Coding Paper

American Association of Oral and Maxillofacial Surgeons

Ambulatory Surgical Center Billing and Coding

I. INTRODUCTION

This coding paper provides an overview of billing and coding for ambulatory surgical centers (ASCs). It covers aspects of coding and reporting facility charges, applicable CMS payment methodologies and the rules that govern these processes. Additionally, the paper includes practical coding examples to illustrate the distinctions between professional and facility charge reporting for common oral and maxillofacial surgery procedures in the ASC setting.

II. DEFINING PROFESSIONAL VERSUS FACILITY CHARGES

When OMSs perform procedures in an ASC setting, coding and billing processes are separated into two distinct charge categories: professional and facility.

- Professional charges cover the services provided by practitioners, including diagnosis, treatment and consultation. These charges capture the clinical care and expertise provided by the physician or qualified healthcare professional.
- Facility charges reflect the costs associated with the healthcare setting where the services are delivered. This includes use of the ASC's space and resources, such as supplies, equipment and clinical staff. Facility fees typically include:
  - Nursing and technical services.
  - Certain drugs and biologicals.
  - Presurgical diagnostics and services (e.g., urinalysis).
  - Medical and surgical supplies (e.g., surgical dressings, splints, casts, appliances and all supplies and equipment furnished by ASCs with surgical procedures).
  - Administrative and housekeeping services.
  - Anesthesia drug supply and materials.

Note: Anesthesia services are invoiced independently from both the surgeon's professional fees and the ASC's facility charges. Depending on contractual arrangements, these services may be billed either by the anesthesia provider or through the facility. Operating surgeons, including OMSs, would not report or bill for anesthesia services when provided by a separate anesthesia professional in any setting, including the ASC.

III. CMS PAYMENT SYSTEMS

While the codes used for surgical and diagnostic procedures generally remain the same whether coding for the ASC or the provider, there are differences in the payment methodologies applied.

CMS payment: Professional services

The federal government has established payment policies for professional services, such as those provided by OMSs, distinct from the reimbursement ASCs receive. These rates are influenced by a variety of factors, including the patient's insurance plan and coverage specifics.

For services covered under Medicare, provider payments are determined by the Medicare Physician Fee Schedule (MPFS). The MPFS calculates reimbursement using the Resource-Based Relative Value Scale (RBRVS), which assigns values to CPT codes based on the complexity of the service and the resources required. Introduced by CMS in 1992, the RBRVS represents a cost blend of three factors:

- Physician work: The time, effort and skills required by a physician to provide a service.
- Practice expense: Costs for clinical staff, supplies, equipment and other practice overhead.
- Professional liability: Costs for malpractice insurance coverage.

Medicare and many other medical insurance carriers utilize the RBRVS.

Payment for professional medical services in a resource-based system varies by the setting in which the procedure is performed. In non-facility settings like an OMS office, reimbursement covers the full cost of delivering the

service, including the practice's supplies and equipment used during a procedure, often resulting in higher payments to providers. Conversely, in facility settings such as ASCs, reimbursement for the surgeon is typically lower as the facility provides the resources and bills separately for their use. For example:

CPT/HCPCS Code	Procedure Description	2026 National Average MPFS Price by Care Setting	
		Non-Facility ($)	Facility ($)
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	475.96	336.68

CMS also designates certain procedures as facility-based (i.e., hospital outpatient, inpatient or ASC setting), evaluating them against the agency's long-standing patient safety criteria. These procedures are eligible for Medicare coverage and payment only when performed in approved facility settings, such as ASCs. For example:

CPT/HCPCS Code	Procedure Description	2026 National Average MPFS Price by Care Setting	
		Non-Facility ($)	Facility ($)
20902	Bone graft, any donor area; major or large	NA*	241.82
21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion[s])	NA*	899.49
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion[s])	NA*	906.83

**NA signifies that the procedure is not priced for the non-facility setting, therefore rarely or never performed in non-facility settings. If a code lacks a non-facility rate, it likely indicates that Medicare will not cover it if performed in an office (Place of Service Code 11).*

Ultimately, while professional reimbursement for certain services may be lower when delivered in ASCs, sometimes it is the only setting where such procedures may be permitted for payment under Medicare rules.

