DENTAL CLINICAL POLICY AND PROCEDURES

PERIODONTAL SERVICES

Created:	11/07/2025
Approved in Dental Review Committee:	11/20/2025
Approved in Policy Committee:	11/24/2025
Effective Date:	01/01/2026
Next Review:	11/24/2028

I. TABLE OF CONTENTS

Anatomical Crown Exposure
Biologic Materials to Aid in Tissue Regeneration
Clinical Crown Lengthening
Connective Tissue Grafts
Flap Procedures
Full Mouth Debridement
Gingivectomy and Gingivoplasty
Local Delivery of Antimicrobial Agents (LDAs)
Osseous Surgery
Periodontal Maintenance
Scaling and Root Planing
Soft Tissue Graft Procedures
Surgical Revision
Wedge Procedure
Documentation Requirements
Non-Covered Services
Benefit Limits
PEHP Dental Master Policy Exclusions and Limitations
Appendix
Applicable CDT Codes

II. POLICY STATEMENT

Periodontics is a specialized field within dentistry that focuses on the prevention, diagnosis, and treatment of diseases and conditions affecting the periodontium—the tissues that support and surround the teeth. This includes the gums (gingiva), the periodontal ligament, the cementum (which covers the tooth root), and the alveolar bone (which anchors the teeth in the jaw). The most common conditions treated by periodontists are forms of periodontal disease, such as gingivitis (inflammation of the gums) and periodontitis (a more advanced infection that can result in gum recession, bone loss, and ultimately tooth loss if untreated).

Periodontists are dental specialists who receive additional training beyond dental school to manage complex periodontal cases. They perform a variety of treatments, ranging from non-surgical procedures like Full Mouth Debridement, Local Delivery of Antimicrobial Agents (LDAs), Periodontal Maintenance, Provisional Splinting, and Scaling and Root Planing (deep cleaning to remove plaque and tartar from below the gumline) to more advanced surgical interventions such as Anatomical Crown Exposure, Bone Replacement Grafts, Clinical Crown Lengthening, Coronal Splinting, Flap Procedures, Gingivectomy and Gingivoplasty, Guided Tissue Regeneration (GTR), Mesial-Distal Wedge Procedure, Osseous Surgery, and Soft Tissue Graft Procedures aimed at restoring lost bone and gum tissue. They also play a critical role in the

placement and maintenance of dental implants, ensuring that the surrounding tissues remain healthy to support long-term success.

Additionally, periodontists often manage patients with systemic conditions that affect oral health, such as diabetes or cardiovascular disease, and collaborate with general dentists and other specialists to develop comprehensive treatment plans. Regular periodontal maintenance therapy is also a key part of periodontics, helping to prevent disease recurrence and maintain the health of the supporting structures over time.

A. **Anatomical Crown Exposure:**

Anatomical crown exposure in periodontics means the part of the tooth covered by enamel that is normally hidden under the gums but becomes visible when the gums recede due to gum disease, injury, or dental surgery like crown lengthening. The anatomical crown starts at the cementoenamel junction (where the enamel meets the root) and extends to the biting surface. When the gum tissue moves down, more of this crown is exposed, which can affect how the tooth looks, feel sensitive, and change how dentists plan treatments like fillings or crowns. Knowing how much of the anatomical crown is exposed helps dentists decide the best way to protect the tooth and keep the gums healthy. It's different from the clinical crown, which is simply the part of the tooth you can see in the mouth.

