Dental Clinical Policy

Subject: Periodontal Surgical Procedures, miscellaneous

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Description

This document addresses miscellaneous periodontal surgical procedures.

The plan performs review of periodontal surgical procedures 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

Periodontal surgical procedures may be required when periodontal health cannot be achieved or maintained non-surgically and may be indicated to eliminate pockets and may involve recontouring of alveolar bone. These procedures may also be indicated when there is a need to expose or lengthen the clinical crown.

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

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 not covered or denied.

Criteria

1. Periodontal Charting
    - Labeled and dated (within 12 months of submitted procedure)
    - 6-point periodontal pocket depth charting as described by the ADA and AAP
    - Pre and post non-surgical periodontal therapy.
2. Submission of dated, labeled, diagnostic quality radiographic images demonstrating either horizontal and/or vertical osseous defects.

3. Benefits will be limited to two quadrants per date of service. Exceptions will be allowed on a case-by-case basis where additional information may be requested.

4. Completion of initial periodontal therapy (e.g. scaling and root planing) allowing a minimum of four weeks prior to any surgical treatment to allow for proper healing and which allows for proper assessment of periodontal status.

5. Benefits are group contract dependent
    - generally limited to one (1) periodontal surgical procedure per quadrant
    - generally limited to once every 36 months.

6. Limited to periodontal pocket depth recordings of 5mm or greater.
7. Limited to natural teeth only.

D4230 and D4231 Anatomical Crown exposure

Is indicated for the following:

- In an otherwise periodontally healthy area to removed enlarged gingival tissue and supporting bone to provide an anatomically correct gingival relationship.
- In an otherwise periodontally healthy area to allow proper contour of restoration
- In an otherwise periodontally healthy area to allow management of a fractured tooth in which the fracture extends subgingivally

Is not indicated for the following:

- Solely for cosmetic/aesthetic purposes
- Patients with an uncontrolled underlying medical condition

Benefits determination for this procedure:

- Primarily cosmetic procedures are not covered
- Group contract dependent

D4268 Surgical Revision Procedure per tooth

Is indicated for the following:

- To refine the results of a previously provided surgical procedure.
- To modify irregular contours of hard or soft tissue

Is not indicated for the following:

- Second stage implant surgery, membrane removal, or redoing a failing soft tissue graft

Benefits determination for this procedure:

- When this procedure is billed within the plan frequency limitations of the initial surgical procedure by the same dentist/dental office, then this procedure is DISALLOWED.
- When this procedure is billed within the plan frequency limitations of the initial surgical procedure by a different dentist/dental office, then this procedure is DENIED.

D4274 Mesial/Distal Wedge Procedure single tooth

Is indicated for the following:

- The presence of active periodontal disease and moderate to deep probing depths (greater than 5mm) on a surface adjacent to an edentulous/terminal tooth area
- The need for increased access to root surface when previous non-surgical attempts have been unsuccessful on a surface adjacent to an edentulous/terminal tooth area

Is not indicated for the following:

- Solely for cosmetic/aesthetic purposes
- Patients who have been non-compliant with previous periodontal therapies
- In areas in which there are teeth with proximal contact
- Is considered inclusive with other surgical procedures in the same anatomical area performed on the same date of service.
- The diagnosis of a cracked tooth, fractured root or external root resorption on a surface adjacent to an edentulous/terminal tooth area, when this cannot be accomplished by non-invasive methods

Benefits determination for this procedure:

- When this procedure is billed within the plan frequency limitations of the initial surgical procedure by the same dentist/dental office, then this procedure is DISALLOWED.
- When this procedure is billed within the plan frequency limitations of the initial surgical procedure by a different dentist/dental office, then this procedure is 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:*

D4230 Anatomical Crown Exposure four or more contiguous teeth
D4231 Anatomical Crown Exposure one to three contiguous teeth
D4268 Surgical Revision Procedure per tooth
D4274 Mesial/Distal Wedge Procedure single tooth

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

References

1. American Dental Association. *Current Dental Terminology. CDT 2015: 31- 32* (©ADA 2015.
2. Proceedings of the World Workshop in Clinical Periodontics: Resective procedures. American Academy of Perio 1989; IV-1 to IV-25.
3. American Dental Association. Statement on Lasers in Dentistry; April 2009
4. American Academy of Periodontology. Guidelines for periodontal therapy. AAP 2001; 72:1624-1628.
5. Claffey N. Decision making in periodontal therapy: The reevaluation. J Clin Periodontal 18:364, 1991.

History

Revision History	Version	Date	Nature of Change	SME
	Initial	9/12/18		Committee
	Revision	11/10/2020	Annual Review	Committee
	Revised	12/04/2020	Annual Review	Committee

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.

Dental HMO coverage is provided by Golden West Health Plan, Inc.