Advanced Coding
for
Oral and Maxillofacial Surgeons

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About the Speaker

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Late Effects

Definition

A late effect (residual) is a condition that results from a previous acute illness or injury that no longer exists.

Key Issues:

1. The original illness or injury has been cured or healed.
2. The patient has a permanent lifelong condition that is a result of the previous condition.

Locating and Sequencing Late Effect Codes

1. Code the residual (deafness, paralysis, etc…)
2. Assign the late effect code, located under the main term “Late” which represents the cause of the original injury or condition.

Practice 1

Assign diagnosis code(s) to the following.

Traumatic arthritis, right TMJ following old fracture of the mandible

Code(s): _________
Neoplasms

Locating Neoplasm Codes

1. Refer to the main term (and subterm if necessary) in the Alphabetic Index representing the morphological type of the neoplasm.

   **Morphology** – *The form and structure of a neoplasm*

   Examples include:
   - Fibroma
   - Melanoma
   - Carcinoma
   - Sarcoma

2. Once the entry representing the morphology has been found, scan the subterms to identify the anatomical site affected.

3. If the anatomical site is not listed, refer to the cross reference that can be found at the morphology entry.

   **Osteogenic sarcoma** – *see also* Neoplasm, bone, malignant

4. Turn to the Neoplasm Table (located in the Alphabetic Index at the main term “Neoplasm”) and find the entry representing the anatomic site.

5. Based on the cross-reference given from Step 3, assign the code from the appropriate column of the table.

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**Practice 2**

*Assign diagnosis code(s) to the following.*

Basal cell carcinoma of external nose

Code(s): __________
Fractures

Traumatic

A traumatic fracture is one that results from an external cause and is classified as either closed or open.

Open fracture: “Open” includes the following descriptions of fractures, with or without delayed healing:

- Compound
- Infected
- Missile
- Puncture
- With foreign body

Closed fracture: “Closed” includes the following descriptions of fractures, with or without delayed healing, unless they are specified as open or compound:

- Comminuted
- Depressed
- Elevated
- Fissured
- Greenstick
- Impacted
- Linear
- Simple
- Slipped epiphysis
- Spiral
- Unspecified

A traumatic fracture not specified as closed or open is coded as closed.

Note: The assignment of ICD-9-CM fracture codes has no relationship to the method of repair. For example, an open repair (CPT code) of a fracture does not automatically mean the diagnosis code should represent an open fracture.

If multiple fractures exist, each fracture should be coded separately, if possible. Often, the Alphabetic Index lists a subterm that provides for a combination code representing “multiple” (e.g., Fracture, mandible, multiple sites). However, an entry such as this should only be used if the medical record does not provide sufficient information to identify each injury separately or the claim form does not provide space to report each individually.
Pathological

A pathological fracture is a spontaneous break due to bone degeneration. The disease process that caused the fracture should be coded, if known.

Practice 3

Assign diagnosis code(s) to the following.

a. Compound fracture of mandible  
   Code(s): __________

b. Spontaneous fracture of the right mandible due to prednisone-induced osteoporosis  
   Code(s): __________

Exercise 1

Assign ICD-9-CM diagnosis codes to the following.

1. Squamous cell carcinoma of the mandibular alveolar ridge

2. Bilateral zygomatic arch fractures

3. Laceration of face with imbedded gravel

4. Maxillary alveolar hypoplasia

5. Metastatic carcinoma to maxillary structure from large intestine; previous resection of bowel with no recurrence

CPT Review

Global Surgical Package

The concept of a global surgical package provides for a single fee to be billed and paid. This single fee covers services normally furnished by the surgeon before, during, and after the procedure. Global surgery policies are also applied to any doctor who performs part of the “global surgery” that is generally considered the responsibility of the surgeon. These policies apply to minor surgical, nonincisional procedures (scopes), and major surgical procedures.

Major Surgical Packages

A major surgical package is applied to a procedure that has been assigned a 60 day postoperative period by the Centers for Medicare and Medicaid Services. The package includes the following:

• A 24-hour (one calendar date) preoperative period, during which no related evaluation and management (E/M) services can be reported. An exception to this billing rule involves unplanned major surgery. Specifically, if the decision to perform the major surgery occurs within this 24-hour period, the related E/M code can be billed with a modifier-57. **Note:** Not all payers will approve payment for this E/M service, since it is within the surgical package timeframe.

• The surgical procedure

• A 90-day postoperative period, during which no related E/M services can be reported.
Minor Surgical Packages

A minor surgical package is applied to a procedure that has been assigned a 0 or 10 day postoperative period by the Centers for Medicare and Medicaid Services. The package includes the following:

- A 0-day preoperative period, which means that the surgical package begins the day of the minor procedure. Given this, no related evaluation and management (E/M) services can be reported on the day of a minor procedure.

- The surgical procedure

- A 0 or 10-day postoperative period, during which no related E/M services can be reported.

Evaluation and Management Review

Office or Other Outpatient Services

These codes are used to report evaluation and management services performed in the doctor’s office, in a hospital’s outpatient areas, or other ambulatory facility. A patient is considered an outpatient until an inpatient hospital admission occurs.

This section of E/M codes differentiates between new and established patients. “A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.” As such, “an established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.”  CPT 2010

When a physician is on call for or is covering for another physician, the patient’s encounter is classified, as it would have been by the physician who is not available.

Hospital Inpatient Services

Surgical Cases

Since preoperative and postoperative visits are normally included in the global surgical package, hospital inpatient service E/M codes are seldom used by OMS practices.
However, hospital E/M codes can be used with a surgery code when:

- a separate **unrelated** condition needs evaluation (payable only with modifiers –24 
  *[Unrelated E/M Service by the Same Physician During a Postoperative Period]* or –25
  *[Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of
  the Procedure or Other Service]* as applicable to the timing of the E/M visit);

- the decision to perform major surgery was made after hospitalization, but within the
  preoperative period of the global surgical package (payable only with modifier –57
  *[Decision for Surgery]*); or

- surgery does not occur immediately after admission and inpatient services are provided prior
  to the onset of the preoperative period of the global surgical package

**Medical Cases**

**Initial Hospital Care**

Codes for initial hospital care include all evaluation and management services provided on the
same day by the **admitting doctor**, unless another significant, **unrelated** service was provided.
In this case, the office/outpatient or emergency department E/M service is payable with the use
of modifier –25.

Normally, all services provided on the same day of admission, even services provided at
different locations, are included in the Initial Hospital Care E/M code.

**Subsequent Hospital Care**

Subsequent hospital care E/M codes are reported on a one per day basis. Depending on the
services provided, several different subsequent hospital care codes could be assigned throughout
the hospitalization.

When submitting a claim, the different level E/M codes should be listed on separate lines and the
number of days at that level should be reported in the Units field of the claim form.

**Hospital Discharge Services**

The E/M codes for hospital discharge services may be used only once per hospitalization. There
is a choice of <30 minutes or >30 minutes spent providing discharge management services. It is
used on the day of discharge, on the day of transfer to another facility, or to a unit within the same hospital that does not use the same medical record.

Hospital discharge service codes include the final examination for the patient, discussion of the hospital stay and discharge instructions, preparation of the medical record, writing of prescriptions, and completion of referral forms.

**DO NOT** submit subsequent hospital care and discharge service codes on the same day of service.

**Consultations**

To qualify for a consultation, the following must be met:

- A consultation must be performed **only after a request** has been made by another doctor, physician, or other appropriate source. The request must be documented in the patient’s medical record. The need for the opinion or advice must be indicated. Simply documenting “refer to physician X for evaluation” is inappropriate.

- The purpose of the consultation is to provide an **opinion or advice**. As such, the OMS needs to consider the purpose of the first patient encounter. Though not “set in stone”, a rule of thumb to consider is:
  - If the referral source has already diagnosed the condition and the need for surgical intervention, the encounter needs to be coded as a new patient. (i.e., removal of 3rd molars)
  - If the referral source is in doubt as to the patient’s diagnosis and is uncertain as to whether surgical intervention is needed, the encounter may meet the criteria of a consultation.

- The consulting doctor can **initiate** diagnostic or therapeutic services during the consultation encounter.

- Documentation must be in the record reflecting the findings of the consultant. The documentation should reflect the consultant’s opinion, as well as any services ordered or performed. CPT does not specify what form the communication must take. Communication may be in writing or the consultant may call the requesting physician with the finding. If the communication is verbal, the phone call and the discussion must be documented by **BOTH** physicians.  

  *CPT Assistant, September 1996*
Common OMS Procedures

Biopsies

Definitions

Biopsy – A biopsy is defined as the removal of a small amount of tissue for pathological study. In the Alphabetic Index, refer to the main term “Biopsy.”

Excisional Biopsy – This is a form of biopsy. Tissue is being removed for pathological study. However, in an excisional biopsy, the entire lesion is removed rather than only a small portion of the lesion. In the Alphabetic Index, refer to the main term “Excision, lesion.”

Excision of Lesions

Skin and Subcutaneous Tissue

As stated above, an excision is a full-thickness removal of the entire lesion. The following considerations must be made when selecting the correct excision code.

1. What is the type of lesion (benign or malignant)?

2. What is the anatomic site?

3. What is the lesion diameter including margins?

A surgeon needs to dictate the greatest clinical diameter of the lesion plus that margin required for complete excision in linear centimeters.
Internal Oral Tissue

Excision of oral tissue lesions can be found under the Alphabetic Index entries “Excision, lesion, gum” and “Excision, lesion, mouth.” Both of these sections are straightforward in their use.

Wound Repairs

Wound repairs are classified in CPT as simple, intermediate, or complex. Explanation of these terms can be found in the Surgical Guidelines of the CPT manual.

Selecting a Repair Code

1. Measure all wounds in centimeters.

2. Classify the repairs as simple, intermediate, or complex.

3. Total the length of all wounds of the same repair classification and report as one repair.

Fracture Repairs

Fixation Removal

Under current RBRVS relative value units, the removal of a fixation device is not included in the surgical package, unless the removal is specified in the description of the procedure.

Internal Devices: If an internal device is removed during the postoperative period (established by the surgical package), report either 20670 (Removal of implant; superficial) or 20680 (Removal of implant; deep) with modifier –78 (Unplanned Return to OR/Procedure Room for a related procedure) or modifier –58 (Staged or Related procedure). If the device is removed after the postoperative period has expired, report the appropriate code with no modifier.

External Devices: An external device is always removed after the fracture heals. Some insurance will permit billing for the external device. In these cases, use CPT code 20670 (Removal of implant; superficial). If anesthesia is required, assign code 20694 (Removal, under anesthesia, of external fixation device).
**Re-Reductions**

When a re-reduction of a fracture or dislocation is performed by the original surgeon, report the procedure code with modifier –76 (*Repeat procedure by same physician*). This modifier is only needed if the exact same procedure is performed the second time.

If the CPT codes are different and the postoperative period of the first procedure has not expired, report the new CPT code with modifier –78 (*Unplanned Return to the OR/Procedure Room by the Same Physician following Initial Procedure for a Related Procedure During the Postoperative Period*). If the postoperative period has expired, report the CPT code without a modifier.

**Bone Grafts**

**Definitions**

1. **Harvested Graft**

   **Allograft:** Tissue removed from a person to be received by another

   **Autograft:** Tissue removed from a donor site of a person to be placed in another site of the same person

2. **Synthetic Graft:** The use of man-made material in a reconstruction procedure, in lieu of bone

   **Note:** When synthetic material is used, assign the appropriate reconstructive procedure and reduce it with modifier –52, if the reconstructive procedure states it already includes obtaining the bone. The reduction is necessary as harvesting of the bone was not performed. In addition to the procedure code, assign 99070 (*Supplies and materials*).

**Platelet Rich Plasma (PRP)**

As of July 1, 2010, a new Category III code is available for reporting the use of platelet rich plasma. A category III CPT code is a temporary code describing an emerging technology, service, and/or procedure that may or may not eventually be converted to a permanent Category I CPT code. The descriptor for code 0232T reads “injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed”.

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Prior to July 1, 2010, code P9020 (platelet rich plasma, each unit) from HCPCS Level II was commonly reported. There are special coverage instructions associated with this code, which means local Medicare carriers may have specific coverage instructions for processing this code. The use of this or any other code does not guarantee payment. OMSs are encouraged to review their Medicare provider manual or carrier’s website, or consult with the third party payer for coverage information.

There is now a CDT code to describe the use of PRP – D7921 (Collection and application of autologous blood concentrate product).

**Exercise 2**

*Answer the following questions according to coding guidelines – not according to individual insurance coverage policies.*

1. An OMS performs an initial inpatient consultation on 3/14. After reading the report, the attending physician asks the OMS to continue monitoring and treating the oral condition as he deems necessary. What type of E/M code would be used for the continuing visits while the patient is hospitalized?
   
   a. Initial Hospital Care  
   b. Subsequent Hospital Care  
   c. Initial Hospital Consultation  
   d. Hospital Follow-up Consultation

2. After seeing a patient in consultation one month ago, the patient is seen today for surgical confirmation and education. During the visit today, the doctor spent 30 minutes discussing the scheduling, surgical technique, and recovery. The surgery is not performed for 3 more days. How would this be reported?
   
   a. Office/Other OP Service, established patient  
   b. Office/Other OP Service, new patient  
   c. Office/Other OP Consultation  
   d. Not billed

Assign both diagnosis and procedure codes to the following.

3. A surgeon performs an incisional biopsy of a 1 cm lesion in the floor of the mouth. Only a portion of the abnormal tissue was removed. A simple suture was required. How would the biopsy be reported if it were reported to a medical insurance company?
4. **Continuation of # 3** – When the pathology report came back, it showed a malignant growth. As such, the patient was taken into surgery to have the entire growth and margins removed. How would the procedure be coded if it were submitted to a medical insurance company?

5. A new patient presents in the ER with trauma after being hit in the face with a chair during a brawl at a bar. The ER physician examined the patient and called the OMS for an evaluation. Examination revealed no serious injuries – only a few lacerations. The following repairs (10 GSP) were made; a simple repair of a 1.6 cm laceration of the left cheek, an intermediate repair of a 3.6 cm laceration of the chin, and a simple repair of a 2.1 cm of the lip. How would the service be reported?

