Coding Paper

American Association of Oral and Maxillofacial Surgeons

Coding for Oral Implants

I. INTRODUCTION

Dental implants have evolved to be a more accepted benefit provided by the OMS based on popularity and advancements over the past several years. However, third-party reimbursement still remains somewhat inconsistent. It is important to clearly communicate to the carrier that the primary purpose of the implant procedure is to correct defective structures in order to restore function to the compromised patient. Various diagnostic codes help "paint the clinical picture" for the third party. In choosing among available codes, remember to formulate an accurate appraisal that is based on the patient's complaints as well as the objective clinical and radiographic findings.

II. ICD-10-CM DIAGNOSIS CODES

Diagnosis codes that may be appropriate for use in implant cases may be found in the following ICD-10-CM categories of codes:

G50	Disorders of trigeminal nerve
J34	Other and unspecified disorders of nose and nasal sinuses
K00	Disorders of tooth development and eruption
K08	Other disorders of teeth and supporting structures
K11	Diseases of salivary glands
K12	Stomatitis and relation lesions
M27	Other diseases of jaws
M81	Osteoporosis without current pathological fracture

Note: This list of associated ICD-10-CM codes is not all-inclusive and includes only the code categories in which an applicable diagnosis code may be found. Some of the codes within these ranges will require the use of a placeholder and/or additional characters. Refer to an ICD-10-CM coding manual to ensure submission of a complete valid code. Appropriate and correct diagnostic coding requires use of both the index describing a condition and the tabular list for confirmation of the specific condition.

III. CPT PROCEDURE CODING

The CPT procedural codes for use in implant reconstruction cases are relatively straightforward in terms of the primary procedure and include the following:

21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete

CPT codes 21248 and 21249 describe reconstruction of the mandible or maxilla with endosteal implants, but they are categorized broadly as "partial" or "complete." The distinction is not based on the number of implants placed per tooth, but rather on the extent of the arch involved.

For instance, CPT code 21248 is reported when three or fewer teeth are replaced or when less than one-half of the dental arch is reconstructed. CPT code 21249 is reported when four or more teeth are replaced or when more than one-half of the arch is reconstructed. Teeth are not itemized separately under CPT, meaning the coding framework is fundamentally different from CDT. Because CDT codes focus on individual tooth implants and CPT codes focus on partial versus complete arch reconstruction, they cannot be mapped one-to-one. Attempting to crosswalk these codes directly would misrepresent the

scope of treatment and lead to inaccurate reporting.

While CPT codes 21248 and 21249 are technically appropriate for implant reconstruction, carriers often interpret and reimburse them differently – for example, applying one flat fee per code regardless of how many implants are placed. To avoid confusion and ensure accurate reporting, if a medical payer accepts HCPCS Level II dental codes, the AAOMS Committee on Healthcare Policy, Coding and Reimbursement recommends reporting CDT/HCPCS code D6010 instead, since it is reported per implant and aligns more clearly with the actual procedure performed.

In addition, CPT codes 21248/21249 include surgically placing the implant device, exposing the integrated implant and providing abutment posts. If abutment posts are not provided, append modifier –52 when reporting the initial procedure.

Note: There is a CCI edit indicating that 21249 and 21248 cannot be reported together on the same DOS unless the procedures meet the criteria for being a distinct procedural service.

According to the CPT manual, examples of this criteria may include: different session, different procedure or surgery, different site or organ system, separate incisions/ excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual.

Some of the CPT codes that may be utilized for the more common concurrent procedures include:

21208	Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	Graft, bone; mandible (includes obtaining graft)

Note: CPT codes 21210 and 21215 are commonly performed in concert with autogenous bone harvest from the anterior or posterior iliac crest. Both codes are reflective of complex, reconstructive procedures and carry high relative value units (RVUs) accordingly. As such, the AAOMS Committee on Healthcare Policy, Coding and Reimbursement emphasizes the use of clinical discretion when crosswalking grafting codes from CDT to CPT as the appropriateness of crosswalking is based on both the intensity of the procedure and degree of reconstruction; therefore, these code may not be appropriate when reporting in conjunction with implants. In the cases of minor reconstructions, the CDT code itself would be more appropriate to report for both dental and medical carriers. CDT bone graft codes are discussed in the Coding Bone Grafts *Coding Paper*.