1. PEHP may consider anatomical crown exposure medically necessary for the following indications:
    a. When there is a need to facilitate the restoration of subgingival (below the gum line) caries, enabling the dentist to effectively clean and restore decay extending beneath the gum line; or
    b. When it is necessary to allow proper contour and placement of restorations, ensuring that fillings or crowns have the correct shape and margins for function and hygiene; or
    c. When management of a subgingivally fractured tooth is required, making the fracture line accessible for repair or restoration without impinging on the biologic width or periodontal attachment.
2. PEHP considers anatomical crown exposure not medically necessary for the following indications (*may not be an all-inclusive list*):
    a. When adequate root coverage cannot be achieved, meaning the gum tissue cannot properly cover the root;
    b. When less invasive alternatives, such as orthodontic extrusion or restorative margin relocation, can achieve the same clinical outcome;
    c. When the member has uncontrolled systemic conditions that contraindicate surgery, such as poorly managed diabetes or bleeding disorders;
    d. When the member is unable to maintain adequate oral hygiene post-operatively, increasing the risk of infection and delayed healing;
    e. When the root surface is extensively damaged by decay or root resorption, compromising the integrity of the tooth;
    f. When the tooth lacks sufficient periodontal support and is considered non-restorable due to advanced bone or attachment loss.
3. Anatomical Crown Exposure Benefit Limit:
    a. Coverage is limited to once per quadrant in a 24-month period, when clinically indicated;
    b. Coverage is excluded when performed solely for cosmetic purposes and is not eligible for separate reimbursement if performed in conjunction with osseous surgery in the same quadrant.

B. **Biologic Materials to Aid in Tissue Regeneration:**

Biologic materials used to aid in gum and bone regeneration are specialized substances applied during periodontal surgery to stimulate the natural repair and regrowth of both gum tissue and bone. These materials provide a framework or biological signals that promote cell growth and tissue healing. These materials can come from various sources including cadaver donated tissue, other species (bovine, porcine, equine), or man-made in a lab/synthetic, and are used to enhance surgical outcomes in the treatment of periodontal disease and tissue defects by facilitating the regeneration of lost or damaged periodontal structures.

1. PEHP may consider biologic materials used to aid in soft and osseous tissue regeneration medically necessary for the following indications:
    a. When aiming to regenerate periodontal ligament, cementum, and alveolar bone lost due to disease or trauma; or

b. When natural healing alone is insufficient to restore lost periodontal structures and adjunctive therapies are needed to support enhanced regeneration; or
c. When performing surgical procedures addressing intrabony defects or furcation involvements, regenerative treatments improve healing and tissue restoration; or
d. When regenerative outcomes are desired in conjunction with flap surgery or guided tissue regeneration, these therapies serve as important adjuncts.

2. PEHP considers biologic materials used to aid in soft and osseous tissue regeneration not medically necessary for the following indications (*may not be an all-inclusive list*):
   a. When active infection or uncontrolled systemic conditions are present, such as uncontrolled diabetes leading to impaired healing, these treatments should not be used;
   b. When defects are limited to soft tissue without bone involvement, therapies designed for bone and soft tissue regeneration are not appropriate;
   c. When members display lack of adequate oral hygiene, the risk of treatment failure dramatically increases, so these treatments are not recommended;
   d. When periodontal support is severely compromised, and the tooth is considered hopeless, regenerative treatments should not be attempted.
3. Biologic Materials to Aid in Tissue Regeneration Benefit Limit:
   a. Coverage is limited to once per surgical site in a 12-month period when performed in conjunction with eligible periodontal surgery. A surgical site is defined as a specific natural retained permanent tooth, a dental implant (identified by the corresponding permanent tooth number), or an edentulous site (identified by the corresponding permanent tooth number) requiring surgical intervention;
   b. Coverage of surgical sites identified as third molars is excluded.

C. **Clinical Crown Lengthening:**

Clinical crown lengthening is a specialized periodontal surgical procedure that involves the careful removal of both gingival (gum) tissue and underlying osseous (bone) tissue to expose a greater portion of the tooth's clinical crown—the visible part of the tooth above the gumline—in the oral cavity. This procedure requires the reflection of a full-thickness flap, meaning the gum tissue is temporarily lifted away from the tooth and bone to provide access for precise bone removal, which alters the crown-to-root ratio by increasing the length of tooth structure visible above the alveolar bone. A sufficient healing period, typically several weeks, is necessary to allow soft tissues and bone to stabilize before the final placement of restorative margins and impressions for crowns or other dental restorations. Crown lengthening is performed in the context of a healthy periodontal environment, where the supporting gum and bone tissues are free from active periodontal disease, distinguishing it from osseous surgery which is primarily aimed at treating periodontitis and involves reshaping bone affected by infection. When adjacent teeth are present, the flap design may be extended to encompass a larger surgical area to maintain proper tissue contours and promote optimal healing. This procedure helps ensure adequate tooth structure for restorative purposes while maintaining periodontal health and esthetics.

