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American Association of Oral and Maxillofacial Surgeons

Coding Paper

Coding for Cleft Lip and Palate Surgery

I. INTRODUCTION

Familiarity and compliance with coding guidelines – particularly ICD-10-CM, CPT, HCPCS and CDT – are necessary to successfully utilize the codes outlined in this paper. The information is presented in three sections, mirroring the chronological evaluation of a cleft lip and palate patient.

II. EVALUATION AND MANAGEMENT SERVICES

The initial examination of a patient with indications for cleft lip and palate management or treatment may be reported using the appropriate evaluation and management (E/M) codes. Particular attention should be directed to the location where the service is provided. For example, it is not uncommon to initially have contact with such a patient at the hospital, especially for a newborn or neonate with a cleft lip and palate. Although, most patients will be seen on an outpatient basis, such as in an OMS office. Several categories of codes exist to describe E/M services when performed in various care settings (e.g., office or other outpatient E/M visits). The CPT manual provides detailed guidelines for the selection of the appropriate level of E/M service for each place of service.

The CPT E/M codes most applicable to the OMS require a medically appropriate history and/or physical examination. According to CPT guidelines, the nature and extent of this examination are determined by the treating physician. In the case of a cleft lip and palate patient, such may include the examination of soft tissues and musculoskeletal functionality, evaluation of speech and hearing, appropriate diagnostic imaging as well as a comprehensive dental examination.

For patients presenting with complex conditions, it is not uncommon for treatment to be managed by multiple providers. As such, there may be instances in which a patient is evaluated by different physicians on the same day. Under Medicare rules, physicians in the same group practice who are in the same specialty are considered as the "same" physician for billing purposes. This means if more than one E/M service is provided on the same day to the same patient by the same physician – or more than one physician in the same specialty in the same group – only one E/M service may be reported. In this case, Medicare states that physicians should select a level of service representative of the combined visits and submit the appropriate code for that level rather than billing separately. An exception would be for E/M services provided to the same patient on the same day for unrelated problems, in which the appropriate modifier would be appended to the E/M code to indicate a separately identifiable service (refer to modifier –25). According to CMS, providers who are in different specialties within the same group practice may each report E/M services individually.

Note: Third-party payer guidelines may limit the number of E/M services billable for the same patient on the same date of service. While it is not uncommon for commercial payers to follow CMS rules, each insurance carrier should be contacted individually to confirm reporting guidelines and/or requirements.

III. CODING FOR CLEFT SURGICAL SERVICES

The AAOMS Committee on Healthcare Policy, Coding and Reimbursement (CHPCR) recommends that the oral and maxillofacial surgeon use the CPT codes described for cleft lip and palate surgery rather than the American Dental Association's Current Dental Terminology (CDT) codes.

The codes for describing cleft lip and cleft palate surgery are found predominantly within the Digestive System section of the CPT manual.

For cleft lip repair procedures, refer to the subheading Repair (Cheiloplasty) under Lips. The following CPT codes may be considered:

40650 Repair lip, full thickness; vermillion only

40652 Repair lip, full thickness, up to half vertical height

40654 Repair lip, full thickness over one-half vertical height, or complex

40700 Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral

40701 primary bilateral, 1-stage procedure

40702 primary bilateral, 1 of 2 stages

40720 secondary, by recreation of defect and reclosure

Note: For bilateral procedure, report 40720 with modifier –50.

40761 with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle

40799 Unlisted procedure, lips

Note: This code may be used to report a cleft lip adhesion procedure.

Frequently, additional reconstructive soft-tissue procedures may be required for cleft lip repair. CPT codes for these procedures may be found in the Integumentary System section under Adjacent Tissue Transfer or Rearrangement:

14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

14041 defect 10.1 sq cm to 30.0 sq cm.

14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

14061 defect 10.1 sq cm to 30.0 sq cm

Note: Additional reconstructive codes that may be applicable to cleft lip repair procedures can be found under Skin Replacement Surgery in the Integumentary System subsection of CPT. Specifically, these include CPT codes 15120-15121, 15135-15136, 15155-15157, 15240-15241, 15260-15261.

For cleft palate surgery, refer to the Digestive System section of CPT, Palate and Uvula, subheading Repair. CPT codes found here include repair procedures of the anterior/posterior hard and soft palate and the alveolar process and are differentiated by the extent of the repair.

The following CPT codes may be considered:

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

42205 Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only

42210 with bone graft to alveolar ridge (includes obtaining graft).

