



Dental Clinical Policy

Subject: Mucogingival Surgery and Soft Tissue Grafting
Guideline #: 04 -204 **Publish Date:** 01/01/2021
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Description

This document addresses mucogingival surgery and soft tissue grafting.

The plan performs review of mucogingival surgery and soft tissue grafting 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

Mucogingival conditions that may require corrective surgery include progressive gingival recession or loss of attached gingiva with concomitant root exposure, absence of or reduced amounts of keratinized attached gingiva, periodontal pocket depth probing extending beyond the mucogingival junction, high frenum attachments and inadequate vestibular depth. Other clinical conditions which may influence the need for treatment include chronic marginal inflammation and root sensitivity.

Clinical and experimental studies have demonstrated that as long as plaque buildup is maintained and is considered under control there is no minimum width of keratinized gingiva necessary to prevent the development of periodontal disease. Therefore, in the presence of good oral health where no plaque buildup is evident, mucogingival surgery and grafting are inappropriate.

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.

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

1. The following must be specifically documented prior to mucogingival surgery:
 - a. Current, dated periodontal chart (within the previous 12 months) documenting:
 - Millimeters of recession (CEJ to gingival margin)
 - Millimeters of attached gingiva
 - Pocket depth measurements (six points/tooth)
 - b. History of progressive recession within 12 months prior to treatment.
 - c. Notation related to the presence of high frenum attachments
 - d. Number of teeth affected
 - e. Photographic documentation of areas demonstrating recession may be required.
 - f. Radiographs might be required dependent on prior dental history.
 - g. Indication of root sensitivity
 - h. Relationship to cervical caries/existing restorations.
 - i. Statement procedure is not cosmetic.
2. In the absence of extraordinary circumstances (e.g. - frenum involvement, chronic inflammation), mucogingival surgery for correction of recession defects will only be considered when periodontal charting indicates recession noting 2 mm of keratinized gingival tissue and one millimeter or less of attached gingiva remaining.
3. Mucogingival surgical procedures include all evaluation and post-operative care for three months and any surgical re-entry for three years.
4. Mucogingival surgery will be considered for treatment of periodontal defects on natural teeth only.
5. Benefits are group contract dependent but generally limited to one (1) periodontal surgical procedure in a [36/60] month period per single tooth or multiple teeth in the same quadrant.
6. In the presence of good oral health where no plaque buildup is evident, mucogingival surgery and grafting are not necessary.
7. Frenectomy or frenuloplasty is considered inclusive when performed in the same area on the same date as a soft tissue graft.

8. Pedicle soft tissue grafts code D4270, subepithelial connective tissue grafts code D4273, D4275-D4278 and combined connective tissue and double pedicle grafts code D4276 may be benefited for graft procedures encompassing a single tooth dependent on group contract provisions.
9. Dermal matrix materials are denied when used for soft tissue grafting.
10. If the implant(s) is/are approved as necessary and appropriate, then the additional procedures should be assessed based upon submitted diagnostics; narrative/rationale and photographs for necessity and appropriateness.

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.

Procedures for claims reporting and adjudicating are categorized by quadrant, site or individual tooth for standard benefits determination and claims processing as defined by ADA CDT (see introduction to the periodontics section).

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

D4270	Pedicle soft tissue graft procedure
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – 1st tooth, implant or edentulous tooth position in graft
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4274	Mesial/distal wedge procedure, single tooth
D4275	Non - autogenous connective tissue graft procedure (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4276	Combined connective tissue and double pedicle graft, per tooth

D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

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	7/10/17	creation	Rosen
	Revision	2/5/18	Related dental policies, criteria	M Kahn
	Revision	2/6/18	Appropriateness and medical necessity	Committee
	Revision	10/08/2020	Annual Review	Committee
	Revised	12/4/2020	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.

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