Alveoloplasty and extraction coding: Smoothing

Alveoloplasties and teeth extractions are among the most common procedures performed in an OMS office. An alveoloplasty involves recontouring supporting bone, sometimes to prepare for a prosthesis or with treatments such as radiation therapy and transplant surgery. It also is performed to address sharp or irregular bony areas of the alveolus bone, often when significant bone recontouring is required after an extraction.

Both Current Procedural Terminology (CPT^) and Current Dental Terminology (CDT*) have distinct criteria for determining when an alveoloplasty is warranted when performed with extractions. An alveoloplasty may be reported only when there is need for bone recontouring and not just the lesser procedure of minor smoothing of facial and septal alveolar bone, which is included when performing an extraction.

CPT and CDT codes for alveoloplasties

CDT defines the procedure of alveoloplasty by quadrant, dividing dental arches into four equal sections. Each quadrant begins at the midline of the arch and extends distally to the last tooth. The quadrant is subdivided into two parts: four or more teeth or tooth spaces and one to three teeth or tooth spaces. This allows coding to be specific to the areas of bone treated.

There are four codes available to report alveoloplasties with or without extractions. CDT codes D7310 and D7311 are used when the alveoloplasty is performed in conjunction with an extraction, and D7320 and D7321 are reported when performed without extractions. All four codes specify in their descriptors that an alveoloplasty is a distinct and separate procedure from an extraction.

These four codes describe the anatomical area of bone encompassed for the alveoloplasty and may be reported in addition to the appropriate extraction code(s) when supported by documentation.

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

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

D7320 alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant

D7321 alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant

CPT defines an alveoloplasty in the code descriptor by "each quadrant" and has a limit of reporting only four units on the same date of service as indicated by CMS National Correct Coding Initiative (NCCI) edit.

41874 alveoloplasty, each quadrant (specify)

CPT code 41874 is commonly reported with MRONJ patients when they experience exposed, sharp necrotic bone and smoothing or recontouring is necessary to relieve discomfort and improve oral function.

Documentation and payer policies

Many medical payers consider alveoloplasties medically necessary when a different diagnosis of a separate procedure (e.g., extractions) is accurately identified and supports the need for the service. An alveoloplasty

out the challenges

is a distinct procedure performed independently of other related surgical procedures and should be documented as such in the patient's chart, which may include a detailed description of the physician's work involved in the procedure. Failure to document the need for the alveoloplasty and provide specific details may result in a denial from a third-party payer.

Some payer policies state that when performed concurrently and in the same location as another surgical procedure – such as a surgical tooth extraction or removal of an impacted tooth – the alveoloplasty is considered inherent to or bundled with the surgical procedure and not separately reimbursable by the payer. Although the presence of a diagnostic code for an alveoloplasty or any other procedure code does not guarantee payment for these services, it is crucial for the OMSs and/or professional staff to reach out to individual payers for clarification to determine coverage and whether the service is deemed billable to the patient. ■

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Medicare alert: Diagnosis codes now required on dental claims

Effective July 1, dental claims submitted for a Medicare-covered service must include a diagnosis code to support the medical necessity of the treatment or procedure. Since 2023, CMS has expanded Medicare coverage and payment for certain dental services inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services. OMSs enrolled in Medicare who are submitting Medicare-covered services on a dental claim form should contact their state's Medicare Administrative Contractor (MAC) to ensure claim acceptance, as the process may involve electronic data interchange enrollment and mandatory claims testing.

AAOMS provides resources on the latest Medicare policy changes, serving as a comprehensive guide for OMSs and professional coding and billing staff. Resources include a series of Medicare FAQs and online articles featuring the latest on Medicare dental policy, OMS enrollment, opting-out procedures and the use of the Advance Beneficiary Notice of Non-coverage (ABN). To learn more about ICD-10-CM coding and Medicare billing, visit AAOMS.org/CodingBilling to register for the ICD-10-CM for OMS and the Medicare 101 for OMS coding courses.