Note 1: This procedure includes grafting from the alveolar crest to the piriform rim.

Note 2: This procedure includes harvesting or obtaining the bone grafting material. When the surgeon performing the reconstructive procedure does not harvest the bone, the procedure code should be reduced by appending modifier –52 (Reduced Services). An example is when an OMS uses bioactive synthetic bone or bone morphogenetic protein (BMP). When such materials are utilized, the surgeon may consider reporting CPT code 99070 (Supplies and materials) in addition to the surgical procedure code. A copy of the invoice should be included with claim submission. Note that payer policies may vary regarding supplies and materials; therefore, each insurance carrier should be contacted individually for reporting and/or reimbursement requirements.

Note 3: To report a bone graft to an alveolar cleft as a secondary procedure for ridge augmentation without a palatoplasty, use code 21210.

For example: A child had a successful alveolar graft at 9 years old; patient is now ready for a dental implant. Additional bone stock is needed to support the dental implant.

Note 4: For cases of bilateral cleft repair, Medicare policy prohibits the use of modifier –50 (Bilateral Procedure) with CPT code 42210 based on anatomical considerations. Therefore, from a procedural coding standpoint, no distinction is made between repair of a

unilateral and bilateral alveolar cleft. An OMS may consider appending modifier –22 (Increased Procedural Services) to capture the increased intensity and physician work for repair of bilateral clefts of the palate. Clinical documentation must support significant additional work, above and beyond that which is generally described by the surgical code.

Note 5: Current National Correct Coding Initiative (NCCI) edits exist when codes 42200, 42205 and 42210 are reported together. In this case, it is allowed and may be appropriate to use a modifier to potentially override the edits for claims adjudication. Clinical documentation must support the services are distinctly separate and medically necessary. Consider CPT modifier –59 (Distinct Procedural Service) or one of the HCPCS -X{EPSU} modifiers, depending on the payer.

41899 Unlisted procedure, dentoalveolar structures

Note: This code may be used to report the extraction of teeth during cleft palate surgery. The clinical scenario would be specified with the appropriate ICD-10-CM code(s). For example, removal of an impacted supernumerary tooth in the cleft may be reported with K00.1 (Supernumerary teeth) or removal of a decayed erupted primary incisor with K02.9 (Dental caries, unspecified). However, it is important to note that complex conditions may require several diagnosis codes to accurately capture the overall clinical picture of the patient. OMSs and professional coders must familiarize themselves with the ICD-10-CM coding and sequencing guidelines to ensure correct reporting. These instructions may be found in the beginning of the ICD-10-CM Manual and at CMS.gov/Medicare/Coding/ICD10.

42215 Palatoplasty for cleft palate; major revision

42220 secondary lengthening procedure

42225 attachment pharyngeal flap

42226 Lengthening of palate, and pharyngeal flap

42227 Lengthening of palate, with island flap

42235 Repair of anterior palate, including vomer flap

42260 Repair of nasolabial fistula

20902 Bone graft, any donor area; major or large

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 42210 contains the phrase "includes obtaining graft;" 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.

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/Physician-Fee-Schedule/Search/Overview. Many commercial carriers follow CMS rules, therefore, it is important to confirm reporting and reimbursement guidelines with each payer prior to claim submission.

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

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

21215 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.

As with CPT code 20902, codes 21210 and 21215 should not be reported when the code describing the primary surgical service states "includes obtaining graft," unless the bone graft procedure is unrelated and distinct from the primary surgical service. Refer to the AAOMS coding paper, Coding Bone Grafts, for additional details on coding bone graft services.

Certain nasal procedures may also be associated with cleft palate surgery. These may be found in the Respiratory System section of the CPT manual. Refer to subheading Repair under Nose. The following CPT codes may be applicable:

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

30600 oronasal

Note: Additional repair codes that may be applicable to cleft palate procedures are also found in the Respiratory System section of CPT. These include services such as rhinoplasty, septoplasty and general nasal region repair. Specifically, these include CPT codes 30400-30630.

The following are recommendations of the CHPCR for ancillary or supplemental services that may be used when treating patients with cleft lip and palate deformities.

