

**BLUE CROSS BLUE SHIELD OF ARIZONA HEALTH CHOICE
DENTAL CLINICAL REVIEW CRITERIA**

| | |
|----------------------|-------------------------------------------|
| Department | Utilization Management |
| Policy Number | D0009 |
| Subject | Periodontal Services and Referrals |
| Attachments | None |

Overview: The objective of this clinical policy is to provide guidance regarding dental and medical necessity in relation to member benefits. It is important to note that these policies do not guarantee payment or specific outcomes. Coverage decisions and the administration of benefits are governed by all relevant terms, conditions, exclusions, limitations, and applicable state and federal regulations. Dental policies and criteria are intended solely for informational purposes and do not serve as medical or dental advice.

Blue Cross Blue Shield of Arizona Health Choice covers periodontal treatment, both surgical and non-surgical, when treatment is necessary based on medical or dental need. The American Academy of Periodontology (AAP) guidelines stress that periodontal health should be achieved in the least invasive and most cost-effective manner. With non-surgical periodontal therapy, many patients can be treated and maintained without the need for surgical intervention. Surgical procedures may be required when periodontal health cannot be achieved or maintained with conservative non-surgical therapies. The following criteria are based on Blue Cross Blue Shield of Arizona Health Choice’s interpretation of periodontal treatment when it considers the treatment medically or dentally necessary.

Criteria:

Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation

The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures and not to be coded multiple times by quadrants.

Indications:

It is the policy of Blue Cross Blue Shield of Arizona Health Choice that full mouth scaling in the presence of generalized moderate or severe gingival inflammation is medically necessary when any of the following conditions are met:

1. Evidence of plaque, calculus, and staining on supra- and sub-gingival tooth surfaces has led to generalized moderate or severe gingival inflammation, without indications of periodontitis.
2. Gingival swelling or inflammation has produced generalized suprabony (pseudo-) pockets affecting more than 30% of the remaining dentition, along with moderate to severe bleeding on probing.

Required documentation:

1. Recent diagnostic quality radiographs (periapical and bitewing images). A panoramic film is not considered adequate for diagnosis of periodontal procedures.
2. Recent periodontal charting.
3. Intraoral photographic images that document gingival conditions.
4. Clinical notes documenting soft tissue conditions.

Limitations and exclusions:

1. One of D4346 every 6 months.
2. Not covered for Medicaid members age 21+ under the Adult Emergency Dental benefit. See Adult Medicaid Coverage Limitations and Exceptions (21+).

Full mouth debridement

This procedure is performed to allow a comprehensive periodontal evaluation and diagnosis at a subsequent visit. Full-mouth debridement involves the removal of subgingival and/or supragingival plaque and calculus that prevents completion of an accurate comprehensive oral evaluation. This service is generally indicated for members who have not received dental care for an extended period of time or who struggle with maintaining daily oral hygiene. Full-mouth debridement is **not** considered therapeutic or preventive care; therefore, it must be followed by definitive treatment such as prophylaxis or scaling and root planing once adequate visualization and assessment of the periodontal condition can be achieved.

Contraindications:

1. Full mouth debridement will not be approved when documentation indicates that a comprehensive or periodontal evaluation was completed prior to, or on the same date as, the requested service, and/or a dental prophylaxis has already been performed.
2. Generalized heavy plaque and calculus accumulation are not present, and there is no obstruction that would prevent or interfere with the performance of a comprehensive oral evaluation.

Required documentation:

1. Clinical notes with documentation of definitive periodontal treatment.
2. Radiographic evidence of heavy sub and/or supragingival calculus.
3. Intraoral photographic images.

Limitations and exclusions:

1. One of D4355 per year.
2. Not covered for Medicaid members age 21+ under the Adult Emergency Dental benefit. See Adult Medicaid Coverage Limitations and Exceptions (21+).

Periodontal scaling and root planing:

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

Periodontal scaling and root planing is justified for the treatment of **4 or more** adjacent or bonded teeth within a quadrant while localized scaling and root planing is justified for the treatment of **less than 4** adjacent or bonded teeth within a quadrant.