CMS annually updates the MPFS, detailing policy changes on its website: CMS.gov/Medicare/payment/fee-schedules/physician. CMS also has developed an online search tool that may be used to access Medicare pricing, relative value and payment policy information by CPT code: CMS.gov/Medicare/physician-fee-schedule/search/overview.

Commercial carriers should be contacted individually to confirm payment methodologies for professional services or for fee-related inquiries.

CMS payment: Facility charges

CMS sets outpatient facility payment rates through a prospective payment system, which is updated annually in the Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System rule. This system assigns predetermined rates based on service categories, designed to cover all aspects of an episode of care.

For hospital outpatient services, payment rates are categorized into Ambulatory Payment Classifications (APCs), grouping services by clinical similarity and resource costs. Each service within an APC is reimbursed at the same rate.

ASC payments are calculated as a percentage of hospital rates under the OPPS for the same or similar services. OMS procedures may be assigned to various ENT, dental or musculoskeletal APCs that range in value from approximately $349.37 to $3,025.62. The table below includes examples of how CPT and CDT codes may be assigned to particular APCs and how the national average rate a facility may receive in 2026 may vary depending on facility type:

CPT/ HCPCS Code	Procedure Description	APC Group	2026 Average Facility Payment Rate	
			Hospital Outpatient Department ($)	ASC ($)
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	APC 5163 Level 3 ENT Procedures	1,481.28	659.17
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated			
21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage	APC 5164 Level 4 ENT Procedures	3,243.07	1,480.50
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant			
D7240	removal of impacted tooth - completely bony	APC 5871 Dental Procedures	1,662.63	349.37
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone			

Additional information on the OPPS, including APC rates is available at CMS.gov/Medicare/payment/prospective-payment-systems/hospital-outpatient.

Note: The OPPS/ASC payment rule establishes facility payment rates for services that meet Medicare coverage and payment requirements. It does not impact provider payment rates for services rendered in ASCs or hospitals.

Payment adjustments and indicators

CMS uses payment indicators to provide specific payment details for services under the ASC payment system. These indicators help determine whether a service is bundled (packaged), typically performed in an office setting (office-based) or requires significant use of a medical device (device-intensive).

Examples of ASC payment indicators that may apply to oral and maxillofacial surgery codes include:

Indicator	Definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D1	Ancillary dental service/item; no separate payment made.
D2	Non office-based dental procedure added in CY 2024 or later.
J8	Device-intensive procedure; paid at adjusted rate.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs.

CMS annually updates payment rates and rules, including ASC payment indicators. Additional information may be found on the CMS website under the ASC payment section, available at CMS.gov/Medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc.

IV. ASC-ELIGIBLE PROCEDURES

Under Medicare, the eligibility of surgical procedures for coverage and payment in ASC settings is determined by CMS based on specific safety and clinical criteria. This includes assessing the potential for significant blood loss, the invasiveness of the procedure and the associated safety risks in different settings. CMS also reviews site-of-service patterns in Medicare claims to identify which procedures require the comprehensive resources of a hospital.

ASC Covered Procedures List

The ASC Covered Procedures List (CPL) includes procedures approved for Medicare payment in ASCs. These are considered by CMS to be safely delivered outside of hospital settings, not typically requiring overnight medical monitoring or care. The list encompasses procedures that:

- Pose minimal risk of significant blood loss.
- Do not require extensive or prolonged invasion of body cavities.
- Do not involve major blood vessels.
- Are not emergent or life-threatening.
- Typically do not require systemic thrombolytic therapy.
- Are not designated solely for inpatient care.
- Are not reported using an unlisted CPT code or excluded by Medicare.

Several oral and maxillofacial surgery procedures are currently on the ASC CPL, including CPT codes that describe excision of bone of the mandible and facial bones, select mandibular reconstructive procedures and open and closed approaches to treating fractures of the maxillofacial region.