1. PEHP may consider clinical crown lengthening medically necessary when all of the following criteria are met:
   a. When a diagnostic radiograph dated within the past 12 months reveals < 3 mm of healthy natural tooth structure between the planned restorative margin and the alveolar crest, indicating encroachment on the periodontal attachment apparatus (biologic width); and
   b. When additional clinical documentation (such as photos or chart notes) is provided to support medical necessity in cases where radiographs do not clearly demonstrate the need; and
   c. When a full-thickness flap is reflected and both gingival (soft) and osseous (hard) tissue are removed to expose tooth structure for restorative purposes; and
   d. When at least four weeks of healing time is allowed following the procedure before placement of the final restoration to ensure proper healing of the bone and soft tissue; and
   e. When the procedure is performed exclusively on natural teeth and not on dental implants or prosthetic appliances; and
   f. When periodontal charting is submitted or available to support a diagnosis of periodontal health and establish treatment necessity; and
   g. When subgingival caries or tooth fracture is present, and removal of soft and hard tissue is required to enable restoration of the affected tooth; and

h. When the periodontal tissues in the treatment area are healthy, and the procedure is not performed in conjunction with treatment for active periodontal disease.

2. PEHP considers clinical crown lengthening not covered or medically necessary for the of the following indications (*may not be an all-inclusive list*):
   a. When performed during osseous surgery for treatment of active periodontal disease, as it is not considered a separate procedure;
   b. When performed in the same quadrant on the same date as active periodontal treatment, including scaling and root planing, gingivectomy, frenectomy, soft or hard tissue grafting, or wedge procedures;
   c. When performed on the same date of service as the crown preparation or placement, as it is considered inclusive;
   d. When excessive bone removal would result in a poor crown-to-root ratio, compromising the long-term prognosis of the tooth;
   e. When soft tissue is merely 'troughed' to expose margins or facilitate impressions or scans, which does not meet the criteria for clinical crown lengthening;
   f. When the primary purpose of treatment is for cosmetic enhancement, such as improving smile appearance or correcting a "gummy smile";
   g. When the procedure is performed solely to correct altered passive eruption, as it is considered cosmetic;
   h. When the procedure is performed to correct congenital or developmental defects, which are considered elective;
   i. When the procedure is performed for cosmetic purposes, regardless of labeling, without restorative necessity;
   j. When tooth structure loss is due to attrition, abrasion, erosion, or abfraction, and not due to caries or fracture.
3. Clinical Crown Lengthening Benefit Limit:
   a. Coverage is limited to once per retained natural permanent tooth, excluding third molars, within a 5-year period when clinically indicated;
   b. Coverage is excluded when performed solely for cosmetic purposes and is not eligible for separate reimbursement if performed in conjunction with osseous surgery in the same quadrant.

D. **Connective Tissue Grafts (CTG):**

In periodontics, a connective tissue graft (CTG) is a surgical technique where tissue is transplanted to areas of gingival recession or thin gum tissue to increase thickness, cover exposed roots, and improve esthetics and function; it is considered the gold standard for root coverage because of its predictability and long-term stability. CTGs can be classified as autogenous (using the patient's own tissue, typically harvested from the palate) or non-autogenous (using donor material such as allografts from human tissue banks, xenografts from animal sources, or alloplasts made of synthetic biomaterials). Autogenous CTGs include variations like the subepithelial connective tissue graft, envelope technique, tunnel technique, and pedicle graft, each chosen based on defect size and anatomy. Non-autogenous grafts are often used when patients lack sufficient donor tissue or prefer less invasive options, though autogenous grafts remain the most predictable for long-term success. All approaches share the goal of reinforcing gingival tissue and restoring periodontal health.

