



Coding for Temporomandibular Surgery

I. INTRODUCTION

Familiarity and compliance with coding guidelines – particularly ICD-10-CM, CPT, HCPCS Level II and CDT – will be necessary in order to use the codes in this paper properly. This paper is divided into three components that pattern the chronological evaluation and treatment of the temporomandibular joint patient.

II. EVALUATION AND MANAGEMENT CODES

Evaluation and Management (E/M) codes in CPT (99202-99499) are billing codes used to describe the professional services physicians and other qualified healthcare providers deliver when evaluating and managing patient health. They cover common encounters such as office visits, hospital care, emergency department services and telemedicine encounters.

E/M codes are organized by patient type (new vs. established), care setting (office, hospital, virtual, etc.), and level of service, which is determined by either medical decision making (MDM) or the total time spent on the visit. MDM takes into account the number and complexity of problems addressed, the amount and type of data reviewed, and the risk of complications or morbidity. Although history and physical examination remain important, they are no longer the primary drivers of code selection.

The levels of E/M services reflect the wide variation in skill, effort, time, responsibility and knowledge required to prevent, diagnose and treat illness or injury. The CPT guidelines include sections that apply broadly across all E/M categories, as well as instructions specific to individual categories and subcategories. Many of these categories contain unique rules or clarifications to guide accurate code selection.

III. ICD-10-CM CODES

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

M15	Polyosteoarthritis
M19	Other and unspecified osteoarthritis
M24	Other specific joint derangements
M26	Dentofacial anomalies (including malocclusion)
M79	Other and unspecified soft-tissue disorders, not elsewhere classified
M87	Osteonecrosis
G44	Other headache syndromes
R22	Localized swelling, mass and lump of skin and subcutaneous tissue
R51	Headache
S01	Open wound of head
S03	Dislocation and sprain of joints and ligaments of head
T84	Complications of internal orthopedic prosthetic devices, implants and grafts

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

Z01.2	Encounter for dental examination and cleaning
Z82.6	Family history of arthritis and other diseases of the musculoskeletal system and connective tissue
Z91.81	History of falling

A supplementary classification of external causes of injury also may 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 Y83.1, a surgical operation with implant of artificial device as the cause of abnormal reaction of the patient or of later complication (e.g., Proplast-Teflon Implant).

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

Note: The list of ICD-10-CM codes provided includes only the code categories in which an applicable diagnosis code may be found and is not all-inclusive. Some of the codes within these ranges will require the use of a placeholder and/or additional characters. Diagnosis codes should be assigned based on the clinical condition of the patient. To ensure proper diagnosis codes are assigned based on the clinical condition of the patient, refer to an ICD-10-CM coding manual.

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 70328-70355 and 70486-70488 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 (e.g., proton) imaging, temporomandibular joint(s)
- 70350 Cephalogram, orthodontic
- 70355 Orthopantomogram (e.g., 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

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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
 - 21048 Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy
 - 21049 requiring extra-oral osteotomy and partial maxillectomy
- Note: CPT codes 21046–21049 are priced for the facility setting and may not be reimbursed in a non-facility setting (POS II). This range of codes appears on the ASC Covered Procedures List (CPL), which means they are reimbursable only when performed in a facility, such as an outpatient hospital setting or ASC. The ASC CPL designates procedures that Medicare reimburses only when performed in the facility setting due to their complexity, intensity of resources required and patient safety concerns.*
- 21050 Condylectomy, temporomandibular joint (separate procedure)
 - 21060 Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
 - 21073 Manipulation of temporomandibular joint(s), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)

21085 Impression and custom preparation; oral surgical splint

Coding tip: *The coding and ability to bill for the surgical splint depends on who is fabricating and supplying the prosthesis. CPT code 21085 can 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 hospital is fabricating and supplying the splint). Another option may be to report CPT code 21085 with a reduced service using modifier –52 when the splint is fabricated by a lab, hospital or another provider. Depending on the payer, an OMS may also consider reporting a supply code (CPT code 99070) along with a copy of the invoice to account for the lab costs. Reporting and reimbursement guidelines may vary by payer; therefore, it is best practice to confirm the insurance carrier how such services should be reported.*

21089 Unlisted maxillofacial prosthetic procedure

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

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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 non-arthroscopic lysis, lavage and manipulation, the AAOMS Committee on Healthcare Policy, Coding and Reimbursement recommends:

- 20605 (Arthrocentesis, aspiration and/or injection; TMJ without ultrasound guidance) or 20606 (Arthrocentesis, aspiration and/or injection; TMJ with ultrasound guidance).
- 21299 (Unlisted craniofacial and maxillofacial procedure)
Note: Because 21299 is an unlisted code, include an explanation of procedure.
- Appropriate anesthesia/sedation code or modifier.
- If the carrier accepts HCPCS Level II codes, D7871 Non-arthroscopic lysis and lavage may be reported.