Effective Jan. 1, 2024, the CPL was expanded to include a range of dental procedures, such as extraction services, alveoloplasty in conjunction with extractions, and removal of maxillary and mandibular tori.

ASC Covered Ancillary Services List

The ASC Covered Ancillary Services List outlines services that are integral to eligible surgical procedures when furnished in the ASC, although some may not qualify for separate payment.

For example, CDT code D7922 (placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site) is categorized as an ASC ancillary service without separate payment. If an OMS performs an extraction requiring bone removal (e.g., D7210) and places an intra-socket dressing (D7922) in an ASC, the facility may receive a single bundled payment from Medicare for both services, provided all coverage and payment criteria are met.

Inpatient Only List and other ASC exclusions

The OPPS/ASC rule also outlines procedures that Medicare does not cover in an ASC setting. Some procedures not reimbursable in ASCs may be covered in hospital outpatient departments, while others are exclusively designated for inpatient care and therefore included on the Inpatient Only (IPO) List.

Procedures that CMS deems are highly invasive, likely to result in major blood loss or require intensive postoperative care are typically designated as inpatient only.

CMS will begin eliminating the IPO list in 2026 beginning with 285 mostly musculoskeletal procedures, including 28 OMS procedures. This change leaves 1,446 services on the IPO list that will be phased out over the next three years by Jan. 1, 2029. The removal of procedures from this list allows for payment in either the inpatient or outpatient setting. In 2026, 271 of these procedures are being added to the ASC CPL, 26 of which are OMS procedures.

OPPS and ASC payment system resources

CMS annually updates its policies and the lists of procedures eligible for coverage in different facility settings. It is important for OMSs and their staff to stay informed of these changes as they can impact patient treatment options and Medicare coverage. For instance, if an OMS performs a procedure in an ASC that is categorized as inpatient only, Medicare will not cover the costs for the surgeon, facility or anesthesia services provided.

Detailed information on the OPPS/ASC rule – including current payment rates, complete list of ASC covered procedures (Addendum AA), covered ancillary services (Addendum BB) and codes excluded from ASC payment (Addendum EE) – is available in the Medicare Ambulatory Surgical Center Payment System section on the CMS website at CMS.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices.

The IPO List (Addendum E) may be found under the hospital outpatient section on the CMS website, available at CMS.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices.

Note: Although the OPPS/ASC rule applies to the Medicare program, some commercial insurers and state Medicaid programs may adopt similar coverage and reimbursement policies. Additionally, commercial payers tend to follow CMS ASC payment classifications.

CMS policy changes for dental services in ASCs

In 2023 and 2024, Medicare expanded coverage to include medically necessary dental services linked to specific medical treatments. This includes dental services related to organ transplants, cardiac valve procedures and treatments for certain cancers, such as chemotherapy, radiation and surgery for head and neck cancers. In 2025, Medicare expanded coverage to include dental/oral exams prior to, or during Medicare-covered dialysis services when used in the treatment of ESRD; as well as dental services to eliminate an oral or dental infection for such patients.

As of Jan. 1, 2026, there are 46 dental surgical procedures included on the ASC CPL, making them eligible for Medicare payment when performed in ASCs. Additionally, nearly 80 dental ancillary services have been added, allowing them to be performed with other covered surgeries in the ASC. This expansion broadens the range of dental procedures billable by ASCs and may also improve patient access to medically necessary ASC-based dental care.

Medicare's dental coverage expansion, applicable to both inpatient and outpatient settings, is limited to procedures deemed integral and linked to select Medicare-covered treatments or services. Both facility and professional fees for these services are reimbursable only when they meet all Medicare coverage criteria.

OMSs and professional coding and billing staff are encouraged to review the current Medicare dental coverage guidelines available at CMS.gov/Medicare/coverage/dental as well as check their local Medicare contractor's website for guidance on billing dental services. A list of Medicare Administrative Contractors (MACs) by jurisdiction is available at CMS.gov.

