Coding Paper

American Association of Oral and Maxillofacial Surgeons

Coding for Trauma and Fractures

I. INTRODUCTION

Detailed discussion of evaluation and management (E/M) codes is beyond the scope of this paper. However, because trauma services often involve coding for emergency department services, certain OMS-related scenarios are briefly addressed.

Other topics covered in this paper include:

- Repair of lacerations (e.g., suturing, flaps)
- Facial fractures and dislocations
- Additional procedures (e.g., tracheostomy)
- Additional diagnosis (e.g., observation for possible injury, contusions, crushing injuries, late effects of injury)
- ADA (CDT) codes

Note: CPT codes should be used for coding trauma whenever possible, but dental or Current Dental Terminology (CDT) coding may overlap with CPT and/or be preferred by some carriers. Therefore, these codes are included at the end of this paper.

II. EVALUATION AND MANAGEMENT CODES

Emergency Department Service E/M codes do not differentiate between new and established patients and the only requirement for using these codes is that the patient has been admitted to the emergency department (ED). Any physician – ED specialty or not – may report the ED E/M codes if evaluation services were rendered in the emergency department. OMSs should consider the following scenarios:

1. If only an OMS (and not an ED physician) evaluates a patient in the emergency department, the OMS may report either an "Emergency Department Services" E/M code (99281-99285) or "Office or Other Outpatient Services" E/M code (99202-99215).

   Note: According to CPT guidelines, if a patient is directed to the ED out of convenience to the doctor (e.g., outside regular office hours), an Emergency Department Services code should not be reported. The requesting physician should report the service with an "Office or Other Outpatient Services" code (99202-99215).

2. If both an OMS and an ED physician evaluate the patient, it is appropriate for the OMS to report an "Office or Other Outpatient Services" E/M code (99202-99215) as the ED physician would report an "Emergency Department Services" E/M code.

3. If a patient is seen by an ED physician and then an OMS is requested for an opinion only, the OMS reports an "Office or Other Outpatient Consultation" code (99242-99245) and the ED physician reports an "Emergency Department Services" E/M code.

   Note: If the above example involves Medicare, both the OMS and ED physician may report a code in the 99281-99285 range. This exception only applies to Medicare claims.

4. If a patient is seen by the ED physician who then transfers care (i.e., responsibility) to an OMS, it is appropriate for the OMS to report an "Office or Other Outpatient Services" E/M code (OMS: 99202-99215).

Note: The CPT manual provides detailed guidelines for selecting the appropriate level of E/M service, as well as specific guidance for ED services. Regardless of the category of E/M codes being considered, the documentation must reflect the level of service provided. If an E/M service results in the decision to perform major surgery (i.e., a procedure with a 90-day global surgical package), modifier –57 (Decision for Surgery) may be appended to the E/M code. In other words, an E/M service with the decision for surgery modifier may be billed separately only for major surgical procedures. In some cases, the "global surgical package" rules may determine if E/M codes are eligible for benefits when services are provided the same day as the surgical procedure. To reiterate, the –57 modifier may be added to the E/M code if the decision to perform surgery is made during this evaluation.

According to CPT guidelines, an individual is an outpatient until inpatient admission occurs. If a patient is admitted as an inpatient by the OMS during or subsequent to an evaluation in the ED or other outpatient setting (e.g., the OMS office), CPT guidelines for reporting "Initial Hospital Inpatient or Observation Care" codes (99221-99223) should be followed. If a consultation is performed in anticipation of, or related to, an admission by another physician or other qualified healthcare professional, and the same consultant performs an encounter once the patient is admitted, refer to the "Subsequent Hospital Inpatient or Observation Care" codes (99231 - 99233) to report the consultant's inpatient encounter. According to CPT, this applies for consultations reported with any appropriate code, such as office or other outpatient visit or office or other outpatient consultation.

Under CPT guidelines, to report services provided to a patient admitted and discharged from the hospital as inpatient or observation status on the same date, and the stay is over eight hours, refer to the "Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)" codes (99234-99236). If the OMS is the admitting physician, HCPCS modifier -AI (Principal physician of record) should be appended to the code for the initial patient visit to identify the OMS as the physician overseeing inpatient care.

