Dental Clinical Policy

Subject: Gingivectomy or Gingivoplasty
Guidelines #: 04-202 **Publish Date: 01/01/2024**
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Description

The plan performs review of gingivectomy or gingivoplasty 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 and/or appropriate does not constitute an indication and/or warranty that the service requested is a covered benefit payable by the dental plan.

Clinical Indications

Gingivectomy or Gingivoplasty is considered appropriate for the treatment of mild to moderate periodontal disease. Gingivectomy or Gingivoplasty is:

1. Performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.
2. A demanding and time-consuming procedure that is indicated for pocket elimination and gingival recontouring in the presence of supra-bony pockets with normal bony configuration.
3. Used to treat gingival disease after nonsurgical methods, such as root planning and scaling, have been unsuccessful in the removal of subgingival deposits of plaque and calculus.
4. A procedure that involves removal of loose or diseased gingival tissue to reduce the size of the pocket between the teeth and the gingiva.
5. A procedure that can also be used to re-sculpt excess gingival tissue as a result of drug induced gingival hyperplasia (ex: Dilantin therapy)

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

Laser Use:

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Gingivectomy is the most common procedure performed with dental lasers. All laser wavelengths can be used to incise gingiva for restorative, cosmetic, and periodontal needs. Utilization of a laser in dental procedures is considered a technique/ armamentarium.

For benefit determination, the use of lasers is considered an adjunct to treatment and is not eligible for an additional or separate benefit.

Gingivectomy or gingivoplasty contraindications include:

1. Treatment for infra-bony pockets.
2. Treatment of pockets extending below the mucogingival junction.
3. The presence of minimal amounts of attached keratinized tissue.
4. Procedures requiring access to alveolar bone.

Criteria

1. Current (within 12 months), dated periodontal charting (6 point periodontal charting) indicating pocket depth recordings of a minimum of 5mm.
2. Current (within 12 months), dated periodontal charting (6 point periodontal charting), after completion of non-surgical periodontal therapy, 4341/4342 and/or periodontal maintenance, D4910, is required.
3. Current (within 12 months) pretreatment radiographs showing periapical area and undistorted image of the alveolar crest.
4. Benefits will be limited to two quadrants per date of service. Exceptions will be allowed on a case by case basis.
5. 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. Exceptions will be allowed on a case by case basis.
6. UPDATE
7. Gingivectomy to allow access for crown(s)/ restoration(s) is group specific but is typically considered incidental to the primary procedure.
8. 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 and only if the pocket depth of the tooth is 5mm or greater.
9. The use of lasers/electrosurgery for an additional benefit is considered an adjunct to treatment. Use of these specialized techniques is not eligible for an additional benefit.
10. Contraindicated in treating infra-boney pockets, pockets extending below the mucogingival junction.
11. Gingivectomy for removing inflamed/hypertrophied tissue around partially erupted or impacted teeth: excision of pericoronal tissue code as D7971.
12. Gingivectomy is considered cosmetic when performed within six months of orthodontic treatment
13. D4212:
    a. Are considered inclusive when performed with crown(s)/ restoration(s) however benefits are group contract dependent.
    b. If diagnostics indicate periodontal support level (bone level, gingival level and/or recession) appears to allow adequate access, the procedure may not be necessary
    c. Consider incidental to placement of crown/restoration if information appears to not support the procedure.
    d. When submitted without associated restorative procedure evaluate per D4211 guidelines
    e. For non-restorative access, e.g. anatomical crown exposure removing both gingival tissue and supporting bone code as D4230, D4231
14. Gingivectomy for the purpose of correcting altered passive eruption is not benefited.

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:*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4999	Unspecified periodontal procedure, by report

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

References

1. CDT 2024 Current Dental Terminology, American Dental Association.
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. American Academy of Periodontology. Treatment of gingivitis and periodontitis (position paper). J Perio; 1997; 12:1246-1253.

History

Revision History	Version	Date	Nature of Change	SME
	initial	4/22/16	creation	Koumaras and Kahn
	Revision	7/10/17	Criteria	Rosen
	Revision	2/6/18	Related dental policies, appropriateness and medical necessity	M Kahn
	Revision	10/01/2020	Annual Review	Committee
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	Revised	10/30/2021	Annual Review	Committee
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Federal and State law, as well as contract language, takes precedence over Dental Clinical Policy. Dental Clinical Policy provides guidance in interpreting dental benefit application. The Plan reserves the right to modify its Dental Clinical Polices and guidelines periodically and as necessary. Dental Clinical Policy is provided for informational purposes and does not constitute medical advice. These Policies are available for general adoption by any lines of business for consistent review of the medical or dental necessity and/or appropriateness of care of dental services. To determine if a review is required, please contact the customer service number on the member's card.