Indications:

It is the policy of Blue Cross Blue Shield of Arizona Health Choice that periodontal scaling and root planing is medically necessary when the following conditions are met:

1. Localized or generalized initial, moderate, or severe chronic periodontitis, defined as the loss of attachment due to destruction of the periodontal ligament and loss of adjacent supporting bone
2. Periodontal probing depths of at least 5 millimeters (mm) with clinical attachment loss (CAL) of at least 2 mm.
3. Radiographic evidence of bone loss (horizontal or vertical)
4. Root surface calculus is frequently demonstrated on radiographs, and tooth mobility may be present.
5. In molars, furcation involvement should not exceed Class I.
6. Radiographic evidence of moderate to heavy subgingival calculus
7. Inflamed gingiva, swollen gingiva, generalized suprabony pockets.

Treatment involves the instrumentation of crown and root surfaces in order to remove plaque, calculus, biofilm and stains. The absence of calculus should be evident on post treatment radiographs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as part of pre-surgical procedures in others.

Required Documentation:

1. Recent (within 6 months) diagnostic quality full-mouth radiographs that include bitewing images. A panoramic film is not considered adequate for diagnosis of periodontal procedures.
2. Recent (within six months) periodontal pocket depth charting with AAP case type, including:
 - a) Pocket depths
 - b) Recession
 - c) Amount of attached gingiva
 - d) Furcation involvement

- e) Mobility
 - f) Bleeding upon probing
 - g) Clinical attachment loss
3. Treatment plan
 4. Chart notes

Periodontal Maintenance Procedures:

This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

Indications:

It is the policy of Blue Cross Blue Shield of Arizona Health Choice that periodontal maintenance is medically necessary when any of the following conditions are met:

1. To maintain the outcomes of non-surgical and surgical periodontal therapy and to prevent recurrence of disease.
2. Provided as a continuation of active periodontal treatment at clinically appropriate intervals.

Contraindications:

1. Absence of a history of scaling and root planing or periodontal surgery.
2. Use for the treatment of gingivitis.

Required documentation:

1. Chart notes documenting history of scaling and root planing or periodontal surgery procedures.
2. Periodontal charting history (pre and post SC/RP).

Limitations:

1. One D4910 is allowed three months after periodontal therapy and then every six months thereafter, with a maximum of two per calendar year. Additional periodontal maintenance may be considered when medically necessary.
2. Not covered for Medicaid members age 21+ under the Adult Emergency Dental benefit. See Adult Medicaid Coverage Limitations and Exceptions (21+).

Gingival irrigation with medicinal agent – per quadrant

This service is not covered by AHCCCS or Blue Cross Blue Shield of Arizona Health Choice for Medicaid members, nor is it included in the supplemental dental benefits offered

through the Health Choice Pathway plan. Gingival irrigation is not indicated due to insufficient evidence of efficacy. Current research demonstrates only limited short-term benefit, as antimicrobial agents used during irrigation are rapidly cleared and do not provide sustained therapeutic effects.

Gingivectomy/Gingivoplasty

Gingivectomy and gingivoplasty are surgical periodontal procedures involving the removal and/or recontouring of gingival soft tissues within the dentogingival complex. These procedures are performed to eliminate supra-bony periodontal pockets, correct gingival enlargement, or provide adequate access for restorative or periodontal therapy. Gingivoplasty may also be completed to reshape gingival tissues to a more physiologic architecture following disease or surgical intervention.

Indications:

1. Elimination of suprabony periodontal pockets measuring a minimum of 5 mm after completion of non-surgical periodontal therapy.
2. Management of gingival enlargements, including drug-induced gingival hyperplasia or other forms of gingival overgrowth that interfere with oral hygiene or periodontal stability.
3. Creation of clinical crown length to allow access for restorative or prosthetic procedures (e.g., in endodontically treated or structurally compromised teeth) when bone removal is *not* required.
4. Exposure of soft-tissue-impacted teeth to facilitate eruption
5. Elimination of pseudopockets (false pockets) caused by excessive gingival tissue when associated with inflammation or plaque retention.

Contraindications:

1. For cosmetic or aesthetic purposes only.
2. If the provider performs other related procedures in the same area (i.e., extraction) on the same day and involving the same tooth or adjacent tissues, the fee for the gingivectomy is considered inclusive and is not separately reimbursable. Gingivectomy performed solely to facilitate another surgical service is regarded as part of the overall procedure and therefore cannot be billed independently.

