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American Association of Oral and Maxillofacial Surgeons

Coding Paper

Coding for Orthognathic Surgery and/or Obstructive Sleep Apnea

I. INTRODUCTION

This paper discusses coding for orthognathic surgery and obstructive sleep apnea (OSA) diagnosis and surgery. Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are continually updated or revised. Familiarity and compliance with coding guidelines – particularly ICD-10-CM diagnostic coding and CPT, HCPCS and CDT – are necessary to use these codes successfully. The information is presented in three sections, mirroring the chronological evaluation of an orthognathic and/or OSA case.

II. EVALUATION AND MANAGEMENT SERVICES

A detailed discussion of Evaluation and Management (E/M) services is beyond the scope of this paper. However, it should be noted that E/M codes require a medically appropriate history and/or physical examination; however, code selection is based on either the level of Medical Decision Making or total time spent on the date of the encounter. Time-based coding may be particularly relevant in oral and maxillofacial surgery due to the extensive data acquisition and pre-operative consultation often required. According to CPT guidelines, the nature and extent of this examination are determined by the treating physician. For patients being evaluated for orthognathic surgery or for the treatment/management of OSA, such may include examination of soft tissues and musculoskeletal functionality, evaluation of speech and masticatory function, classification and measurement of occlusal relationship and facial measurements, sleep apnea testing or sleep study, nasopharyngoscopy, as well as a comprehensive dental examination. Appropriate diagnostic imaging and articulated study models are often crucial adjuncts in the patient's evaluation.

The CPT manual provides detailed guidelines for selecting the appropriate level of E/M service, as well as specific guidance for certain categories of E/M visits. This information may be found in the beginning of the E/M chapter within CPT. OMSs are encouraged to familiarize themselves with these guidelines for appropriate code selection of E/M services. Although it is not unusual to have contact with such patients in various care settings, most will be seen for an evaluation on an outpatient basis, such as in an oral and maxillofacial surgery office. Place of service codes to be mindful of include:

Office	11
Inpatient Hospital	21
On Campus – Outpatient Hospital	22

III. CODING FOR ORTHOGNATHIC SURGERY PRE-SURGICAL WORK-UP

Several codes may be considered to report the individual components of a pre-surgical work-up. CPT codes are primarily used to report OSA as well as other syndromes and conditions requiring orthognathic surgery because such conditions may be considered by payers to be generally medical-in-nature rather than categorized as dental services. However, with the adoption of nationally recognized code sets under HIPAA Administrative Simplification, CDT or "D-codes" may be reported to a medical carrier if an appropriate CPT code is not available. For 2D imaging services provided as part of an orthognathic work-up, consider the following codes:

70350/ D0340	Cephalogram, orthodontic
70355/ D0330	Orthopantogram (e.g., panoramic X-ray)
70100	Radiologic examination, mandible; partial, less than 4 views
70110	Radiologic examination, mandible; complete, minimum of 4 views
70140	Radiologic examination, facial bones; less than 3 views
70150	Radiologic examination, facial bones; complete, minimum of 3 views

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D0350 2D oral/facial photographic image obtained intra-orally or extra-orally

D0701 panoramic radiographic image – image capture only

D0702 2-D cephalometric radiographic image – image capture only

D0703 2-D oral/facial photographic image obtained intraorally or extra-orally – image capture only

Diagnostic 3D assessment of patients continues to increase for orthognathic or other craniofacial surgical planning. Under CPT, most diagnostic imaging and/or radiology services, although described by a single code, include two distinct portions: a *professional* component and a *technical* component.

The professional component provided by an OMS may include supervision, interpretation and a written report that reflects the OMSs independent diagnostic findings. To claim only the professional portion of a service, append modifier –26 (Professional Component) to the appropriate CPT code. Modifier –26 is appropriate when an OMS reviews or interprets an X-ray taken elsewhere.

The technical component of a service includes the provision of all equipment, supplies, personnel and costs related to taking the image. To claim only the technical portion of a service, append modifier –TC (Technical Component) to the appropriate CPT code. Modifier –TC is appropriate when an OMS office captures the image but forwards the data elsewhere for interpretation.

If an image is taken in the same office as the OMS who interprets the image and provides a written report, there is no need to append a modifier.