In certain circumstances, CPT guidelines allow the reporting of multiple E/M services on the same date. When a patient is admitted to the hospital on inpatient or observation status in the course of an encounter in a different site of service (e.g., the OMS office or emergency department), these services are separately reportable with modifier –25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service) from initial inpatient or observation care services. However, it is important to note payer guidelines may limit the number of E/M services billable on the same day by the same provider, regardless of the site of service. For example, under CMS, Medicare will not allow payment for two E/M office visits billed by a physician, or physician of the same specialty from the same group practice, for the same beneficiary on the same day unless the E/M visits provided on the same day are for unrelated problems.

Due to the varied intensity of cases and because emergency healthcare providers often treat patients over an extended period, time is not a descriptive component nor is it used in code selection for ED levels of E/M services. As such, emergency department E/M codes are based only on MDM.

III. REPAIR (LACERATIONS)

The CPT book classifies the repair of wounds as simple, intermediate or complex. For precise definitions and current guidance, refer to Repair (Closure) in the Integumentary System section of the CPT manual.

The general instructions for coding the repair of wounds state the closure should be measured in centimeters, and the lengths of multiple wounds of the same classification (i.e., simple, intermediate, complex) and location should be added together and reported as a single item. Simple explorations of nerves and blood vessels and ligation of vessels in an open wound are considered part of the closure – as is debridement unless it is extensive, carried out separately or without immediate primary closure. For extensive debridement of soft tissue and/or bone, see code range 11010-11047. Repair of nerves, vessels and tendons should be reported under the appropriate system (such as nervous, cardiovascular, musculoskeletal). The repair of these associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier –51 may apply.

Note: 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 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. However, 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.

In addition to the length and complexity of the laceration, it is necessary to code the location of the wound as follows:

REPAIR – SIMPLE

12001-12007	Scalp and neck
12011-12018	Face, ears, eyelids, nose, lips, mucous membranes

REPAIR – INTERMEDIATE

12031-12037	Scalp
12041-12047	Neck
12051-12057	Face, ears, eyelids, nose, lips, mucous membranes

REPAIR – COMPLEX

13120-13122	Scalp
13131-13133	Forehead, cheeks, chin, mouth, neck
13151-13153	Eyelids, nose, ears, lips

TREATMENT OF WOUND DEHISCENCE

12020-12021	Superficial wound, simple closure
13160	Extensive or complicated, secondary closure

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

Flaps and/or tissue (e.g., Z-, W-, V-Y plasty, rotation or advancement flaps) must be created by the surgeon to accomplish repair and do not apply when they merely result from the direct closure or rearrangement of the wound(s):

14020-14021	Scalp
14040-14041	Forehead, cheeks, chin, mouth, neck
14060-14061	Eyelids, nose, ears, lips
14301-14302	Any area

There are a variety of codes (15002-15778) that may be considered where reporting services such as free skin grafts, pedicled, tube, myocutaneous and/or other more extensive flaps. There are eight codes in the integumentary system section (15011-15018), which allow reporting of harvest, preparation and application of skin for skin cell suspension autograft of varying graft size.

ADDITIONAL REPAIR (Laceration codes from other systems)

Digestive

40650-40654	Repair (cheiloplasty), lips
40830-40831	Repair laceration, vestibule of mouth
41250-41252	Repair laceration, floor of mouth and/or tongue
42180-42182	Repair laceration, palate
42500-42505	Plastic repair, salivary duct
42900	Repair, pharynx

Eye

67930-67935	Repair, eyelid
68700	Plastic repair, canaliculi

ICD-10-CM CODES FOR LACERATIONS OF HEAD AND NECK

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

S00-S09	Injuries to the head
S10-S19	Injuries to the neck
L08	Other local infections of skin and subcutaneous tissue
T18.0	Foreign body in mouth
V00-Y99	External causes of morbidity
Z03	Encounter for medical observation for suspected diseases and conditions ruled out
Z04	Encounter for examination and observation for other reasons

Coding tip: External Causes of Morbidity Codes (V00-V99) capture how the injury or health condition happened; where it happened; whether the injury or health condition was unintentional, accidental or intentional; the patient's activity at the time of the event and the person's status (e.g., civilian or military). There is no national requirement for external cause code reporting however, some providers may be subject to state-based external cause code reporting

mandates. External cause code reporting may also be a requirement for some payers. Refer to the Chapter 20 guidelines in the ICD-10-CM manual to ensure appropriate reporting and sequencing of external causes of morbidity codes.