6. A patient underwent open repair of bilateral mandibular fractures (90 GSP) 55 days ago. The patient had both right open mandibular angle and left open mandibular body fractures. The patient presents today for removal of the fracture appliance (external) under general anesthesia (30 minutes). How would the service be reported?
Lab Work

Coders should not add additional diagnoses to the patient’s case on the basis of an abnormal laboratory finding alone. Standard laboratory work (i.e., blood work, cultures) is not interpreted by a doctor. Only diagnoses established by a doctor should ever be coded. Consider the following situation.

A patient presents with a large abscess. The doctor drains the abscess and sends a sampling to a lab for a culture and sensitivity. When the results arrive, it shows staphylococcal growth. The claim has not yet been submitted so the coder goes ahead and assigns a code for a staphylococcal infection. (Bad move)

Though the culture results stated a staph growth, the coder cannot assign the code until the OMS reviews the report and concurs.

Pathology and Cytology Reports

It is appropriate for coders to take diagnoses from pathology and cytology reports. As mentioned previously, only diagnoses established by doctors should be coded. A pathologist is a physician. Therefore, diagnoses that appear on pathology and cytology reports can be coded as confirmed conditions.
Radiology Results

In accordance with the previous discussion, a radiologist is a physician. Therefore, diagnoses found on radiology reports can be coded as confirmed diagnoses.

Given the fact that the OMS may disagree with the findings of another doctor, it is advised that the OMS review the reports.

Poisonings and Adverse Reactions

Definitions

Poisoning: Poisoning occurs when a drug or chemical is given or taken in error regardless of whether the occurrence was accidental or purposeful.

Adverse Reaction: Adverse reaction occurs in spite of proper administration of correct substance.

Table of Drugs and Chemicals

The table is located in the Alphabetic Index after the entries for the letter “Z.” The table includes poisoning codes (960-989 categories) and five columns of various E codes. Four of these five columns represent causes of poisonings - Accident, Assault, Suicide, or Undetermined poisonings.

Note: Do not assign the E code for suicides unless medical record documentation clearly indicates that the poisoning was an attempt to end one’s life. The coder should not make assumptions as to why a patient consumed or exposed himself to a drug or chemical.

An additional column of E codes represents Therapeutic Use. Therapeutic Use E codes are only used when coding adverse reactions.
Sequencing of Poisoning Codes

1. Assign an appropriate poisoning code (960-989) from the Table of Drugs and Chemicals
2. Code the effect (vomiting, rash, etc…)
3. Assign an appropriate E code from any column in the Table of Drugs and Chemicals EXCEPT Therapeutic Use. (optional)

Practice 4

*Assign diagnosis code(s) to the following.*

Accidental overdose of Demerol Code(s): __________

Sequencing Adverse Reaction Codes

1. Code the effect (vomiting, rash, etc…)
2. Assign an appropriate E code from the Therapeutic Use column of the Table of Drugs and Chemicals

Practice 5

*Assign diagnosis code(s) to the following.*

a. Drug rash; patient on penicillin Code(s): __________

b. Bisphosphonate related osteonecrosis of jaw; oral medication Code(s): __________
Special Considerations

- Effects of a prescribed medication mixed with alcohol is coded as a poisoning of both agents. There will be two poisoning codes and two poisoning E codes.

- Effects of a prescribed medication with an over-the-counter medication is coded as a poisoning of both agents. Again, there will be two poisoning codes and two poisoning E codes.

- Effects of two or more prescription medications are coded as an adverse reaction of all agents. A separate adverse effect E code is assigned for each medication involved.

Example

A patient was very anxious the evening before reconstructive surgery. In addition, he was feeling congested and was concerned that he would not get enough sleep. Therefore, he took both Valium and Sudafed. Later, his wife was unable to rouse him and called 911 for a transport to the ER. The wife reports to the ER staff that Dr. Smith (OMS) was his doctor and Dr. Smith is called to the ER. The patient is diagnosed with extreme drowsiness.

Codes: 969.4; 971.2; 780.09; E980.3; E980.4

Exercise 3

Assign code(s) for each of the following.

1. Nausea and vomiting; reaction to Amoxicillin (penicillin-family)

2. Temporary hypotension that occurred during the administration of propofol (28:04.92 American Hospital Formulary List)

3. Abnormal reaction to a combination of Nytol and Valium
4. Cushingoid appearance due to steroid therapy
5. Hypersensitivity to aspirin

E Codes

Introduction

E codes are used to identify how injuries occur. E codes can NEVER be sequenced as the principal diagnosis. Therefore, it should also be noted that an E code can NEVER be reported by itself.

The use of E codes to identify the cause of an injury is currently optional, unless required by a specific insurance company. For instance, some worker’s compensation companies will require an E code on the claim.

The Alphabetic Index for E codes is located after the Table of Drugs and Chemicals in the Alphabetic Index. Codes can be verified in the Tabular List by referring to the E code chapter, which is located after the V code chapter. When looking for E codes, remember to reference how the injury took place. Common main terms include: Accident, Assault, Fall, Fire, or Gunshot.

Multiple External Causes

If multiple events cause multiple injuries, a separate E code should be assigned identifying each external cause. Normally, the first listed E code should correspond to the cause of the most serious diagnosis. However, in the following instances, sequencing is mandated.

Abuse - First, if a patient receives an injury due to abuse, the child or adult abuse E code has priority over all other applicable E codes. For instance, if a patient is lacerated with a knife
during an abusive encounter, the abuse E code would be sequenced before the E code for “cut by knife.”

**Cataclysmic (or natural disaster) Event** - Cataclysmic event E codes take priority over other E codes. If a patient falls escaping a tornado, the tornado E code is sequenced first and the E code representing a “fall” would be listed afterward.

**Transport Accident** - Lastly, if a person is injured during a transport accident, the transport E code is sequenced first. For instance, if a patient is injured in a vehicular collision by broken glass, the motor vehicle accident E code is listed first with the E code for “cut by broken glass” second.

**Category E849 (Place of Occurrence)**

There is one E code category that deserves special attention. Category E849 is entitled Place of Occurrence. If you know where it took place, this should be reported as well.

The E849 codes are italicized. Italicized codes in ICD-9-CM cannot be used alone and must be sequenced as secondary diagnosis codes. In the case of E codes, E849 must be used in combination with another E code and E849 must be sequenced as a secondary E code.

**Practice 6**

Assign diagnosis code(s) to the following.

A patient fell down a flight of stairs at home and fractured his zygoma.       Code(s): __________
Activity and Status E Codes

In 2010, two E code sections were added to better describe the circumstances in which an event or illness occurs.

External Cause Status (Category E000)

Status E codes are used to indicate the patient’s work status at the time of an injury. Examples include civilian work, military activity, or other – such as leisure activity. Codes from Category 000 should not be assigned for poisonings, adverse reactions, misadventures, or late effects. In addition, they should only be assigned together with other E codes.

Activity (Categories E001-E030)

Activity E codes are used to identify the type of activity the patient was engaged in at the time of an injury.

Codes from Category E000 and Categories E001-E030 can be used together or in combination with other E codes.

Example

A patient fell from a ladder while painting the exterior of his home. During the fall, he fractured the mandible.

1. 802.20 (Closed fracture of mandible)
2. E881.0 (Fall from ladder)
3. E016.9 (Other activity involving property and land maintenance …)
   Used to represent painting of the exterior of the house.
4. E000.8 (Other activity – work status)
5. E849.0 (Place of occurrence home)
V Codes

Purpose

V codes provide classifications for:

- patients who use health services but are not currently ill and need a service that only a healthcare provider can render or administer,
- patients with a resolving disease or injury that requires aftercare of that disease or injury, or
- circumstances or problems that influence a patient’s current illness or injury, but in itself is not a current injury or illness.

Locating V Codes

V codes can be found in the Alphabetic Index under main terms such as:

- Admission for
- Aftercare
- Follow up
- Vaccination
- Donor
- Observation

Note: This is not an all inclusive list of main terms.

Sequencing V Codes

Most V codes may be used as either a principal (first listed) diagnosis code or a secondary code, depending on the circumstances of the encounter. However, certain V codes are restricted in their use. A complete list of proper V code sequencing is found in the table below.

“History of” V Codes

“History of” V codes are only assigned when the past condition or status currently influences the methods of diagnosing and/or treating a patient. In ICD-9-CM, “history of” means that the patient used to have a condition, but no longer has this condition.
Note: A coder must be aware of those conditions which are life-long conditions (such as diabetes). There will not be a “history of” V code in the Alphabetic Index for these conditions. This is important to remember, as doctors do not always document in the same terms as the ICD-9-CM guidelines. For instance, “history of diabetes” would not be assigned a V code. It would be assigned a current diabetes code. Remember, in ICD-9-CM, the “history of” V codes represent PAST conditions, not current ones.

Practice 7

Assign diagnosis code(s) to the following.

a. The patient has a history of having undergone previous radiation treatment.  
   Code(s): __________

b. A coder locates in the record that the patient has a history of diabetes.  
   Code(s): __________

Cancelled Surgery

Variations

There are three V codes that represent a cancelled surgery. These can be found in the Alphabetic Index under the entry “Surgery, not done because of”.

  Surgery  
  not done because of  
  contraindication  
  patient’s decision  
  specified reason NEC

These codes ALWAYS serve as a secondary diagnosis. The principal diagnosis will be the condition after study that necessitated the need for the healthcare encounter.
**Contraindication** – This V code is used when the patient’s health status caused the cancellation. This could be cardiac arrest, atrial fibrillation, etc...

**Specified Reason** – This V code is used when some other event forces the cancellation of the surgery. The patient did not electively cancel nor did the patient’s health status prevent the surgery from continuing. This could be a tornado, fire, bomb, electricity outage, etc...

**Sequencing of Codes**

Mandatory sequencing of codes involved is:

1. Assign a code representing the reason for the surgery
2. Assign an appropriate code from V64.0-V64.2
3. If V64.1 is used, assign an additional code for the contraindication

**Practice 8**

Assign diagnosis code(s) to the following.

A patient was seen in the office for removal of impacted 3rd molars. After removing 2 teeth, the electricity went off requiring the cancellation of the remaining surgery. Code(s): __________

**“Status Post” V Codes**

When a patient has a device (i.e., implant, pacemaker, -ostomy), organ transplant, or previous surgery, and the nature of the previous healthcare status impacts patient care, a V code should be assigned identifying the fact. These V codes can be found under the main term “Status.”
Practice 9

Assign diagnosis code(s) to the following.

A patient, who has a tracheostomy in place, needs to have a fractured mandibular body repaired. The tracheostomy places the patient at a surgical high risk.  

Code(s): __________

Drug Resistant Infections

If a patient’s infection is stated as being resistant to a certain antibiotic, two codes need to be reported.

1. Assign a code for the infection.
2. Assign a drug resistant V code. These can be found under the main term “Resistance to”.

Practice 10

Assign diagnosis code(s) to the following.

A patient has a dentoalveolar abscess. A culture and sensitivity reveals that the bacterial growth is staphylococcus. Further, the bacteria are resistant to forms of penicillin.  

Code(s): __________

Fracture Aftercare

According to ICD-9-CM coding guidelines, a fracture code should be used only for an initial treatment encounter. After the initial encounter, future claims during the healing period should carry a “fracture aftercare V code.”

This same guideline can be applied to other aftercare scenarios as well.
Follow Up Examinations

During Treatment

If a patient is undergoing repeated tests or follow-up visits due to ongoing monitoring of an unresolved condition, the unresolved condition is coded. No follow-up V code is needed.

Following Completion of Treatment

If the condition has been resolved, follow-up visits should be reported with a code from category V67 (Follow up examination). These codes can be found in the Alphabetic Index under the main term “Follow up.” The V67 codes most commonly used by an OMS office are V67.00, V67.09 or V67.4.

It is important to note that only one V67 code can be reported on a case. If the patient has undergone more than one modality of treatment, only report the most recently completed modality.

Possible Results of a Follow-Up Examination

When a patient presents to the office for a follow-up visit, one of three events can take place.

Recurrence of or Remaining Condition

If the condition being followed up is still present, continue to code the condition.

No Recurrence, Continuation, or Complication of the Condition

If the condition no longer exists, assign an appropriate V67 code. In this case, a history of V code should also be assigned to reflect the previous condition.

No Recurrence or Continuation of the Condition, but an Abnormality is Revealed

Lastly, a patient can be clear of the follow up condition, but a new condition is found. A code needs to be assigned identifying the new condition as well as a history of V code reflecting the previous condition.
Practice 11

Assign diagnosis code(s) to the following.

a. A patient with a radicular cyst presents today for continuing care of the condition.
   Code(s): __________

b. A patient presents today for a routine 1-year follow-up visit following orthognathic surgery. The doctor finds no problems.
   Code(s): __________

Preoperative Evaluations

A V code is commonly used to describe encounters for preoperative examinations (e.g., surgical clearance). However, the use of a pre-operative examination V code (V72.8X) depends on the nature of the encounter. Consider the following possibilities.

Note: See Medicare coverage of dental services on Page 36.

Patient With Chronic or Previously Diagnosed Condition

When a patient has a known condition that needs to be evaluated during the encounter, the encounter is not considered to be administrative or routine in nature. Therefore, the known condition is the principal (first-listed) diagnosis.

1. Assign the code for the chronic or known condition

2. Assign a code for each new abnormality found upon examination, if applicable
Preventive Examination

Examination Reveals an Abnormal Finding

1. Assign a V code for the routine or administrative examination
2. Assign a code for the newly discovered condition
3. Pre-existing and chronic conditions may also be included as additional codes as long as they did not receive the primary focus of the encounter.