Required documentation:

1. Recent diagnostic quality radiographs (periapical and bitewing images). A panoramic film is not considered adequate for diagnosis of periodontal procedures.
2. Recent periodontal charting.
3. Intraoral photographic images of the affected site(s).
4. Chart notes, including a narrative documenting medical and/or dental necessity, must be provided and must clearly substantiate the clinical conditions that meet the indications for gingivectomy.

Gingival Flap Procedures, Including Root Planing

Gingival flap is a surgical procedure involving reflection of soft tissue to improve access to infected root surfaces in order to eliminate the local etiology of periodontal disease.

Indications:

The following conditions are generally considered to be indications for performing a gingival flap procedure:

1. Treatment of moderate to deep periodontal pockets requires access to the roots of the teeth to accomplish the removal of granulation tissue and debridement of root surfaces.
2. Periodontally involved teeth must show periodontal pocket depths of at least 5 millimeters, along with loss of attachment and/or radiographic evidence of bone loss.
3. when less invasive periodontal therapy, such as nonsurgical scaling and root planing, fails to remove rough cementum, dentin, or subgingival calculus, as evidenced by residual root surface irregularities or persistent inflammation.

Contraindications:

A gingival flap procedure may be considered not medically necessary, clinically inappropriate, or below acceptable standards of care when any of the following conditions are present:

1. No clinical signs of periodontal disease.
2. Gingival inflammation that can be effectively managed with nonsurgical periodontal therapy
3. Performing the procedure on a tooth with a hopeless periodontal, endodontic, or structural prognosis.
4. Poor patient compliance with oral hygiene or recommended supportive care
5. Medical conditions that make periodontal surgery unsafe, such as a history of diabetes, chemotherapy or radiation involving the head and neck.

Required documentation:

1. Recent diagnostic quality radiographs, including bitewing images. A panoramic film is not considered adequate for diagnosis of periodontal procedures.
2. Recent periodontal charting.
3. Intraoral photographic images of the affected site(s).
4. Chart notes, including a narrative documenting medical and/or dental necessity, must be provided and must clearly substantiate the clinical conditions that meet the indications for gingival flap.

Clinical Crown Lengthening - Hard Tissue

Clinical crown lengthening is a dental procedure in which the bone surrounding a tooth is reshaped or removed to expose more of the tooth's surface. The procedure involves a full thickness flap and removal of bone for functional reasons. The goal is to increase the amount of available tooth structure above the osseous crest, to allow a restorative procedure on a tooth.

Indications:

A crown-lengthening procedure is indicated when the following clinical criteria are met:

1. When subgingival caries or fracture requires removal of soft and hard tissue to enable restoration of a tooth.
2. The tooth must be endodontically treated tooth.
3. Performed in a healthy periodontally environment.
4. An adequate crown-to-root ratio must remain after crown lengthening, as removing too much supporting bone can leave the tooth structurally unstable and compromise its long-term prognosis.

Contraindications:

A crown-lengthening procedure is not indicated when any of the following criteria are present:

1. When performed for cosmetic reasons.
2. Poor crown-to-root ratio after the procedure.
3. Teeth with severe periodontal involvement, advanced mobility, vertical root fractures, or non-restorable structural damage are not appropriate candidates for crown lengthening.
4. Vital tooth.

Limitations and Exclusions:

1. Crown-lengthening is not a covered benefit for adult Medicaid members age 21 and older under AHCCCS or Blue Cross Blue Shield of Arizona Health Choice.
2. Crown-lengthening is also not included as a covered service under the Health Choice Pathway supplemental dental benefits.

Osseous Surgery:

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting bone (osteotomy) and/or non-supporting bone (osteoplasty).

Indications:

Osseous surgery is medically/dentally necessary when any of the following conditions

are met:

1. Vertical bone loss of 3mm or greater.
2. Radiographic bone loss (RBL) extends to middle third of root and beyond.
3. Generalized infrabony pocketing of 6 mm or greater that has not improved following periodontal scaling and root planing (SRP).
4. Generalized clinical attachment loss of 5 mm or greater.
5. Less invasive treatment approaches, such as non-surgical periodontal therapy, have been unsuccessful in eliminating the disease.
6. Class III furcation involvement.
7. Moderate to severe ridge defect.