To report 3D imaging services, consider the following codes:

70486 Computed tomography, maxillofacial area; without contrast material

70487 Computed tomography, maxillofacial area; with contrast material(s)

70488 Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections

70544 Magnetic resonance angiography, head; without contrast material(s)

70545 Magnetic resonance angiography, head; with contrast material(s)

70547 Magnetic resonance angiography, neck; without contrast material(s)

70548 Magnetic resonance angiography, neck; with contrast material(s)

Other MRI codes of the head and neck that may be applicable include 70546 and 70549.

Three-dimensional image postprocessing is a distinct diagnostic procedure that describes a separate process that can be applied to a CT, MRI, ultrasound or other tomographic modality (e.g., tomographic refers to imaging by sections or sectioning). This service captures the 3D reconstruction or 3D manipulation that takes place after the image has been taken. For example, surgical planning software merges digital cast data with the CBCT DICOM file to create a complete 3D model. This 3D model may be used for specific measurements (such as identifying the type of malocclusion or overjet in orthognathic evaluations) or to plan the location and angle of placement for Endosseous implants. Postprocessing manipulation performed by the OMS on his or her own equipment may be additionally reportable. Consider the following CPT codes for reporting such services:

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

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

Note: Coding and reimbursement for supplemental products such as cutting guides, osteogenesis parallel guides and titanium plates may be dependent upon the place of service, the nature of the surgical procedure or

inclusive to the postprocessing component and therefore not separately reportable.

There are CDT codes for cone beam imaging (also called 3D imaging) that may be applicable in the radiographic assessment of some patients. Code selection will depend on several factors, including the desired field of view and whether the OMS captures and/or interprets the 3D image. In CDT terminology, "capture" refers to the acquisition of the CBCT scan, while "interpretation" refers to the clinician's documented diagnostic evaluation and written report of the findings. Consider the following CDT codes:

Image with Interpretation

D0364 cone beam CT capture and interpretation with limited field of view – less than one whole jaw

D0365 cone beam CT capture and interpretation with field of view of one full dental arch – mandible

D0366 cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium

D0367 cone beam CT capture and interpretation with field of view of both jaws; with or without cranium

D0368 cone beam CT capture and interpretation for TMJ series including two or more exposures

Image Capture Only

D0380 cone beam CT image capture with limited field of view – less than one whole jaw

D0381 cone beam CT image capture with field of view of one full dental arch – mandible

D0382 cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium

D0383 cone beam CT image capture with field of view of both jaws, with or without cranium

D0384 cone beam CT image capture for TMJ series including two or more exposures

D0706 intraoral – occlusal radiographic image – image capture only

D0709 intraoral – comprehensive series of radiographic images – image capture only

Additional CDT imaging codes that may be used to report 3D surface scans as part of the pre-surgical work-up include:

D0801 3D intraoral surface scan – direct

D0802 3D dental surface scan – indirect

D0803 3D facial surface scan – direct

D0804 3D facial surface scan – indirect

For these services, the term "direct" means that the patient is present when the image is captured. For example, when an intraoral camera is used to capture digital images directly in the patient's mouth. On the other hand, "indirect" means the patient is not present when the image is captured. For instance, when a diagnostic model, impression or 3D printed model is scanned to create a 3D surface scan.

CDT code D0396 is reported for the printing of a physical model (similar to a tooth cast or jaw model) after a surface scan.

D0396 3D printing of a 3D surface scan

As with CPT, virtual treatment simulation or postprocessing of images or image sets is a separate procedure that may be reported with the appropriate CDT codes. Consider the following:

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

Coding tip: CDT code D0393 is used to report the merging of the CBCT data, digital cast information, digital waxup or prosthetic plan, and the virtual planning of the implant position. The use of 3D or virtual treatment simulation using image volumes may be used in the pre-surgical work-up for several different types of procedures including, but not limited to, dental implant placement, orthognathic surgery and orthodontic tooth movement.

D0395 fusion of two or more 3D image volumes of one or more modalities

As digital technology evolves, computer-aided digital workflow continues to streamline the pre-surgical planning process for OMSs. Computer-aided digital workflow, which may also occasionally be referred to simply as digital workflow or CAD-CAM, utilizes various combinations of CBCT DICOM Data, digital surface scans and specialized software, along with 3D printing technology to create a completely virtual surgical walk through of the planned surgical procedure.