A sinus lift is essentially a bone graft to the maxilla. As such, this procedure may be reported to a medical carrier using CPT code 21210. When utilizing freeze-dried synthetic bone materials (non-autogenous bone materials only) without surgical bone graft harvesting, modifier –52 should be appended to code 21210 with a corresponding appropriate reduction in the fee. The reduced modifier is necessary as harvesting of the bone was not performed. The material cost of the freeze-dried or synthetic bone, if supplied by the surgeon, may be reported by utilizing CPT code 99070 (*Supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies or materials provided)* along with an invoice to account for the additional supply cost.

IV. CODING THE REMOVAL OF IMPLANTS

Utilize CPT codes 20670 (removal of implant; superficial) or 20680 (removal of implant; deep) to code the removal of implants.

ICD-10-CM diagnostic codes that may be considered for implant failure may be found within the code category M27 – Other diseases of jaws or T85.7 – Infection and inflammatory reactions due to other internal prosthetic devices, implants and grafts.

V. SAMPLE CASE OF CODING FOR IMPLANTS – DENTAL

A 55-year-old patient recently had an implant placed in site #30 to replace a congenitally missing tooth. The implant is failing due to peri-implantitis. The implant will be removed, the site will require a bone graft, and a resorbable collagen membrane will be used to cover the graft. After a period of healing, a surgical guide is fabricated, and an endosseous implant is placed.

Procedures:

1. Surgical removal of implant from #30 site.
2. Bone graft at the time of implant removal.
3. Resorbable membrane at the time of implant removal.
4. Fabrication of a surgical guide.
5. Replace implant at #30 site with one of larger diameter and shorter length at a subsequent date.

Diagnoses

M27.62, K00.0

Failed, dental implant, due to, periodontal infection

Absence, teeth, congenital

CDT

D6100	surgical removal of implant
D7953	bone graft at the time of implant removal
D7956	membrane, edentulous area, resorbable
D6190	surgical guide, by report
D6010	new implant placement

VI. CDT PROCEDURE CODES

CDT provides an in-depth list of codes with reporting implants and related procedures. These codes may be found in the Implant Services, Oral and Maxillofacial Surgery and Periodontics categories of the CDT coding manual.

Common CDT codes for the OMS to consider when reporting implant services may include:

D6010	surgical placement of implant body; endosteal implant
D6011	surgical access to an implant body (second-stage implant surgery)
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6013	surgical placement of mini implant
D6040	surgical placement; eposteal implant (subperiosteal)
D6050	surgical placement; transosteal implant
D6051	interim implant abutment placement
D6055	dental implant supported connecting bar
D6056	prefabricated abutment – includes placement
D6057	custom abutment – includes placement
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
D6081	scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocekt depts; includes cleaning of the implant surfaces, without flap entry and closure
D6085	interim implant crown
D6089	accessing and retorquing loose implant screw - per screw
D6090	repair of implant/abutment supported prosthesis
D6091	replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6096	remove broken implant retaining screw
D6100	surgical removal of implant body
D6101	debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure
D6102	debridement and osseous contouring of a peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure
D6103	bone graft for repair of peri-implant defect
D6104	bone graft at time of implant placement; placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately
D6105	removal of implant body not requiring bone removal or flap elevation

D6114 implant/abutment supported fixed denture for edentulous arch-maxillary

D6115 implant/abutment supported fixed denture for edentulous arch-mandibular

D6116 implant/abutment supported fixed denture for partially edentulous arch-maxillary

D6117 implant/abutment supported fixed denture for partially edentulous arch-mandibular

D6118 implant/abutment supported interim fixed denture for edentulous arch-mandibular

D6119 implant/abutment supported interim fixed denture for edentulous arch-maxillary

D6180 implant maintenance procedures when a full arch hybrid prosthesis is not removed, including cleansing of prosthesis and abutments

Note: CDT code D6180 may be reported per arch when a provider performs implant maintenance and the prosthesis is not removed.

