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Dental Clinical Policy

Subject: Guided Tissue Regeneration
Guidelines #: 04-209
Status: Revised

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Description

This document addresses the procedures for guided tissue regeneration.

The plan performs review of guided tissue regeneration 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

Guided tissue regeneration is a surgical procedure used to achieve new bone, cementum and PDL attachment to a periodontally diseased tooth. Guided tissue regeneration may be appropriate for:

- Class II furcation involvement
- Vertical defects (intrabony and infrabony)
- Use in conjunction with bone grafting

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. Guided tissue regeneration should generally be confined to vertical, multi-walled or narrow defects with areas of vertical bone loss or class II furcation defects.
2. Guided tissue regeneration procedures are generally limited to treatment of periodontal and peri-implant defects (dependent upon group contract).
3. Guided tissue regeneration procedures associated with endodontic therapies or with minor periradicular surgery are typically not a covered benefit as bone heals by secondary intention.
4. Documentation of the necessity of guided tissue regeneration for periodontal purposes must include all associated, current (within 12 months) diagnostic, dated, properly oriented, pretreatment radiographic images demonstrating vertical bone defects.
5. Current (within 12 months), dated, post initial therapy periodontal charting (6-point periodontal charting) indicating pocket depths of a minimum of 5mm.
6. Guided tissue regeneration is not considered for benefits when performed in conjunction with soft tissue grafting procedures.
7. Benefits for guided tissue regenerations may be allowed when performed in conjunction with dental implants dependent on group contract.
8. The use of biologic materials for soft or osseous tissue regeneration will not be considered in conjunction with guided tissue regenerations.
9. Guided tissue regeneration procedures include post-operative management for the immediate three months following surgery as well as for any surgical re-entry for three years (group contract dependent).
10. For major guided tissue regeneration (reconstructive) procedures, the patient's medical plan should be checked for coverage.

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:*

D3432 Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
D4266 Guided tissue regeneration – resorbable barrier, per site
D4267 Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)

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

References

1. American Academy of Periodontology. Parameters of Care 2000. https://www.perio.org/sites/default/files/files/parameters.pdf
2. American Academy of Periodontology Glossary of Periodontal Terms.
3. Corbella S, Taschieri S, Elkabbany A, et al. Guided Tissue Regeneration Using a Barrier Membrane in Endodontic Surgery. Swiss Dent J. 2016; 126(1) :13-25.
4. Pretzl B, Kim TS, Holle R, et al. Long - term results of guided tissue regeneration therapy with non-resorbable and bioabsorbable barriers. IV. A case series of infrabony defects after 10 years. J Periodontol. 2008 Aug;79(8):1491-9
5. Soldatos NK, Stylianou P, Koidou VP, et al. Limitations and options using resorbable versus nonresorbable membranes for successful guided bone regeneration. Quintessence Int. 2017; 48(2):131-147.
6. CDT 2023 Current Dental Terminology, American Dental Association.

History

Revision History	Version	Date	Nature of Change	SME
	Initial	05/06/2020	Initial	Committee
	Revised	12/04/2020	Annual Review	Committee
	Revised	10/30/2021	Annual Review	Committee
	Revised	10/28/2022	Annual Review	Committee

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.