Dental Clinical Policy

Subject: **Osseous Surgery** (Periodontal)
Guideline #: 04-205 **Publish Date:** 01/01/2021
Status: **Revised** **Last Review Date:** 12/04/2020

Description

This document addresses the procedure of osseous surgery used in the treatment of periodontal disease when there is resultant bone loss.

The plan performs review of osseous surgery due to contractual requirements that necessitate benefits for dental services meet specific contract requirements. For example, plan contract(s) may require the provision of benefits for services that meet generally accepted standards of dental care at the lowest cost that properly addresses the patient's condition. The conclusion that a particular service is medically or dentally necessary does not constitute an indication or warranty that the service requested is a covered benefit payable by the dental plan.

Clinical Indications

When gingivitis progresses to periodontal disease, osseous surgery may be necessary. For osseous surgery to be appropriate, bone loss (horizontal or vertical defects) must be documented around teeth and dental implants. An associated history of pocket depth recordings must be equal to or greater than 5mm with spontaneous bleeding or bleeding upon probing must also be demonstrated.

Dental review as it applies to accepted standards of care means dental services that a Dentist, exercising prudent clinical judgment, provides to a patient for the purpose of evaluating, diagnosing or treating a dental injury or disease or its symptoms, and that are: in accordance with the generally accepted standards of dental practice; in terms of type, frequency and extent and is considered effective for the patient's dental injury or disease; and is not primarily performed for the convenience of the patient or Dentist, is not cosmetic and is not more costly than an alternative service.

For dental purposes, "generally accepted standards of dental practice" means:

- Standards that are based on credible scientific evidence published in peer-reviewed, dental literature generally recognized by the practicing dental community
- specialty society recommendations/criteria
- the views of recognized dentists practicing in the relevant clinical area
- any other relevant factors from credible sources

Criteria

Osseous surgery procedures are considered appropriate with:

1. Completion of initial periodontal therapy (e.g. scaling and root planing) allowing a minimum of four weeks prior to any surgical treatment for the tissues to properly heal which allows for proper assessment of the success or failure of non-surgical therapy.
2. Documentation by pocket depth recording post initial therapy demonstrating pocket depths greater than or equal to 5mm.
3. Current (within 12 months), dated periodontal charting (6 point periodontal charting as described by AAP and ADA) indicating pocket depth recordings of a minimum of 5mm.
4. Submission of clinical, diagnostic radiographic images demonstrating either horizontal and/or vertical osseous defects.
5. When radiographic images are not demonstrative, a detailed narrative describing periodontal case type, percentage of bone loss, measured furcation involvement, and description of the vertical defect may be requested,
6. Benefits will be limited to two quadrants per date of service. Exceptions will be allowed on a case-by-case basis.
7. Benefits are group contract dependent but are limited to one (1) osseous surgical procedure in a given period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is a minimum of 5mm.
8. Periodontal surgical procedures such as, but are not limited to, gingivectomy or gingivoplasty, anatomical crown exposure, gingival flap procedure, apically repositioned flap, clinical crown lengthening, and surgical revision procedure are considered inclusive with osseous surgery.

Dependent upon group contract, osseous surgery may be appropriate for the treatment of periodontal disease defects on natural teeth and dental implants. Dental implants will be considered the same as a natural tooth as it relates to quadrant surgery.

Osseous surgery post-operative management as well as for any surgical re-entry has a frequency limitation as per group contract.

Note: Whether a service is covered by the plan, when any service is performed in conjunction with or in preparation for a non-covered or denied service, all related services are also either non-covered or denied.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CDT *Including, but not limited to, the following:*

D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
D6101	Debridement and osseous recontouring of peri-implant defect or defects surrounding a single implant, surface cleaning of the exposed implant surfaces, including flap entry and closure.
D6102	Debridement and osseous recontouring of a peri-implant defect or defects surrounding a single implant, and includes surface cleaning of the exposed implant surfaces, including flap entry and closure

IDC-10 CM Diagnoses for Dental Diseases and Conditions: See the current CDT code book for details

References:

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History

Revision History	Version	Date	Nature of Change	SME
	initial	12/14/16	creation	M Kahn G Koumaras
	Revision	2/8/17	General verbiage	Rosen
	Revision	2/16/18	Appropriateness/medical necessity, criteria	M Kahn
	Revision	10/08/2020	Annual Review	Committee
	Revised	12/4/2020	Annual Review	Committee

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Federal and State law, as well as contract language, and Dental Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Clinical Policy Committee are available for general adoption by plans or lines of business for consistent review of the medical or dental necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical or dental necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical or dental necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.