Oral Surgery Coding & Reimbursement Alert

CPT® Coding Strategies: Perfect Your TMJ Arthrotomy Reporting With This Expert Guidance

Use a modifier for bilateral procedures.

If your oral surgeon is performing an arthrotomy of the TMJ, check the need for preauthorization for the procedure while understanding the coverage criteria to avoid the risk of denial. You should also be aware of bundling edits if you are planning to report arthrotomy with other TMJ procedures.

Learn the Appropriate Codes For Reporting an Arthrotomy Procedure

For arthrotomies of the temporomandibular joint, you'll use CPT® code, 21010 (Arthrotomy, temporomandibular joint).

When reporting an arthrotomy, your reporting for the procedure will not be completed if you do not include an appropriate covered diagnosis code for which your oral surgeon is performing the procedure. Not all diagnosis will get you coverage for the procedure. Some of the covered diagnosis for performing an arthrotomy of the TMJ will include:

- 524.60 (Temporomandibular joint disorders unspecified)
- 524.61 (Temporomandibular joint disorders adhesions and ankylosis [bony or fibrous])
- 524.62 (Temporomandibular joint disorders arthralgia of temporomandibular joint)
- 524.63 (Temporomandibular joint disorders articular disc disorder [reducing or non-reducing])
- 524.64 (Temporomandibular joint sounds on opening and/or closing the jaw)
- 524.69 (Temporomandibular joint disorders other specified temporomandibular joint disorders)

ICD-10: When you begin using ICD-10 codes post Oct.1, 2015, these above mentioned diagnosis codes in ICD-9 will crosswalk to M26.6- (Dentofacial anomalies [including malocclusion] and other disorders of jaw). Depending on the identified diagnosis, you have to choose an appropriate one-to-one crosswalk code from the code range M26.60-M26.69. For instance, if your clinician identifies the condition as arthralgia, you have to report M26.62 (Arthralgia of temporomandibular joint).

Example: Your oral surgeon reviews a 33-year-old female patient with complaints of pain in the left TMJ for a period of over two years. She has limitations of opening her jaw and the pain aggravates whenever she tries to chew on any type of hard food.

The patient has had a history of orthodontic treatment to correct malocclusion when she was about 17 years old. She has had a previous arthroscopy but that has not helped in alleviating her symptoms or improved the opening of her jaws. Your clinician had previously placed the patient on soft diet and pain killing medications for the past month but this has not brought any improvements to her condition.

Your clinician orders x-rays and CT scan that help your surgeon identify ankylosis of the left TMJ. Your surgeon decides to perform an arthrotomy on the left TMJ.

What to report: You'll report 21010 for the arthrotomy procedure. 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.

Be Informed About TMJ Coverage Limitations and Documentation Guidelines

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.

Preauthorize: Many of the other payers also won't provide coverage for procedures performed on the TMJ. So, ensure that you check with the payer beforehand if the arthrotomy that your surgeon is planning to perform is covered and if so, if it is covered for the specific diagnosis for which your clinician is planning to perform the procedure.

Some payers might even ask you to get clearance from their in-house patient management representatives who will review the history, findings of the physical examination, imaging studies, conservative treatment that the patient has undergone in the months prior and the management that has been planned by your oral surgeon.

Documentation guidelines: In order to prove medical necessity for the arthrotomy, you will have to include documentation about previously prescribed conservative management procedures such as avoiding chewing hard foods, pharmacological management, and physical therapy. In spite of providing conservative management for more than two weeks, your clinician should note symptoms such as pain, difficulty in chewing, restricted range of motion in either jaw opening, lateral movements of the jaw or if there is continued deviation of opening of the jaw present.

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 is not originating because of a dental problem and is specific to the TMJ to further substantiate the medical necessity of the arthrotomy.

Know the Rules For Reporting 21010 With Other Codes

You report 21010 when your surgeon performs an arthrotomy of the TMJ on one side. If your clinician also operates on the other side, you will have to report another unit of 21010. Since you need to let the payer know that both the sides were treated and to avoid denial, you need to append the modifier 50 (Bilateral procedure) to the second unit of 21010.

Sometimes, you might be faced up with a scenario wherein your surgeon performs two different procedures together (on the same joint or the other TMJ). In such a case, you will need to know if you are able to report two procedural codes for the same patient on the same calendar date of service. For this you need to be aware of Correct Coding Initiative (CCI) edits that are in place for reporting other TMJ procedural codes with 21010.

You will not face any edits if you are reporting an arthrocentesis (20605, Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; without ultrasound guidance) with 21010. Again, you will not face any edits if your surgeon is performing a diagnostic arthroscopy (29800, Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy [separate procedure]) with arthrotomy. However, you will face edits if your surgeon is planning on performing a surgical arthroscopy (29804, Arthroscopy, temporomandibular joint, surgical) with arthrotomy.

Modifier indicator: For the edits between arthroscopy codes and arthrotomy codes, the modifier indicator is '1,' which means you can unbundle the two codes and report them separately if a suitable modifier is used. Since the arthroscopy code, 29804, is the column 2 code in the edit with arthrotomy codes, you will have to use a modifier with 29804. The modifier that you have to append to 29804 is 59 (Distinct procedural service).

2015 change: Since you have additional modifiers that you can use as substitute for the 59 modifier that came into effect after Jan.1, 2015, you can think of using the modifier XS (Separate Structure) instead of modifier 59 if your oral surgeon is handling these procedures on different TMJ joints for the same patient on the same calendar date of service.