Coding Paper

American Association of Oral and Maxillofacial Surgeons

Coding for Dentoalveolar Procedures in Conjunction with Extractions

I. INTRODUCTION

This paper clarifies which codes to use when performing an alveoloplasty in conjunction with extractions; an incision and drainage in conjunction with extraction(s); and/or removing a cyst in conjunction with extraction(s).

Under both dental (CDT) and medical (CPT) coding, the use of local anesthesia is considered an inherent component of these procedures as well as any surgical procedure; therefore, it is not billed separately.

In general, Medicare does not cover items and services for the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. Similarly, Medicare does not permit payment for dental services performed in connection with excluded services, such as alveoloplasty or dental ridge reconstruction to prepare the mouth for dentures. Note that some commercial medical carriers may follow CMS guidelines or have similar policies regarding coverage and payment for dental services. However, there are ICD-10-CM diagnostic codes that may indicate a specific reason for performing an extraction(s) as well as the dentoalveolar procedures mentioned in this paper and may support medical necessity for coverage by medical plans in certain instances. Keep in mind, the presence of a diagnostic code for an alveoloplasty, cyst removal or incision and drainage – or any procedure code – does not guarantee payment for these services. It is crucial for the OMS practitioner and his or her staff to understand the intricacies of reimbursement for procedural services by each carrier, managed care organization or Medicare. It also is helpful to become familiar with payer policies and the patient's benefits to determine if or when dental procedures are covered by medical plans.

II. CODING FOR EXTRACTIONS WITH ALVEOLOPLASTY

Using CDT and CPT Codes

An alveoloplasty is performed only when there is need for significant bone recontouring in the area of the extraction. The smoothing of the socket bone is considered part of the extraction procedure and should not be coded separately. The smoothing of the socket site includes facial and septal alveolar bone. As with any surgical procedure, alveoloplasties must be accurately described and documented in the patient record. If it is documented that contouring of the bone was performed but no significant description of the work involved with the procedure is mentioned, it will be difficult to justify that an alveoloplasty was performed rather than the typical smoothing or removal of bone associated with an extraction. *Failure to document the reason for the alveoloplasty and accurately describe the surgical procedure may lead to the claim being disallowed by the third-party payer.*

D7310 alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant

OR

D7311 alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant

OR

41874 Alveoloplasty, each quadrant (specify)

Examples where an alveoloplasty with extractions would be appropriate are:

a. In conjunction with multiple extractions.
b. Irregular alveolus with sharp bony projections.
c. Pre-prosthetic bone contouring.
d. Prior to radiation therapy for head and neck malignancy.
e. Prior to cardiac surgery with valve replacement.
f. In conjunction with any medical diagnosis where there is a risk of complications from oral infections.

ICD-10-CM Codes

Diagnosis codes that may be appropriate for use in dentoalveolar surgical cases may be found in the following ICD-10-CM categories of codes:

C03	Malignant neoplasm of gum
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites (mandible)
C79	Secondary malignant neoplasm of other specified site
D00	Carcinoma in situ of oral cavity, esophagus and stomach
D10	Benign neoplasm of mouth and pharynx
D16	Benign neoplasm of bone and articular cartilage
D37	Neoplasm of uncertain behavior of oral cavity and digestive organs
D48	Neoplasm of uncertain behavior of other and unspecified sites
K04	Diseases of pulp and periapical tissues
K08	Other disorders of teeth and supporting structures
K12	Stomatitis and related lesions
M26	Dentofacial anomalies (including malocclusion)
M27	Other diseases of the jaw
M35	Sjogren syndrome
R22	Localized swelling, mass and lump of skin and subcutaneous tissue
S01	Open wound of head
S02	Fracture of skull and facial bones
T66	Radiation sickness, unspecified
T84	Complications of internal orthopedic devices, implants and grafts
Z92.3	Personal history of radiation

III. CODING FOR CYST REMOVAL WITH EXTRACTIONS

It is critical there be documentation of additional work associated with a cyst removal when submitted in conjunction with extraction codes. Even in a situation where CDT codes are used for the extraction and CPT codes are used for the cyst removal, the claim may be denied if the cyst removal is not clearly documented as requiring extra work.