Examination Reveals Only Normal Findings

1. Assign a V code for the routine or administrative examination

Practice 12

Assign diagnosis code(s) to the following.

a. A non-Medicare patient is evaluated pre-operatively by an OMS prior to heart valve surgery (atrial valve stenosis). The patient shows no sign of dental infection. Code(s): __________

b. A non-Medicare patient is evaluated pre-operatively by an OMS prior to heart valve surgery (atrial valve stenosis). The patient has a long history of severe dental caries and acute gingivitis. Code(s): __________
Observation and Evaluation

The observation and evaluation codes represent a patient who is suspected of having a condition and after study the examination is normal. ICD-9-CM contains an instructional note in the Tabular List that reads:

“This category is to be used when persons without a diagnosis are suspected of having an abnormal condition, without signs or symptoms, which requires study, but after examination and observation, is found not to exist. This category is also for use for administrative and legal observation status.”

To use an observation and evaluation code (category V71), the following criteria must be met.

- The patient must have a specific suspected condition, and
- The patient has NO signs or symptoms of the suspected condition, and
- After study, the patient does not have the suspected condition.

Example

A patient is seen in the office for possible osteonecrosis of the jaw. The patient has been taking a bisphosphonate-based medication for 8 years. Examination shows that she does not have the condition.

- If the patient was experiencing symptoms of osteonecrosis at the time of the encounter (or specified by the referring doctor), the coder would assign codes for each presenting symptom.

- If the patient was asymptomatic, the coder would report V71.89 (Observation of other specified suspected condition)
HIV-Related Conditions

Exposure to HIV

Occasionally, you may have a patient who notifies you that he has been exposed to HIV. If the doctor feels this is significant, a V code can be assigned representing this status. The code is V01.79 and can be found under the main term “Exposure to.”

HIV with Symptoms

Code 042 (Human immunodeficiency virus [HIV] disease) is assigned once the HIV-positive patient begins to experience symptoms or manifestations. If an AIDS patient is having surgery and the AIDS is considered a significant diagnosis to report, the following sequencing should be used.

1. Code the reason for the surgery
2. Assign the code 042 (AIDS)
3. Assign a code for the AIDS-related manifestation

HIV without Symptoms

In contrast to the use of code 042, some patients test positive for HIV, but do not exhibit any AIDS-related manifestation at the time. These cases can be reported with code V08. This code is found under the main term “human immunodeficiency virus.”
Prolonged Evaluation and Management Services

The prolonged E/M service codes can be used whenever extensive time is spent providing evaluation and management services to one patient over a 24-hour period. Each of these codes is “add ons” and must be used in addition to another E/M code representing the quality of the H&P.

There are two types of prolonged E/M service codes: 1) Face-to-Face (with the patient) and 2) Not Face-to-Face (with the patient). The latter is designed to help doctors represent time spent researching a diagnosis and treatment plan or discussing a case with another doctor. Unfortunately, most third party payers will not reimburse doctors for non-face-to-face time. However, prolonged face-to-face time is a commonly covered.

Face-to-Face Prolonged E/M Service Codes (99354-99357)

The codes representing the first hour are 99354 and 99356, representing outpatient and inpatient settings respectively. Prolonged E/M services are based on prolonged time for a 24 hour period. Therefore, only one 99354 or 99356 can be assigned each day. Prolonged time of less than 30 minutes is not reported.

After the first hour is reported, you can represent each additional 30 minutes of prolonged time by using 99355 or 99357. It is important to realize that a full 30 minutes does not have to be met. These codes can be used to represent the last 15-30 minutes. Any time less than 15 cannot be reported.

There is no hard and fast rule of how to determine how much time on a date of service would be considered routine vs. prolonged. However, a relatively simple method is to refer to the time frame associated with the E/M service of the day. If there is additional time beyond this, apply the previous rules.
Practice 13

Assign only the CPT codes for the following.

The doctor saw a patient in the office at 9:00 AM for a continuing infection that was not responding to outpatient treatment. He was evaluated at the problem focused level which took 15 minutes. He was admitted a patient to the hospital on the same day at the comprehensive, moderate complexity level. The doctor saw the patient in the hospital at 12:00 PM at which he spent 30 minutes with the patient and preparing records. At 5:30 PM, he stopped in again to check on the patient and stayed 15 minutes. At 7:00 PM, the hospital called the doctor and informed him the patient was having seizures. He traveled to the hospital and stayed 37 minutes.

How should the doctor report today’s services?   Code(s):__________

Medicare Coverage of Tooth Extractions

Medicare Policy

Medicare will pay for dental services that are 1) an integral part a covered procedure (e.g., reconstruction of the jaw following accidental injury), or 2) for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw.

Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, if performed during an inpatient hospitalization.
Coding Guidelines

Tooth Extractions Prior to Radiation Treatment for Head or Neck Malignancy

1. Assign code V07.8 (Other prophylactic measures)
2. Assign an appropriate code for the malignancy of head or neck
3. Assign procedure codes reflecting each tooth extraction

Pre-Operative Evaluation (Kidney Transplant or Heart Valve Replacement)

1. Assign a code from subcategory V72.83 (Other specified pre-operative examination)
2. Assign a code for the condition requiring surgery
3. Assign a code for any conditions discovered during the pre-operative evaluation
4. Assign an E/M code from 99213-99233 (Subsequent hospital care), 99251-99255 (Inpatient consultation), or D0150 (Comprehensive oral examination).

Practice 14

Assign diagnosis code(s) to the following.

A Medicare patient is evaluated in the hospital pre-operatively by an OMS prior to heart valve surgery (aortic valve stenosis). The patient is found to have severe dental caries and acute gingivitis.  

Code(s): __________

Exercise 4

1. The patient underwent surgery several weeks ago and presents today for removal of an internal fixation device.

   What is the diagnosis code(s)?
2. The patient was treated for an abscessed tooth. The patient is known to be allergic to penicillin.

What is the diagnosis code(s)?

3. The patient has mandibular retrognathia. After anesthesia was started, the patient went into seizures. The reconstruction was canceled.

What is the diagnosis code(s)?

4. The patient is seen for a routine checkup following a malignancy found in the floor of the mouth three years ago. It was treated by an excision of the lesion. Each follow-up exam has revealed no recurrence or metastasis. Today's visit also shows no evidence of recurrence.

What is the diagnosis code(s)?

5. A patient with full blown AIDS sustained a fracture of the right mandibular condyle.

What is the diagnosis code(s)?

6. A patient presents with an acute infection of the mouth. He informs the staff he is HIV positive.

What is the diagnosis code(s)?

7. Multiple facial fractures due to a gunshot wound received during a robbery of his home. The robber fired the pistol in an attempt to kill the homeowner.

What is the diagnosis code(s)?
8. The patient fractured his nose. He was a rider on a moped when he fell off while going down the road.

What is the diagnosis code(s)?

9. A patient sustained a compound fracture of the body of the right mandible when she was injured during a terrorist bombing at a restaurant.

What is the diagnosis code(s)?

10. A patient underwent a repair of a traumatic mandibular fracture four weeks ago. The patient presents to the office today for a follow up visit. During the visit, an x-ray is taken to evaluate the healing process.

What is the diagnosis code(s)?

11. A Medicare patient was seen in the office for removal of all teeth in preparation for radiation treatment for a primary brain (occipital lobe) malignancy.

What is the diagnosis code(s)?

12. A Medicare patient was seen in consultation in the hospital for preoperative clearance prior to a kidney transplant for nephrosclerosis. The OMS did not find any dental problem that would place the patient at a surgical risk.

What is the diagnosis code(s)?

13. A patient is seen in the office for the first time for a consultation. The case is extremely difficult. The H&P is written at the comprehensive, high level. Total time with the patient took 130 minutes.

What is the CPT code(s)?
14. A doctor evaluates an established patient in the office at the detailed level for joint pain and swelling. This took 35 minutes. Later that day, the same patient was hit in the side of his face by a football and is now experiencing increased pain. The patient returned to the office for an unplanned encounter.

The doctor determines that there is no injury, though the trauma has aggravated the joint problem. This second visit took 20 minutes.

What is the CPT code(s)?
Vignette 1

A 58-year-old Type I diabetic patient who has used daily insulin injections for 5 years presents with a partially edentulous mandible and maxilla due to periodontal disease. He has significant bone loss (severe) resulting in nerve impingement in the left mandible that results in sharp pain each time he chews when his denture is in place. He also has very little maxillary bone (moderate loss) below the sinus. The case will be done as an outpatient at the local hospital because the doctor is concerned about controlling his blood sugar.

Treatment Plan:

1. Bilateral sinus lifts with freeze dried bone graft
2. Implants on each side to replace the first and second maxillary molars
3. Reposition the inferior alveolar nerve which has become exposed in the left posterior mandible
4. Place 4 implants in the anterior mandible

For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

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Hint on page 69.
Vignette 2

A 14-year-old boy fell off his bike at a park and was seen in the emergency room at the request of the ER physician. He has broken and subluxated (knocked loose) his maxillary central incisors causing an alveolar fracture, has a 3 cm laceration inside of his upper lip, and a broken jaw on the right side just below the mandibular condyle.

Services rendered include:

1. Admission to the hospital
2. History and Physical (detailed, low complexity)
3. Suture laceration of upper lip
4. Repair of alveolar fracture with stabilization of maxillary incisors using arch bar
5. Closed reduction of mandible using arch bars to wire teeth together
6. Discharged on rounds the next afternoon in good condition

For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

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Hint on page 69.
Vignette 3

A 23-year-old presents for definitive management of her “bad bite” for which she has been in braces for the last 22 months. The problems began when she started having TMJ and muscle pain that the orthodontist said was because of her bite. The OMS states the diagnosis is vertical maxillary deficiency with mandibular prognathism and mandibular hyperplasia.

The surgical plan is as follows:

1. Lefort 1 osteotomy
2. Bone graft from hip
3. Sagittal split osteotomy of mandible with screw fixation
4. Coronoidectomies
5. Chin advancement with screw fixation

For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

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Hint on page 70.
Vignette 4

A 27-year-old patient is seen in the SICU following an MVA collision with another car. A consultation (detailed, low complexity) request was obtained from his orthopedic surgeon. He is noted to have bilateral zygoma fractures, a maxillary anterior alveolar fracture, mandibular symphysis (open into the mouth) and angle fractures that communicate intraorally, and a deep jagged laceration measuring 4.5cm extending from just below the eye to the angle of the mandible. He is edentulous in the maxilla and has an upper denture.

That day, he underwent the following procedures:

1. Placement of a cranial halo to facilitate reduction of the maxilla
2. Layered closure of facial laceration
3. ORIF of bilateral zygoma fractures
4. ORIF of mandible fractures with bone plating at each site (multiple approaches)
5. Closed reduction of maxillary alveolar fracture by wiring and securing the denture to the halo

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For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

Hint on page 70.
Vignette 5

A 19-year-old patient presents on referral from his orthodontist for evaluation and treatment. He has a history of cleft lip and palate that were repaired as a child. Eight months ago he had an implant placed in the #30 site to replace a congenitally missing tooth. The implant is failing and infected. He has numbness of his lower right lip that began after the implant was placed. This due to a compressed 5th cranial nerve. In addition, the patient has maxillary hypoplasia and maxillary alveolar hypoplasia.

The OMS treatment plan includes:

1. Removal of implant from # 30 site
2. Decompress inferior alveolar nerve via a sagittal split osteotomy on the right side and repair the nerve with a sural nerve graft
3. Surgically assisted rapid palatal expansion
4. Iliac crest bone graft to repair alveolar cleft in the area of the left maxillary canine (sinus lift)
5. Replace implant at # 30 site with one of larger diameter and shorter length

For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

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Hint on page 71.
Vignette 6

The patient presents with a large unsightly hypertrophic scar extending from the corner of her right eye down to the angle of her mandible. The scar developed following extensive injuries from an MVA 14 months ago in which she was thrown through the windshield. Scar contraction and muscle injuries have led to mechanical ptosis of her right eyelids and cicatricial ectropion.

The OMS treatment plan includes:

1. Upper lid blepharoplasty with wedge resection of the tarsal plate
2. Lower lid blepharoplasty, extensive with ectropion repair
3. Right brow lift
4. Scar revision of 11cm hypertrophic scar of right face by excision and multiple w-plasties (tissue transfer)
5. Laser removal of 17 small granulomas formed from glass fragments that entered the skin and eventually self exfoliated

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For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

Hint on page 71.
Vignette 7

A 41-year-old male is referred for evaluation and treatment of severe swelling secondary to a periapical abscess with fistula involving the mandibular left first molar. The tooth is broken off at the gum line. The infection is so severe that the patient now has cellulitis.

Treatment rendered under deep sedation (30 minutes) in the office is as follows:

1. Surgical removal of tooth #19
2. I & D of left submandibular and masticator spaces via intraoral approach with placement of a rubber drain. Pus was prepped and sent in for Culture and Sensitivity.
3. IV push Ancef® 500 mg

Encounter 1 – Day of Surgery

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Encounter 2 – Three days later

4. The patient returned three days later. The drain was removed and wound sutured. The patient was given Rocephin® 1 gram IM. Culture came back as Group A Streptococcus.

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For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

Hint on page 72.

Vignette 8

Encounter 1 – Initial Visit

A new patient, 16-year-old female, presents on referral from her orthodontist for evaluation and treatment of a closed dislocation of the TMJ that she sustained in a soccer game 5 weeks ago at school, when she was elbowed by another player. She cannot open her mouth very wide despite wearing a splint and undergoing physical therapy. After reviewing her records, confirming her history, examining her and explaining the proposed surgery, the OMS has spent just over an hour with her (comprehensive, high complexity).

The diagnosis is closed lock of the right TMJ articular disc. The proposed surgery is arthroscopy with lysis and lavage.
For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

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**Alert**

**Encounter 2 – Day of Surgery**

Three days later, at surgery, the OMS performed a diagnostic arthroscopy and found that the meniscus was perforated and decided to open the joint and do a menisectomy. He then placed a dermis graft taken from the right buttock. The patient was under deep sedation for 45 minutes.

