



# Dental Clinical Policy

**Subject:** Gingivectomy or Gingivoplasty

**Guideline #:** 04-202

**Status:** Revised

**Publish Date:** 01/01/2022

**Last Review Date:** 10/30/2021

## 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 does not constitute an indication 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. 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.
2. 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.
3. A procedure that involves removal of loose or diseased gingival tissue to reduce the size of the pocket between the teeth and the gingiva.
4. 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:

Applications for and research on lasers in dentistry continues to expand since their introduction to the dental profession. Dental laser systems are cleared for marketing in the United States via the Food and Drug Administration (FDA) Premarket Notification [510(k)] process.

The review team determines if the product under review meets relevant criteria for “substantial equivalence” to a predicate device (the term “predicate” is used to describe any device that is marketed for the same use as the new device, even if the actual technologies are not the same).

There are currently more than twenty cleared indications for use for dental lasers in the United States. Dental lasers obtaining 510(k) clearance may be labeled, promoted, and advertised by the manufacturer for only those specific indications for use for which the devices have been cleared for marketing. Dental laser manufacturers must seek FDA 510(k) clearance for each laser product and each specific indication for use. Not every laser is cleared for every conceivable use. Therefore, FDA marketing clearances apply to certain products that are specific to the manufacturer and product. Additional uses for dental lasers are considered “off label use.”

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. Rapid healing and reduced pain post operatively has been reported with patients rarely needing periodontal packing or sutures. The thermal effects of diodes, Nd: YAG and CO<sub>2</sub> lasers can cause collateral damage, but in properly trained hands these devices can be effective. Erbium lasers pulsed technology, shallow penetration, and water absorption produces a minimal thermal effect and minor procedures can sometimes be achieved with no anesthetic at all. The nearly “cold cutting” effect of erbium tissue interaction creates a remarkable post-operative course.

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.

For self-funded plans claims are administered by UniCare Life & Health Insurance Company.

## Criteria

1. Current (within 12 months), dated periodontal charting (6 point periodontal charting) indicating pocket depth recordings of a minimum of 5mm.
2. A current (within the most recent 12 months) periodontal pocket probing chart, after completion of non-surgical periodontal therapy, 4341/4342 and/or periodontal maintenance, D4910, is required.
3. Current pre-treatment 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 six 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.
6. Gingivectomy will be considered for treatment of periodontal defects involving natural teeth only.
7. Gingivectomy to allow access for restorative procedures 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/electrosurg 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. 4210/4211 is considered cosmetic when done within six months of orthodontic treatment (1110/4341/4342 and/or 4346 should be tried first)
13. D4212:
  - a. May be considered 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

## 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

**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. 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

	Revised	12/4/2020	Annual Review	Committee
	Revised	10/30/2021	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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