V. CODING FOR ASC-BASED SERVICES

A facility fee encompasses charges by an ASC for the use of its space, equipment, supplies and clinical staff necessary to perform a procedure or service.

In most cases, ASCs use the same CPT, CDT and HCPCS codes as individual providers to report the use of the facility's resources related to specific procedures. Under CMS rules, ASCs may report facility charges for ASC-eligible surgical procedures and certain ancillary services for which separate payment is permitted. This applies to all codes on the ASC CPL and covered ancillary services list, including CDT codes for Medicare-covered dental services.

As mentioned, CMS expanded opportunities for ASCs to be reimbursed for Medicare-covered dental services by adding CDT codes to the lists of ASC-eligible procedures. This enables ASCs to report specific dental procedures tied to individual payment rates, potentially offering a mechanism for more appropriate facility reimbursement for Medicare-covered dental services.

For example, an OMS performs six extractions requiring bone removal and tooth sectioning, along with an incision and drainage of intraoral soft tissue for a Medicare beneficiary receiving radiation therapy for head and neck cancer. Both procedures are included on the ASC CPL and are eligible for payment in the ASC, provided they meet Medicare coverage criteria. Therefore, the OMS and ASC would report the same codes for these procedures, reflecting their respective services:

- D7210 *extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated*
- D7510 *incision and drainage of abscess - intraoral soft tissue*

Note: Some medical carriers may still require use of CPT code 41899 (Unlisted procedure, dentoalveolar structures) to report facility charges for dental surgeries performed in ASCs. Before recent updates to CMS coding and coverage rules, this code was the only reporting mechanism available for most dental services in these facilities. Although Medicare does not reimburse 41899 in the ASC, Medicaid and some commercial carriers may allow payment. Facility coders should verify each payer's reporting requirements prior to claim submission.

Facility code G0330

In response to advocacy efforts by a coalition of organizations, including AAOMS, CMS created HCPCS facility code G0330 in 2023. Initially implemented for hospital outpatient settings, CMS extended its use to ASCs starting Jan. 1, 2024:

G0330 Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room.

While G0330 provides a mechanism for ASCs to report facility charges for certain Medicare-covered dental rehabilitative procedures, CMS has set limitations on the code's use in the ASC:

- G0330 may be used to report covered dental surgical or rehabilitative procedures not listed on the ASC CPL or covered ancillary services list.
- ASCs should use more specific CPT, HCPCS or CDT codes from the lists of ASC-eligible services to describe dental services performed whenever possible, instead of HCPCS code G0330.
- G0330 may only be reported once per encounter and only with one or more ancillary dental services for which separate payment is not permitted.

G0330 enables facility fees associated with a Medicare-covered dental rehabilitative service requiring monitored anesthesia and a facility OR. **This code is intended to be used by facilities — not providers** — to capture the cost associated with furnishing dental services that meet Medicare coverage criteria. Providers, including OMSs should continue to report their professional ASC-based services using CPT and CDT codes, as appropriate.

Note: G0330 is specific to the Medicare program. However, some commercial payers and state Medicaid agencies that align with CMS facility services guidelines may choose to adopt G0330 and recognize it for payment in the ASC setting. Refer to the coding scenarios in Section VIII. for examples of when G0330 may/may not be reported in the ASC.

Other considerations for facility fee billing

When coding and billing facility fees, ASC and hospital coders must navigate various administrative and procedural requirements:

- **Billing format:** ASCs typically submit claims using the CMS-1500 form or its electronic equivalent, in accordance with CMS guidelines. Some payers may require the UB-04 form (CMS-1450) or its electronic counterpart, which differs from Medicare's standard. ASCs should consult with each payer to confirm reporting requirements. Billing format also may be clarified during contract negotiations with the insurance carrier.
- **Modifier use:** Modifiers detail aspects of services or procedures that influence coding and reimbursement of facility resources. While many modifiers used for professional services also are applicable to ASCs, exceptions do exist. Appendix A of the CPT code book provides a list of modifiers suitable for both ASC and hospital outpatient settings. While not an all-inclusive list, the following table provides examples of modifiers relevant to ASC billing:

