Coding for Alveoloplasty with Extractions

I. INTRODUCTION

Current Dental Terminology (CDT) defines the procedure of alveoloplasty by quadrant. A quadrant is defined as one of four equal sections into which the dental arches can be divided. Each quadrant begins at the midline of the arch and extends distally to the last tooth.

The quadrant is subdivided into two parts, defined as 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.

The American Medical Association *Current Procedural Terminology (CPT 2013)* does not define alveoloplasty per quadrant except by the term "quadrant."

REQUIRED CODING MATERIALS

Before coding any procedure it is necessary to have the most current copy of the ADA's CDT manual, the AMA's CPT manual and the two volume set of ICD-9-CM. Volumes 1 and 2 of the ICD-9-CM cover diagnostic coding, which is mandatory for filing claims to medical third party payers and Medicare. Volume 1 represents a tabular listing of conditions, diseases, and symptoms; while volume 2 is the alphabetical listing.

Beginning with CDT 2013, the CDT coding manual will be updated annually just as the CPT and ICD-9-CM manuals. The latest revision became available in 2013. The current volume, CDT 2013 supersedes all previous CDT manuals. CDT is a five digit coding set with the numerical digits preceded by a "D." CDT is the HIPAA accepted code set for reporting dental procedures.

CPT, CDT and ICD-9-CM are revised annually. CPT becomes available in mid-November of each year. ICD-9-CM has previously been revised twice a year, in April and October. However, with ICD-10-CM implementation approaching, the government has placed a freeze on ICD-9-CM changes. It is unclear at this time how often ICD-10-CM will be updated once it takes effect. Thus, reporting a current procedure or diagnosis using a previous year's edition may be inaccurate and adversely affect reimbursement or lead to unnecessary delays in claims processing.

II. CODING FOR EXTRACTIONS WITH ALVEOLOPLASTY USING CDT CODES

Under both medical (CPT) and dental (CDT) coding, the use of local anesthesia is considered an inherent component of any surgical procedure, and is not billable separately.

An alveoloplasty is defined as a "surgical procedure for recontouring supporting bone, sometimes in preparation for a prosthesis," other treatments such as radiation therapy and transplant surgery, or to address sharp or significantly irregular bony areas.

D7310 – alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant is used when bone recontouring is performed involving four or more teeth or tooth spaces.

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

The two codes above are used when the alveoloplasty is a distinct surgical procedure from extraction and/or surgical extractions. As such, these codes may be reported in addition to the extraction codes below when supported by documentation.

Two codes describe the anatomical area of bone encompassed in the alveoloplasty. When the area is less than four teeth or tooth areas, the code for one to three teeth or tooth spaces is used.

D7140 – extraction, erupted tooth or exposed root (elevation, and/or forcep removal). The descriptor of this code includes routine removal of tooth structure, minor smoothing of socket bone and closure as necessary.

D7210 – surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated. The descriptor for this code also includes the minor smoothing of socket bone and closure.

There is now a distinct difference in what qualifies as an alveoloplasty with extractions. An alveoloplasty is performed only when there is need for significant bone recontouring in the area of the extraction and not just the lesser procedure of smoothing the socket bone. The smoothing of the socket site includes facial and septal alveolar bone.

The Code Maintenance Committee of the ADA does not recognize the use of the term sextant. Therefore, when performing an alveoloplasty with extractions that crosses the mid-line (i.e. tooth #6 to #11), you would report D7311 (one to three teeth) twice.

For procedures such as exostosis or tori removal, use the specific codes for these procedures.

As with any surgical procedure, alveoloplasties must be accurately described and documented in the patients chart. 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.

Examples where alveoloplasty with extractions would be appropriate:

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

III. CODING FOR ALVEOLOPLASTY WITH EXTRACTIONS USING ICD-9-CM-CODES

As a general rule, extractions are not covered by medical plans or Medicare. There are ICD-9-CM diagnostic codes which would indicate a specific reason for performing the extraction(s) and may allow submission of claims to medical plans. Some of these are:

143.0	Malignant neoplasm of upper gum
143.1	Malignant neoplasm of lower gum
143.9	Malignant neoplasm of gum, unspecified site
170.1	Malignant neoplasm of mandible
198.89	Secondary malignant neoplasm of other specified site
210.4	Benign neoplasm of other and unspecified parts of the mouth
213.1	Benign neoplasm of lower jaw bone
230.0	Carcinoma in situ of lip, oral cavity and pharynx
235.1	Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
238.0	Neoplasm of uncertain behavior of bone and articular cartilage
522.4	Acute apical periodontitis of pulpal origin
522.5	Periapical abscess without sinus
522.7	Periapical abscess with sinus
524.72	Alveolar mandibular hyperplasia
524.74	Alveolar mandibular hypoplasia
524.79	Other specified alveolar anomaly
525.0	Exfoliation of teeth due to systemic causes
525.11	Loss of teeth due to trauma
526.4	Inflammatory conditions of jaw
682.0	Facial Cellulitis
784.2	Swelling, mass, or lump in head and neck
873.63	Fracture, tooth
873.72	Open wound of gum (alveolar process) complicated
873.73	Fracture, tooth, complicated
990	Effects of radiation, unspecified
996.67	Infection and inflammatory reaction due to other internal orthopedic device, implant and graft
V15.3	Personal history of irradiation (previous exposure to therapeutic radiation)

Since there is no code to indicate a patient who is to undergo radiation therapy, valve replacement, or AV shunt, the underlying disease process would be the diagnosis,

but an additional notation or letter of necessity may be required for coverage. Although not listed above, there are also several ICD-9-CM codes which indicate a "dental" diagnosis for extractions.

If one of these ICD-9-CM diagnostic codes applies to the surgical case, and the case will be submitted to a medical carrier, the CPT alveoloplasty code 41874 would be used. If an alveoloplasty is performed in conjunction with other separately identifiable procedures the modifier -51 is attached.

Remember, however, that the presence of a diagnostic code, the alveoloplasty codes or any other procedure code, does not guarantee payment for these services. It is crucial for the OMS and his/her staff to understand the intricacies of reimbursement for alveoloplasty with extractions by each carrier, managed care organization or Medicare.

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.

Coding Paper

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery (OMS). This paper discusses coding for alveoloplasty with extractions. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-9-CM) and treatment (CPT/CDT) coding for alveoloplasty with extractions. When indicated, you will be referred to 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 continually updated or revised. The AAOMS Committee on Health Care and Advocacy has developed these coding guidelines in order to assist the membership to use the coding systems effectively and efficiently.

Revised March 2013