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

IV. FACIAL FRACTURES AND DISLOCATIONS

To properly code fractures, several terms must be considered. In general, ICD-10-CM classifies fracture codes as either "traumatic" or "pathological." A traumatic fracture is caused by some type of accident, fall or other force. A pathological fracture is a broken bone caused by disease. Coding for fracture care is often complex. Therefore, detailed documentation regarding the specifics of the injury, the patient's condition and the treatment is needed to ensure accurate coding and appropriate reimbursement for the services rendered.

The terms "open" and "closed" are found in both diagnosis (ICD-10-CM) and treatment (CPT) codes. By definition, a closed fracture is one in which the bone breaks but does not puncture the skin. An open fracture, on the other hand, is one in which the bone breaks through the skin causing an open wound. As related to diagnosis, the term "open" includes, but is not limited to, fractures that are "compound," "infected" or "caused by puncture with a foreign body or missile." According to ICD-10-CM coding guidelines, a fracture not indicated as open or closed should be coded as "closed." Certain ICD-10-CM categories, such as fractures, have been assigned seventh characters. The applicable seventh character is required for all codes within the category, or as the notes in the Tabular List instruct. If a code that requires a seventh character is not six characters in length, one or more placeholder "X" must be used to fill the empty characters.

When coding for treatment, the terms "open" and "closed" are used to indicate whether the surgeon directly viewed and reduced the fracture (the term "manipulation" also may be used) through a wound created by the injury or the surgeon for access. It is therefore possible to have an "open" fracture treated by a "closed reduction" and a "closed" fracture treated by an "open" reduction.

Fractures also may be categorized as "displaced" or "nondisplaced". In a displaced fracture, the bone snaps into two or more parts and moves so that the two ends are not aligned properly. In a nondisplaced fracture, the bone cracks part or all the way through but does not move and maintains its proper alignment. According to ICD-10-CM instructions, a fracture not specified as displaced is coded as nondisplaced.

Descriptions for treatment of facial fractures in CPT may specify with or without "dental wiring" or "interdental fixation," requiring that each description be carefully read to be certain it accurately captures the procedure performed.

If fixation of the fracture is required, it is necessary to identify whether this was performed internally or externally. Internal fixation is when, after an open reduction, the fracture is plated or wired directly. Closed reduction is where the fracture is reduced and stabilized using external fixation (e.g., external pins or halo-type appliance) or interdental wiring. Historically, the AAOMS Committee on Healthcare Policy, Coding and Reimbursement has provided examples of an "approach" as used in code 21470 to include: 1) an incision, 2) internal fixation, such as plating, and 3) intermaxillary fixation. If both an incision and plating were performed, code 21470 would apply for the fracture repair. It is important to note that 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. An OMS may consider CPT codes 20670-20680. Additional procedures that may be applicable to trauma and fracture repair are outlined in Section V.

Coding tip: If the removal of the fixation device is performed during the global period of the fracture repair surgery, it is 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. Additionally, postoperative radiographs are not part of the global package and are billable services with the appropriate codes.

The term "percutaneous," as it relates to fracture treatment, identifies a procedure where the surgeon treats the fracture "through the skin" (e.g., using a malar screw or a towel clip for reduction of a fracture of the zygomatic arch or complex).

