Coding for Trauma and Fractures

I. INTRODUCTION

Detailed discussion of evaluation and management (E/M) codes is not within the scope of this paper, but because trauma services so often involve coding of emergency department services, some of the issues will be addressed.

1. If the patient is met in the ER by the oral and maxillofacial surgeon and is not evaluated by the ER physician, the oral and maxillofacial surgeon may code services provided in the emergency room using the ER codes (99281-99285).

2. If the patient is seen and evaluated by the ER physician and subsequently by the OMS, it would be appropriate for the oral and maxillofacial surgeon to report an “office or other outpatient services” E/M code (99201-99215).

3. If the patient is seen and evaluated by the ER physician and then an OMS is requested for opinion only, it would be appropriate for the OMS to report an “office or other outpatient consultation” E/M code (99241-99245). Effective January 1, 2010, Medicare no longer recognizes E/M codes 99241-99245. For a Medicare patient the above scenario would be coded as a new or established patient E/M visit with E/M codes that represents where the visit occurred and identifies the complexity of the treatment performed.

4. If the patient is seen and evaluated by the ER physician, and the ER physician subsequently transfers care to the OMS, it would be appropriate for the OMS to report an “office or other outpatient services” E/M code (99201-99215).

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

As always, the documentation must reflect the level of service provided. The "-57" modifier may be added to the ER consultation code if the decision to perform surgery is made during this evaluation.

If after evaluation in the ER (or office) the OMS decides to admit the patient, he or she should be aware that according to CPT, Initial Hospital Care codes (99221-99223) include admission-related services provided by the physician on the date of admission at other sites of service (e.g. the office or emergency department). To reiterate, a decision must be made, to code for the ER evaluation/consultation, or for the Initial Hospital Care Services. In some cases, "the global surgical package" rules may determine whether or not E/M codes will be eligible for benefits when performed on the same day as surgery. Again, the "-57" modifier may be added to the ER consultation code if the decision to perform surgery is made during this evaluation.

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

The subjects covered in this paper will include:

- REPAIR OF LACERATIONS (suturing, flaps, etc.)
- FACIAL FRACTURES AND DISLOCATIONS
- ADDITIONAL PROCEDURES (e.g., tracheostomy)
- ADDITIONAL DIAGNOSES (e.g., observation for possible injury, contusions, crushing injuries, and late effects of injury)
- ADA (CDT) CODES

II. REPAIR (LACERATIONS)

The CPT book classifies the repair of wounds as simple, intermediate or complex (please refer to the “Repair (Closure)” Section of the Integumentary System area of the CPT manual for precise definitions).

The general instructions for coding the repair of wounds state that the closure should be measured in centimeters, and that 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. The OMS is instructed to list the more complicated procedure first, followed by the less complicated procedure.
using a “-51” (multiple procedure) modifier. 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 (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” applies.”

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

**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
13150-13153 eyelids, nose, ears, lips

**TREATMENT OF WOUND DEHISCENCE**

12020-12021, 13160 - For Larger wounds use also 13122, 13133, 13153

**ADJACENT TISSUE TRANSFER OR REARRANGEMENT**

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

14020-14021 scalp
14040-14041 forehead, cheeks, chin, mouth, neck
14060-14061 eyelids, nose, ears, lips
14301-14302 any area

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Free skin grafts, pedicled, tube, myocutaneous and other more extensive flaps are not often involved in the primary treatment of oral and maxillofacial trauma, and will not be discussed in this paper. The oral and maxillofacial surgeon is directed to codes 15002-15777.

**ADDITIONAL REPAIR (Laceration Codes from Other Systems)**

**Digestive**

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

**Eye**

67930-67935 Repair eyelid
68700 Plastic repair of canaliculi

**ICD-9-CM CODES FOR LACERATIONS OF HEAD AND NECK**

Open Wound of Head and Neck (870.0-874.9)
Superficial Injury, eye & adnexa (918.0-918.9)
Superficial injury of face, neck, scalp, except eye (910.0-910.9)

**III. FACIAL FRACTURES AND DISLOCATIONS**

To properly code fractures, several terms must be understood. The terms “open” and “closed” are found in both diagnosis (ICD-9-CM) and treatment (CPT) codes. As related to diagnosis, the term “open” includes fractures that are: “compound,” “infected,” or “caused by puncture with a foreign body or missile.” Other fractures and those not indicated as either closed or open should be coded as “closed.” There are different ICD-9-CM codes for open and closed fractures, indicated by the “fourth-digit” of the code (e.g., 802.2 mandible fx-closed, 802.3 mandible fx-open), and “fifth-digit” codes to further identify location. Always remember to code as specifically as possible and that a fourth- or fifth-digit code is required when one is available.
When coding for treatment, the terms “open” and “closed” are used to indicate whether or not the surgeon directly viewed and reduced the fracture (the term “manipulation” is sometimes used) through a wound created by the injury or created by 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.