CPT Modifier	Description
Modifier –50	Bilateral Procedure ***Coding tip:*** *The use of modifier –50 for reporting bilateral procedures performed in ASCs differs among payers. Some carriers may not accept modifier –50 for ASC claims, instead requiring the procedure to be reported with either the LT and RT HCPCS modifiers on separate lines or as a single entry with a "2" in the units field to indicate a bilateral service. Carriers should be consulted to confirm reporting requirements.*
Modifier –52	Reduced Services ***Coding tip:*** *ASCs may use modifier –52 to indicate the discontinuation of a procedure that does not require anesthesia, as noted by several local Medicare carriers. This modifier reduces the payment to reflect that the procedure was not fully completed. ASCs should verify the specific reporting guidelines with each payer.*
Modifier –59	Distinct Procedural Service ***Coding tip:*** *Modifier –59 and HCPCS XE, XP, XS, XU modifiers are used in ASC settings to distinguish procedures that are distinct because they occurred during separate encounters, at different anatomical sites, or were performed by different practitioners. These modifiers may override National Correct Coding Initiative (NCCI) edits similar to those in physician billing, applicable to payers that follow Medicare NCCI guidelines. ASCs should verify the application of modifiers –59 and X{EPSU} with CMS guidelines and confirm with private payers to ensure proper use.*

Continued

CPT Modifier	Description
Modifier –73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia ***Coding tip:*** *ASCs use modifier —73 to indicate a surgical procedure was terminated prior to induction of anesthesia or initiation of the procedure. For example, a procedure terminated during preoperative evaluation of the patient. In this case, the ASC would report the surgical procedure code and append modifier –73. The provider may report the appropriate evaluation and management service code.*
Modifier –74	Discontinued Outpatient Hospital/Ambulatory Surgical Center (ASC) Procedure After Administration of Anesthesia ***Coding tip:*** *If a surgical or diagnostic procedure is terminated after administration of anesthesia or initiation of the procedure due to extenuating circumstances or threat to patient well-being, the ASC may report the appropriate procedure code and append modifier –74. The provider also may report the code describing the service but would append modifier –53 to indicate a discontinued procedure.*
Modifier TC	Technical Component ***Coding tip:*** *Used by ASCs for procedures with both professional and technical components when only the technical component is furnished by the ASC. For example, a CT scan captured with the ASC's equipment but interpreted by an OMS.*

Note: Unlike the professional fee schedule, ASCs typically do not have a postoperative global period; their payment only includes the facility services and supplies used on the day of surgery. Any necessary follow-up care after the day of the procedure is generally billed separately.

ASC billing for non-covered services

The approach to billing for services not covered by Medicare in ASCs varies widely. Commonly, billing departments use an ASC "APC 0" designation for services not included on the ASC Covered Procedures List, indicating these services require self-payment. This may apply for services not covered by Medicare in the ASC, reflecting an adjustment in the code's valuation to account for practice expenses on the professional side. As a result, Medicare reimburses the provider at the non-facility rate, which is typically higher than the facility rate, making it unnecessary to charge patients an additional facility fee. However, services completely outside Medicare and ASC coverage may be billed to patients at the usual and customary rate.

Professional coding for ASC-based services

A detailed discussion of professional coding for ASC-based services is outside the scope of this paper. However, because coding for facility-based services can be complex, certain considerations are briefly addressed.

OMS professional services in an ASC would be coded just as they are for services rendered in the office or hospital setting, using the appropriate CDT, CPT and ICD-10-CM codes based on the patient's insurance coverage and nature of the procedure. Claims should be submitted on the CMS-1500 claim form or its electronic equivalent, indicating Place of Service 24 – Ambulatory Surgical Center.

OMSs and professional coders should follow payer-specific guidelines, which may influence the coding process. For instance, some medical payers may prefer the use of CDT codes for certain procedures, such as extractions, over an unlisted CPT code. Additionally, all claims must accurately reflect the treating provider's name, NPI, billing entity and treatment location.