CDT Codes

The following codes may be considered when reporting a cyst removal when the surgical procedure is distinctly separate from an extraction:

D7450	removal of benign odontogenic cyst or tumor, lesion diameter up to 1.25 cm
D7451	removal of benign odontogenic cyst or tumor, lesion diameter greater than 1.25 cm
D7460	removal of benign nonodontogenic cyst or tumor, lesion diameter up to 1.25 cm
D7461	removal of benign nonodontogenic cyst or tumor, lesion diameter greater than 1.25 cm

Clinical examples of cyst removal with extractions:

1. A 28-year-old male presents with impacted Tooth #32 with a large radiolucent lesion extending into the ramus of the mandible. Lesion measures 3 cm by 2.5 cm. Tooth #32 is horizontal with displacement posteriorly. The removal of the cyst and Tooth #32 requires a mucoperiosteal flap with superior extension up the ramus. Tooth #32 requires bone removal to develop exposure of the tooth and is sectioned. The cyst requires bone removal to provide access to the boundaries of the mass in order to be removed and submitted for pathology evaluation.
2. A 45-year-old female presents with a history of being hit in the mouth approximately five years previously. Her chief complaint is pain and swelling involving Tooth #23, 24 and 25. X-ray of the area shows a large radiolucency measuring approximately 2.5 cm by 2 cm. Tooth #23, 24 and 25 are found with severe bone loss and mobility. A full-thickness mucoperiosteal flap is developed from Tooth #22 to Tooth #25; bone is removed exposing a cystic mass. Tooth #23, 24 and 25 are removed with forceps technique. The cystic mass is curetted and removed. For removal of this mass, there has to be access developed to adequately remove the lesion.

   For both clinical examples, it is recommended to delay submitting the claim to third-party payers until a pathology report is received confirming the diagnosis.

CPT and ICD-10-CM Codes

Diagnosis codes that may be considered appropriate to use for cyst removal in conjunction with extractions may be found in the following ICD-10-CM categories:

K04 Diseases of pulp and periapical tissues

K09 Cysts of oral region not elsewhere classified

M27 Other diseases of the jaws

Any one of the following CPT codes may be reported for benign cyst removal. If a cyst removal is performed in conjunction with other separately identifiable procedures, appending modifier –51 may be necessary to indicate multiple procedures have been rendered.

21030 Excision of benign tumor or cyst of maxilla or zygoma by enucleation or curettage

21040 Excision of benign tumor or cyst of mandible, by enucleation and/or curettage

21046 Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s)

21047 requiring extra-oral osteotomy and partial mandibulectomy (e.g., locally aggressive or destructive lesion(s)

41825 Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair

41826 with simple repair

41827 with complex repair

IV. CODING FOR INCISION AND DRAINAGE WITH EXTRACTIONS

As with any surgical procedure, incision and drainage must be accurately described and documented in the patient's record. Failure to document the reason for the incision and drainage and accurately describe the surgical procedure may lead to the claim being disallowed by the third-party payer.

CDT Codes

The following codes may be considered when reporting an incision and drainage procedure that is distinctly separate from an extraction:

D7510 incision and drainage of abscess – intraoral soft tissue

D7511 incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

D7520 incision and drainage of abscess – extraoral soft tissue

D7521 incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

CPT and ICD-10-CM Codes

Diagnosis codes that may be reported for incision and drainage in conjunction with extractions may be found in the following categories of ICD-10-CM codes:

K04 Diseases of pulp and periapical tissues

K05 Gingivitis and periodontal diseases

K06 Other disorders of gingiva and edentulous alveolar ridge

K12 Stomatitis and related lesions

M27 Other diseases of jaws

Note: The lists of ICD-10-CM codes provided throughout this paper are not all-inclusive and include only the code categories in which applicable diagnosis codes may be found. Some of the codes within these ranges will require placeholders and additional characters. An ICD-10-CM coding manual should be referenced to ensure submission of a complete valid code. Only those conditions supported by the medical/dental record documentation should be reported. Although there may be a diagnosis code that fits the description for medical necessity, there is no guarantee for reimbursement.