Contraindications:

1. Uncontrolled systemic or medical conditions that impair healing or increase surgical risk, including uncontrolled diabetes, history of bisphosphonate therapy, chemotherapy or head-and-neck radiation.
2. Cases where nonsurgical periodontal therapy can still achieve periodontal stability.
3. Severe periodontal compromise or a non-restorable prognosis demonstrated by Class III mobility.

Limitations and Exclusions:

1. Not covered for Medicaid members age 21+ under the Adult Emergency Dental benefit. See Adult Medicaid Coverage Limitations and Exceptions (21+).

Required documentation:

1. Clinical chart and treatment notes documenting conditions listed in the indications for use of osseous surgery.
2. Current diagnostic quality bitewing and periapical radiographs showing all teeth involved in the planned procedure.
3. Complete periodontal charting, including the following:
 - a) periodontal charting is required following SRP healing and prior to osseous surgery for pocket depth comparison.
 - b) pocket depth
 - c) bleeding upon probing
 - d) recession
 - e) amount of attached gingiva
 - f) furcation involvement
 - g) clinical attachment loss

Guided tissue regeneration

A surgical procedure with the goal of achieving new bone, cementum, and PDL attachment

to a periodontally diseased tooth, using barrier devices or membranes to provide space maintenance, epithelial exclusion, and wound stabilization.

Indications:

1. For the treatment of periodontal defects characterized by vertical (intrabony and infrabony) bone loss.
2. For Class II furcation defects where regeneration is predictable.

Contraindications:

1. Teeth with a poor or hopeless prognosis.
2. Uncontrolled medical conditions or medications that increase surgical risk or impair healing.
3. There is a sufficient amount of bone for complete and adequate healing.

Limitations and Exclusions:

1. Guided tissue regeneration is not covered when performed in conjunction with dental implant or implant-related services.
2. Not covered for Medicaid members age 21+ under the Adult Emergency Dental benefit. See Adult Medicaid Coverage Limitations and Exceptions (21+).

Gingival Grafts

Soft tissue grafting involves obtaining soft tissue, usually from the individual's palate (roof of the mouth) or a tissue bank and surgically attaching it to areas of gum recession or inadequate gum tissue. The graft serves to thicken and reinforce the gum tissue, covering exposed root surfaces and restoring a more natural gumline. It can also help prevent further recession and improve the overall health of the gums.

Types of grafts include:

- Pedicle
- Connective tissue
- Free gingival
- Combined connective tissue and pedicle

Indications:

Gingival graft is medically/dentally necessary when any of the following conditions are met:

1. Insufficient keratinized or attached gingiva (less than 2 mm)
2. Progressive or clinically significant gingival recession or chronic inflammation.
3. Minimum of 3 mm recession required.

Limitations and exclusions:

1. Any dental procedure performed solely for cosmetic/aesthetic reasons.
2. Procedures that are considered to be Experimental, Investigational or Unproven
3. Any dental procedure not directly associated with dental disease.
4. Not covered for Medicaid members age 21+ under the Adult Emergency Dental benefit. See Adult Medicaid Coverage Limitations and Exceptions (21+).

Required documentation:

1. Narrative demonstrating medical/dental necessity— non cosmetic in nature.
2. Complete periodontal charting, including:
 - tooth number or numbers and location of mucogingival defect i.e. lingual, facial
 - amount of recession in millimeters
 - amount of attached gingiva in millimeters
 - presence of inflammation
 - influence of frenum
 - indication of root sensitivity
 - relationship to restorative care
3. Photographic documentation of areas demonstrating recession may be required.
4. Current diagnostic quality bitewing and periapical radiographs showing all teeth involved in the planned procedure.

Adult Medicaid Coverage Limitations and Exceptions (21+)

Coverage Limitation

1. Periodontal procedures are not covered for Medicaid members 21 years of age and older under the Adult Emergency Dental benefit.
2. Coverage may be allowed for adult members when the member is an organ transplant candidate.

Coding/Billing

The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by dental/medical necessity criteria and specific benefit plans or other regulatory conditions. This list of codes may not be all inclusive.