For detailed information on OMS professional coding and appropriate modifier use, refer to the library of AAOMS coding and billing papers, online courses and other coding and reimbursement resources available at AAOMS.org.

VI. ASC ACCREDITATION

To charge facility fees in conjunction with professional services, an oral and maxillofacial surgery practice must be accredited as an ASC and hold a license to operate an ambulatory surgical center within its state. ASC accreditation permits the practice to bill for the use of its facilities, which includes supplies, equipment and clinical staff. This applies to specific procedures approved for ASC settings by Medicare and other payers following CMS guidelines that do not include practice expenses on the professional side.

Some OMS offices may be accredited through an office-based surgery program, but currently such facilities do not have the ability to bill a surgical center fee. Only accredited ASCs and/or state licensed facilities may submit facility charges to state or government payers. Commercial payer contracts vary, and reporting facility fees should be evaluated with individual payer contracts.

Regulations and Certificate of Need (CON)

ASCs are subject to stringent state and federal regulations. Many states require a Certificate of Need (CON) before a facility may seek accreditation as an ASC. A CON is a regulatory tool that requires certain healthcare providers, including ASCs, to obtain government approval before opening or expanding its facilities or services. The ASC would need to demonstrate there is a genuine need for these changes within the community it serves.

Medicare certification for ASCs requires compliance with specific conditions of participation, which can be validated through accreditation by one of four organizations authorized by CMS: the Accreditation Association for Ambulatory Health Care, The Joint Commission, the Accreditation Commission for Health Care and QUAD A. Additionally, state-specific licensing and accreditation are managed by each state's department of health and/or licensing, which works with ASCs to ensure local standards and requirements are met.

VII. RESOURCE MATERIAL

No single resource fully covers ASC facility billing. OMSs and their staff are encouraged to regularly consult the latest materials. Additionally, they may consider engaging with national and state-level organizations that specialize in ASC-related information and offer updates online. For Medicare billing, MACs may provide guidance on coding and billing for ASC services.

Additional resources include:

- CMS.gov | Ambulatory Surgical Center Payment
- CMS Internet Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 14 – Ambulatory Surgical Centers
- Search the Medicare Physician Fee Schedule

VIII. ASC CODING SCENARIOS

The following case studies demonstrate the reporting of common procedures performed by OMSs in ASCs, along with the average reimbursement rates ASCs might expect for these procedures when covered by Medicare.

Case 1

An OMS performs a comprehensive oral exam; extraction requiring bone removal of Tooth #22, 23 and 24; alveoloplasty and intraoral I&D.

OMS Code (Professional Service)	ASC Code (Facility Charge)	2026 ASC ($) Payment Rate (National Average)
D0150 comprehensive oral evaluation - new or established patient	D0150	0.00*
D7210 extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated (three units)	D7210 (three units)	659.17**
D7311 alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	659.17**
D7510 incision and drainage of abscess - intraoral soft tissue	D7510	388.55**

**Ancillary dental service, separate ASC payment may not be made.*

***Many carriers, including CMS, employ a multiple procedure payment reduction (MPPR) on the facility side for most ASC-eligible services. This means the primary service code on the ASC claim is allowed at 100 percent and subsequent services are reduced by 50 percent. This includes scenarios in which multiple units of the same procedure code are reported. For example, in the case above, the first unit of D7210 may be allowed at 100 percent, whereas each subsequent unit/service would be reduced by 50 percent. Most Medicare contractors will automatically apply the payment reduction, although when billing commercial plans, the OMS practice should confirm if the plan will automatically apply the reduction or if the practice should adjust the fee prior to submitting the claim.*

Case 2

An OMS performs four extractions in the lower left quadrant requiring bone removal and the excision of a benign tumor of the mandible by enucleation and curettage.