1. PEHP may consider connective tissue grafts medically necessary for the following indications:
   a. Augmentation of peri-implant soft tissue to improve stability and long-term implant success; or
   b. Correction of mucogingival defects that impair function, esthetics, or patient comfort; or
   c. Coverage of exposed root surfaces due to gingival recession when there is documented root sensitivity or risk of root caries; or
   d. Increase of keratinized or attached gingiva when inadequate tissue compromises periodontal health or oral hygiene; or
   e. Ridge or site development to facilitate placement of prosthetics or implants.
2. PEHP considers connective tissue grafts not medically necessary for the following indications (*may not be an all-inclusive list*):
   a. Cosmetic enhancement only, including procedures performed solely to improve appearance without functional or health benefit;
   b. Coverage of exposed root surfaces when there is no documented sensitivity, caries risk, or functional impairment;

c. Esthetic correction of gingival margins performed solely for patient preference without periodontal disease or recession;
d. Procedures performed in the absence of periodontal disease or mucogingival defect requiring treatment;
e. Treatment requested solely for prosthetic convenience when adequate tissue exists for oral health and hygiene.

3. Connective Tissue Grafts Benefit Limit:
   a. Coverage is limited to once per treated site in a 24-month period, when performed in conjunction with eligible periodontal surgery. A treated site is defined as a specific natural retained permanent tooth, a dental implant (identified by the corresponding permanent tooth number), or an edentulous site (identified by the corresponding permanent tooth number) requiring surgical intervention, excluding third molars.

E. **Flap Procedures:**

In periodontics, flap procedures are surgical techniques in which a section of the gingival (gum) tissue—referred to as a gingival flap—is carefully incised and temporarily lifted or "reflected" away from the teeth and underlying alveolar bone while remaining attached on one side to preserve its blood supply. This controlled separation allows direct access to the tooth roots and bone for procedures such as scaling and root planing, osseous (bone) surgery, bone grafting, dental implant placement, crown lengthening, or other corrective and regenerative treatments. Flap surgery is commonly used to manage moderate to severe periodontal disease, reduce periodontal pocket depths, and promote the regeneration or preservation of the supporting structures of the teeth. After the necessary intervention is performed beneath the gumline, the flap is repositioned and sutured to support proper healing and restore periodontal health. A specific variation, the apically positioned flap, involves repositioning the flap toward the root tip (apex) of the tooth to reduce pocket depth and improve long-term access for maintenance and surgical care.

1. PEHP may consider flap procedures (i.e., apically positioned flap and gingival flap) medically necessary for the following indications:
   a. When non-surgical treatments such as scaling and root planing fail to provide sufficient access to the affected root surfaces or alveolar bone; or
   b. When probing reveals moderate to deep pockets around teeth, showing progression of periodontal disease that requires surgical management; or
   c. When the anatomy of the flap procedure would improve root coverage on a natural tooth leading to better long term prognosis.
2. PEHP considers flap procedures (i.e., apically positioned flap and gingival flap) not medically necessary for the following indications (*may not be an all-inclusive list*):
   a. When esthetic concerns outweigh clinical benefit, particularly in anterior regions where gingival contour or papilla preservation is critical, and less invasive alternatives may be more appropriate;
   b. When insufficient attached gingiva or inadequate tissue thickness is present, making flap reflection and repositioning risky due to potential gingival recession or compromised healing;
   c. When oral hygiene is poor or the member is non-compliant, as successful outcomes depend heavily on effective plaque control before and after surgery;
   d. When periodontal pockets are shallow (≤ 3 mm) and can be effectively treated with routine hygiene methods;
   e. When systemic medical conditions contraindicate surgery, such as uncontrolled diabetes, bleeding disorders, or significant immunosuppression, unless cleared by the member's medical provider;
   f. When there is no clinical or radiographic evidence of active periodontal disease or supporting tissue defects, bone loss, or deep pocketing that would require surgical intervention.
3. Flap Procedures Benefit Limit:
   a. Coverage of apically positioned flap procedures is limited to once per retained natural permanent tooth, excluding third molars, in a 24-month period when clinically indicated and performed during eligible periodontal surgery, with a maximum of 3 procedures per lifetime of the tooth;
   b. Coverage of gingival flap procedures, including root planing, is limited to once per quadrant within a 24-month period when clinically indicated. Coverage is not eligible for separate reimbursement when performed in conjunction with osseous surgery in the same quadrant.