D6190 radiographic/surgical implant index, by report

Note: CDT code D6190 may be reported when a radiographic/implant index guide or surgical guide is fabricated. D6190 may be used to report different types of surgical guides, including digital, nondigital, fully or partially guided and single or multiple units. The code nomenclature indicates "by report" therefore a narrative should be submitted with the claim.

D6191 semi-precision abutment – placement

D6192 semi-precision abutment – placement

D6193 replacement of an implant screw

Note: CDT code D6193 may be reported when an implant screw cannot be retorqued and the provider determines an implant screw is at risk for breakage and needs to be replaced.

D6198 remove interim implant component

D6199 unspecified implant procedure, by report

D7939 indexing for osteotomy using dynamic robotic assisted or dynamic navigation

Note: D7939 is reported when dynamic robotic assisted or navigation is utilized to create the index for osteotomy position instead of a static guide. CDT code D7939 does not include the placement of the implant; therefore, implant placement may be reported separately.

D7993 surgical placement of craniofacial implant – extra oral

D7994 surgical placement: zygomatic implant

The following codes also may be considered when reporting blood products, osseous contouring, bone replacement grafts and the placement of biologic materials to aid in osseous regeneration.

D7921 collection and application of autologous blood concentrate product

Note: Platelet-rich plasma (PRP), when appropriate, may also be reported with 0232T injection(s), platelet-rich plasma, any tissue, including image guidance, harvesting and preparation when performed. Code 0232T is a Category III CPT code, which is a temporary code describing an emerging technology, service and/or procedure that may or may not eventually be converted to a Category I CPT code.

D7922 placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site

D7950 osseous, osteoperiosteal or cartilage graft of the mandible or maxilla-autogenous or non-autogenous, by report (use this code for ridge augmentation or reconstruction to increase the alveolar ridge height, width and/or volume; includes obtaining autograft and/or allograft material)

D7951	sinus augmentation with bone or bone substitutes via a lateral open approach (the augmentation of the sinus cavity to increase the alveolar height for reconstruction of edentulous portions of the maxilla; the procedure is performed via a lateral open approach; this includes obtaining the bone and/or bone substitutes; placement of a barrier membrane, if used, should be reported separately)
D7952	sinus augmentation via a vertical approach (the augmentation of the sinus to increase alveolar height by vertical access through the ridge crest by raising the floor of the sinus and grafting as necessary; this includes obtaining the bone or bone substitutes)
D7953	bone replacement graft for ridge preservation – per site (osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of tooth extraction to preserve the alveolar ridge integrity)
D7295	harvest of bone for use in autogenous grafting procedures
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site
D4266	guided tissue regeneration , natural teeth – resorbable barrier, per site
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site
D4286	removal of non-resorbable barrier
D6106	guided tissue regeneration - resorbable barrier, per implant
D6107	guided tissue regeneration - non-resorbable barrier, per implant
D7956	guided tissue regeneration, edentulous area - resorbable barrier, per site
D7957	guided tissue regeneration, edentulous area - non-resorbable barrier, per site

AAOMS offers the Coding for Implants and Bone Grafts course as well as the *Coding Bone Grafts* Coding Paper, which provides further coding guidance.

Coding Paper

Note: The list of CDT, CPT and ICD-10-CM codes in this coding paper is not all-inclusive. AAOMS recommends reporting codes applicable to the service(s) rendered and the patient's specific clinical condition as determined by the provider.

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 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 anyone in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-10-CM) and treatment (CPT/CDT) coding for oral implants. When indicated, reference 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 regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.

Revised January 2026