

Dental Clinical Policy: Alveoloplasty

Reference Number: CP.DP.33

Last Review Date: 12/24

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Description

Alveoloplasty is a procedure to remove and/or smooth irregular bone tissue. While usually done in conjunction with tooth extractions, it is considered an independent and separate procedure and may also be as a standalone procedure in an already edentulous area. Typically, alveoloplasty is performed when preparing alveolar ridges for prosthetic devices such as partial and complete dentures, or bridges and implants when covered by state-specific regulation. Alveoloplasty may also be performed to remove excess alveolar bone arising from a pathologic condition, or as a preventive measure prior to radiation therapy or transplant surgery.

Policy/Criteria

- I. It is the policy of Envolve Dental Inc.® that alveoloplasty is **medically necessary** when any of the following conditions are met:
 - A. When removal or reshaping of irregular alveolar bone is necessary for appropriate fitting of a prosthetic device;
 - B. When removal or reshaping of irregular alveolar bone is necessary to prepare for radiation therapy or transplant surgery;
 - C. When it is necessary to remove alveolar bone arising from a pathologic condition;
 - D. When it is necessary to provide stability for dental implant placement if implants are covered benefits under state-specific regulations;
 - E. Does not have any of the following contraindications:
 1. When minor smoothing and removal of socket bone is necessary;
 2. When no prosthesis is planned;
 3. When removal or reshaping of irregular alveolar bone is performed following the removal of third molars and no prosthesis is planned or possible;
 4. When the patient has already undergone aggressive/high dose radiation therapy to the head and neck, especially in the area of concern;
 5. When removing bone would potentially harm vital structures;
 6. When the alveolar ridge has diminished to a point where additional bone removal would be harmful;
 7. When unmanaged medical conditions such as uncontrolled diabetes or resistance to infection are present;
 8. When bleeding disorders are present or at times when certain medications affecting bone metabolism have been employed (e.g., bisphosphonates).
 - F. Required documentation to support medical necessity include the following:
 1. Clinical chart and treatment notes documenting conditions listed in the indications for performing alveoloplasty;
 2. Dental/medical history notes documenting planned radiation therapy or transplant surgery, if applicable;
 3. Diagnostic-quality panoramic radiographic image, or alternatively, sufficient periapical radiographic images demonstrating alveolar bone conditions.

Coverage Limitation/Exclusions

- I. One D7310, D7311, D7320, or D7321 per quadrant per lifetime.

Coding Implications

This clinical policy references Current Dental Terminology (CDT®). CDT® is a registered trademark of the American Dental Association. All CDT codes and descriptions are copyrighted 2024, American Dental Association. All rights reserved. CDT codes and CDT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Retrospective review/analysis or fraud, waste and abuse initiatives that identify mis-coding (upcoding) resulting in higher reimbursement than allowed for the correctly coded service, or does not provide documentation supporting performing and/or completing claimed services may result in the recoupment of the identified monetary variance by any of the following means: a) from the payment for other claimed services; or b) directly from the provider.

CDT® Codes	Description
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

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
K06.3	Horizontal alveolar bone loss
K06.8	Other specified disorders of gingiva and edentulous alveolar ridge
K06.9	Disorder of gingiva and edentulous alveolar ridge, unspecified
K08.101	Complete loss of teeth, unspecified cause, class I
K08.102	Complete loss of teeth, unspecified cause, class II
K08.103	Complete loss of teeth, unspecified cause, class III
K08.104	Complete loss of teeth, unspecified cause, class IV
K08.401	Partial loss of teeth, unspecified cause, class I
K08.402	Partial loss of teeth, unspecified cause, class II
K08.403	Partial loss of teeth, unspecified cause, class III
K08.404	Partial loss of teeth, unspecified cause, class IV
K08.191	Complete loss of teeth due to other specified cause, class I

K08.192	Complete loss of teeth due to other specified cause, class II
K08.193	Complete loss of teeth due to other specified cause, class III
K08.194	Complete loss of teeth due to other specified cause, class IV
K08.491	Partial loss of teeth due to other specified cause, class I
K08.492	Partial loss of teeth due to other specified cause, class II
K08.493	Partial loss of teeth due to other specified cause, class III
K08.494	Partial loss of teeth due to other specified cause, class IV
K08.20	Unspecified atrophy of edentulous alveolar ridge
K08.21	Minimal atrophy of the mandible
K08.22	Moderate atrophy of the mandible
K08.23	Severe atrophy of the mandible
K08.24	Minimal atrophy of the maxilla
K08.25	Moderate atrophy of the maxilla
K08.26	Severe atrophy of the maxilla
M26.70	Unspecified alveolar anomaly
M26.71	Alveolar maxillary hyperplasia
M26.72	Alveolar mandibular hyperplasia
M26.73	Alveolar maxillary hypoplasia
M26.74	Alveolar mandibular hypoplasia
M26.79	Other specified alveolar anomalies
M27.61	Osseointegration failure of dental implant
M27.62	Post-osseointegration biological failure of dental implant
M27.63	Post-osseointegration mechanical failure of dental implant
M27.69	Other endosseous dental implant failure

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	06/20	06/20
Annual Review	12/22	12/22
Annual Review and Format Change	12/23	12/23
Annual Review	12/24	12/24

References

1. American Association of Oral and Maxillofacial Surgeons. Coding for Alveoloplasty with Extractions. Retrieved from https://aamos.org/images/uploads/pdfs/aleoloplasty_with_extractions.pdf. Accessed June 22, 2020.
2. American Dental Association. CDT 2024: Dental Procedure Codes. American Dental Association, 2024.
3. Drew, SJ. Atlas of Oral and Maxillofacial Surgery. Elsevier, Inc. 2016. Chapter 13, Alveoloplasty; pp.113-119.
4. Fragiskos, F.D. Preprosthetic Surgery. In: Fragiskos, F.D. (eds) Oral Surgery. Springer, Berlin, Heidelberg. 2007, Chapter 10.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed dental/medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Envolve Dental makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. “Envolve Dental” means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Benefit Options, Inc, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Envolve Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Envolve Dental. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Envolve Dental retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute dental or medical advice, dental treatment or dental care. It is not intended to dictate to providers how to practice dentistry. Providers are expected to exercise professional dental and medical judgment in providing the most appropriate care, and are solely responsible for the dental and medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating dentist in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <https://www.cms.gov> for additional information.

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