Historically, orthognathic surgery relied upon cephalometric films and tracings to plan surgical movements. With the advancement of surgical software programs, facial tracings are being replaced with virtual 3D images, splint fabrication, treatment planning at a computer and the use of 3D-printed titanium fixation hardware and cutting guides.

Coding tip: There may not always be a CPT code available that accurately describes the item or service furnished to the patient. For example, there are no CPT codes to describe diagnostic casts (D0470) or 3D surface scans. Therefore, when furnished as part of the digital workflow, the CDT codes for these services would be appropriate to report both the dental and medical carriers, when applicable.

As part of the digital workflow, diagnostic casts and bite registration may be scanned and compiled into a virtual template that allows for virtual surgery on the computer. If utilizing 3D surface scan technology, the images may be uploaded directly into the surgical planning software. Highly skilled engineers and the oral and maxillofacial surgeon participate in the planning session to complete the virtual surgical movements and place the patient in the final position.

Once the ideal post-surgical placement is established, a surgical splint may be prepared and fabricated. The surgical adjunct is tailored to fit the patient's anatomy and surgical plan and guides the surgeon during the procedure, ensuring the bones or teeth are repositioned precisely as planned. The digital workflow also can be used to plan and fabricate intermediate splints for multi-phase surgeries, or surgical cutting guides and fixation hardware that guide the surgeon for osteotomies to avoid damage to other structures. The digital planning process also is particularly valuable in two-jaw cases as it allows for accurate planning and execution of complex movements and alignments.

Note: An OMS may opt to have an outside laboratory fabricate an oral surgical splint. Appropriate reporting of this service, as determined by who fabricates it, is discussed later in this paper.

As technology advances, more aspects of the surgical planning and device fabrication processes are becoming fully digitally enabled. For example, an OMS may opt to utilize digital scanning software in lieu of traditional impressions or a cast model. In this scenario, a software program is used to take STL formatted data generated from the intraoral scan to design a surgical splint. This all-digital workflow allows the pre-surgical work-up process to take place entirely in-house, which may be advantageous to both the OMS and the patient.

It is important to note that there is not one specific code under either CPT or CDT for reporting computer-aided digital workflow. However, there are codes that may be reported based on the individual components of the virtual planning session, as well as the technology utilized. For more information, refer to the AAOMS *Coding the Digital Workflow* Coding Paper.

Under the Oral and Maxillofacial Surgery Category of Service in CDT are a family of codes that may be reported by the OMS as adjuncts to orthognathic surgery or when managing a patient with a skeletal malocclusion or other dentoalveolar disorder(s): temporary anchorage devices (TADs). The OMS may consider the following CDT codes:

D7292 placement of temporary anchorage device [screw-retained plate] requiring flap

D7293 placement of temporary anchorage device requiring flap

D7294 placement of temporary anchorage device without flap

Coding tip: The codes for TAD placement do not include removal. To report the removal of temporary anchorage devices, refer to CDT codes D7298, D7299 or D7300, as appropriate.

Under both CPT and CDT, codes exist to report intraoral or interdental fixation that applies to "the placement of

an intermaxillary fixation appliance used for documented medically accepted treatments not in association with fractures."

Consider the following:

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

D7998 intraoral placement of a fixation device not in conjunction with a fracture

IV. OSA AND ORTHOGNATHIC SURGERY

Because OSA and orthognathic surgery are more likely to be considered for coverage under medical insurance rather than dental, it is the recommendation of the AAOMS Committee on Healthcare Policy, Coding and Reimbursement that the oral and maxillofacial surgeon utilize CPT codes rather than the American Dental Association's CDT codes to report surgical services. The codes describing orthognathic and OSA surgical procedures may be found in several sections of the CPT manual's surgery chapter including the Musculoskeletal System, Respiratory System and Digestive System. Consider the following CPT codes to report orthognathic surgery and OSA surgical procedures:

20680 Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod, or plate)

Coding tip: Under Medicare or a resource-based relative value scale (RBRVS), the removal of a fixation device is not included in the surgical package of fracture repair codes unless the removal is specified in the description of the procedure. In these cases, the removal of a fixation device may be reported separately.

If the removal of the fixation device is performed during the global period of the fracture repair surgery, it may be necessary to append modifier –58 (Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period) to indicate to the insurance carrier that the second surgery (removal of device) was planned prior to or at the time of the initial procedure. In addition, postoperative radiographs are not part of the global package and are billable services with the appropriate codes.