To report prosthetic devices used as adjuncts for cleft lip and palate treatment, consider the following codes:

21076 Impression and custom preparation; surgical obturator prosthesis

Note: This code includes taking impressions, custom preparation and delivery of the prosthesis. It is assigned a 10-day global surgical package; therefore, subsequent adjustments of the prosthesis beyond 10 days may be billed with the appropriate E/M code. CPT code 21076 may be used to report Pre-surgical Nasoalveolar Moulding (NAM).

21084 Impression and custom preparation; speech aid prosthesis

Note: This code is appropriately reported when the physician or other qualified healthcare professional designs and prepares the prosthesis. This code should not be reported if the prothesis is prepared by an outside laboratory. 21084 carries a 90-day global period.

42280 Maxillary impression for palatal prosthesis

Note: This code may be used when an OMS takes impressions of the maxilla in the office, but the prosthesis is fabricated by an outside laboratory. If the physician takes the impression, designs and prepares the palatal prosthesis, consider CPT code 21082 or 21083.

The OMS may choose to use the –22 modifier if the maxillary impression is made under anesthesia.

42281 Insertion pin-retained palatal prosthesis

Note: This code may be reported when the OMS delivers or inserts a prosthesis that has been fabricated by an outside laboratory. This may also include limited adjustments made to the

prosthesis, if necessary. 42281 carries a 10-day global period, therefore subsequent adjustments of the prosthesis beyond 10 days may be billed with the appropriate E/M code.

The CHPCR does NOT recommend the use of CPT code 21085 *Impression and custom preparation; oral surgical splint* for cleft palate prostheses. This code is more appropriately used in connection with orthognathic surgery and only when the OMS makes an impression and customizes the splint from a cast model or fabricates a splint via digital scanning software and 3D printing.

CPT codes from the Integumentary System section of the CPT manual may be used to report a tongue flap procedure for the closure of a large palatal fistula. Consider the following CPT codes:

15576 Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral

15600 Delay of flap or sectioning of flap (division and inset); at trunk

Coding tip: This code may be used to report the "take down" of the tongue flap, including plasties performed on the dorsal (upper) aspect of the tongue and the pedicle that is attached to the palate. The patient typically returns two weeks post-inset of the tongue flap to take down the pedicle from the dorsal tongue and inset the remaining posterior 90 degrees of the tongue flap. In other words, the flap take down is a planned or staged procedure typically performed within the global period of the initial procedure. Therefore, the -58 modifier must be appended to CPT code 15600 to indicate the follow-up surgery was planned at the time of the initial procedure. Failure to do so may lead to the rejection of the claim for the second surgery, as it could be considered part of the comprehensive service covered by the initial surgery's global package. Note that modifier –58 would not be necessary if the second procedure is performed outside of the global period of the initial surgery.

III. MODIFIERS FOR CLEFT LIP AND PALATE SURGERY

The following code modifiers may have some application in the reporting of services for cleft lip and palate surgery:

–50 Bilateral Procedure

–51 Multiple Procedures

–52 Reduced Services

–58 Staged or Related Procedure of Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

–59 Distinct Procedural Service

–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.

It is important to note that reporting and reimbursement guidelines for modifier use can vary by insurance carrier or plan. It is encouraged for OMSs and professional coders to confirm such guidance directly with the payer to proactively prevent claim denials.

IV. 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 cleft palate repair. 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)*.

V. ICD-10-CM CODING FOR CLEFT LIP AND PALATE SURGERY

Correct usage of the CPT (procedural) and the ICD-10-CM (diagnosis) coding systems require that the appropriate ICD-10-CM codes be linked to the surgical procedures listed in the CPT code set. Incredible specificity has been built into the ICD-10-CM section under congenital anomalies to cover the spectrum of disorders associated with cleft lip and palate deformity. Diagnosis codes that may be applicable may be found in the following ICD-10-CM categories of codes:

Q35 Cleft palate

Q36 Cleft lip

Q37 Cleft palate with cleft lip

Q38 Other congenital malformations of tongue, mouth and pharynx

K00 Disorders of tooth development and eruption

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury

Note: The list of associated ICD-10-CM code categories is not all-inclusive. They merely represent select ICD-10-CM categories under which applicable diagnosis codes may be found. Some of the codes within these ranges will require the use of a placeholder and/or additional characters. Refer to current ICD-10-CM coding manual guidelines to ensure the submission of a complete and valid code.

VI. GLOBAL SURGICAL PACKAGE (GSP)

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 (including in the hospital and/or office, as appropriate).

Surgical services reported for cleft lip and palate repair 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.*

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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 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, 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 cleft lip and palate 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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