A cover letter and copy of the operative report should accompany the claim to the insurance company for consideration.

For coding guidance on reporting anesthesia/sedation coding, refer to the [Coding for Anesthesia Services Coding Paper](#).

V. CDT CODES FOR TEMPOROMANDIBULAR JOINT SURGERY

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CDT codes may also be used to report temporomandibular joint imaging, therapeutic and surgical procedures. Appropriate codes can be found in both the Diagnostic and Oral & Maxillofacial Surgery sections of the CDT book:

- D0320 temporomandibular joint arthrogram, including injection
- D0321 other temporomandibular joint radiographic images, by report
- D0330 panoramic radiographic image
- D0340 2D cephalometric radiographic image – acquisition, measurement and analysis
- D0350 2D oral/facial photographic image obtained intra-orally or extra-orally
- D0351 3D photographic image
- 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 – maxilla, with or without cranium
- D0367 cone beam CT capture and interpretation with field of view of both jaws; with or without cranium
- 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
- D0385 maxillofacial MRI image capture
- D0368 cone beam CT capture and interpretation for TMJ series including two or more exposures
- D0369 maxillofacial MRI capture and interpretation
- D0701 panoramic radiographic image – image capture only
- D0703 2D oral/facial photographic image obtained intra-orally or extra-orally – image capture only

- D0704 3D photographic image – image capture only
- D0706 intraoral – occlusal radiographic image – image capture only
- D0709 intraoral – complete series of radiographic images – image capture only
- D0801 3D intraoral surface scan - direct
- D0802 3D dental surface scan - indirect
- D0803 3D facial surface scan - direct
- D0804 3D facial surface scan - indirect

Note: Additional coding information for the pre-surgical workup component is discussed in the [Coding the Digital Workflow Coding Paper](#).

Codes from the Oral & Maxillofacial Surgery category include:

- D7830 manipulation under anesthesia
Usually done under general anesthesia or intravenous sedation
- D7840 condylectomy
Removal of all or portion of the mandibular condyle (separate procedure)
- D7850 surgical discectomy with/without implant
Excision of the intra-articular disc of a joint
- D7852 disc repair
Repositioning and/or sculpting of a disc; repair of perforated posterior attachment
- D7854 synovectomy
Excision of a portion or all of the synovial membrane of a joint
- D7856 myotomy
Cutting of muscle for therapeutic purposes (separate procedure)
- D7858 joint reconstruction
Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials



- D7860 arthrotomy
Cutting into a joint (separate procedure)
- D7865 arthroplasty
Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes)
- D7870 arthrocentesis
Withdrawal of fluid from a joint space by aspiration
- D7871 non-arthroscopic lysis and lavage
Inflow and outflow catheters are placed into the joint space. The joint is lavaged and manipulated as indicated in an effort to release minor adhesions and synovial vacuum phenomenon as well as to remove inflammation products from the joint space
- D7873 arthroscopy: lavage and lysis of adhesions
Removal of adhesions using the arthroscope and lavage of the joint cavities
- D7874 arthroscopy: disc repositioning and stabilization
Repositioning and stabilization of disc using arthroscopic techniques
- D7875 arthroscopy: synovectomy
Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique
- D7876 arthroscopy: discectomy
Removal of disc and remodeled posterior attachment via the arthroscope
- D7877 arthroscopy: debridement
Removal of pathologic hard and/or soft tissue using the arthroscope
- D7880 occlusal orthotic device, by report
Presently includes splints provided for treatment of temporomandibular joint dysfunction
- D7899 unspecified TMD therapy, by report
Used for procedure that is not adequately described by a code. Describe procedure.

For TMJ splints, CPT code 21089 (Unlisted Maxillofacial Prosthetic Device) may be reported when the OMS takes an impression of the area and fabricates the device. Reporting CPT 21089 requires thorough documentation

of the prosthetic device, including a detailed description of the appliance and clinical notes to support medical necessity. If an outside laboratory is fabricating the appliance, CPT supply code 99070 may be reported. In this instance, an invoice from the laboratory and narrative should accompany the claim to the insurance carrier. Dental insurance carriers, as well as some medical carriers, may prefer the use of CDT/HCPCS code D7880 (occlusal orthotic device, by report).