21120 Genioplasty; augmentation (autograft, allograft, prosthetic material)

21121 Genioplasty; sliding osteotomy, single piece

21122 Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)

21141 Reconstruction midface, Le Fort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft

21142 Reconstruction midface, Le Fort I; 2 pieces, segment movement in any direction, without bone graft

21143 Reconstruction midface, Le Fort I; 3 or more pieces, segment movement in any direction, without bone graft

21145 Reconstruction midface, Le Fort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)

21146 Reconstruction midface, Le Fort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)

21147 Reconstruction midface, Le Fort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)

21150 Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)

21151 Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)

21154 Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I

21155 Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I

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21159 Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I

21160 Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I

21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft

21194 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)

21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation

21196 Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation

21198 Osteotomy, mandible, segmental;

21199 Osteotomy, mandible, segmental; with genioglossus advancement

21206 Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)

21685 Hyoid myotomy and suspension

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410 Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip

30420 Rhinoplasty, primary; including major septal repair

30430 Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

30435 Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)

30450 Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)

30460 Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only

30462 Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies

30465 Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal)

30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

30540 Repair choanal atresia; intranasal

30545 Repair choanal atresia; transpalatine

30560 Lysis intranasal synechia

30580 Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)

30600 Repair fistula; oronasal

30620 Septal or other intranasal dermatoplasty (does not include obtaining graft)

30630 Repair nasal septal perforations

31040 Pterygomaxillary fossa surgery, any approach

30801 Ablation, soft tissue of inferior turbinates, unilateral or bilateral; superficial

30802 Ablation, soft tissue of inferior turbinates, unilateral or bilateral; intramural

41120 Glossectomy; less than one-half tongue

42145 Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)

42200 Palatoplasty for cleft palate, soft and/or hard palate only

42821 Tonsillectomy and adenoidectomy

42975 Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing, flexible, diagnostic

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When treating orthognathic or OSA patients, procedures or services may be required in addition to those described by the previously listed codes. Examples of such codes include:

20902 Bone graft, any donor area; major or large

Coding tip: According to CPT guidelines, this code is used for obtaining autogenous bone or other tissues through a separate skin incision, but only when the harvest of the graft material is not included in the code or descriptor for the primary surgical service. For example, CPT code 21145 contains the phrase "includes obtaining autografts," therefore the harvest of the graft is inclusive to the procedure regardless of whether obtained via the same or separate incision. In this case, bone graft harvest would not be reported separately.

If the primary procedure does include obtaining the graft and the harvest is performed by a separate surgeon, the appropriate modifier should be used to indicate this to the insurance carrier. Depending on the specifics of the case, modifier –52 (Reduced Services) or modifier –62 (Two Surgeons) may be appropriate. In situations where another surgeon assists with the procedure, modifier –80 (Assistant Surgeon) may be used, or modifier –82 (Assistant Surgeon—when qualified resident surgeon is not available) when applicable.

For example, modifier –52 is used when a service or procedure is partially reduced or eliminated at the physician's discretion. In other words, appending modifier –52 indicates the OMS did not perform the entire procedure as described by the CPT code, including when a separate surgeon harvests the bone. In this case, the OMS would report the code that describes the surgical procedure and append modifier –52 while the surgeon who performs the graft harvest would use the appropriate CPT code to report the harvest (e.g., 20902).

On the other hand, if the OMS and another surgeon are both acting as primary surgeons performing distinct aspects of the same procedure, modifier –62 may be more appropriate. Each surgeon would report the same CPT code and append modifier –62 to indicate their co-surgeon status.

Note that not all surgical CPT codes may be eligible for co-surgeon billing. The Medicare Physician Fee Schedule Look-Up Tool is a helpful resource for determining the services for which two surgeons may be paid under Medicare rules. The Look-Up Tool is available at CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup. Many commercial carriers follow CMS rules, therefore it is important to confirm reporting and reimbursement guidelines with each payer prior to claim submission.

21210 Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)

21215 Graft, bone; mandible (includes obtaining graft)

Coding tip: When utilizing freeze-dried synthetic bone materials (non-autogenous bone materials only) without surgical bone graft harvesting, modifier –52 should be appended to either 21210 or 21215 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) 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.

For procedures that may not include bone grafting such as isolated malar bone grafting, there are two coding options.