Any of the following CPT codes may be reported for incision and drainage. If an incision and drainage procedure is performed in conjunction with other separately identifiable procedures, append modifier –51 to indicate multiple procedures have been rendered.

40800 Drainage of abscess, cyst, hematoma, vestibule of mouth; simple

40801 complicated

41000 Intraoral incision and drainage of abscess, cyst or hematoma of tongue or floor of mouth; lingual

41005 sublingual, superficial

41006 sublingual, deep, supramylohyoid

41007 submental space

41008 submandibular space

41009 Intraoral incision and drainage of abscess, cyst or hematoma of tongue or floor of mouth; masticator space

41015 Extraoral incision and drainage of abscess, cyst or hematoma of floor of mouth; sublingual

41016 submental

41017 submandibular

41018 masticator space

41800 Drainage of abscess, cyst or hematoma from dentoalveolar structures

V. CODING FOR OTHER SURGICAL PROCEDURES IN CONJUNCTION WITH EXTRACTIONS

As with any procedure performed at the same time as extractions, documentation must detail the additional work associated with extractions and any one of the following procedures. Even in situations where CDT codes are used for the extraction and CPT codes are used for surgical procedures, the claim may be denied if the work involved with each procedure is not clearly documented.

CPT Codes

21031 Excision of torus mandibularis

21032 Excision of maxillary torus palatinus

40804 Removal of embedded foreign body, vestibule of mouth; simple

40805 complicated

40806 Incision of labial frenum (frenotomy)

40818 Excision of mucosa of vestibule of mouth as donor graft

40819 Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)

40840 Vestibuloplasty; anterior

40842 posterior, unilateral

40843 posterior, bilateral

40844 entire arch

40845 complex (including ridge extension, muscle repositioning)

40899 Unlisted procedure, vestibule of mouth

41115 Excision of lingual frenum (frenectomy)

41520 Frenoplasty (surgical revision of frenum, e.g., with Z-plasty)

41530 Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session

41599 Unlisted procedure, tongue, floor of mouth

41805 Removal of embedded foreign body from dentoalveolar structures; soft tissues

41806 bone

41820 Gingivectomy, excision gingiva, each quadrant

41821 Operculectomy, excision pericoronal tissues

41822 Excision of fibrous tuberosities, dentoalveolar structures

41823 Excision of osseous tuberosities, dentoalveolar structures

41828 Excision of hyperplastic alveolar mucosa, each quadrant (specify)

41830 Alveolectomy, including curettage of osteitis or sequestrectomy

41850 Destruction of lesion (except excision), dentoalveolar structures

41870 Periodontal mucosal grafting

41872 Gingivoplasty, each quadrant (specify)

CDT Codes

D4210 gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant

D4211 gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant

D4212 gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth

D4270 pedicle soft-tissue graft procedure

D7111 extraction, coronal remnants – primary tooth

D7340 vestibuloplasty – ridge extension (secondary epithelialization)

D7350 vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

D7465 destruction of lesion(s) by physical or chemical method, by report

D7471 removal of lateral exostosis (maxilla or mandible)

D7472 removal of torus palatinus

D7473 removal of torus mandibularis

D7485 reduction of osseous tuberosity

D7509 marsupialization of odontogenic cyst

D7530 removal of foreign body from mucosa, skin or subcutaneous alveolar tissue

D7540 removal of reaction producing foreign bodies, musculoskeletal system

D7550 partial ostectomy/sequestrectomy for removal of non-vital bone

D7920 skin graft (identify defect covered, location and type of graft)

D7922 placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site

D7961 buccal/labial frenectomy (frenulectomy)

D7962 lingual frenectomy (frenulectomy)

D7963 frenuloplasty

D7970 excision of hyperplastic tissue – per arch

D7971 excision of pericoronal gingiva

D7972 surgical reduction of fibrous tuberosity

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Note: The list of CDT, CPT and ICD-10-CM codes in this coding paper is not all-inclusive. AAOMS recommends reporting codes applicable to the service(s) rendered and the patient's specific clinical condition as determined by the provider.

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 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 anyone in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-10-CM) and treatment (CPT/CDT) coding for dentoalveolar procedures in conjunction with extractions. When indicated, reference the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.

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