Dental Clinical Policy

Subject: Gingival Flap Procedure and Apically Positioned Flap
Guideline #: 04-207 **Publish Date:** 01/01/2021
Status: Revised **Last Review Date:** 12/04/2020

Description

This document addresses the Gingival Flap Procedure, including root planing, and Apically Positioned Flap.

The plan performs review of gingival flap procedure and apically positioned flap 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

The gingival flap procedure or apically positioned flap are considered appropriate for the treatment of mild to severe periodontal disease when non-surgical methods such as scaling and root planing have been unsuccessful in removal of below the gum deposits of plaque (biofilm) and calculus and where, due to supra-bony pocket depths osseous recontouring and bone grafting are not required. A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue.

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. Treatment of diseased gingiva after nonsurgical methods, such as root planning and scaling, have been unsuccessful in the removal subgingival of plaque and calculus. Periodontal charting, after completion of non-surgical periodontal therapy (D4341/D4342) or periodontal maintenance (D4910) is required.

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

2. Current (within 12 months), dated periodontal charting (6 point periodontal charting as described by AAP and ADA) indicating pocket depth recordings of a minimum of 5mm.
3. Current pre-treatment radiographs showing periapical area and undistorted image of the alveolar crest.
4. The procedure is indicated in the presence of supra-bony pocket depths where there is a need for increased access to root surfaces
5. Chart notes may be requested in order to demonstrate a soft tissue flap was reflected/resected or planned, to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished with this procedure.
6. Benefits will be limited to for two quadrants per date of service. Exceptions will be allowed on a case by case.
7. Gingival lap procedures will be considered for treatment of periodontal defects involving natural teeth only. Gingival flap procedures will not be considered when the procedure is performed around implants.
8. For benefit determination, the use of lasers is considered an adjunct to treatment and is not eligible for an additional or separate benefit.
9. Gingival flap procedure or apically positioned flap **are not performed for the following:**
    a. Treatment for infra-bony pockets.
    b. Treatment of pockets extending below the mucogingival junction.
    c. The presence of minimal amounts of attached keratinized tissue.

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:*

D4240	Gingival Flap Procedure including root planing – four or more teeth
D4241	Gingival Flap Procedure including root planing – one to three teeth
D4245	Apical Positioned Flap

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.
6. Current Procedural Terminology - CPT® 2017 Professional Edition – American Medical Association. All rights reserved.
7. Current Dental Terminology - CDT © 2017 American Dental Association. All rights reserved.
8. ICD-10-CM 2017: The Complete Official Codebook. All rights reserved.

History

Revision History	Version	Date	Nature of Change	SME
	initial	3/12/18	creation	M Kahn
	Revised	11/04/2020	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.