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**Hint on page 73.**

**Vignette 9**

The patient, a 37-year-old male, is referred from his dentist for closure of a sinus communication that has persisted following extraction one year ago of his left maxillary first molar causing chronic sinus infections. The patient has persistent drainage from his left maxillary sinus and frequently gets oral liquids in his nose. The dentist has asked that a lingual frenectomy be considered since the patient is tongue-tied and has a hypertrophic frenum. A gingival graft is also needed for the recession he has in the mandibular incisor region.

**The surgical plan is as follows:**
Closure of O-A fistula with nasal antrotomy
Lingual frenectomy with z-plasty
Mandibular labial frenectomy with palatal graft
Placement of “suck down splint” (custom made) to cover palate after graft and O-A fistula repair.
Deep sedation, 30 minutes

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For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

Vignette 10

Encounter 1

A 68-year-old man presents with a two-centimeter non-healing ulcerative lesion of the posterior tongue. The lesion is excised (with closure) and the pathologist’s diagnosis is squamous cell CA.

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**Encounter 2**

After seeing the oncologist who recommends radiation therapy, the patient returns to have teeth removed prior to beginning treatment. The OMS removes teeth # 6,7,8,9,11,14, 17,18,19,22,25,and 26. Alveoplasty is performed at each site to get good closure and better prepare the patient for a partial denture later.

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<th>ICD-9-CM</th>
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For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

**Encounter 3**

After radiation the patient develops osteoradionecrosis and the OMS removes several pieces of dead bone from the lower jaw (sequestrectomy).

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For a comparison, code each procedure with both CPT and CDT. Remember, CDT codes can be placed on a medical insurance claim.

*Hint on page 74.*
Vignette 11

In this vignette, you have been given the original codes submitted to the carrier. While assigning your codes, determine what errors were made.

Encounter 1

A 47-year-old man diagnosed with severe obstructive sleep apnea presents for consultation after being referred by his primary care provider who has been treating the patient medically for the condition. A comprehensive H&P with moderate complexity and a nasopharyngoscopy (Work RVU 0.84 – 0 GSP) is performed. A written report is sent to the PCP.

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<th>Diagnosis Codes</th>
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Encounter 2

The patient returns (one month after Encounter 1) for follow-up and discussion of recommended surgery – reconstruction of the upper airway via maxillary osteotomies (LeFort I) (Work RVU 19.57 – 90 GSP) & mandibular sagittal split with internal fixation (Work RVU 20.83 – 90 GSP) and genioglossus muscle advancement (Work RVU 16.73 – 90 GSP). This visit is at the detailed H&P, moderate complexity level. Surgery is scheduled at the hospital for two weeks later.

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**Encounter 3**

The patient is admitted to the hospital at the detailed H&P, moderate complexity level. The recommended procedures listed above are performed the day of admission.

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**Encounter 4**

The patient did well postoperatively until an infection developed eight weeks post op. The patient has developed an osteomyelitis associated with the right ramus of the mandible and is admitted to the hospital and placed on IV Cleocin 900 Q6H. The admission H&P is performed at the detailed H&P, moderate complexity level. Daily visits at the problem focused H&P level are made until discharge. On Day 3, the patient undergoes debridement of the right mandible (Work RVU 10.03 – 90 GSP), removal of the mandibular fixation plate (RVU 5.96 – 90 GSP), and drain placement (RVU 2.63 – 10 GSP). The patient is discharged on Day 6. Discharge services take 45 minutes.

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*Hint on page 75.*
Vignette 12

A 66 year old male presented to your office for evaluation and treatment of a non-healing area after an extraction of tooth # 19, performed 6 months previously by a different doctor. The patient reports the extraction was difficult and took 1 ½ hours. The patient’s medical history is significant for multiple myeloma which he has been being treated for the last 5 years with Zomeda and then Aredia (both are intravenous, nitrogen-containing bisphosphonate). The patient has a foul odor to the mouth and a large area of exposed bone with exudates pooling in the site of the extraction.

The oral and maxillofacial performs an initial evaluation at the comprehensive, comprehensive, moderate complexity level. The patient’s diagnosis is Bisphosphonate-Related Osteonecrosis of Jaw (BRONJ).

If the claim was sent to a medical carrier, how would it be reported?

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Hint on page 75.
Vignette 13

The patient is a 35 y/o male who presented to your office via referral from the general dentist for evaluation and treatment of wisdom teeth. The patient has been having pain on the right side with a history of infection treated with antibiotics. A panoramic radiograph was taken at the dentist’s office, which showed overlapping of the roots of #32 with the inferior alveolar nerve. At this time, a Cone beam examination is requested of the area. The OMS performed a consultation and a two dimensional i-CAT scan, with results communicated back to the general dentist in writing. The diagnosis was impacted third molar.

If this claim was sent to a dental carrier, how would it be reported?

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Hint on page 76.

Vignette 14

A 16-year-old female presents to your office on referral from her PCP regarding a jaw injury which occurred 2 days prior. The patient stated that while playing in high school lacrosse finals she was accidentally struck in the right jaw with a lacrosse stick. She now has pain, external swelling, difficulty opening her jaw, and chewing food. An initial examination and review of systems shows an otherwise healthy 16 year old in moderate distress, limited vertical opening (20 mm) and deviation to the right on opening.

Encounter 1

The patient presents for consultation with possible jaw fracture, contusions, disc dislocation, and intra-articular hemorrhage. The doctor spends 35 minutes on the examination and also takes bilateral open and closed TMJ radiographs (negative for fracture and DJD). The exam is at the comprehensive H&P, moderate complexity level. The radiographic findings and treatment sequences are discussed with the patient/mother for an additional 40 minutes.
**Encounter 2**

Four days later, the patient returns after an approved treatment protocol was obtained from her insurance company. The initial sequence of treatment includes anti-inflammatory medication (Lodine 300 mg, BID), mandibular splint, acupuncture with electrical stimulation, and six weeks of physical therapy (manipulation, heat/cold packs, increase ROM, and reeducation of muscles). The OMS is responsible for splint therapy: models, impressions, and a custom-prepared splint for the patient. A follow-up evaluation is made at the problem-focused level.

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**Encounter 3**

After the six weeks of treatment, the patient presents for reevaluation and there has been little to no change in the pain and vertical opening. There is still deviation to the right. Open and closed MRIs of the right and left TMJs are ordered. The doctor spends 17 minutes performing the follow-up (expanded problem focused H&P) exam and discussing options with the mother and patient.

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**Encounter 4**

The MRIs showed anterior displacement of the right disc, mild-moderate effusion, and mild-moderate mucoid degeneration, and no movement of the disc suggestive of fibrous adhesions. This is consistent with Wilkes III and Schellhas III. The patient presents today for discussion of the MRIs and proposed treatment. The doctor plans arthroscopic surgery to tie back the disc. 45 minutes is spent discussing the MRIs and the proposed surgical treatment.

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**Encounter 5**

The patient presents at the hospital for arthroscopic surgery of the right TMJ. A detailed preoperative H&P is documented prior to surgery. During the procedure to suture the displaced disc back, one of the instruments breaks and it cannot be retrieved through the cannula. The doctor decides to perform an open arthroplasty. During the arthroplasty, the doctor accidentally slips medially with a sharp periosteal elevator. Very brisk bleeding is encountered from the medial aspect of the joint. This is not stopped by pressure. The doctor decides to tie off the external carotid. This stops the bleeding. The broken instrument is then retrieved and the preauricular area sutured and the patient returned to the recovery room in satisfactory condition.

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*Hint on page 76.*
Vignette 15

OPERATIVE REPORT

POSTOPERATIVE DIAGNOSES:

1. Maxillary LeFort I level fracture
2. Maxillary palatal fracture
3. Right parasymphysisal fracture of mandible
4. Right zygomaticomaxillary complex fracture
5. Left zygomaticomaxillary complex fracture
6. Right condylar fracture
7. Left condylar fracture
8. Nasal bone fracture
9. Nasal septal fracture
10. Chin laceration, complex in nature, measuring 6 cm to bone
11. Palate laceration, 5 cm, full-thickness into the nasal cavity
12. Complex lip laceration measuring 5 cm total involving the lower lip

PROCEDURES:

1. ORIF maxillary LeFort I level fracture (RVU 10.85 – 90 GSP) -
2. ORIF maxillary palatal fracture (RVU 10.85 – 90 GSP)
3. ORIF right parasymphysisal fracture of mandible (RVU 17.54 – 90 GSP)
4. ORIF right zygomaticomaxillary complex fracture (RVU 7.19 – 90 GSP)
5. ORIF left zygomaticomaxillary complex fracture (RVU 7.19 – 90 GSP)
6. Closed reduction right condylar fracture of mandible with intermaxillary fixation (RVU 6.64 – 90 GSP)
7. Closed reduction left condylar fracture of mandible with intermaxillary fixation (RVU 6.64 – 90 GSP)
8. Closed reduction of nasal fracture with stabilization splint (RVU 1.88 – 10 GSP)
9. Closed reduction of nasal septal fracture without splint stabilization (RVU 3.29 – 90 GSP)
10. Closure of complex chin laceration measuring 6 cm total (RVU 6.58 – 10 GSP)
11. Closure of complex palate laceration/tear measuring 5 cm total (RVU 3.87 – 10 GSP)
12. Closure of 5 cm lower lip laceration, total, intermediate nature (RVU 2.87 – 10 GSP)
13. Advancement flap closure of maxillary defect in the buccal vestibule (RVU 8.6 – 90 GSP)
ANESTHESIA: General via nasal intubation

INDICATIONS FOR SURGERY:

I was asked by the trauma service to see this 20-year-old female in the ER after being involved in a motor vehicle collision at a low rate of speed earlier today. The patient was riding a bicycle with a helmet but sustained the above mentioned significant facial injuries. Examination in the emergency department revealed a patient who was somnolent, but in no acute distress and easily arousable. Facial edema consistent with the above injuries was noted. The patient demonstrated a lower lip laceration which was multiple in nature, a chin laceration full-thickness to bone approximately 6 cm with an area of avulsion. The extraocular movements were intact. Visual acuity was at baseline. The patient demonstrated no diplopia by report. There was no evidence of global entrapment. The patient did demonstrate mild subconjunctival hemorrhage bilaterally. She demonstrated mild crepitus over the nasal bone. There was evidence of septal deviation and nasal bleeding.

The patient opened two fingerbreadths with significant displacement of the maxilla and mandible. The patient demonstrated avulsed maxillary incisors. The patient demonstrated a grossly mobile left hemi-maxilla with a less mobile right hemi-maxilla. A palatal split was noted full-thickness to the uvula. The nasal cavity was visualized. The patient’s mandible was significantly displaced in the right parasymphyseal region. The patient demonstrated evidence of bilateral subcondylar injury. There was crepitus over the right and left zygomaticomaxillary complex region. The patient’s neck was non-tender and supple.

The CT scan revealed the above mentioned injury and this was reviewed with the trauma doctor. A detailed discussion regarding treatment options as well as risks, benefits, and complications was held with the patient’s mother and the patient, which included bleeding, infection, malunion, nonunion, malocclusion, loss of teeth, future dental work, potential for additional surgery, scarring, change in cosmesis, nasal dyspnea, future temporomandibular joint problems, and need for removal of hardware, and numbness to face, jaws, lips and tongue. The patient and mother asked appropriate questions which were answered. The consent form was signed. The patient and mother desired for me to proceed with surgery with plans for me to admit her as an inpatient after surgery. (comprehensive H&P, high complexity)

OPERATIVE FINDINGS:

Findings were consistent with the above diagnoses. The patient’s maxilla was grossly comminuted. A midline split was noted separating the left maxilla from the cuspid region posteriorly. A palatal split was noted almost to the uvula and communicated with the nasal cavity. The right and left zygomaticomaxillary complex fractures were displaced but minimally. The patient’s right and left condylar fractures were noted but minimally displaced as well. The complex chin laceration was noted with an area of avulsion in the middle portion. This was stellate in nature. The patient’s lip laceration was very ragged. The patient demonstrated a tear...
to the maxillary vestibule bucally adjacent to the maxillary incisors and this required an
advancement flap for primary closure.

DESCRIPTION OF SURGERY:

The patient was identified in the holding area and transported to operating room number six
where she was placed in supine position on the operating table. After adequate induction of
general anesthesia, the patient was intubated via the nasal route without difficulty. After this had
been accomplished, the nasal tube was secured in a typical fashion for this oral and maxillofacial
surgical procedure. After this had been accomplished, the patient’s eyes were protected with
Lacrilube ointment and corneal shields. The patient’s extremities were padded and protected to
prevent injury. After this had been accomplished, the patient was prepped and draped in a sterile
manner consistent with this maxillofacial surgical procedure.

At this point, the surgeon’s attention was directed to the oral cavity which was meticulously
debrided, irrigated and suctioned. The posterior pharyngeal throat pack was then placed. After
this had been accomplished, attention was directed to the maxillary dentition where an Erich arch
bar was adapted to the remaining maxillary dentition and secured utilizing 24 gauge stainless
steel wire loops in interdental fashion. It should be noted that the maxillary fracture was
reapproximated prior to placing the arch bar after the arch bar had been placed from the first
molar region on the right to the first molar region on the left.

At this point, attention was directed to the mandibular arch where a bridle wire was placed
around the teeth immediately adjacent to the parasymphysisal fracture on the right side to
facilitate reduction and then an Erich arch bar was placed from the first molar region on the right
to the first molar region on the left and secured utilizing 24 gauge stainless steel wire in an
interdental fashion.

After this had been accomplished, attention was directed to the right and left condylar region.
The patient’s mandible was distracted, the condylar fractures were reduced, and the patient was
brought up into intermaxillary fixation in what appeared to be a premorbid occlusion based on
wear facets and occlusal patterns. The patient was secured into intermaxillary fixation utilizing
26 gauge stainless steel wire loops.

