



**Presented By**  
Kandra Sellers, RDH, BA  
Founder & CEO

Kandra Sellers, RDH, BA  
kandra@tipsmedicalbilling.com  
612.418.7870





# EMERGENCY EVALUATION





# Mandible

## Cyst Removal & Bone Graft- Common CPT Codes

- 9920\_ Evaluation, New Patient
- 9921\_ Established Evaluation, Established Patient
- 70355 Screening Orthopantagram (Panorex)
- 70486 CT Scan Maxillofacial w/o contract
- 76100 Tomographic Study of CT





# Mandible

## Cyst & Bone Graft-Common Diagnosis Codes

- R68.84      Jaw Pain
- G50.1      Atypical Facial Pain
- M27.2      Osteomyelitis/Infection
- K12.2      Cellulitis, Face
- R59.0      Lymphadenopathy
- R93.0      Abnormal Radiographic Finding
- M27.40      Unspecified Cystic Lesion
- K04.8      Radicular Cyst
- K08.22      Moderate Atrophy of the Mandible
- K08.23      Severe Atrophy of the Mandible





# SUPERBILL

(COMMUNICATION TOOL ONLY-NEVER GOES TO INSURANCE CARRIER)

## Evaluations – Emergency Infection



# EMERGENCY EVALUATION



PT Name: \_\_\_\_\_

DOS: \_\_\_\_\_

Provider: XXXXXX

Prior  Claim  **Emergency**

## Evaluation and Management

New Pt	Time	MDM	Time	Est Pt
99202	15-29	Straightfwd	10-19	99212
99203	30-44	Low	20-29	99213
99204	45-59	Moderate	30-39	99214
99205	60-74	High	40-54	99215
Prolonged staff time (>45 min) 99415				
Time Seated: _____				
Time Discharge: _____				

## Imaging/Tomographic/CT

- 70355 Orthopantogram (Screening)
- 70486 CT scan, Maxillofacial w/o contrast
- 76380 CT scan, Limited Local (Repeat)
- 76100 Tomographic study  
(use this code if no prior auth on a CT)

## Surgery

- | RIGHT                    | LEFT                     | POSTERIOR                | ANTERIOR                 | JP                       | _____   |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21210 Bone Graft, Maxilla   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21215 Bone Graft, Mandible  |
|                          |                          |                          |                          | <input type="checkbox"/> | Bone in a bottle? (Modifier: 52)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21248 Reconstruction of Max/Mand, partial<br>(1-3 bone stabilizers per Jaw) # of incisions _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21249 Reconstruction of Max/Mand, complete<br>(4-6 bone stabilizers per Jaw) # of incisions _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21085 Diagnostic/Surgical Stent   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21089 Interim/provisional/final prosthesis  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41899 Surgical Odontectomy  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41899 Misc. Dentoalveolar Procedure (crown, endo, dental restorations...)                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41870 Periodontal mucosal grafting  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41874 Alveoloplasty   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21030 Cyst removal (max)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21040 Cyst removal (mand)   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 30580 Repair Fistula oromaxillary   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 40819 Excision of frenum, labial or buccal (lip)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 41115 Excision of lingual frenum (tongue)   |

## DIAGNOSIS CODES TO JUSTIFIES THE PROCEDURES RENERED

### IMAGING

- 70355 Orthopantogram-Annual Screening**
- Z12.89 Maxillo-facial cancer screening
  - Z12.81 Oral cancer screening

### SURGERY/IMAGING

- 21030/21040 CYST**
- G50.0 Trigeminal neuralgia
  - G50.1 Atypical facial pain
  - R68.84 Jaw Pain
  - J32.0 Chronic maxillary sinusitis
  - M27.2 Inflammation/infection/osteomyelitis of the jaw (cyst)
  - K12.2 Cellulitis, face
  - R59.0 Lymphadenopathy
  - R93.0 Abnormal radiographic finding
  - M27.40 Cyst, unspecified of the Mand/Max
  - K04.8 Radicular Cyst, Max/Mand
  - J32.0 Oro-antral fistula sinus communication

