: The procedure and diagnosis cross codes may not be all inclusive. If the procedure/condition is not listed, please see the appropriate code book.

When applicable, relative value units and official Medicare manual references are also included.

Evaluation and Management

This section provides documentation guidelines and tables showing CPT evaluation and management (E/M) codes for different levels of care. The components that should be considered when selecting an E/M code are also included.

ICD-9-CM Guidelines and Index

An overview of the 2015 ICD-9-CM coding conventions and guidelines is presented in this section. A comprehensive alphabetic index of ICD-9-CM diagnosis codes specific to OMS services is in the index at the end of this section.

A separate ICD-9-CM index lists the E codes commonly associated with the circumstances and conditions that could cause injury to teeth and oral structures and may require OMS services.

Note: This is not a complete ICD-9-CM index. If the condition is not listed, please refer to your ICD-9-CM code book.

Appendix

The appendix contains the unlisted codes most frequently used by the OMS as well as some CPT codes that do not lend themselves to illustrations.

CCI Edits

To access the Correct Coding Initiative (CCI) edits please go to <http://www.optumcoding.com/cciedits>. You will be updated via e-mail every quarter when the newly released CCI edits are available so that you may remain current.

How to Use This Guide

The first three chapters: "The Reimbursement Process," "Documentation—An Overview," and "Claims Processing" may be read in their entirety and/or used as references. When using this Coding and Payment Guide for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

- **Step 1.** Carefully read the medical record documentation that describes the patient's diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.
- **Step 2.** Locate the appropriate CPT or dental procedure code in the chapter titled "Procedure Codes." Read the explanation and determine if that is the procedure performed and supported by the medical record documentation.
- **Step 3.** At this time, review the additional information pertinent to the specific code found in the coding tips, IOM

D7540

D7540 removal of reaction producing foreign bodies, musculoskeletal system

May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone.

Explanation

The provider removes a reaction-producing foreign body within the musculoskeletal system. The physician removes a foreign body, such as a splinter or a piece of wire, embedded in the bone of dentoalveolar structures or in muscle tissue that is causing an abscess, infection, or hematoma. The physician may be able to simply grasp the object with an instrument and remove it. If the object is further embedded, mucosal incisions may be made to reach the foreign body in the bone or muscle and remove it, possibly with an osteotome or with the aid of separately reportable radiographic imaging, as necessary. The incision may be packed if contaminated by the object and left to drain with later closure or healing by granulation.

Coding Tips

Any evaluation or radiograph is reported separately. Third-party payers may require clinical documentation and/or x-rays before making payment determination. Check with payers to determine their specific requirements. Some third-party payers may require that this service be reported using the CMS-1500 claim form and the appropriate CPT code(s).

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

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

oral soft tissue. Subcutaneous fat layers beneath oral mucosa or gingiva; excludes bone and teeth.

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

CPT Codes

- 10120 Incision and removal of foreign body, subcutaneous tissues; simple
- 10121 Incision and removal of foreign body, subcutaneous tissues; complicated
- 20520 Removal of foreign body in muscle or tendon sheath; simple
- 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-9-CM Diagnostic Codes

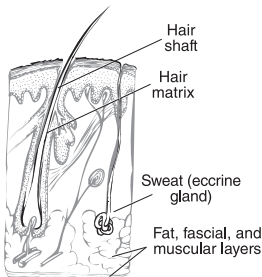
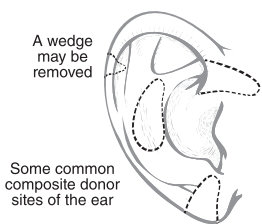
- 525.66 Allergy to existing dental restorative material — (Use additional code to identify the specific type of allergy)
- 526.4 Inflammatory conditions of jaw
- 873.53 Open wound of lip, complicated
- 873.72 Open wound of gum (alveolar process), complicated
- 873.73 Tooth (broken) (fractured) (due to trauma), complicated
- 873.79 Open wound of mouth, other and multiple sites, complicated
- 910.7 Face, neck, and scalp except eye, superficial foreign body (splinter), without major open wound, infected
- 935.0 Foreign body in mouth
- 996.40 Unspecified mechanical complication of internal orthopedic device, implant, and graft — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69)
- 996.67 Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft — (Use additional code to identify specified infections)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

	Work Value	Non-Fac PE	Fac PE	Malpractice	Non-Fac Total	Fac Total
D7540.....	0.00	0.00	0.00	0.00	0.00	0.00

15760

15760 Graft; composite (eg, full thickness of external ear or nasal ala), including primary closure, donor area



Explanation

The physician takes a full-thickness composite graft of more than one tissue type, such as a mixture of cartilage, from the external ear or nasal ala area, with a scalpel. This type of graft is used on defects that need both skin and structural support to ensure survival of the graft with minimal scarring and contraction, and to maintain the continuity of the local flesh. The graft tissue is "assembled" into the recipient bed and primary closure is done on the donor area with layered sutures.

Coding Tips

Repair of the donor site that requires a skin graft or local flaps is considered an additional, separate procedure and should be coded separately. Extensive immobilization and/or repair of the donor site is reported separately. For free full-thickness graft, see codes from range 15200-15261.

Terms To Know

full thickness skin graft. Graft consisting of skin and subcutaneous tissue.

Synonym(s): FTSG.

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

CDT Codes

D7920 skin graft (identify defect covered, location and type of graft)

ICD-9-CM Diagnostic Codes

- 140.5 Malignant neoplasm of lip, inner aspect, unspecified as to upper or lower
- 140.8 Malignant neoplasm of other sites of lip
- 141.0 Malignant neoplasm of base of tongue
- 142.1 Malignant neoplasm of submandibular gland
- 142.2 Malignant neoplasm of sublingual gland
- 142.8 Malignant neoplasm of other major salivary glands
- 143.0 Malignant neoplasm of upper gum
- 143.1 Malignant neoplasm of lower gum
- 143.8 Malignant neoplasm of other sites of gum
- 144.0 Malignant neoplasm of anterior portion of floor of mouth
- 144.1 Malignant neoplasm of lateral portion of floor of mouth
- 144.8 Malignant neoplasm of other sites of floor of mouth
- 145.0 Malignant neoplasm of cheek mucosa
- 145.1 Malignant neoplasm of vestibule of mouth
- 149.8 Malignant neoplasm of other sites within the lip and oral cavity
- 160.2 Malignant neoplasm of maxillary sinus
- 160.3 Malignant neoplasm of ethmoidal sinus
- 160.4 Malignant neoplasm of frontal sinus
- 160.5 Malignant neoplasm of sphenoidal sinus
- 171.0 Malignant neoplasm of connective and other soft tissue of head, face, and neck
- 172.0 Malignant melanoma of skin of lip
- 195.0 Malignant neoplasm of head, face, and neck
- 209.31 Merkel cell carcinoma of the face
- 235.0 Neoplasm of uncertain behavior of major salivary glands
- 235.1 Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
- 873.50 Open wound of face, unspecified site, complicated
- 873.51 Open wound of cheek, complicated
- 873.53 Open wound of lip, complicated
- 873.54 Open wound of jaw, complicated

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

	Work Value	Non-Fac PE	Fac PE	Malpractice	Non-Fac Total	Fac Total	FUD
15760.....	9.86	13.03	9.10	1.34	24.23	20.30	090