Coding for Temporomandibular Surgery

I. INTRODUCTION

Familiarity and compliance with the other AAOMS coding papers, particularly the initial papers related to ICD-9-CM diagnosis coding and procedural coding guidelines utilizing CPT, HCPCS Level II and CDT, will be necessary in order to use these codes properly.

Participation in AAOMS coding courses will provide valuable information to facilitate the use of the codes correctly. This paper is divided into three components that pattern the chronological evaluation and treatment of the temporomandibular joint patient.

REQUIRED CODING MATERIALS

Before attempting to code any claims for services, it is necessary to have a current copy of the American Medical Association CPT (Current Procedural Terminology), and the two-volume set of ICD-9-CM. Volumes 1 and 2 of the ICD-9-CM cover diagnostic coding which is mandatory in filing claims with Medicare, and other third party payers. Volume 1 represents a tabular listing of conditions, diseases, and symptoms; while volume 2 is the alphabetical listing. Volume 3 of the ICD-9-CM is only for hospitals, and is not necessary for the OMS office.

CPT, CDT and ICD-9-CM are revised annually. CPT becomes available in mid-November of each year. ICD-9-CM has previously been revised twice a year, in April and October. However, with ICD-10-CM implementation approaching, the government has placed a freeze on ICD-9-CM changes. It is unclear at this time how often ICD-10-CM will be updated once it takes effect. Thus, reporting a current procedure or diagnosis using a previous year's edition may be inaccurate and adversely affect reimbursement or lead to unnecessary delays in claims processing.

II. EVALUATION AND MANAGEMENT CODES

The CPT guidelines direct the use of evaluation and management codes. This section of the CPT text is divided into broad categories such as office visits, hospital visits and consultations. This classification is identified by type of service, place of service and the patients' status. The selection of the appropriate level of E/M services can typically be based on the following key components:

1) History
2) Examination
3) Medical Decision Making

III. ICD-9-CM DIAGNOSIS CODES

To code accurately, it is necessary to have a working knowledge of medical terminology and to understand the characteristics, terminology and conventions of the ICD-9-CM, Volume II (Alphabetic Index to ICD-9-CM). Generally the condition can be identified alphabetically and an appropriate code selected. Second, reference Volume I of ICD-9-CM to locate the selected code and identify any exclusion notes or other instructions that would direct the use of a different code. The most specific classification may require a five digit ICD-9-CM code.

Available ICD-9-CM diagnosis codes and ranges of codes that may be appropriate for use in temporomandibular joint surgery are:

(520-579) Diseases of the Digestive System:

524.5 Dentofacial functional abnormalities, e.g., abnormal jaw closure and malocclusion

524.50 Dentofacial functional abnormality, unspecified

524.51 Abnormal Jaw closure

524.52 Limited mandibular range of motion

524.53 Deviation in opening and closing of the mandible

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524.59 Other dentofacial functional abnormalities

524.6 Temporomandibular joint disorders (excludes current temporomandibular dislocation and strain)

524.60 Temporomandibular joint disorders, unspecified

524.61 Adhesions and ankylosis (bony or fibrous)

524.62 Arthralgia of Temporomandibular joint

524.63 Articular disc disorder (reducing or non-reducing)

524.64 TMJ sounds on opening and/or closing

524.69 Other specified temporomandibular joint disorders

526.89 Other specified diseases of the jaw-unilateral condylar hyperplasia of mandible (this classification is an exclusion from major anomalies jaw size)

(710-739) Diseases of the musculoskeletal system and connective tissue:

710-719 Arthropathies and related disorders (these entities include pyogenic arthritis, condrocalcinosis, arthropathies, acromegaly, rheumatoid arthritis,osteoarthritis)

730.XX Osteomyelitis, acute and chronic

733.4 Aseptic necrosis of bone

733.45 Jaw

733.49 Other

(780-799) Symptoms, Signs and ill-defined conditions:

782.2 Localized superficial swelling, mass or lump

784.0 Headache

(830-839) Dislocation:

830 Dislocation of jaw (includes jaw, cartilage, meniscus, mandible, maxilla and temporomandibular joint)

830.0 Closed dislocation

830.1 Open dislocation

(840-848) Sprains and strains of joints and adjacent muscles:

848.1 Jaw-temporomandibular (joint), (ligament)

(996-999) Complications of surgical and medical care, not elsewhere classified

996.40 Unspecified mechanical complication of internal orthopedic device, implant, and graft

996.41 Mechanical loosening of prosthetic joint

996.42 Dislocation of prosthetic joint

996.43 Prosthetic joint implant failure

996.44 Peri-prosthetic fracture around prosthetic joint

996.45 Peri-prosthetic osteolysis

996.46 Articular bearing surface wear of prosthetic joint

996.47 Other mechanical complication of prosthetic joint implant

996.49 Other mechanical complication of other internal orthopedic device, implant, and graft

Additional classifications that influence the patient's health status and direct contact with health care providers are classified as V-codes. Two codes that have bearing relative to temporomandibular joint disorders are:

V41.6 Problems with swallowing and mastication

V72.2 Comprehensive dental examination (to be used only as a primary diagnosis code)

V15.88 Personal history of fall

V17.81 Family history of Osteoporosis

V17.89 Family history of other musculoskeletal diseases

A supplementary classification of external causes of injury can provide additional information related to diagnosis coding. One particular code relates to a surgical or medical procedure as the cause of an abnormal reaction in the patient or of a later complication. This would apply for code E878.1, a surgical operation with implant of artificial device (e.g., Proplast Teflon Implant).