\*\*\*Pick a Atrophy code(s), below if you need to graft\*\*\*

### GRAFTING & IMPLANTS 21248/21249/41874

- J34.89 Pneumatization of max sinus
- M89.08 Disuse Atrophy, Single jaw/site
- M89.09 Disuse Atrophy, Multiple jaws/site
- K08.22 Moderate Atrophy of Mandible
- K08.23 Severe Atrophy of Mandible
- K08.25 Moderate Atrophy of Maxilla
- K08.26 Severe Atrophy of Maxilla
- M27.40 Cyst, unspecified of the Mand
- M26.79 Irregular alveolar process

### IMPLANT FAILURE

- M27.61 Osseointegration failure
- M27.62 Post-osseointegration biological failure
- M27.63 Post-osseointegration mechanical failure
- M27.69 Other endosseous failure

### COMPLICATIONS OF SURGERY

- T81.83 Persistent post procedural fistula
- T84.318 Breakdown (mechanical) of other bone devices, implants, grafts
- M27.3 Alveolitis of the Jaw (Dry Socket)/inflammation

- 20670 Implant removal-superficial
- 20680 Implant removal-deep

### OTHER MISC

- M81.8 Disuse Osteoporosis
- T84.69XA Infected Implant
- K01.1 Impacted teeth
- M27.3 Alveolitis of the Jaw (Dry Socket)/inflammation
- K03.2 Erosion of the teeth
- K03.3 Pathological resorption
- K11.7 Disturbances of salivary secretion
- K13.70 Unspec lesions of oral mucosa
- M35.0 Sjogren's Disease
- T45.8XA Side effect oral bisphosphonate
- Z48.814 Follow-up to surgery-oral cavity
- Z01.818 Other preprocedural examination
- Z92.21 Personal history of chemotherapy
- Z92.3 Personal history of irradiation
- Z87.891 Personal hx of nicotine dependence
- G89.18 Acute Post-op pain
- K05.22 Pericoronitis- Aggressive periodontitis, unspecified

### COMORBID CONDITIONS

- Z86.79 Personal history of hypertension
- Z86.39 Personal history of diabetes
- Z68. \_\_\_\_\_ BMI index
- E78.5 Hyperlipidemia

### FRENUM DISORDERS

- R47.86 Speech disturbances
- M26.59 Other dentofacial functional abnormalities
- M27.0 Developmental disorders of jaw
- Q38.1 Ankyloglossia (tongue)
- F80.0 Phonological disorder (cannot articulate, speech, sounds)
- F80.89 Other dev. Disorders of speech and language
- K13.0 Frenum (lip)
- Q79.9 Abnormal muscle pull

Other: \_\_\_\_\_





21. DIAGNOSIS OR NATURE OR ILLNESS OR INJURY Relate A-L to service line below (24E)*						ICD Ind.*	0 - ICD-10-CM	22. RESUBMISSION PAYER CLAIM NO:	
A.	R6884	B.	G501	C.	M272	D.	R930	Not required if CLAIM FREQ	
E.	M2740	F.	K0822	G.		H.		23. PRIOR AUTHORIZATION	
I.		J.		K.		L.		G1	
24	A.* Date of Service Date or Date Range	B.* Place of Service	C. EMG	D.* CPT/HCPCS (View List)	D. Modifiers		E.* Diagnosis Pointer	F.* \$ Charges	G.* Minutes or Units
1	Date 06/20/2023	Note: Select 11	Y	99214	25	A B C D		250.00	UN 1
2	Date 06/20/2023	Note: Select	Y	70355		D E F		150.00	UN 1
3	Date 06/20/2023	Note: Select	Y	70486		D E F		200.00	UN 1
4	Date 06/20/2023	Note: Select	Y	76100		D E F		200.00	UN 1
5	Date	Note: Select							UN
6	Date	Note: Select							UN
25. FEDERAL TAX I.D. NUMBER*			SSN	EIN	26. PATIENT'S CONTROL NO.*		27. ACCEPT ASSIGNMENT*	28. TOTAL CHARGE	29. AMOUNT PAID
123456789					TOMMYTOOTH		A - Assigned	800.00	



# Thank you!

**Kandra Sellers, RDH, BA**

Medical Billing Specialist

[kandra@tipsmedicalbilling.com](mailto:kandra@tipsmedicalbilling.com)

[TIPSMedicalBilling.com](http://TIPSMedicalBilling.com)



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