Coding guidelines and best practices direct providers and professional coders to code to the highest level of specificity possible. This applies to both diagnosis and procedure codes. When using procedure codes to report the repair of multiple injuries or fractures, each component should be reported separately to the extent possible. National Correct Coding Initiative (NCCI) edits may exist when reporting certain codes together (Procedure-to-Procedure edits) or when reporting multiple units or line items of one code in the same surgical encounter (Medically Unlikely Edits). The NCCI encompasses both types of edits. In certain cases, the appropriate use of a modifier (e.g., CPT modifier –59 Distinct Procedural Service or the HCPCS -X{EPSU} modifiers) may potentially bypass these edits, provided the clinical documentation supports the procedures are medically necessary and distinctly separate. The NCCI program was originally developed by CMS to streamline coding practices under Medicare Part B. However, many commercial payers adopt Medicare rules for claims adjudication, therefore, providers and coders should familiarize themselves with these edits. CMS.gov provides additional information and resources, including the NCCI Policy Manual and provider FAQs.

Coding tip: In cases in which a modifier is not allowed to bypass a NCCI edit, an OMS may consider reporting one fracture code and append modifier –22 (Increased Procedural Service). A narrative and/or documentation supporting the extra work associated with repairing two or more fractures of a single bone (e.g., additional time, increased intensity, etc.) should be included with claim submission.

Some insurance carriers may have rules or guidelines specific to the reporting of bilateral fracture repair. Some fracture care codes applicable to the OMS may not be eligible for bilateral reporting with the use of modifier –50 (Bilateral Procedure). One resource to establish this is the Medicare Physician Fee Schedule Look-Up Tool.

Additionally, some circumstances may call for the use of HCPCS modifier –LT or –RT. Some payers – including Medicare – also may apply a payment adjustment for bilateral surgeries. Given these considerations, providers should confirm reporting and payment guidelines with the payer prior to claim submission.

In addition, modifier –52 (Reduced Services) may be appropriate in some instances. For example, in the case of a bilateral fracture where both CPT codes state "includes interdental fixation" but only one set of arch bars is applied, the reduced services modifier –52 should be used. The following categories of codes may be used for reporting fractures:

MUSCULOSKELETAL FRACTURES

21315-21337	Nasal fractures
21338-21340	Nasoethmoid fractures
21343-21344	Frontal sinus fracture
21345-21348	Nasomaxillary fractures (Le Fort II)
21355-21366	Malar area, including zygomatic arch and malar tripod fractures
21385-21408	Orbital fractures
21421-21423	Palatal or maxillary fractures (Le Fort I)
21431-21436	Craniofacial separations (Le Fort III)
21440-21445	Alveolar ridge fractures (separate procedures)

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.

21450-21470	Mandible fractures
21480-21490	TMJ dislocations

ICD-10-CM CODES FOR FRACTURES AND TMJ DISLOCATIONS

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

M26	Dentofacial anomalies [including malocclusion]
M27	Other diseasess of jaws
M80-M85	Disorders of bone density and structure
S02	Fracture of skull and facial bones
S03	Dislocation and sprain of joints and ligaments of head
S06	Intracranial injury
S12	Fracture of cervical vertebra and other parts of neck

V. ADDITIONAL PROCEDURE (CPT) CODES

20670-20680	Removal of hardware (e.g., wires, plates, interdental fixation)
21085	Impression and custom preparation; oral surgical splint

Note: 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 modifer –52 when the splint is fabricated by a lab, hospital or another provider. Depending on the payer, an OMS also may 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.

21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21497	Interdental wiring, for condition other than fracture
30901-30906	Control of nasal hemorrhage
31500	Emergency intubation, endotracheal
31600-31610	Tracheostomies
42960-42962	Control of oropharyngeal hemorrhage
42970-42972	Control of nasopharyngeal hemorrhage

Additionally, most sections within CPT include codes for unlisted procedures by anatomical structure/area that may be used if no other code accurately captures the procedure.

VI. ADA (CDT) CODES

D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth
D7610-D7680	Treatment of closed fractures
D7710-D7780	Treatment of open fractures
D7810-D7830	Reduction of dislocation and management of other temporomandibular joint dysfunctions
D7852	disc repair
D7910-D7912	Repair of traumatic wounds and complicated suturing
D7946-D7949	Le Fort I, II and III
D7990	emergency tracheotomy

Coding Paper

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

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

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

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-10-CM) and treatment (CPT/CDT) coding for trauma and fractures. When indicated, reference the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.

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