20900 Bone graft, any donor area; minor or small

20902 Bone graft, any donor area; major or large

In general, many of the CPT codes found in the Musculoskeletal System section under Repair, Revision, and/or Reconstruction describe procedures that "includes obtaining graft." Therefore CPT bone graft codes such as codes 21210 and 21215 should not be reported in addition to these orthognathic surgical procedures unless the graft is unrelated to the jaw surgery. Refer to the AAOMS coding paper, *Coding Bone Grafts*, for additional details on coding bone graft services.

42226 Lengthening of palate, and pharyngeal flap

Note: May be indicated for velopharyngeal insufficiency/incompetence (VPI)

42280 Maxillary impression for palatal prosthesis

42281 Insertion of pin-retained palatal prosthesis

64582 Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array

64583 Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator

64584 Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array

92511 Nasopharyngoscopy with endoscope (separate procedure)

Note: Under CPT, certain services are designated with the term "separate procedure." This indicates a particular service is commonly carried out as an integral component of a total procedure. OMSs are encouraged to follow all applicable guidelines for code selection and/or reporting to avoid unnecessary claim denials and fraudulent billing practices such as routine unbundling.

Adjunctive Services in Orthognathic Surgery and OSA

Other services that may be considered adjuncts to orthognathic or OSA surgical procedures include:

0232T Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed

Note: 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. Depending on the carrier, an alternative may be to report CDT code D7921 collection and application of autologous blood concentrate product.

20999 Unlisted Procedure Musculoskeletal System

21085 Impression and custom preparation; oral surgical splint

Coding tips:

- The coding and ability to bill for the surgical splint depends on who is fabricating and supplying the prosthesis. CPT code 21085 may only be reported when the physician or other qualified healthcare professional designs and prepares the prosthesis (e.g., not prepared by an outside laboratory or when the vendor is fabricating and supplying the splint). In other words, when the splint is not fabricated by an outside laboratory. If the OMS does not fabricate the surgical splint, consider the following coding scenarios: 1) If taking traditional or alginate impressions in the office, CPT code 99070 may be reported and submitted with a copy of the lab invoice to account for the supplies and materials used or 2) CPT code 21085 may be reported with a reduced services modifier -52 to indicate to the payer the fabrication services were performed elsewhere. Reporting and reimbursement guidelines may vary by payer; therefore, it is best practice to confirm with the insurance carrier how such services should be reported.
- An OMS may use intraoral scanning software and a 3D printer to digitally design and fabricate a surgical splint. In this case, it would be appropriate to report 21085 to capture the work preparing the prosthesis. Any imaging services, as well as image manipulation and/or postprocessing or 3D printing of a 3D surface scan, are separately reportable, as applicable to the patient encounter.
- There may be instances when a patient requires two separate splints on the maxilla and mandible on the same date of service (e.g., when undergoing maxillomandibular advancement for treatment of sleep apnea or in orthognathic/reconstructive surgery when two splints – an intermediate and final – are required for proper positioning of both jaws on the same day). CPT code 21085 is assigned a Medically Unlikely Edit (MUE) of 2 and a Medicare Administrative Indicator (MAI) of 3. This permits reporting of both an intermediate and final splint on the same date of service when documentation supports the need for both surgical splints.

  Additionally, because CPT code 21085 carries a 10-day

global period, an OMS may consider rendering and reporting 21085 11 days or more prior to the surgical procedure to avoid the procedure being denied within the global period of the surgical service.

21089 Unlisted maxillofacial prosthetic procedure

Coding tip: There is no CPT code to report the design and preparation of a sleep apnea device. Therefore, 21089 may be used when the OMS takes an impression of the area and fabricates the sleep apnea device. As with any unlisted procedure code, it is best to include a detailed description of the service or device with claim submission. Alternatively, if an outside laboratory is fabricating the appliance, CPT supply code 99070 may be reported. An invoice from the laboratory and detail narrative should accompany the claim when reporting this code.

E0485 Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment

E0486 Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment

Coding tip: It is important to confirm whether the HCPCS Level II "E" codes are acceptable when submitted by an OMS, as some payers may require a doctor to be enrolled as a DME supplier in order to report these codes.