After his had been accomplished, attention was directed to the patient’s parasymphysisal fracture
of the mandible. Utilizing a combination of sharp and dull dissection, the parasymphysisal
fracture was identified. Care was taken to protect the mental nerves on the right and left side
from injury. At this point, the parasymphysisal fracture was reduced anatomically and secured
utilizing a four-hole KLS 2.0 mm titanium bone plate with appropriate screws superiorly.
Theses screws were monocortical to avoid injury to teeth. At the inferior portion of the
laceration, a four-hole titanium bone plate was meticulously adapted and secured utilizing the
appropriate 2.0 mm titanium bone screws. At this point, the patient’s mandibular fracture was
reduced and fixated.
At this point, attention was directed to the patient’s maxillary dentition where a full-thickness mucoperiosteal flap was made in the vestibule with care being taken to incorporate the anterior mucosal tears to the vestibule in the area adjacent to the avulsed teeth. A combination of sharp and blunt dissection was then utilized to expose the anterior and lateral aspects of the maxilla and the zygomaticomaxillary buttress region. The patient’s maxilla was found to be grossly comminuted both on the right and left side.

After this had been accomplished, the patient’s zygomaticomaxillary complex fracture on the left side was reduced as was the patient’s hemi-maxillary fracture. These were plated utilizing a four-hole 2.0 mm titanium L-pate with appropriate 2.0 mm titanium bone screws. A four-hole 2.0 m titanium bone plate was placed on the piriform rim region to secure the maxillary LeFort I level/palatal fracture.

At this point, attention was directed to the right hemi-maxilla where the zygomaticomaxillary complex was reduced at the buttress region and secured to the reduced maxilla utilizing a four-hole L-shaped 2.0 mm titanium bone plate with appropriate screws. On the piriform rim region, another four-hole L-shaped 2.0 mm titanium bone plate was placed to fixate the maxilla and secured utilizing the 2.0 mm titanium bone screws.

After this had been accomplished, palpation was held at the infraorbital rim and zygomaticomaxillary suture area bilaterally. No steps were evident and the fractures were stable. It was deemed no further reduction or treatment of the bilateral zygomaticomaxillary complex fractures were indicated. It should be noted that the right and left zygomaticomaxillary complex fractures were displaced.

After this had been accomplished, the maxillary mandibular operative sites were copiously irrigated with normal saline solution and suctioned. Bone which had been removed from the sinus and anterior maxilla was utilized to graft the maxillary defects around the right and left side. The right maxillary defect was much worse that the left. These grafts were self-retaining in the fracture sites.

After this had been accomplished, an advancement flap was created for the area of avulsed maxillary anterior teeth. This advancement flap was then brought forward and the maxillary alveolus which was edentulous in this region was primarily closed. This advancement flap was incorporated into the existing incision which was placed in the buccal aspect of the maxilla. This vestibular incision was then closed utilizing 4-0 Vicryl suture in a running horizontal mattress fashion. The advancement flap was closed with 4-0 Vicryl suture in an interrupted fashion. Good primary closure was obtained.

After this had been accomplished, attention was directed to the mandibular surgical site which was irrigated as was the maxilla copiously. This was closed primarily utilizing 4-0 Vicryl suture in a running horizontal mattress fashion.
After this had been accomplished, the patient was released from intermaxillary fixation and found to function in a stable and reproducible pattern based on wear facets and occlusal patterns. Utilizing 4-0 Vicryl suture, the patient’s palatal laceration was closed with difficulty although good primary closure was obtained. Good palatal reduction was obtained with the above mentioned reduction and plating. After this had been accomplished, the patient’s oral cavity was meticulously irrigated with normal saline solution and suctioned. The posterior pharyngeal throat pack was then removed. The patient was then brought up into intermaxillary fixation and secured with care being taken to not displace the right and left subcondylar fractures. The patient was secured into intermaxillary fixation in what appeared to be her premorbid occlusion with 26 gauge stainless steel wire loops.

After this had been accomplished, attention was directed to the patient’s lip laceration which was closed primarily with 4-0 chromic suture in an interrupted fashion. It should be noted that this laceration of the lip was very ragged in nature. After this had been accomplished, attention was directed to the chin laceration which was meticulously debrided and irrigated as was the lip laceration. Deep sutures were placed consisting of 4-0 Vicryl and then the skin was closed utilizing 6-0 Prolene suture in both running and interrupted fashion. Good primary closure was obtained.

At this point, attention was directed to the patient’s nasal fracture in which the nasal cavities were packed with a cocaine solution on neuro-cottonoids with strings. Once this had been accomplished, utilizing a butter knife and Asch forceps, the septum was reduced and the nasal bones were reduced. This was accomplished working around the nasal tube. After this had been accomplished, the nose was repaired with steri-strips and Mastisol solution, and a Thermoplast splint was placed over the external bony nose to facilitate and maintain reduction. No intraoral stabilization was utilized.

At this point, a nasogastric tube was carefully placed and the stomach contents were suctioned. Approximately 300 cc of dark red blood was suctioned from the stomach. At this point in care, the patient was turned over to the anesthesia team. The patient was extubated in the operating room and transported to the PACU in stable and good condition. Estimated blood loss was less than 150 cc. The patient received crystalloid solution only and no blood products were given. No specimens were taken. No drains were placed. No cultures were sent.
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*Hint on page 77.*
Coding In Physician Offices

Coders in a physician’s office will frequently have a dual role of a coder and biller, unlike in a hospital where the two functions are distinctly separate. In a physician’s office, coders may be positioned in a separate office away from patient traffic or may be located in the registration and discharge area of the office because coding is tied to the process of generating a demand bill – one that patients can take with them.

Due to the fact that coding normally takes place at the same time the claim is generated, coders in doctor’s offices may have limited access to medical record documentation.

As such, many coders rely on the information located on superbills or encounter forms. If this is done, it is imperative that someone later verifies that the final medical record documentation supports diagnoses and procedures selected on the superbill.

Coding Credentials

- **AHIMA (American Health Information Management Association)**
  - CCS (Certified Coding Specialist)
  - CCS-P (Certified Coding Specialist - Physician based)
  - CCA (Certified Coding Associate)

- **AAPC (American Academy of Professional Coders)**
  - CPC (Certified Professional Coder)
  - CPC-H (Certified Professional Coder - Hospital based)
Why Seek a Coding Credential?

The exams previously discussed require a person to know all aspects of coding – not just those seen in oral and maxillofacial surgery. As such, many people seek a coding credential simply to satisfy a personal goal – a satisfaction of knowing that they demonstrate a professional level of knowledge and ability.

In addition, new job opportunities will present themselves for credentialed coders. Coders will be capable of working in a variety of physician offices, nursing homes, hospitals, and more.

Lastly, many doctors are supportive of employees expanding their knowledge and professional status. This support may come in the form of promotions or changes in job responsibilities, financial rewards, or simply emotional support. Sometimes its nice just to know that your employer is proud of your accomplishment and proud to have you on staff.

Continuing Education

Internal

Offices can educate their coding and billing staff by having a doctor or other clinical-based employee provide a short training session to the office staff explaining a specific disease or surgery.

In addition, coding related publications need to be circulated to the coding staff. Examples of publications include Medicare Part B bulletins or the AAOMS Today. The Today is sent to the doctors, but it needs to be routed to the coders. This publication is also available online to both AAOMS members and their staff at http://www.aaoms.org.

External

External training can be obtained through workshops, conference calls, online courses, college courses, or correspondence programming. Source organizations include:

- AHIMA and AAPC (provide numerous programs for credentialed coders)
- Private training or consulting companies
- State or regional OMS associations
- State Medicare carriers, and
- AAOMS
No matter how the coder is educated, management needs to maintain logs identifying the employee’s participation in the activity. Common information to maintain is the date, title of program or description of activity, and the name of the employee.

Physician Office Based Coding Competencies

Data Identification
- Read and interpret medical record documentation to identify codeable diagnoses and procedures
- Assess the adequacy of medical record documentation to ensure that it supports the codes assigned
- Apply knowledge of disease processes to accurately assign codes to diagnoses/conditions not listed in the Alphabetic Index of ICD-9-CM
- Apply knowledge of procedures to accurately assign codes to procedures/services not listed in the Alphabetic Index of CPT

Coding Guidelines
- Understand the use of modifiers in CPT
- Apply the nationally approved “ICD-9-CM Coding Guidelines for Outpatient Services”
- Demonstrate knowledge of ICD-9-CM instructional notations and conventions which impacts diagnosis sequencing
- Apply knowledge of CPT guidelines, format, and notes to locate and properly sequence codes for services and procedures
- Confirm E/M codes based upon medical record documentation using nationally recognized E/M guidelines
- Recognize when an unlisted CPT code must be used
- Ability to recognize potential coding quality problems

Regulatory Guidelines
- Apply regulatory agency guidelines (i.e., CMS) to coding principles
- Observe guidelines on bundling and unbundling
- Have knowledge of the global surgical package
- Have knowledge of various reimbursement methodologies
- Execute policies and procedures on medical record documentation, coding, claims filing, and claims appeals
Coding

- Exclude from coding those procedures which are component parts of an already assigned procedure code
- Assign HCPCS Level II codes correctly
- Attach modifiers to procedure or service codes
- Appropriately code for professional vs. technical components, when applicable
- Assign ICD-9-CM codes for conditions evaluated or treated during the encounter. Assign CPT codes for procedures/services rendered during the encounter

Data Quality

- Query physicians when additional information is needed for coding or clarity of information
- Link ICD-9-CM codes to proper CPT codes to ensure accurate claims submission
- Verify that CPT codes, ICD-9-CM codes, and Place of Service codes on the claim form correctly support the services performed
- Determine educational needs for office staff relating to coding, reimbursement, documentation rules, and potential penalties/sanctions

Physician Query Process

When should a doctor be queried?

A doctor should be queried whenever conflicting, ambiguous, or incomplete documentation exists relating to a significant diagnosis or procedure. This would include variations between the encounter form and the medical record documentation. A word of caution is that the query process should be consistent. Do not query the doctor only when reimbursement could be affected. This could be interpreted as being a sign of upcoding.

A doctor should also be queried when referral information significantly differs from the OMS’s final diagnosis. Coders need to be careful here. Some degree of difference is expected given the fact that an OMS is a specialist. Not all differences in documentation need to be queried.

Doctors should not be queried if the documentation discrepancy does not impact the code selection.
Query Format

The facility should create a standard query form containing basic patient identification information and areas for coders to ask a question and doctors to provide a response with a signature line. Informal sticky notes or scratch pads are not appropriate.

The coder should state the facts and ask an open-ended question that requires the doctor to write a response. Designing the question in a yes/no or agree/disagree format is not appropriate. In addition, the question should not lead the doctor in a way that it can be interpreted that the doctor was coached into providing the answer the coder wanted.

Miscellaneous Query Information

The query cannot discuss any financial implications of the doctor’s clarification. For instance, you cannot notify the doctor that you are confused between two procedure codes and the respective reimbursement. Codes should represent the services rendered – not which service pays the best.

Do not design the form so that the coder does all the work and the doctor simply makes a quick entry and signs off. These query forms are to be maintained for a period of time beyond any potential insurance audit. This is normally seven years. The doctor’s response must be clear and specific.

Lastly, if the medical record needs to be amended, the doctor should do so following all professional standards for amending medical records or making late entries.

Coding Volume Analysis

Determining how many coders are needed in a healthcare facility requires two pieces of information – how many hours of coding needs to be done a day and how many coding hours are available a day.

Determining the number of coding hours needed

To determine the number of coding hours generated by the work load, only three steps need to be completed. You will need to identify the total number of encounters seen by the practice a year. This should include office visits, inpatient hospital encounters, hospital outpatient encounters,
etc…. In addition, you will need to establish a standard reflecting the number of records that can be coded in one hour.

Now the formula begins,

1. Take the total number of annual encounters and divide this by 12. This gives you the average number of encounters per month.
2. Next, divide the average number of encounters per month by 20. This is typically the number of days worked per month. If your practice is not open 5 full days a week, you need to divide by the total number of days worked per month.
3. Lastly, divide the number of records to be coded each day by the standard per hour, this results in the number of coding hours required each day the office is open.

### Hometown OMS

**Determining the Number of Coding Hours Needed Per Day**

**Statistics**

- Annual encounters = 5,200
- Employees work 5 days a week
- Professional coding standard = 9 physician office records can be coded in one hour (*coding from medical record documentation*)

5,200 encounters ÷ 12 months = **433.33 encounters per month**

433.33 encounters per month ÷ 20 working days = **21.66 health records per day**

21.66 health records per day ÷ 9 records per hour = **2.4 coding hours required per day**

**Determining the number of coders needed**

1. First, we need to calculate the number of work hours in a year. This is based on a full time equivalent or FTE. Therefore, an FTE works 40 hours a week X 52 weeks a year. This gives the maximum number of hours that can be worked per year.
2. However, an FTE does not actually work 52 weeks a year. Therefore, you need to remove the days of vacation, sick leave, training, and any other days that are applicable to your practice.
3. Next, you will need to consider the percent of time spent each day on the coding process. Many workers wear numerous hats and do not spend 8 hours a day coding. Multiply this percentage by the number of productive work hours per year.

4. Now, divide this number by 12. This gives you the number of productive work hours per month.

5. Divide the number of productive work hours per month by the number of coding work days per week. Remember to use the number of days your practice is open per week. This tells you how many coding hours an FTE can give you per day.

6. Last step, take the number of needed coding hours from the first formula and divide that by the number of hours one FTE can provide you each day. This gives you the number of FTEs you need to get the job done.