CDT codes

Key: C.....Covered service N.....Non-covered service

| Code | Description | Medicaid Age 0-20 | Medicaid Age 21+ | Medicare HCP |
|-------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------|--------------|
| D4210 | Gingivectomy or gingivoplasty - four or more | C | N | C |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | C | N | C |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or teeth bounded spaces per quadrant | C | N | C |
| D4241 | Gingival flap procedure, including root planing – one to three teeth or tooth bounded spaces per quadrant | C | N | C |
| D4249 | Clinical crown lengthening - hard tissue | C | N | N |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | C | N | C |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bonded spaces per quadrant | C | N | C |
| D4263 | Bone replacement graft – retained natural tooth - first site in quadrant | C | N | C |
| D4264 | Bone replacement graft – retained natural tooth - each additional site in quadrant | C | N | C |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration, per site | C | N | N |
| D4266 | Guided tissue regeneration, natural teeth - resorbable barrier, per site | C | N | C |
| D4267 | Guided tissue regeneration, natural teeth – nonresorbable barrier, per site | C | N | C |
| D4270 | Pedicle soft tissue graft procedure | C | C | C |
| D4273 | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft | C | N | C |
| D4274 | Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area) | C | N | C |

| | | | | |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------|---|---|---|
| D4275 | Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft | C | N | C |
| D4276 | Combined connective tissue and pedicle graft, per tooth | C | N | C |
| D4286 | Prefabricated post and core in addition to crown | C | N | N |
| D4322 | Splint – intra-coronal; natural teeth or prosthetic crowns | C | N | N |
| D4323 | Splint – extra-coronal; natural teeth or prosthetic crowns | C | N | N |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant | C | N | C |
| D4342 | Periodontal scaling and root planing - one to three teeth, per quadrant | C | N | C |
| D4346 | Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation | C | N | N |
| D4355 | Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on subsequent visit | C | N | C |
| D4910 | Periodontal maintenance | C | N | C |
| D4920 | Unscheduled dressing change (by someone other than the treating dentist or their staff) | C | N | C |
| D4999 | Unspecified periodontal procedure, by report | C | N | C |

The following CDT codes are not covered:

| Codes | Description |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth |
| D4230 | Anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4231 | Anatomical crown exposure - one to three teeth or tooth bounded spaces per quadrant |
| D4245 | Apically positioned flap |
| D4268 | Surgical revision procedure, 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 |

| | |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 |
| 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 |
| D4348 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth |
| D4381 | Localized delivery of antimicrobial agents |
| D4921 | Gingival irrigation with medicinal agent – per quadrant |

References:

- American Dental Association. CDT 2026 Current Dental Procedures (2026).
- American Academy of Periodontology Parameter on chronic periodontitis with slight to moderate loss of periodontal support. 2000.
- American Academy of Periodontology. Parameter on Periodontal Maintenance. 2000
- American Academy of Periodontology Task Force Report on the Update to the 1999 Classification of Periodontal Diseases and Conditions. J Periodontol. 2015 Jul; 86 (7):835-8. doi: 10.1902/jop.2015.157001. Epub 2015.
- Proestakis G, Soderholm G, et al. Gingivectomy versus flap surgery: the effect of the treatment of infra-bony defects. A clinical and radiographic study. Journal of Clinical Perio 1992 Aug;19(7):497-508.
- American Academy of Pediatric Dentistry. Guidelines for Periodontal Therapy (2018).
- American Academy of Pediatric Dentistry. Research, Science and Therapy Committee Guidelines of the American Academy of Periodontology. Treatment of plaque-induced gingivitis, chronic periodontitis, and other clinical conditions. J Periodontol 2001.
- American Academy of Pediatric Dentistry. Periodontal Conditions in Pediatric Dental Patients (Revision 2024)
- AHCCCS Medical Policy Manual Chapter 300-Covered Services- 310-D1–Dental Services for Members 21Years of Age And Older.

Policy History/Review Date:

| | |
|------------------|------------|
| Developed Date | 07/01/2004 |
| Last Review Date | 05/2026 |
| Next Review Date | 05/2027 |

This policy will be reviewed on an annual basis.