F. **Full Mouth Debridement:**

Full mouth debridement in periodontics is an extensive cleaning procedure designed to thoroughly remove heavy accumulations of plaque, calculus (tartar), and bacterial biofilm from all tooth surfaces throughout the entire mouth. This treatment is typically necessary when the buildup is so severe that routine dental cleaning or prophylaxis cannot adequately address the problem or allow for a proper examination of the gums and underlying tissues. By eliminating these deposits, full mouth debridement helps reduce gum inflammation, bleeding, and infection, creating a healthier environment for the gums. It also enables the dentist or periodontist to perform a more accurate assessment and diagnosis of any existing periodontal disease. Usually completed over one or two appointments, full mouth debridement serves as a critical first step to prepare the mouth for more targeted periodontal therapies, such as scaling and root planing or surgical interventions, to manage and treat periodontal conditions effectively.

1. PEHP may consider full mouth debridement medically necessary for the following indications:
    a. When clinical documentation shows significant deposits, restricted access to periodontal areas, and a necessity for comprehensive cleaning prior to additional treatment; or
    b. When full mouth debridement serves as an initial procedure to prepare for more advanced periodontal treatments like scaling, root planing, or surgical intervention; or
    c. When the accumulation of plaque, calculus, or biofilm is too severe for routine dental cleaning to adequately remove or to permit an accurate periodontal assessment.
2. PEHP considers full mouth debridement not medically necessary for the following indications (*may not be an all-inclusive list*):
    a. When a comprehensive oral evaluation can be completed without preliminary removal of plaque, calculus, and soft debris and a full diagnosis can effectively be reached;
    b. When it is being used inappropriately to bypass benefit limitations or to unbundle services, such as using full mouth debridement as a substitute for routine prophylaxis or as a preliminary cleaning for cosmetic purposes;
    c. When localized or quadrant-based periodontal therapy is already planned and can be initiated immediately without requiring preliminary debridement;
    d. When no excessive supragingival or subgingival deposits are present that would obstruct periodontal charting, radiographs, or clinical examination;
    e. When the member has recently received debridement or prophylaxis, and no significant accumulation of calculus or debris exists that would interfere with diagnostic procedures.
3. Full Mouth Debridement Benefit Limit:
    a. Coverage of full mouth debridement to enable a comprehensive periodontal evaluation is limited to once in a 24-month period.

G. **Gingivectomy and Gingivoplasty:**

Gingivectomy and gingivoplasty are common periodontal surgical procedures used to improve gum health and appearance. A gingivectomy involves the surgical removal of overgrown, inflamed, or infected gum tissue, typically to reduce deep periodontal pockets caused by gum disease, making it easier to clean the teeth and maintain oral hygiene. This procedure is often necessary when non-surgical treatments are no longer effective. On the other hand, a gingivoplasty focuses on reshaping and contouring the existing healthy gum tissue to correct abnormalities in the gum line, enhance aesthetics, and promote better function. It is commonly performed to create a more natural, symmetrical appearance around the teeth. While gingivectomy targets disease control, gingivoplasty is primarily cosmetic, though the two are frequently performed together to achieve both therapeutic and aesthetic outcomes.