**Hometown OMS**

**Determining the Number of Coders Needed To Keep Workload Current**

**Statistics**

- Vacation time = 2 weeks (80 hours)
- Sick time = 1 day per month (96 hours)
- Office holidays = 11 days (88 hours)
- Annual coding training = 2 days (16 hours)

40 hours a week X 52 weeks a year = **2080 work hours per year**

2080 work hours per year – 264 hours – 16 hours = **1800 Actual work hours per year**

1800 actual work hours per year X 44% of time spent coding per day = **792 Productive hours per year**

792 productive hours per year ÷ 12 = **66 Productive hours per month**

66 productive hours per month ÷ 20 coding days per month = **3.3 Coder hours available per day**

2.4 coding hours required each day ÷ 3.3 coder hours available per day = **.727 Number of needed coders or 1 FTE**
**Vignette Hints**

**Vignette 1**

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Partial edentulous maxilla and mandible</td>
<td></td>
</tr>
<tr>
<td>2. Periodontal disease causing tooth loss</td>
<td></td>
</tr>
<tr>
<td>3. Mandibular atrophy</td>
<td></td>
</tr>
<tr>
<td>4. Maxillary atrophy</td>
<td></td>
</tr>
<tr>
<td>5. Trigeminal nerve impingement</td>
<td>The inferior alveolar nerve is the 3rd branch of the trigeminal nerve (cranial nerve). The inferior alveolar nerve is referenced in the treatment plan.</td>
</tr>
<tr>
<td>6. Type I diabetes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dental implant, complete</td>
<td>18.77</td>
</tr>
<tr>
<td>2. Dental implant, partial</td>
<td>12.74</td>
</tr>
<tr>
<td>3. Sinus lift – bilateral</td>
<td>11.69</td>
</tr>
<tr>
<td>4. Reposition of the cranial nerve</td>
<td>The procedure must be reduced because man-made grafting material was used.</td>
</tr>
<tr>
<td></td>
<td>6.99</td>
</tr>
</tbody>
</table>

**Vignette 2**

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Right subcondylar (mandible) fracture</td>
<td></td>
</tr>
<tr>
<td>2. Alveolar fracture</td>
<td></td>
</tr>
<tr>
<td>3. Laceration of inside of lip</td>
<td></td>
</tr>
<tr>
<td>4. Broken teeth</td>
<td></td>
</tr>
<tr>
<td>5. E Code: Pedal cycle (bicycle) accident</td>
<td></td>
</tr>
<tr>
<td>6. E Code: Occurring at public park</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repair of mandibular fracture with interdental fixation (Arch bars)</td>
<td>6.64</td>
</tr>
<tr>
<td>2. Repair of alveolar ridge fracture</td>
<td>3.44</td>
</tr>
<tr>
<td>3. Suture of laceration, vestibule of mouth</td>
<td>2.57</td>
</tr>
<tr>
<td>4. Evaluation and Management – Initial hospital care</td>
<td>This code must be modified to show that the decision to perform surgery took place within the Global Surgical Package.</td>
</tr>
<tr>
<td></td>
<td>1.92</td>
</tr>
</tbody>
</table>
## Vignette 3

### Diagnoses
1. Maxillary hypoplasia (deficiency)
2. Mandibular hyperplasia
3. Mandibular prognathism

### Procedures
1. LeFort I reconstruction  
   - Obtaining bone graft is included in the code.  
   - Work RVU = 23.94
2. Reconstruction of mandible - sagittal split with internal fixation  
   - Work RVU = 20.83
3. Coronoidectomy – bilateral  
   - Work RVU = 8.62
4. Chin advancement (genioplasty)  
   - Work RVU = 7.81

## Vignette 4

### Diagnoses
1. Zygomatic arch fractures
2. Alveolar fracture
3. Mandibular symphysis fracture
4. Mandibular angle fracture
5. Lacerated cheek
6. E Code: MVA collision
7. E Code: Occurring on the street

### Procedures
1. Repair of fixation of mandibular fractures – bilateral  
   - Work RVU = 17.54
2. Repair of zygoma fractures – bilateral  
   - Work RVU = 16.77
3. Placement of cranial halo  
   - Work RVU = 5.26
4. Repair of alveolar ridge fracture  
   - Work RVU = 3.44
5. Layered (intermediate) closure of cheek laceration  
   - Work RVU = 2.87
6. Evaluation and Management – Inpatient consultation  
   - Work RVU = 1.88

---

*This needs to be modified to show that the decision to perform the major surgery took place after the Global Surgical Package began.*
**Vignette 5**

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infected implant (orthopedic device)</td>
<td>1. Rapid palatal expansion</td>
</tr>
<tr>
<td>2. Compressed 5th cranial nerve</td>
<td>Work RVU = 20.28</td>
</tr>
<tr>
<td>3. Anodontia (congenitally absent tooth)</td>
<td></td>
</tr>
<tr>
<td>4. Maxillary hypoplasia</td>
<td>2. Nerve graft of head or neck</td>
</tr>
<tr>
<td>5. Maxillary alveolar hypoplasia</td>
<td>Work RVU = 17.60</td>
</tr>
</tbody>
</table>

There is not a specific CPT code for rapid palatal expansion. The closest code is 21142. However, this must be reduced because the entire procedure is not carried out. (Covered in the Beyond the Basic Coding Course)

<table>
<thead>
<tr>
<th>Procedures</th>
<th>3. Dental implant – partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Sinus lift</td>
<td>Work RVU = 12.74</td>
</tr>
<tr>
<td>5. Revision (decompression) of trigeminal nerve</td>
<td>Work RVU = 6.99</td>
</tr>
<tr>
<td>6. Removal of superficial implant (dental implant)</td>
<td>Work RVU = 1.79</td>
</tr>
</tbody>
</table>

**Vignette 6**

This is a late effect situation.

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hypertrophic scar</td>
<td>1. W-plasties</td>
</tr>
<tr>
<td>2. Mechanical ptosis</td>
<td>Work RVU = 10.83</td>
</tr>
<tr>
<td>3. Cicatricial ectropion</td>
<td>This code includes the excision of the hypertrophic scar.</td>
</tr>
<tr>
<td>4. Foreign body granuloma</td>
<td>2. Brow lift (Repair of brow ptosis)</td>
</tr>
<tr>
<td>Diagnosis found in treatment plan</td>
<td>Work RVU = 6.82</td>
</tr>
<tr>
<td>5. Late effect of open wound</td>
<td>3. Ectropion excision blepharoplasty</td>
</tr>
<tr>
<td>6. E Code: Late effect of MVA</td>
<td>Work RVU = 6.19</td>
</tr>
<tr>
<td>Procedures</td>
<td>4. Tarsal wedge blepharoplasty</td>
</tr>
<tr>
<td>5. Destruction of 15+ benign lesions (foreign body granulomas)</td>
<td>Work RVU = 5.48</td>
</tr>
</tbody>
</table>

| Procedures                  | 5. Destruction of 15+ benign lesions (foreign body granulomas) | Work RVU = 1.85 |
### Vignette 7

#### Encounter 1

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Facial cellulitis</td>
<td></td>
</tr>
<tr>
<td>2. Periapical abscess with sinus (fistula)</td>
<td></td>
</tr>
<tr>
<td>3. Retained root (broken tooth at gum line)</td>
<td></td>
</tr>
</tbody>
</table>

There is a Use Additional Code note to identify the organism. However, on this date, you do not know the organism. Therefore, it is not necessary to assign an organism code.

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I&amp;D masticator space</td>
<td>3.71</td>
</tr>
<tr>
<td>2. I&amp;D submandibular space</td>
<td>3.46</td>
</tr>
<tr>
<td>3. Therapeutic injection (specify substance or drug) – IV push</td>
<td>0.18</td>
</tr>
<tr>
<td>4. Anesthesia by surgeon</td>
<td></td>
</tr>
<tr>
<td>5. Surgical removal of root</td>
<td></td>
</tr>
<tr>
<td>6. Handling of specimen for transfer</td>
<td></td>
</tr>
<tr>
<td>7. HCPCS Level II Code: Ancef 500 mg</td>
<td></td>
</tr>
</tbody>
</table>

#### Encounter 2

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Facial cellulitis</td>
<td></td>
</tr>
<tr>
<td>2. Group Streptococcus A infection</td>
<td></td>
</tr>
<tr>
<td>3. Periapical abscess with sinus (fistula)</td>
<td></td>
</tr>
<tr>
<td>4. Retained root</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Therapeutic injection (specify substance or drug) – intramuscular</td>
<td>0.17</td>
</tr>
<tr>
<td>2. HCPCS Level II Code: Recephin, 1 gram</td>
<td></td>
</tr>
</tbody>
</table>
### Vignette 8

#### Encounter 1

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Closed dislocation of TMJ</td>
<td></td>
</tr>
<tr>
<td>2. Articular disc disorder (lock)</td>
<td></td>
</tr>
<tr>
<td>3. E Code: Struck by person in sports</td>
<td></td>
</tr>
<tr>
<td>4. E Code: Occurring at school sports field (stadium)(playground)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluation and Management – Office, new patient</td>
<td>3.17</td>
</tr>
</tbody>
</table>

#### Encounter 2

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4. Same as Encounter 1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TMJ meniscectomy</td>
<td>11.07</td>
</tr>
<tr>
<td>2. TMJ diagnostic arthroscopy</td>
<td>6.84</td>
</tr>
<tr>
<td>3. Anesthesia by surgeon</td>
<td></td>
</tr>
</tbody>
</table>

### Vignette 9

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Persistent postoperative fistula (sinus)</td>
<td></td>
</tr>
<tr>
<td>2. Chronic maxillary sinusitis</td>
<td></td>
</tr>
<tr>
<td>3. Tongue tied</td>
<td></td>
</tr>
<tr>
<td>4. Hypertrophic frenum</td>
<td></td>
</tr>
<tr>
<td>5. Gingival recession</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Oral surgical splint</td>
<td>8.99</td>
</tr>
<tr>
<td>2. Repair of oromaxillary fistula</td>
<td>6.88</td>
</tr>
<tr>
<td>3. Sinus antrotomy</td>
<td>3.07</td>
</tr>
<tr>
<td>4. Lingual frenectomy with Z-plasty (frenoplasty)</td>
<td>2.51</td>
</tr>
<tr>
<td>5. Labial frenectomy</td>
<td>2.83</td>
</tr>
<tr>
<td>6. Periodontal mucosal grafting</td>
<td>0.00</td>
</tr>
<tr>
<td>7. Anesthesia by surgeon</td>
<td></td>
</tr>
<tr>
<td>Vignette 10</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Encounter 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. Malignant neoplasm of posterior tongue</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Excision of tongue lesion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Encounter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. Admission for prophylactic measures</td>
</tr>
<tr>
<td>2. Malignant neoplasm of posterior tongue</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Alveoloplasty, each quadrant</td>
</tr>
<tr>
<td>2. Extractions (12)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Encounter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. Osteoradionecrosis</td>
</tr>
<tr>
<td>2. Late effect of radiation</td>
</tr>
<tr>
<td>3. E Code: Late effect of medical service</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Alveolectomy (Removal of bone pieces – sequestrectomy)</td>
</tr>
</tbody>
</table>
### Vignette 11

<table>
<thead>
<tr>
<th>Encounter 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. Sleep apnea</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Evaluation and Management – Office consultation</td>
</tr>
<tr>
<td>2. Nasopharyngoscopy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Encounter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. <em>Same as Encounter 1</em></td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Evaluation and Management – Office, established patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Encounter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. <em>Same as Encounter 1</em></td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Mandibular reconstruction with internal fixation</td>
</tr>
<tr>
<td>2. LeFort I</td>
</tr>
<tr>
<td>3. Genioglossus advancement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Encounter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. Infection of dental implant</td>
</tr>
<tr>
<td>2. Osteomyelitis of jaw</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Debridement (excision of bony material) of mandible</td>
</tr>
<tr>
<td>2. Removal of dental implant</td>
</tr>
<tr>
<td>3. I&amp;D of mouth lesion</td>
</tr>
</tbody>
</table>

*All surgical procedures need to be modified since they occurred during a postoperative period of Encounter 3.*

| 4. Evaluation and Management – Initial hospital care | Work RVU = 1.92 |

<table>
<thead>
<tr>
<th>Vignette 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnoses</strong></td>
</tr>
<tr>
<td>1. Osteonecrosis</td>
</tr>
<tr>
<td>2. E Code: Therapeutic use of bisphosphonate</td>
</tr>
<tr>
<td>3. Multiple myeloma</td>
</tr>
<tr>
<td><strong>Procedures</strong></td>
</tr>
<tr>
<td>1. Evaluation and Management – Office, new patient</td>
</tr>
</tbody>
</table>
### Vignette 13

**Procedures**
1. Two dimensional i-CAT
2. Consultation service

### Vignette 14

#### Encounter 1

**Diagnoses**
1. Dislocation of jaw
2. Articular disc disorder
3. Mandibular deviation on opening and closing
4. E Code: Hit by other person with object during sports
5. E Code: Accident occurring at playground (school)

**Procedures**
1. Evaluation and Management – Office consultation  Work RVU = 3.02
2. X-ray, TMJ  Work RVU = 0.24

#### Encounter 2

**Diagnoses**
1. Same as Encounter 1

**Procedures**
1. Custom oral surgical splint  Work RVU = 8.99

*Given the fact that the procedure for the splint carries a 10 day Global Surgical Package, coding an E/M service for the 2nd encounter would be problematic. If you wanted to attempt submission, an E/M code would need to carry modifier -25.*

#### Encounter 3

**Diagnoses**
1. Articular disc disorder
2. Mandibular deviation on opening and closing

**Procedures**
1. Evaluation and Management – Office, established patient  Work RVU = 0.97

#### Encounter 4

**Diagnoses**
1. Articular disc disorder

**Procedures**
1. Evaluation and Management – Office, established patient  Work RVU = 2.11
### Encounter 5

<table>
<thead>
<tr>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Articular disc disorder</td>
</tr>
<tr>
<td>2. Acknowledgement that an arthroscopic procedure was converted to an open approach (V code)</td>
</tr>
<tr>
<td>3. Accidental laceration during a procedure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Arthroplasty</td>
</tr>
<tr>
<td>2. Ligation (tying off) of carotid artery</td>
</tr>
</tbody>
</table>

### Vignette 15

<table>
<thead>
<tr>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fracture of maxilla</td>
</tr>
<tr>
<td>2. Fracture of palate</td>
</tr>
<tr>
<td>3. Fracture of mandibular symphysis</td>
</tr>
<tr>
<td>4. Fracture of mandibular condyle</td>
</tr>
<tr>
<td>5. Fracture of nose</td>
</tr>
<tr>
<td>6. Laceration of chin</td>
</tr>
<tr>
<td>7. Laceration of palate</td>
</tr>
<tr>
<td>8. Laceration of lip</td>
</tr>
<tr>
<td>9. E Code: Bicycle (pedal cycle) accident</td>
</tr>
<tr>
<td>10. E Code: Accident occurring in street</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Open repair of mandibular (symphysis) fracture</td>
</tr>
<tr>
<td>2. Open repair of maxillary fracture (LeFort I type)</td>
</tr>
<tr>
<td>3. Adjacent flap (tissue transfer) buccal vestibule</td>
</tr>
<tr>
<td>4. Open repair of zygomatic arch – bilateral</td>
</tr>
<tr>
<td>5. Closed repair of mandibular fracture</td>
</tr>
<tr>
<td>6. Repair of chin laceration</td>
</tr>
<tr>
<td>7. Repair of palate laceration</td>
</tr>
<tr>
<td>8. Closed repair of nasal septum fracture</td>
</tr>
<tr>
<td>9. Repair of lip laceration, intermediate</td>
</tr>
<tr>
<td>10. Closed repair of nasal fracture</td>
</tr>
<tr>
<td>11. Evaluation and Management – Initial hospital care</td>
</tr>
</tbody>
</table>

Only surgical procedures are subject to multi-procedure reductions. Therefore, it is appropriate to list non-surgical codes (like the E/M code) after the surgical codes.
Mandibular Anatomy

Prevalence of Mandibular Fractures
ZMC Fracture

A. ZMC Fracture

B. Zygomatic Arch Fracture

C. Zygomatic Arch Fracture
LeFort I

LeFort II
LeFort III

Dentofacial Anomalies

Maxillary prognathism  Jaw without prognathism  Mandibular prognathism
Orthognathic Surgery

Before and after profiles, showing correction of a protruding lower jaw

To correct a receding lower jaw, the jaw is moved forward from behind the teeth, a portion of the chin is moved forward and both areas of the jaw bone are held in place using plates and screws.