OMS Code (Professional Service)	ASC Code (Facility Charge)	2026 ASC ($) Payment Rate (National Average)
21040 Excision of benign tumor or cyst of mandible, by enucleation and/or curettage	21040	1,480.50
D7210 extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated (four units)	D7210 (four units)	659.17*

**As indicated above, the MPPR may apply.*

Case 3

An OMS performs an arthrocentesis of the TMJ, TMJ manipulation requiring anesthesia and injections of the ligaments surrounding the TMJ, all bilaterally.

OMS Code (Professional Service)	ASC Code (Facility Charge)	2026 ASC ($) Payment Rate (National Average)
21073-50 Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	21073**	303.11
20550-50 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	20550**	33.23†
20605-59-50* Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	20605**-59^	32.56†

**An NCCI edit exists when 20605 is reported with either 21073 or 20550. Clinical documentation must support use of a modifier to bypass the edit, demonstrating the arthrocentesis as both distinctly separate and medically necessary. Coders should confirm with the payer whether modifier –59 or a X{EPSU} HCPCS modifier is preferred. Modifier –59 is reported in the first position to potentially bypass the NCCI edit, modifier –50 is reported second to indicate a bilateral service.*

***As all services on the ASC facility claim are performed bilaterally, facility coders should confirm bilateral reporting guidelines with the payer. Modifier –50 may be recognized on the ASC claim, or the carrier may prefer HCPCS LT/RT modifiers. The number of units reported for each bilaterial service should also be verified with the carrier.*

^According to the Medicare NCCI Policy Manual, NCCI procedure-to-procedure edits used for practitioner claims are also used for ASC claims. Therefore, appending modifier –59 or the appropriate X{EPSU} would be required to indicate the arthrocentesis is a distinct service on the facility side.

†As indicated above, the MPPR may apply.

Note: ASC facility charges do not cover the professional fees of the surgeon or the anesthesia provider. Both practitioners bill separately for the professional component of their services. For guidelines on coverage, billing, payment policies and procedures for services rendered in ASCs, refer to the Medicare Claims Processing Manual, Chapter 14.

Case 4

An OMS performs a closed treatment of a nasal bone fracture with manipulation and the reimplantation of four upper anterior teeth.

OMS Code (Professional Service)	ASC Code (Facility Charge)	2026 ASC ($) Payment Rate (National Average)
21320 Closed treatment of nasal bone fracture with manipulation; with stabilization	21320	1,480.50
D7270 tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth (four units)	D7270	349.37*

**As indicated above, the MPPR may apply.*

Case 5

An OMS performs a problem-focused limited oral evaluation, takes an intraoral periapical X-ray, removes erupted Tooth #28 and 29 and places intra-socket dressing in each site to aid in hemostasis.

OMS Code (Professional Service)	ASC Code (Facility Charge)	2026 ASC ($) Payment Rate (National Average)
D0140 limited oral evaluation - problem focused	D0140	0.00*
D0220 intraoral - periapical first radiographic image	D0220	0.00*
D7140 extraction, erupted tooth or exposed root (elevation and/or forceps removal) (two units)	D7140 (two units)	349.37**
D7922 placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site (two units)	D7922 (two units)	0.00*

* *Ancillary dental service, separate ASC payment may not be made.*

** *As indicated above, the MPPR may apply.*

Case 6

An OMS performs a vestibuloplasty and full mouth debridement. Due to the patient's underlying medical condition, the procedure required monitored anesthesia in a facility setting.

OMS Code (Professional Service)	ASC Code (Facility Charge)	2026 ASC ($) Payment Rate (National Average)
D7340 vestibuloplasty - ridge extension (secondary epithelialization)	G0330*	1,480.50
D4355 full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	D4355	0.00**

**According to CMS rules, for dental procedures not on the ASC Covered Procedures List, such as D7340, when furnished with a covered ancillary dental service. ASCs may report G0330 to seek reimbursement for the associated resource costs.*

***Ancillary dental service, separate ASC payment may not be made.*

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

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

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

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery. This paper discusses ambulatory surgical center coding and billing. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-10-CM) and treatment (CPT/CDT) coding. 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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