Oral Surgery Coding & Reimbursement Alert

CPT® Coding Strategies: Upgrade Your TMJ Arthroscopy Accuracy With This Expert Advice

Check the need for prior authorization for the procedure.

If your maxillofacial surgeon is planning on performing a diagnostic or surgical arthroscopy, you'll need to ensure that all the coverage criteria are satisfied. . You should also know if you need to report an additional E/M code for the preoperative management, while being aware of all the edits you will face when trying to report this procedure with other procedural codes. Understand Coverage Criteria for Arthroscopy of TMJ When your oral surgeon performs an arthroscopy procedure of the temporomandibular joint, you report the procedure with these two CPT® codes:

- 29800 (Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy [separate procedure])
- 29804 (Arthroscopy, temporomandibular joint, surgical)

You report 29800 when your surgeon performs only a diagnostic arthroscopy (only visualizes the joint using the arthroscope), whereas you report 29804 when your surgeon performs some corrective measures while visualizing the TMJ joint through the arthroscope. "Don't forget to use the correct ICD-9-CM code from the range 524.60-524.69 to help support the CPT® code that you are reporting," says **Barry Shipman, DMD**, clinical professor, University of Florida School of Dentistry, Hialeah Dental Center.

Example: Your oral surgeon reviews a 29-year-old male patient who has been complaining of severe pain in the left TMJ area, along with increasing difficulty in chewing for the past four weeks or so. The patient also has limitations in opening and closing the mouth and also experienced some clicking. The patient had been earlier advised to go on a soft diet and avoid hard chewing for about two weeks. The patient had also been advised to take pain killing medication for the same period of time but this failed to produce any pain relief.

Your clinician orders x-rays and ultrasonography of the TMJ that enables your clinician to diagnose the patient with internal derangement with internal adhesion. Your clinician then plans to perform an arthroscopy to help remove the adhesions and allow the disc to move freely.

What to report: You'll turn to 29804 for this 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.

Reminder: Not all payers will provide coverage for procedures performed on the TMJ. So, ensure that you check with the payer beforehand if the arthroscopy 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 a 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: Payers will consider the arthroscopy procedure medically necessary if previously prescribed conservative management procedures such as avoiding chewing hard foods, pharmacological management, and physical therapy have failed to remove symptoms and this is documented specifically. Despite this conservative management for more than two weeks, your clinician should note symptoms such as pain, difficulty in chewing, and there is 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.

Your clinician should provide documentation about imaging studies such as MRI or other x-rays that have been performed and interpreted to support the necessity of the procedure. "This is all determined by the clinical record," adds Shipman. "Be sure to record correctly your clinical findings. This should include time and management." Also, your clinician should provide details that the problem is not originating because of a dental problem and is specific to the TMJ to substantiate the medical necessity of the surgery.

Watch CCI When Reporting With Other TMJ Codes

You will face bundling if you are trying to report arthroscopy with other TMJ procedure codes. So, if your oral surgeon performs arthrocentesis (20605, Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa] ; without ultrasound guidance) and arthroscopy on the same calendar date of service, you'll face edits according to Correct Coding Initiative (CCI) edits. The edits hold good for both diagnostic and surgical arthroscopic procedures with arthrocentesis.

Modifier indicator: For the edits between arthroscopy codes and arthrocentesis 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 arthrocentesis code, 20605, is the column 2 code in the edit with arthroscopy codes, you will have to use a modifier with 20605. The modifier that you have to append to 20605 is 59 (Distinct procedural service).

You will also face edits if you are trying to report arthroscopy with arthrotomy (21010, Arthrotomy, temporomandibular joint) procedures. However, you will only face edits between surgical arthroscopy and arthrotomy procedures. There are no edits if you are reporting a diagnostic arthroscopy and an arthrotomy procedure on the same calendar date of service.

Again, as with the arthrocentesis code, the modifier indicator for the code bundling between arthroscopy and arthrotomy code is '1.' Since the surgical arthroscopy code is the code in the column 2 of the CCI edits, you will have to append the modifier to this code to unbundle the codes. Again, the modifier that you will use is 59.

2015 Change: Since you have additional modifiers that you can use as substitute for the 59 modifier that come 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.

Know When to Report E/M Code Additionally

Your oral surgeon will perform a preoperative evaluation of the patient prior to performing the arthroscopy. You cannot report a separate E/M code for the preoperative management of the patient prior to the procedure. Also, CCI edits are in place that prohibits you from using an E/M code for evaluation of the patient prior to the procedure.

However, there are instances when you are allowed to report a separate E/M code for an evaluation done prior to the procedure. This can be done only if a separate and significantly identifiable E/M service was provided to the patient that is not a direct evaluation of the patient for the persisting problem for which the procedure has been planned.

Also, the modifier indicator for the bundling of E/M codes with 20605 carry the modifier indicator '1,' which indicates that you can unbundle and report both the codes if a suitable modifier is used. Since the E/M codes form the column 2 codes in the edits with 20605, you will have to append the modifier to it. The appropriate modifier that you will have to use with the E/M code is 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).