Before and after upper jaw surgery to correct an open bite. The upper jaw is held together with plates and screws.
Temporomandibular Joint
Implant Healing Cap Abutment Impression Taken Crown
Various Functions of Implants

Crowns

Bridges

Dentures
Nerves to Avoid – Inferior Alveolar Canal and Nerve (2 mm)

Example: Incisor #8
Types of Implants

Blade

Transosteal
Beyond the Basics Review

Practice 1

716.18; 905.0
  Arthritis, traumatic, other specified site
  Late effect, fracture, face and skull

Practice 2

173.30
  Carcinoma, basal cell – see Neoplasm, skin, malignant
  Neoplasm, skin, nose, malignant, primary

Practice 3

a. 802.30
  Fracture, mandible, open

b. 733.19; 733.09; E932.0
  Fracture, pathological, specified site
  Osteoporosis, drug-induced
  (There is a Use Additional Code note at 733.09 to use a third code.)
  Table of Drugs and Chemicals, prednisone, therapeutic use
Exercise 1

1. 143.1
   Carcinoma – see Neoplasm, by site, malignant
   Neoplasm, mandible, alveolar, ridge or process, carcinoma
   If you obtained 170.1, you need to take note of an Excludes note at 170.1 that states “Excludes carcinoma, any type except intraosseous or odontogenic”.

2. 802.4
   Fracture, zygoma

3. 873.50
   Wound, open, face, complicated

4. 524.73
   Hypoplasia, maxillary, alveolar

5. 198.5; V10.05
   Neoplasm, bone, malignant, metastatic
   History of, malignant neoplasm, large intestine

6. 682.0; 873.50; 041.10
   Cellulitis, face
   Wound, open, face, complicated
   Infection, staphylococcus

7. 800.11
   Fracture, frontal bone – see Fracture, skull, vault
   Fracture, skull, vault, with cerebral contusion, no LOC

Exercise 2

1. B
   Only the attending physician on an inpatient case can use “Initial Hospital Care and “Hospital Discharge Service” codes. As such, when more than one doctor is following a case, all additional doctors use “Subsequent Hospital Care” codes to report E/M services.

2. A
3. 528.9; 41108
   Lesion, organ or site NEC – see Disease, by site
   Disease, mouth
   Biopsy, floor of mouth
   It is recommended that the claim not be submitted to the insurance carrier until a pathology report is received.

4. 144.9; 41116
   Neoplasm, mouth, floor of mouth
   Excision, lesion, floor of mouth

5. 873.41; 873.44; 873.43; E968.2; E849.6; 12052; 12013-51
   Wound, open, cheek
   Wound, open, chin
   Wound, open, lip
   Assault, fight, with weapon, blunt or thrown
   Accident, occurring at, public building NEC
   Wound, repair, intermediate
   Wound, repair, simple

6. 802.35; 802.38; 20694-58; Anesthesia code(s)
   Fracture, mandible, angle, open
   Fracture, mandible, body, open
   Removal, under anesthesia, of external fixation system
   Return to the OR within the 90 days of the previous major surgery.
   Anesthesia
   Anesthesia services can be reported in a variety of ways, such as CPT anesthesia codes, Anesthesia by Surgeon modifier (-47), or HCPCS Level II anesthesia codes (D Codes).

Advanced Coding Principles

Practice 4

965.09; E850.2
   Table of Drugs and Chemicals, Demerol, Poisoning column
   Table of Drugs and Chemicals, Demerol, Accident column
Practice 5

a. 693.0; E930.0
   **Rash**, drug
   Table of Drugs and Chemicals, Penicillin, Therapeutic Use column

b. 733.45; E933.6
   **Necrosis**, aseptic, jaw
   Table of Drugs and Chemicals, Bisphosphonate, Oral, Therapeutic Use column

Exercise 3

1. 787.01; E930.0
   **Nausea**, with vomiting
   Table of Drugs and Chemicals, Penicillin, Therapeutic Use column

2. 796.3; E938.3
   **Hypotension**, transient
   Table of Drugs and Chemicals, Drug, AHFS List, 28:04, intravenous anesthetics, Therapeutic Use column

3. 963.0; 969.4; E980.4; E980.3
   Table of Drugs and Chemicals, Nytol, Poisoning column
   Table of Drugs and Chemicals, Valium, Poisoning column
   Table of Drugs and Chemicals, Nytol, Undetermined column
   Table of Drugs and Chemicals, Valium, Undetermined column
   *The use of accidental E codes could be used in addition to “undetermined”.*

4. 255.0; E932.0
   **Cushingoid due to steroid therapy**
   Table of Drugs and Chemicals, Steroids NEC, Therapeutic Use column

5. 995.27; E935.3
   **Hypersensitivity**, drug
   Table of Drugs and Chemicals, aspirin, Therapeutic Use column
Practice 6

802.4; E880.9, E849.0
  Fracture, zygoma
  Fall, down, staircase (In the E code Alphabetic Index)
  Accident, occurring at, home (In the E code Alphabetic Index)

Practice 7

a. V15.3
   History of, radiation therapy

b. 250.00
   Diabetes, unspecified
   Diabetes is a life-long condition. Therefore, there is not a “history of” V code. This would be coded as a current diagnosis.

Practice 8

520.6; V64.3
  Impacted, tooth
  Surgery, not done because of, specified reason NEC

Practice 9

802.28; V44.0
  Fracture, mandible, body
  Status, tracheostomy

Practice 10

522.5; 041.10; V09.0
  Abscess, dentoalveolar
  Infection, staphylococcal NEC
  Resistance, resistant (to), penicillins
Practice 11

a. 522.8
   Cyst, radicular

b. V67.09
   Follow-up, specified surgery NEC

Practice 12

a. V72.83
   Examination, preoperative, specified NEC

b. 521.00; 523.00
   Caries, dental
   Gingivitis, acute

Practice 13

99222; 99356
   Evaluation and Management, hospital
   Evaluation and Management, prolonged services
   97 minutes total with the patient on the day of admission. According to CPT, a
   doctor would normally spend 50 minutes performing a comprehensive, moderate
   complexity initial inpatient service. This leaves 47 minutes of prolonged services.

Practice 14

V72.83; 424.1; 521.00; 523.00
   Examination, preoperative, specified NEC
   Stenosis, aortic (valve)
   Caries, dental
   Gingivitis, acute

Exercise 4

1. V54.01
   Removal, device, fixation, internal

   Note: Many insurance companies will instruct practices to continue
   assigning the original surgical diagnosis.
2. 522.5, V14.0
   Abscess, tooth
   History of, allergy to antibiotic agent, penicillin

3. 524.10, V64.1, 780.39
   Retrognathia, mandible
   *The Alphabetic Index takes the coder to 524.06. However, when the Tabular List is read, it is clear that “Unspecified retrognathism is assigned to 524.10."
   Surgery, not done because of, contraindication
   Seizures

4. V67.09, V10.02
   Follow up, specified surgery
   History of, malignancy, mouth

5. 802.21, 042
   Fracture, mandible, condylar process
   Human immunodeficiency virus

6. 528.9, V08
   Infection, mouth
   Human immunodeficiency virus, infection

7. 802.9, E965.0; E849.0
   Fracture, face, open (*There is an open wound associated with the fracture."
   Gunshot – see Shooting
   Shooting, inflicted by other person, intentional, hand gun
   Accident (to), occurring (at)(in), house (private)

8. 802.0, E818.3; E849.5
   Fracture, nasal
   Accident, motor vehicle, not involving a collision – see categories E8816-E819
   *In the front of the E code chapter in the Tabular List is a classification of various types of equipment. According to this list, a moped is considered a motorcycle for coding purposes.*
   Accident (to), occurring (at)(in), street

9. 802.38, E979.2; E849.6
   Fracture, mandible, body, open
   *A compound fracture is an open fracture.*
   Terrorism, bomb
   Accident (to), occurring (at)(in), restaurant
10. V54.19
    Aftercare, fracture, healing, traumatic, specified site

11. V07.8; 191.4
    Prophylactic, measure, specified type NEC
    Neoplasm, brain, occipital lobe, primary

12. V72.83; 403.90
    Examination, preoperative, specified NEC
    Nephrosclerosis

13. 99245; 99354
    The visit was documented at the high level within the grouping. In addition, the
description of the code states that a doctor typically spends 80 minutes
performing a comprehensive, high exam. Given the fact that the doctor spent 130
minutes, this would qualify as a prolonged service.

14. 99214
    The exam took 35 minutes. This only leaves 20 prolonged minutes. Guidelines state
    that prolonged minutes of <30 are not reported.

## Advanced Coding Vignettes

### Vignette 1

**Diagnoses**

525.50; 525.12; 525.23; 525.25; 350.8; 250.01
   1. Edentulism, partial
   2. Loss, tooth, acquired, due to, periodontal disease
   3. Atrophy, alveolar process or ridge, mandible, severe
   4. Atrophy, alveolar process or ridge, maxilla, moderate
   5. Disorder, nerve, trigeminal, specified NEC
   6. Diabetes, (Type I represented by a 5th digit)

**CPT**

21249; 21248; 21210-52-50; 64716
   1. Reconstruction, mandible, with implant
   2. Reconstruction, maxilla, with implant
Note that while these are the appropriate CPT codes, based on discrepancy as to how carriers interpret 21248 and 21249 and how these codes are reimbursed (eg, one flat fee per code regardless of how many implants are placed rather than for each implant) the AAOMS Committee on Health Care and Advocacy recommends members instead report the CDT/HCPCS code D6010 since it is to be reported per implant and is less confusing.

3. Bone graft, maxilla
4. Neuroplasty, cranial nerve

CDT

D7951 x 2; D6010 x 8; D7999
1. Sinus lift
2. Implant, endosteal/endosseous
3. Oral and maxillofacial surgery
   
   There is no trigeminal nerve release code in CDT.

Vignette 2

Diagnoses

802.22; 802.8; 873.61; 873.63; E826.1; E849.4
1. Fracture, mandible, subcondylar
2. Fracture, alveolus
3. Wound, open, buccal mucosa
4. Fracture, tooth
5. Accident, bicycle
6. Accident, occurring (at)(in), park
   
   Both 5 & 6 are found in the E Code Alphabetic Index.

CPT

21453; 21440-59; 40831; 99221-57
1. Fracture, mandible, closed treatment, interdental fixation
2. Fracture, alveolar ridge, closed treatment
   
   Because the procedure is listed as a “separate procedure”, it is necessary to use modifier –59 (Distinct procedure) to show that it is distinctly different from the other surgical procedures.
3. Mouth, repair, laceration
4. Evaluation and Management, hospital
   
   The decision to perform major surgery occurred within the surgical package. Therefore, one E/M can be billed with modifier –57 (Note: Not all carriers will reimburse this.)
CDT

D7640; D7910; D7670
1. Fracture, mandible, simple closed reduction
2. Wound, treatment of
3. Alveolus, fracture

Vignette 3

Diagnoses

524.03; 524.02; 524.10
1. Hypoplasia, maxillary
2. Hyperplasia, mandibular
3. Prognathism
   The Alphabetic Index takes the coder to 524.00. However, when the Tabular List is read, it is clear that “Unspecified prognathism is assigned to 524.10.