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 represents the procedure performed.

It is necessary to identify whether fixation of the fracture was “internal” or “external.” 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.” It is important to note that under Medicare or a resource-based relative value system (RBRVS), the relative values for fixation procedures do not include the removal of the fixation devices, unless specifically stated in the procedural description. In these cases, the removal of the fixation devices may be billed separately under codes 20670 through 20680 (see additional procedure codes under Section IV). It may be necessary to append the -58 staged procedure modifier when the removal of the fixation is performed during the global period of the fracture repair surgery.

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.)

Each component of a multiple injury should be coded separately whenever possible. For example, use fracture of the mandible, closed, subcondylar (802.22), angle (802.25), symphysis (802.26) rather than fracture of mandible, multiple sites (802.29).

We recommend appending the -59 modifier (Distinct Procedural Services), in addition it may be necessary to use the "-52" (reduced services) modifier. 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.

**MUSCULOSKELETAL FRACTURES**

21310-21337 Nasal Fractures
21338-21340 Nasoethmoid Fractures
21343-21344 Frontal Sinus
21345-21348 Nasomaxillary Fractures (LeFort II)
21355-21366 Malar Fractures, Zygomatic Arch, and Malar Tripod
21385-21408 Orbital Fractures
21421-21423 Palatal or Maxillary Fractures (LeFort I)
21431-21436 Craniofacial Separations (LeFort III)
21440-21445 Alveolar Ridge Fractures (separate procedures)
21450-21470 Mandible Fractures
21480-21490 TMJ Dislocations
21495 Hyoid Bone Fractures

**ICD-9-CM CODES FOR FRACTURES AND TMJ DISLOCATIONS**

Skull (800.0-801.9,803.0-804.9)
Facial bones (802.0-802.9)
Trachea, Larynx, Hyoid, Thyroid Cartilage (807.5-807.6)
Intracranial injury without skull fracture (850.0-854.1)
Pathological fractures (733.1-733.19); (include the cause if known)
Malunion of fracture (733.81)
Nonunion of fracture (733.82)
Dislocation of the jaw (830.0-830.1)
Other ill-defined sprains and strains (e.g., TMJ) (848.1)

**IV. ADDITIONAL PROCEDURE (CPT) CODES**

20670-20680 Removal of hardware (e.g., wire, plates, interdental fixation, etc.)
21085 Oral surgical splint (if fabricated by the surgeon)
21100 Application of halo for maxillofacial fixation (separate procedure)
21497 Interdental wiring for other than fracture
30901-30906 Nasal hemorrhages
31500 Intubation, endotracheal
31600-31610 Tracheostomies
42960-42962 Oropharyngeal hemorrhages
42970-42972 Nasopharyngeal hemorrhages
Most sections have codes for unlisted procedures that may be used if no other codes are appropriate.

V. ADDITIONAL DIAGNOSIS (ICD-9-CM) CODES
Observation for other specified suspected condition (V71.8) (requires fifth digit)
Contusion of face, scalp, neck (920)
Contusion of eye and adnexa (921.0-921.9)
Crushing injury of face, scalp, neck (925.1, 925.2)
Foreign body in mouth (935.0)
Late effect (sequelae) of injury:
  fracture of skull and face bones (905.0)
  dislocation (905.6)
  sprain or strain (905.7)
  open wound of head and neck (906.0)
Avulsed tooth (873.63, 873.73)

VI. ADA (CDT) CODES
D7270 Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7610-D7680 Treatment of fractures- simple (i.e., “closed” per ICD-9-CM)
D7710-D7780 Treatment of fractures- compound (i.e., “open” per ICD-9-CM)
D7810 Open reduction of dislocation of TMJ
D7820 Closed reduction of dislocation of TMJ
D7852 Disc repair (separate procedure)
D7910-D7912 Suturing of lacerations
D7990 Emergency tracheotomy

Note: 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 to you 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 you or anyone else in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisers.