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Oral Surgery Coding & Reimbursement Alert

CPT® Coding Strategies: Graft Choice Helps You Zero in on the Right Arthroplasty Code

Hint: Don't report same side condylectomy or coronoidectomy separately.

If your surgeon is planning on performing an arthroplasty of the temporomandibular joint (TMJ), you should be aware of the various code choices that you can choose from for the procedure depending on the material used for grafting. You should also watch CCI if you are planning on reporting other TMJ surgical procedures with arthroplasty.

Choose From Three Codes For Reporting Arthroplasty

When your oral surgeon performs an arthroplasty of the TMJ, you have three codes to choose from, depending on the material he chooses to use for replacing the joint. The three codes that you can use to report a TMJ arthroplasty are:

- 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)

As you can see from the descriptors to the arthroplasty codes elaborated above, you will choose the appropriate code depending on the graft material that your surgeon uses for the procedure.

"Your surgeon might want to use different type of graft materials for performing an arthroplasty, namely, autografts, allografts or a prosthetic graft material," says **Barry Shipman, DMD,** clinical professor, University of Florida School of Dentistry, Hialeah Dental Center. If the graft is obtained from the patient from another site, such as a costochondral rib, or if your clinician uses the temporalis muscle in the form of a myofascial flap, you will have to report the arthroplasty procedure with 21240.

Instead, if your clinician uses graft material from another human donor or from a cadaver, then you report the arthroplasty procedure with 21242.

However, if your clinician uses a completely fabricated prosthetic joint system (such as the TMJ Concepts prosthesis, the Christensen TMJ Fossa-Eminence Prosthesis System [partial TMJ prosthesis], the Christensen TMJ Fossa-Eminence/Condylar Prosthesis System [Christensen total joint prosthesis], or the W. Lorenz TMJ prosthesis), you will have to report the arthroplasty procedure with 21243.

Coding tip: You do not have to report a separate code for obtaining the graft if your clinician is performing the arthroplasty using an autograft. The work involved in obtaining the graft material is included in the CPT® code 21240 and should not be reported separately with another CPT® code.

Example: Your oral surgeon reviews a 44-year-old female patient with complaints of severe pain in the right TMJ for a period of over five years. She has limitations of opening her jaw (<35mm) and the pain aggravates whenever she tries to chew on any type of hard food. She has had a previous arthroscopy but that has not helped in alleviating her symptoms or improved the opening of her jaws.

She complains that her jaw opening has become even more limited over the past few months and conservative treatment prescribed to her has not been of any kind of help.

Upon radiographic and CT scan examination, your surgeon observes loss of vertical height and severe resorption of the condyle on the right side.

Based on history, and observation from imaging studies, your clinician arrives at the diagnosis of ankylosis of the TMJ on the right side. Your surgeon decides to perform arthroplasty using a costochondral rib graft.

What to report: You'll report 21240 for the arthroplasty since your clinician used an autograft. You report the diagnosis with the ICD-9 code, 524.61 (Temporomandibular joint disorders adhesions and ankylosis [bony or fibrous]) or M26.61 (Adhesions and ankylosis of temporomandibular joint) if you are using ICD-10 codes.

Observe Coverage Criteria and Documentation Requirements

According to Medicare statute, 1862(a)(12) of the Social Security Act, payment "for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth" are excluded. As a result, Medicare generally does not cover treatment for TMJ disorders. And other payers, following Medicare's lead, also won't provide coverage for surgical procedures of the TMJ. Some payers, even if they provide coverage, require pre-authorization for the arthroplasty procedure

Action plan: In order to obtain prior authorization, you will need to provide documentation to the payer informing them about the procedure, the medical necessity of performing the procedure, and details about the conservative treatment options that were tried prior to your clinician deciding to resort to surgical means of correction.

You should also include documentation about any imaging studies (such as MRI or other x-rays) that have been performed and interpreted to support the necessity of the procedure.

Also, don't forget to include details which show that the problem didn't arise because of a dental problem and is specific to the TMJ to further substantiate the medical necessity of the surgery.

Watch Edit Bundles When Reporting Arthroplasty With Other Surgical Procedures

When your clinician is performing an arthroplasty of the TMJ joint, he might be performing other surgical procedures on the same side or on the joint on the opposite side. When you are faced with such a situation, you will need to know if you can report a different procedural code for the same patient on the same calendar date of service.

If you are reporting any one of the arthroplasty codes (21240, 21242 or 21243) with arthrocentesis (20605, Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; without ultrasound guidance) or a diagnostic arthroscopy (29800, Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy [separate procedure]), you will face edits.

However, the modifier indicator for these edit bundles is '1,' which means that you can overcome the edits by using a suitable modifier. Since the arthrocentesis and the diagnostic arthroscopy code are the column 2 codes in the edit bundle with arthroplasty codes, you will have to append the modifier to these codes to break the edit. The most likely modifier that you will use is 59 (Distinct procedural service) or XS (Separate Structure).

You will not face any edits if you are trying to report a surgical arthroscopy code (29804, Arthroscopy, temporomandibular joint, surgical) with any of the arthroplasty codes.

Also, during an arthroscopy, your surgeon might undertake procedures like a meniscectomy (21060, Meniscectomy, partial or complete, temporomandibular joint [separate procedure]), condylectomy (21050, Condylectomy, temporomandibular joint [separate procedure]) or a coronoidectomy (21070, Coronoidectomy [separate procedure]).

When performed on the same side, you should not report these procedures separately. However, if performed on the opposing side joint, then you can report them separately. There is no edit bundle for reporting an arthroplasty with a coronoidectomy.

You will face bundling if you are reporting a meniscectomy or a condylectomy with an arthroplasty. "When your surgeon performs additional types of procedures with the arthroplasty, you should look at using an appropriate modifier such as 59, 70 or even a modifier 50 if the procedure is bilateral," adds Shipman.

Modifier indicator: Again, the modifier indicator for these above mentioned procedures with an arthroplasty is '1,' which means you can overcome the edit bundle by using a suitable modifier such as 59 or XS. You append the modifier with the meniscectomy or the condylectomy code as they form the column 2 code in the edit bundle.