For patients undergoing orthognathic surgery, a compression or pressure bandage may be used for postoperative jaw support. When furnished by the OMS, this may be reported using CPT 99070 (supplies and materials) and submitted to the insurance carrier with supporting documentation and/or an invoice, if applicable. However, it is important to note that reporting and reimbursement guidelines may vary by payer.

CDT and CPT Category III Codes for Sleep Apnea-Related Services

Services related to sleep apnea appliances and oral appliance therapy may be reported using the following CDT and CPT Category III codes (HCPCS Level I):

CDT Codes (Sleep Apnea Appliances & OAT Services):

D9947 Custom sleep apnea appliance fabrication and placement

D9948 Adjustment of custom sleep apnea appliance

D9949 Repair of custom sleep apnea appliance

D9953 Reline custom sleep apnea appliance (indirect)

D9954 Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device

D9955 Oral appliance therapy (OAT) titration visit

D9956 Administration of home sleep apnea test

D9957 Screening for sleep-related breathing disorders

Category III Codes (effective July 2025):

0964T Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; single arch, without mandibular advancement mechanism

0965T Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, non-fixed hinge mechanism

0966T Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, fixed hinge mechanism

V. DISTRACTION OSTEOGENESIS

Distraction osteogenesis may be performed using either an external or internal (intraoral) distraction device. The placement of an external distractor or fixator may be reported using CPT code 20690 or 20692. In terms of reporting an internal distraction device, it is the opinion of the Committee on Healthcare Policy, Coding and Reimbursement that this type of device may be reported one of two ways, based on the clinical discretion of the surgeon: 1) use the existing CPT codes that describe external fixation devices (i.e., 20690 or 20692) or 2) report an unlisted CPT code and submit detailed clinical documentation, including operative report and an explanation of the device.

When coding for distraction osteogenesis procedures, there may be instances in which the primary surgical service is not carried out to completion based on the description of the code. For instance, if the revision, repair or construction of an osteotomy is not carried out in its entirety, (e.g., procedure was performed unilaterally) appending modifier –52 to the surgical CPT code would be appropriate.

There also may be certain circumstances in which an OMS may consider appending modifier –22 to reflect greater than normal complexity. For instance, when performing a mandibular advancement using distraction osteogenesis on a neonate, the patient's age may add a significant level of complexity to the procedure.

Note: If adjustment of an external distractor device requires IV sedation or general anesthesia, report CPT code 20693 Adjustment or revision of external fixation system requiring anesthesia (e.g., new pin[s] or wire[s] and/or new ring[s] or bar[s]). According to CPT Assistant, 20693 would be appropriately reported only when anesthesia is required to provide an adjustment or revision of the external fixation system following the initial application of the system. If an external distractor is adjusted without anesthesia or with only local anesthesia within the global period, the service is not billed. CPT code 20694 Removal, under anesthesia, of external fixation system may be reported when IV sedation or general anesthesia is required to perform removal of the external fixator system. Removal of the external fixator performed without anesthesia is not a separately reportable procedure according to CPT. The terms "requiring anesthesia" and "under anesthesia" included in codes 20693 and 20694 are used to indicate the complexity of the service as described by the codes. In other words, anesthesia administration is not included in these services. If the insurance company allows coverage for anesthesia by surgeon, the anesthesia services may be reported separately.

VI. MODIFIERS FOR SURGERY

The following code modifiers may likely have some application in the reporting of services for OSA/ orthognathic surgery. Refer to Appendix A of the CPT manual for complete descriptions for each modifier:

–50	Bilateral Procedure
–51	Multiple Procedures
–52	Reduced Services
–58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
–62	Two Surgeons
–66	Surgical Team
–80	Assistant Surgeon

Note: HCPCS modifier -AS is used to indicate when a licensed physician assistant, nurse practitioner or clinical nurse specialist served as the assistant at surgery. The determination of whether a physician assistant or other type of non-physician practitioner may serve as an assistant-at-surgery typically depends on the specific state medical or dental practice acts and regulations. Such rules vary by state and define the scope of practice for healthcare professionals, including physicians and non-physician practitioners.