1. PEHP may consider gingivectomy or gingivoplasty medically necessary for the following indications:
    a. When gingival overgrowth is present and is caused by medications such as phenytoin, cyclosporine, or calcium channel blockers, or is associated with a documented systemic condition (e.g., leukemia, hormonal disorders), and the overgrowth results in functional impairment or increases the risk of progressive periodontal disease; or
    b. When periodontal pockets exceed standard probing depths (e.g., > 5 mm), do not respond to non-surgical periodontal therapy, and prevent effective oral hygiene due to anatomical limitations; or
    c. When the procedure is necessary for the elimination of a suprabony periodontal abscess to facilitate healing and restore periodontal health.

2. PEHP considers gingivectomy and gingivoplasty not medically necessary for the following indications (*may not be an all-inclusive list*):
    a. When anatomical limitations exist—such as a shallow palatal vault (a low-arched roof of the mouth) or a prominent external oblique ridge (a bony ridge on the lower jaw)—which restrict surgical access and control, making soft tissue excision unsafe or ineffective;
    b. When bone recontouring or evaluation is required, such as in the treatment of infrabony defects (bone loss occurring below the gum line around a tooth) or to examine and reshape bone morphology (bone structure), procedures that necessitate osseous (bone) surgery rather than gingival tissue removal;
    c. When the base of the periodontal pocket extends apical (below) to the mucogingival junction (the boundary between the attached gingiva and movable mucosa), because removing soft tissue alone cannot adequately eliminate deep pockets or restore healthy attachment without addressing underlying bone defects.
3. Gingivectomy and Gingivoplasty Benefit Limit:
    a. Coverage is limited to once per retained natural permanent tooth, excluding third molars, per restoration in a 3-year period when performed to allow access for a restorative procedure;
    b. Coverage is limited to once per quadrant in a 24-month period when performed for periodontal indications and not in conjunction with a restorative procedure.

H. **Local Delivery of Antimicrobial Agents (LDAs):**

Local Delivery of Antimicrobial Agents (LDAs) refers to the targeted administration of antimicrobial substances directly to the site of infection, allowing for high local drug concentrations while minimizing systemic exposure and associated side effects. This approach is particularly effective for treating localized and isolated infections—such as periodontal disease, bone infections, or surgical wounds—where systemic therapy may be less effective or carry greater risks. LDAs often utilize controlled-release systems like gels, fibers, or microspheres to sustain antimicrobial activity at the site. Common agents used include antibiotics (e.g., doxycycline, tetracycline), antiseptics (e.g., chlorhexidine), and other antimicrobial compounds, making LDAs a valuable strategy in improving treatment outcomes and reducing the risk of antimicrobial resistance.

1. PEHP may consider local delivery of antimicrobial agents (LDAs) medically necessary for the following indications:
    a. When adjunctive therapy is needed to reduce bacterial load in specific, limited periodontal sites to improve clinical outcomes; or
    b. When periodontal pockets are ≥ 4 mm and persistent localized infection did not respond adequately to conventional scaling and root planing; or
    c. When the member demonstrates good oral hygiene but requires additional targeted antimicrobial therapy for localized infection; or
    d. When systemic antibiotics are contraindicated or to minimize systemic antibiotic use.
2. PEHP considers local delivery of antimicrobial agents (LDAs) not medically necessary for the following indications (*may not be an all-inclusive list*):
    a. When active acute infection shows significant signs of systemic involvement and systemic antibiotic therapy is indicated;
    b. When generalized periodontal disease affects multiple sites requiring comprehensive treatment;
    c. When periodontal pockets are shallow (< 4 mm) and can be managed effectively with standard non-surgical therapy alone;
    d. When the member is unable or unwilling to maintain proper oral hygiene, reducing treatment effectiveness.
3. Local Delivery of Antimicrobial Agents Benefit Limit:
    a. Coverage is limited to once per retained natural permanent tooth, excluding third molars, in a 3-month period when clinically indicated.