Neoplasms can be coded by anatomical site and identified as malignant, benign, in-situ, uncertain behavior or unspecified. This is found within the alphabetic index and the tabular list should be used for final refinement.

IV. CPT PROCEDURAL CODES FOR TEMPOROMANDIBULAR JOINT SURGERY

The CPT procedural codes fall into two categories; diagnostic imaging and musculoskeletal system surgery. The diagnostic radiology and diagnostic imaging include codes 70328 through 70355 and 70486 through 70488 for temporomandibular joint imaging.

70328 Radiologic examination, temporomandibular joint, open and closed mouth; unilateral

70330 bilateral

70332 Temporomandibular joint arthrography, radiological supervision and interpretation

70336 Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)

70350 Cephalogram, orthodontic

70355 Orthopantogram (eg, panoramic x-ray)

70486 Computed tomography, maxillofacial area; without contrast material

70487 with contrast material(s)

70488 without contrast material, followed by contrast material(s) and further sections

The musculoskeletal procedure codes include:

20552 Injection(s); single or multiple trigger point(s), one or two muscle(s)

20553 Injection(s); single or multiple trigger point(s), three or more muscle(s)

20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular)

21025 Excision of bone (e.g., for osteomyelitis or bone abscess); mandible

21040 Excision of benign tumor or cyst of mandible; by enucleation and/or curettage

21044 Excision of malignant tumor of mandible

21045 radical resection

21046 Excision of benign tumor or cyst of mandible; requiring intraoral osteotomy

21047 requiring extra-oral osteotomy and partial mandibulectomy

21050 Condylectomy, temporomandibular joint (separate procedure)

21060 Meniscectomy, partial or complete, temporomandibular joint (separate procedure)

21073 Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)

21085 Impression and custom preparation; oral surgical splint

21110 Application of interdental fixation device for conditions other than fracture or dislocation, includes removal

21116 Injection procedure for temporomandibular joint arthrography

21240 Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)

21242 Arthroplasty, temporomandibular joint with allograft

21243 Arthroplasty, temporomandibular joint, with prosthetic joint replacement

21247 Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)

21255 Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)

21450 Closed treatment of mandibular fracture; without manipulation

21451 with manipulation

21465 Open treatment of mandibular condylar fracture

21480 Closed treatment of temporomandibular dislocation; initial or subsequent

21485 complicated (e.g. recurrent requiring intermaxillary fixation or splinting), initial or subsequent

21490 Open treatment of temporomandibular dislocation

21497 Interdental wiring, for condition other than fracture

29800 Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)

29804 Arthroscopy, temporomandibular joint, surgical (Note: surgical arthroscopy always includes diagnostic arthroscopy)

21299 Unlisted craniofacial/maxillofacial procedure

21499 Unlisted musculoskeletal procedure, head

For appropriate anesthesia / sedation coding refer to the *Coding for Anesthesia Services* Coding Paper.

For Non-Arthroscopic Lysis, Lavage and Manipulation, the CHCA has recommended using:

21299 Unlisted Craniofacial Procedure

20605 Arthrocentesis, TMJ Anesthesia Code or Modifier

Or if the carrier accepts HCPCS Level II codes, can use:

D7871 Non-arthroscopic lysis and lavage

V. GLOBAL SURGICAL PACKAGE

The global surgical package concept must be considered in the reporting of CPT codes. It is determined by CPT that the use of the procedure code on a claim form will cover, subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical), the surgical care (the operation) and postoperative care in the hospital and in the office. This will cover a follow-up period of 90 days. The proper usage of CPT and ICD-9-CM codes will allow accurate reporting of surgical services provided by oral and maxillofacial surgeons.

Coding Paper

Note: This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided to you in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by you or anyone else in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisers.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery (OMS). This paper discusses coding for Temporomandibular Surgery. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-9-CM) and treatment (CPT/CDT) coding for Temporomandibular Surgery. When indicated, you will be referred to the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical, and dental services. Diagnostic and procedure codes are continually updated or revised. The AAOMS Committee on Health Care and Advocacy has developed these coding guidelines in order to assist the membership to use the coding systems effectively and efficiently.

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