VII. ICD-10-CM CODING FOR OSA AND/OR OTHER SYNDROMES AND CONDITIONS REQUIRING ORTHOGNATHIC SURGERY

Correct usage of the CPT (procedural) and the ICD-10-CM (diagnosis) coding systems requires that the appropriate ICD-10-CM codes be linked to the surgical procedures listed in the CPT universe. Diagnosis codes for OSA and other disorders requiring orthognathic surgery may be found in the following ICD-10-CM categories:

D56	Thalassemia
D57	Sickle-cell disorders
E22	Hyperfunction of pituitary gland
E23	Hypofunction and other disorders of the pituitary gland
E78	Disorders of lipoprotein metabolism and other lipidemias
G43	Migraine
G47	Sleep disorders

K00	Disorders of tooth development and eruption
M26	Dentofacial anomalies [including malocclusion]
M27	Other diseases of jaws
M85	Other disorders of bone density and structure
M89	Other disorders of bone
M95	Other acquired deformities of musculoskeletal system and connective tissue
Q67	Congenital musculoskeletal deformities of head, face, spine and chest
Q74	Other congenital malformation of limb(s)
Q75	Other congenital malformation of skull and face bones
Q77	Osteochondrodysplasia with defects of growth of tubular bones and spine
Q78	Other osteochondrodysplasias
Q79	Congenital malformations of musculoskeletal system, not elsewhere classified
Q87	Other specified congenital malformation syndromes affecting multiple systems
Q97	Other sex chromosome abnormalities, female phenotype, not elsewhere classified
Q98	Other sex chromosome abnormalities, male phenotype, not elsewhere classified

The list of associated ICD-10-CM code categories is not all-inclusive. It merely represents select ICD-10-CM categories under which applicable diagnosis codes may be found. Some of the codes within these ranges require the use of a placeholder and/or additional characters or digits. Reference current ICD-10-CM coding manual guidelines to ensure submissions of a valid code.

VIII. GLOBAL SURGICAL PACKAGE

Global surgical packages must be considered when reporting CPT codes. Under CPT, this means payment for the surgical procedure includes, subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical), the surgical care (operation) and typical postoperative follow-up care (in the hospital and/or office, as appropriate).

Surgical services reported for orthognathic or OSA surgeries typically are major procedures that carry a 90-day global period. According to Medicare guidelines, major procedures include one day prior to surgery, the day of the surgery and the 90 days immediately following the surgery (a total of 92 days).

Initial consultation or evaluation by the surgeon to determine the need for major surgeries may be billed separately using modifier –57 (Decision for Surgery). *Note: The E/M service with the decision for surgery modifier may be billed separately only for major surgical procedures (e.g., 90-day global codes).*

In general, the surgeon should not bill any E/M service codes during the patient's stay related to an orthognathic procedure. However, a significant, separately identifiable E/M service by the same physician on the same day of the procedure may be reported using the appropriate E/M service code and appending modifier –25. Note that appropriate documentation to support the medical necessity of this service should be included with claim submission.

Additional considerations on global surgical packages include the following:

- Under CPT, codes exist to report hospital inpatient or observation discharge services (99238–99239). According to CPT guidelines, these codes may be used to report all services provided to a patient on the date of discharge, as long as the patient is not admitted and discharged the same day. For a patient admitted and discharged from hospital inpatient or observation status on the same date, consider 99234–99236.
- CPT code 99024 Postoperative follow-up visit should be used to report routine postoperative visits during the global period for the surgery. This code is for reporting purposes only, as reimbursement for routine postoperative care is typically included in the surgical code itself. However, documenting follow-up care, including the level of complexity involved provides evidence as to the work performed in the global package. When surgical codes are revalued, this helps to ensure surgeons are reimbursed adequately for all the work they perform.

- Postoperative X-rays, even when done within the global period, may be billed.
- E/M services unrelated to the original procedure but performed during the global period of the original procedure may be billed using modifier –24.
- An unplanned but related return to the operating or procedure room during the postoperative period is reported with modifier –78.

IX. TEACHING FACILITIES AND RESIDENT SERVICES

In academic settings, such as teaching hospitals, it is not uncommon for residents or interns to assist in major surgical procedures such as orthognathic surgery. Medicare rules generally prohibit payment for the services of an assistant-at-surgery in teaching hospitals, except under limited circumstances. According to CMS, Medicare pays for medical/surgical services provided by residents and interns training in their approved program(s) through both direct and indirect graduate medical education payments. Therefore, an OMS would not report or bill for a resident assisting at surgery because the payments to teaching programs already include compensation for having residents perform these services.