CPT

21145; 21196; 21070-50-59; 21121
1. Reconstruction, midface, with bone graft
2. Reconstruction, mandibular rami, with internal rigid fixation
3. Coronoidectomy
   The procedure is documented in the plural. Therefore, it is a bilateral procedure. Also, this is listed in CPT as a “separate procedure”. It is best to use modifier –59 (Distinct procedure).
4. Genioplasty

CDT

D7946; D7950; D7941; D7944; D7991
1. LeFort I
2. Graft, ridge augmentation
   Unlike CPT, the LeFort I procedure code does not include obtaining the graft.
3. Osteotomy – mandibular rami
4. Osteotomy – segmented or subapical
5. Coronoidectomy
Vignette 4

Diagnoses

802.4; 802.36; 802.35; 873.41; 802.9; E819.9; E849.5
1. **Fracture**, zygoma
2. **Fracture**, mandible, body, symphysis, open
3. **Fracture**, mandible, angle, open
4. **Wound**, open, cheek
5. **Fracture**, alveolus, open
6. **Accident**, motor vehicle, unspecified person
7. **Accident**, occurring at, street

*Both 6 & 7 are found in the E Code Alphabetic Index.*

CPT

21365-50; 21470; 20661; 21440-59; 12052; 99243-57
1. **Fracture**, mandible, open treatment (bilateral)
2. **Fracture**, zygoma, open treatment
3. **Application**, halo, cranial
4. **Fracture**, alveolar ridge, closed treatment
   *Because the procedure is listed as a “separate procedure”, it is necessary to use modifier –59 (Distinct procedure) to show that it is distinctly different from the other surgical procedures.*
5. **Wound**, repair, intermediate
6. **Evaluation and management**

CDT

D7680 x 2; D7780 x 2; D7680; D7911; D7999
1. **Fractures**, treatment of, malar/zygomatic arch
   *Gets the coder to the general area*
2. **Fractures**, treatment of, mandible
   *Gets the coder to the general area*
3. **Fractures**, treatment of, alveolus
4. **Suturing**, complicated
5. **Oral and Maxillofacial Surgery** (Unlisted oral procedure – Halo application)
Vignette 5

Diagnoses

996.67; 350.8; 520.0; 524.03; 524.73
1. **Complication**, infection, due to, orthopedic device
2. **Compression**, cranial nerve, fifth
3. **Absence**, tooth
4. **Hypoplasia**, maxillary
5. **Hypoplasia**, maxillary, alevolar

CPT

21142-52; 64885; 21248; 21210; 64716; 20670-59
1. **LeFort I**, two piece
2. **Nerve**, graft
3. **Reconstruction**, mandible, with implant
4. **Bone graft**, maxilla
5. **Decompression**, nerve
6. **Removal**, implant
   *Because the procedure is listed as a “separate procedure”, it is necessary to use modifier –59 (Distinct procedure) to show that it is distinctly different from the other surgical procedures.*

CDT

D6100; D7951; D7999; D7999; D7947; D6010
1. **Implant support prosthesis**, removal
2. **Sinus Lift**
3. **Oral and Maxillofacial Surgery** (Unlisted oral procedure – nerve decompression)
4. **Oral and Maxillofacial Surgery** (Unlisted oral procedure – nerve graft)
5. **LeFort I**, osteotomy (Rapid palatal expansion)
6. **Implant**, endosteal/endosseous
**Vignette 6**

**Diagnoses**

704.1; 374.33; 374.14; 709.4; 906.0; E929.0

1. **Scar**, hypertrophic
2. **Ptosis**, mechanical
3. **Ectropion**, cicatricial
4. **Granuloma**, foreign body, skin
5. **Late**, effect of, wound open, face
6. **Late, effect of**, motor vehicle accident

*Found in the E Code Alphabetic Index.*

**CPT**

14041; 67900; 67917; 67916; 17004

1. **Tissue**, transfer, adjacent, skin
   *Includes the excision of the scar*

   1. **Brow pyrosis**, repair
2. **Blepharoplasty**, ectropion, extensive
3. **Blepharoplasty**, ectropion, excision tarsal wedge
4. **Destruction**, lesion, skin, benign

**CDT**

D7999; D7999; D7999; D7412; D7465

1. **Oral and Maxillofacial Surgery** (upper blepharoplasty with tarsal wedge)
2. **Oral and Maxillofacial Surgery** (lower blepharoplasty, extensive)
3. **Oral and Maxillofacial Surgery** (brow lift)
4. **Lesions**, surgical excision of
5. **Lesions**, surgical excision of

**Vignette 7**

**Diagnoses – Encounter 1**

682.0; 041.01; 522.7; 525.3

1. **Cellulitis**, face
2. **Infection**, streptococcus, group, A
3. **Abscess**, periapical, with sinus
4. **Retained**, dental root
CPT – Encounter 1

41009; 41008; 41008-47; 41899; 99000; 96374; J0690
1. Incision and Drainage, abscess, mouth
2. Incision and Drainage, abscess, mouth
3. Anesthesia by surgeon
   Note: Anesthesia services could also be reported with 00170 or D9220. If billing anesthesia with -47 or 00170, additional HCPCS Level II codes can be reported for the specific medication administered. However, anesthetic agents are included in Dental anesthesia codes.
4. Unlisted Services and Procedures, gum
5. Handling, specimen
6. Injection, Intravenous Push
7. Ancef

CDT – Encounter 1

D7510; D7250; D9610; D9220
1. Abscess, incision and drainage, uncomplicated
2. Root, removal
3. Drugs, therapeutic parenteral, single administration
4. Anesthesia

Diagnoses – Encounter 2

682.0; 041.01; 522.7; 525.3

CPT – Encounter 2

96372; D0696
1. Injection, intramuscular, antibiotic
2. Rocephin, per 250 mg (4 units)

CDT – Encounter 2

D9610
1. Drugs, therapeutic parenteral, single administration
Vignette 8

Diagnoses – Encounter 1

830.0; 524.63; E917.0; E849.4
1. **Dislocation**, temporomandibular joint
2. **Lock**, joint – see **Derangement**
   
   **Derangement**, joint, temporomandibular joint
   
   *This gives you 524.69. However, when reviewing the 524.6 subcategory, you can see that articular disc disorders fall under 524.63.*
3. **Hit by**, other person, in sports
4. **Accident**, occurring (at)(in), park
   
   *Both 3 & 4 are found in the E Code Alphabetic Index.*

CPT – Encounter 1

99205
1. **Evaluation and management**

CDT – Encounter 1

D0150
1. **Evaluations**

Diagnoses – Encounter 2

830.0; 524.63; E917.0; E849.4

CPT – Encounter 2

21060; 29800; 21060-47
1. **Meniscectomy**, temporomandibular joint
2. **Arthroscopy**, diagnostic, temporomandibular joint
3. Anesthesia by surgeon
   
   *Note: Anesthesia services could also be reported with 00170 or D codes.*

CDT – Encounter 2

D7850; D7872; D9220; D9221
1. **Temporomandibular joint**, treatment
2. **Arthroscopy** – diagnosis
3. **Sedation**, deep
4. Sedation, deep

Vignette 9

Diagnoses

998.6; 473.0; 750.0; 523.20; 528.5
1. Fistula, postoperative
2. Sinusitis, maxillary
3. Tongue tie
4. Recession, gingival
5. Hypertrophy, frenum, lip

CPT

21085; 30580; 31020; 40819; 41520; 418.70; 30580-47
1. Splint, oral surgical
2. Fistula, nose, repair
3. Antrotomy, sinus, maxillary
4. Frenoplasty
5. Frenectomy
6. Graft, gum mucosa
7. Anesthesia by surgeon

Note: Anesthesia services could also be reported with 00170 or D codes.

CDT

D7260; D7960; D4271; D5982; D9220
1. Fistula, oroantral
2. Frenectomy/frenotomy
3. Graft, soft tissue
   Includes the donor site graft and the frenectomy
4. Stent
5. Sedation, deep
Vignette 10

Diagnoses – Encounter 1

141.0
1. Carcinoma – see Neoplasm, by site, malignant Neoplasm, tongue, posterior

CPT – Encounter 1

41113
1. Excision, lesion, tongue

CDT – Encounter 1

D7441
1. Neoplasms, removal of

Diagnoses – Encounter 2

V07.8; 141.0
1. Prophylactic, measure, specified type NEC
2. Carcinoma – see Neoplasm, by site, malignant Neoplasm, tongue, posterior

CPT – Encounter 2

41874 X 4; 41899 X 12
1. Alveoloplasty
2. Unlisted procedure, dentoalveolar structures

CDT – Encounter 2

D7140 X 12; D7310 X 4
1. Extraction
2. Alveoloplasty with extractions
Diagnoses – Encounter 3

526.89; 909.2; E879.2
1. **Osteoradionecrosis**
2. **Late**, effect(s), radiation
3. **Late effect of**, medical or surgical procedure, test or therapy, resulting in, abnormal or delayed reaction or complication – see **Reaction, abnormal**
   
   **Reaction**, abnormal, radiological procedure or therapy
   
   *Found in the E Code Alphabetic Index.*

CPT – Encounter 3

41830
1. **Alveolectomy**

CDT – Encounter 3

D7550
1. **Sequestrectomy**

Vignette 11

Diagnoses – Encounter 1

327.23
1. **Apnea**, sleep, obstructive

CPT – Encounter 1

99244-25; 92511
1. **Evaluation and Management**, consultation
2. **Nasopharyngoscopy**

Two Errors

1. **Diagnosis was miscoded**
2. **In theory, it is fine to code a diagnostic service from the Medicine chapter along with an E/M. Only codes from the Surgery chapter are subject to Global Surgical Packages. However, modifier -25 on the Consultation code would be appropriate.**
Diagnoses – Encounter 2

327.23
   1. Apnea, sleep, obstructive

CPT – Encounter 2

99214
   1. Evaluation and Management, office and other outpatient, established

Two Errors

   1. Diagnosis was miscoded
   2. Given the fact that the OMS scheduled the follow-up visit, it does not meet the definition of a consultation.

Diagnoses – Encounter 3

327.23
   1. Apnea, sleep, obstructive

CPT – Encounter 3

21196; 21141; 21199
   1. Reconstruction, mandibular rami, with internal rigid fixation
   2. LeFort I
   3. Advancement, genioglossus

Two Errors

   1. Diagnosis was miscoded
   2. Related E/M services cannot be billed on the day of major surgery. Also, even if permitted, the E/M services would not have been billed as an Office Consultation.
Diagnoses – Encounter 4

996.67; 526.4
1. Complication, infection, due to device, implant, graft, orthopedic
2. Osteomyelitis, jaw

CPT – Encounter 4

21025-78; 20680-78; 40801-78; 99221
1. Excision, bone, mandible
2. Removal, fixation device
3. Incision and Drainage, lesion, mouth
4. Evaluation and Management, hospital

Five Errors

1. This encounter is due to a complication of the rigid fixation placed during the previous surgery. This is not acknowledged correctly in the diagnosis codes. (996.67)
2. Sleep apnea does not need to be coded during this encounter. (327.23 – mistakenly780.53)
3. Code 528.0 (Stomatitis) is not only not applicable to the case, but is also invalid. Code 528.0 requires a 5th digit.
4. Each of the procedures need Modifier -78 (Unplanned return to the OR for a related condition during a postoperative period)
5. The doctor can bill for an initial E/M for Day 1 of the hospitalization. This is before the surgical package begins on Day 2. However, it should not be coded as a consultation.
Vignette 12

Diagnoses

733.45; E933.7; 203.00
1. Osteonecrosis
2. Bisphosphonate, intravenous, therapeutic use
   *Found in the Table of Drugs and Chemicals*
3. Myeloma (multiple), not in remission
   *Unless clearly documented as being in remission, myeloma is coded as active. This use of 203.00 would be considered optional for the oral and maxillofacial surgeon. However, it does help to tie the patient’s encounter together.*

CPT

99203
1. Evaluation and Management, office and other outpatient, new patient
   *Because the scenario does not support the three criteria of a consultation (referral, examination, consultation report being sent back to the referral source), the case is coded as a new patient.*

Vignette 13

Diagnoses - Encounter 1

830.0; 524.63; 524.53; E917.0; E849.4
1. Dislocation, jaw
2. Articular, disc disorder
3. Deviation, mandible, opening and closing
4. Hit, other persons, with blunt object, in sports
5. Accident, occurring at, playground/school
   *Both 4 & 5 are found in the E Code Alphabetic Index.*

CPT – Encounter 1

99244; 70330
1. Evaluation and Management, consultation
2. X-ray, temporomandibular joint
Diagnoses - Encounter 2

830.0; 524.63; 524.53; E917.0; E849.4

CPT – Encounter 2

21085
1. **Impression, Maxillofacial**, oral surgical splint

Diagnoses – Encounter 3

524.63; 524.53; 99213
1. **Articular**, disc disorder
2. **Deviation**, mandible, opening and closing

CPT – Encounter 3

99213
1. **Evaluation and Management**, office and other outpatient

Diagnoses - Encounter 4

524.63
1. **Articular**, disc disorder

CPT – Encounter 4

99215
1. **Evaluation and Management**, office and other outpatient

Diagnoses - Encounter 5

524.63; V64.43; 998.2
1. **Articular**, disc disorder
2. **Arthroscopic Surgical Procedure Converted to Open**
3. **Complication**, accidental puncture or laceration during a procedure
CPT – Encounter 5

21240; 37600
  1. **Arthroplasty**, temporomandibular joint
  2. **Ligation**, artery, carotid

Vignette 14

D0362; D9310
  1. **Scan**, cone beam, two dimensional
  2. **Consultation**

Vignette 15

Diagnoses

802.4; 802.8; 802.26; 802.21; 802.0; 873.44; 873.65; 873.43; E813.6; E849.0
  1. **Fracture**, maxillary
  2. **Fracture**, palate
  3. **Fracture**, mandible, symphysis
  4. **Fracture**, mandible, condylar
  5. **Fracture**, nose
  6. **Wound, open**, chin
  7. **Wound, open**, palate
  8. **Wound, open**, lip
  9. **Accident**, pedal cycle, cyclist
 10. **Accident**, occurring (at)(in), street

*Both 9 & 10 are found in the E Code Alphabetic Index.*

CPT

21470; 21423; 21453-50-52; 14040; 13132; 21360-50; 42182; 21337-59; 12052; 21320; 99223-57
  1. **Fracture**, mandible, open treatment
  2. **Fracture**, maxillary or palate, open treatment (LeFort I type)
  3. **Tissue**, transfer, adjacent, skin
  4. **Fracture**, zygomatic arch, open treatment
  5. **Wound**, repair, complex
6. **Fracture**, mandible, closed treatment, interdental fixation
7. **Repair**, palate, laceration
8. **Fracture**, nasal septum, closed treatment
9. **Wound**, repair, intermediate
10. **Fracture**, nasal bone, closed treatment
11. **Evaluation and Management**, hospital