VI. GLOBAL SURGICAL PACKAGE

Global surgical packages must be considered when reporting CPT codes. In the surgery chapter of CPT, the surgical package definition 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 (the operation) and typical postoperative follow-up care.

CPT code 21085 carries a 10-day global surgical package. Therefore, if 21085 is reported within 10 days prior to another surgical procedure, the claim for that procedure may be denied because it falls within the global period of the splint preparation.

Coding Tip: If surgery or an additional surgical splint is planned at the time of rendering CPT code 21085 and will occur during the 10-day global period, the additional splint and other applicable codes may be reported by appending modifier –58 (staged procedure). This modifier indicates that the appliance or surgery was planned as part of the initial procedure’s global period. Always verify appropriate usage with individual payers before appending modifier –58.

Note: Effective April 1, 2025, the NCCI committee approved a request from AAOMS to increase the MUE for CPT code 21085 from 1 to 2. This update permits reporting of two splints on the same date of service for a surgical encounter, when clinically appropriate.

Surgical services reported for TMJ procedures 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 – 92 days total.

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.

VII. Other Related TMJ Services

Many OMSs provide Botox injections for both cosmetic purposes and therapeutic use, including pain relief and pain management associated with chronic migraine headaches, facial nerve conditions and TMJ disorders. Per CPT coding principles, botulinum toxin codes can only be reported once per session, even though multiple injections may be performed in sites along a particular muscle. In addition, you also may report the HCPCS Level II code of the drug being used. Depending on the carrier, when reporting a HCPCS Level II drug code, you also may need to indicate the amount of units used/not used by appending modifier –JW or –JZ to the claim form. CMS provides an FAQ explaining billing guidelines on how modifier –JW and –JZ is appropriately reported.

There are two possible CPT codes and one HCPCS code that may be used to report Botox.

- 64615 Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine)
- 64616 Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (e.g., for cervical dystonia, spasmodic torticollis)
- J0585 Injection, onabotulinum toxin A, 1 unit
- D9913 administration of neuromodulators
- D9914 administration of dermal filler

Note: CDT code D9913 may be reported for injections of botulinum toxin directly into an underlying muscle, causing the muscle to relax and change the appearance of the overlying skin, for smoothing purposes.

CDT code D9914 may be reported for injections to increase the size of gingival papilla and to plump up wrinkles and smooth lines on the face. It may also be used to help eliminate or decrease the size of black triangles for patients with gingival recession or post periodontal treatment.



Compliance with payer-specific guidelines is equally critical to successful claim submission and reimbursement for TMJ procedures. Insurance carriers often require detailed documentation, including operative reports, diagnostic imaging and medical necessity statements, before approving coverage. Many payers also mandate prior authorization for surgical interventions, prosthetic devices or certain therapeutic services. Failure to follow these requirements can result in delayed payment or claim denials. OMSs and professional staff should proactively verify coverage criteria, obtain preauthorization when indicated and maintain thorough records to ensure claims are processed efficiently and in accordance with payer policies.

Trigger point injection therapy is used for the treatment of myofascial pain syndrome and is a common procedure performed by OMSs for TMJ pain management. The pain of active trigger points can begin as an acute single muscle syndrome resulting from stress overload or injury to the muscle, or can develop slowly because of chronic or repetitive muscle strain. In terms of reimbursement, it is important to check payer policies for specific coverage criteria or frequency limitations. Some payers consider trigger point injections medically necessary for patients with temporomandibular pain. However, Medicare generally does not cover treatment for TMJ diagnoses alone as it may be excluded under traditional policy exclusions relating to the teeth and jaws.

There are two possible CPT codes for reporting trigger point injections:

- 20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- 20553 Injection(s); single or multiple trigger point(s), 3 or 4 muscles

Note: Local anesthesia is included with the trigger point injection codes. Imaging guidance may be reported in addition to the medication used for the injection; however, platelet rich plasma or other needle insertions without injections may not be reported. If imaging guidance is performed, see CPT codes 76942, 77002, 77021.

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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.

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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 discusses coding for temporomandibular surgery. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-10-CM) and treatment (CPT/CDT) coding for temporomandibular surgery. 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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