In a teaching facility, an OMS may report assistant-at-surgery services only if a qualified resident is not available at the time of the procedure and there is documentation to support this. In this case, the provider may report the appropriate surgical CPT code and append modifier –82 *Assistant Surgeon (when qualified resident surgeon not available)*.

X. MISCELLANEOUS CODING TIPS

CDT code D7944 *osteotomy – segmented or subapical* may be an exception to the rule that orthognathic procedures are more specific in CPT as opposed to CDT. Of the several codes under CPT which may be linked as potential cross codes for this service, none describe it completely. For example, code 21198 *Osteotomy, mandible, segmental;* clearly describes a segmental osteotomy; however, it is not defined as subapical. 21199 *Osteotomy, mandible, segmental; with genioglossus advancement* includes anatomical structures such as the genial tubercle (e.g., bony protrusion on the lingual aspect of the mandible below the roots of the incisor teeth). Lastly, 21206 *Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)* generally lacks specificity in comparison to D7944. Keep in mind, although CDT codes are reportable to medical carriers because of HIPAA Administrative Simplification, this does not prohibit an insurance plan or carrier from developing specific reporting and/or reimbursement guidelines for certain codes or procedures. Further, the existence of a code (CPT or CDT) does not guarantee reimbursement for the service.

Some of the codes presented in this paper describe inherently bilateral services; for example, CPT code 21196 *Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation*. Therefore, when such a service is performed unilaterally, modifier –52 (Reduced Services) should be appended to the surgical procedure code to indicate this to the payer.

Reporting orthognathic surgery procedures:

- When reporting more than one surgical procedure, it is best practice to list the most complex or intense procedure first, followed by the less complicated procedure(s) because many payers apply a multiple procedure reduction to each additional procedure after the first reported code. Appending modifier –51 (Multiple Procedures) to subsequent services may be required to indicate to the insurance carrier that multiple procedures were performed during the same surgical session. Although, requirements for the use of modifier –51 can vary by payer. Therefore, any reporting and payment guidelines for multiple surgical procedures should be confirmed with the payer prior to claim submission.
- Osteotomy codes "requiring a bone graft" – but that specify "includes obtaining autograft" or "includes obtaining graft" – should be appended with modifier –52 if an allograft is utilized. The same principle would apply to CPT codes 21210 and 21215.
- 21196 is the same as "SSO with bone plates," "Obwegeser osteotomy with rigid internal fixation (RIF)" and "Sliding osteotomy with rigid fixation."
- The appropriate use of certain modifiers (e.g., –62 and –80) may depend on the surgical code being reported, as well as the payer's guidelines for the service. For Medicare, the Physician Fee Schedule Look-Up Tool is a helpful resource for determining which modifiers may be applicable for certain codes; for example, if a certain CPT code is eligible for

assistant surgeon billing. The Look-Up Tool is available at CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup. Many commercial carriers adopt Medicare rules and guidelines, therefore, it is important to confirm reporting requirements and reimbursement rules directly with the payer prior to claim submission.

- For application of an interdental fixation device for conditions other than fracture or dislocation, consider reporting CPT code 21110 *Application of interdental fixation device for conditions other than fracture or dislocation, includes removal*.

Reconstructive Versus Cosmetic Procedures

Many payers post coverage policies on their websites that can be a valuable resource in determining the carrier's coverage parameters for certain types of services or conditions. Specifically, many plans may outline what constitutes cosmetic versus reconstructive under the plan, as well as the carrier's definition of medical necessity, all of which may impact coverage and payment. For example, CMS considers cosmetic surgery to include "any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member."

Some surgical services that may be considered cosmetic include:

- Lipectomy (e.g., 15838)
- Facial implants for augmentation (e.g., 21125)
- Bony augmentation and osteoplasty (e.g., 21127, 21208-21209)
- Genioplasty for cosmetic reasons (e.g., 21120-21123)

Note: Reporting does not guarantee reimbursement if the procedure is contractually excluded by the carrier. Genioplasty for sleep apnea (hypersomnia with sleep apnea) should be submitted with documentation of the diagnosis, such as sleep studies and clinical notes. In cases where the surgical intent is genioglossus advancement, the more appropriate procedure code may be osteotomy, mandible, segmental; with genioglossus advancement.

Note: The list of modifiers, as well as 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.

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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 orthognathic surgery and/or obstructive sleep apnea. When indicated, a reference 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 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.

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