I. **Osseous Surgery:**

Osseous surgery in periodontics is a specialized surgical procedure designed to treat the damage caused to the supporting bone around teeth due to advanced periodontal disease. This procedure involves carefully reshaping, smoothing, or removing diseased or irregular bone tissue (known as osseous defects) to eliminate deep periodontal

pockets and restore a more natural and healthy bone contour. By correcting these bony defects, osseous surgery helps to reduce the areas where harmful bacteria can accumulate, thereby improving gum attachment and preventing further progression of the disease and support structure loss. Additionally, this procedure aims to make it easier for patients to maintain proper oral hygiene. Osseous surgery is typically recommended after initial non-surgical treatments—such as scaling and root planing—have failed to fully resolve deep pockets or bone loss, or when there is a need to repair bone architecture for better periodontal health.

1. PEHP may consider osseous surgery medically necessary when all of the following criteria are met:
   a. Periodontal pockets measure ≥5 mm, are accompanied by bleeding on probing (a clinical sign of active inflammation), and there is radiographic evidence of alveolar bone loss, indicating progression of periodontal disease; and
   b. There has been insufficient clinical improvement following non-surgical therapy, such as scaling and root planing (SRP), a deep cleaning method used to remove plaque and tartar below the gumline and smooth root surfaces even though the patient exhibits appropriate home care and hygiene; and
   c. The procedure is part of a comprehensive periodontal treatment plan aimed at restoring and maintaining periodontal health; and
   d. The teeth are still class II mobile at most with good prognosis if bone contours can be improved.
2. PEHP considers osseous surgery not medically necessary for the following indications (*may not be an all-inclusive list*):
   a. When bone defects are not well-defined or do not require reshaping, meaning natural healing or non-surgical therapies are sufficient to restore periodontal health;
   b. When esthetic concerns in the surgical site outweigh the clinical benefits of osseous surgery, especially in highly visible areas where tissue contour changes would be undesirable;
   c. When inflammation and periodontal disease can be controlled with non-surgical treatment alone, without the need for surgical intervention;
   d. When inadequate attached gingiva or thin tissue biotype is present, which could result in poor healing or increased risk of gingival recession after surgery;
   e. When periodontal pockets are shallow (typically ≤ 3 mm) and can be effectively managed with non-surgical therapies or preventative therapies;
   f. When systemic health conditions contraindicate surgery, such as uncontrolled diabetes or bleeding disorders, unless cleared by the member's medical provider.
3. Osseous Surgery Benefit Limit:
   a. Coverage is limited to once per quadrant within a 24-month period when clinically indicated, and to a maximum of two full-quadrant osseous surgeries per quadrant per lifetime;
   b. Anatomical crown exposure, clinical crown lengthening, and gingival flap procedures are considered inclusive when combined with osseous surgery in the same quadrant.

J. **Periodontal Maintenance:**

Periodontal maintenance is an essential ongoing dental procedure performed after active periodontal therapy, such as scaling and root planing or surgery, to help patients maintain oral health and prevent the recurrence or progression of gum disease. This preventive care involves professional cleaning that removes plaque and calculus both above and below the gumline, careful monitoring of periodontal status including checking gum attachment levels and reinforcing effective oral hygiene practices. Typically scheduled every three to four months depending on the patient's individual risk factors and healing response, periodontal maintenance aims to control bacterial buildup and preserve the supporting structures of the teeth, ensuring long-term stability and health.

1. PEHP may consider periodontal maintenance medically necessary for the following indications:
   a. When a member has completed active periodontal therapy, periodontal maintenance is indicated to prevent recurrence of disease; or
   b. When a member has a history of periodontitis but is currently stable, periodontal maintenance is indicated to monitor and preserve periodontal health; or
   c. When a member is at high risk for periodontal disease progression, such as due to smoking, diabetes, or genetic predisposition, periodontal maintenance is indicated to manage risk factors; or
   d. When a member is receiving supportive care following periodontal surgery, periodontal maintenance is indicated as part of the long-term treatment plan; or

e. When a member shows signs of recurrent inflammation or attachment loss, periodontal maintenance is indicated to intervene early and prevent further deterioration; or
f. When a member with a previous diagnosis of periodontitis has dental implants, periodontal maintenance is indicated to monitor peri-implant tissues and prevent peri-implant disease.

2. PEHP considers periodontal maintenance not medically necessary for the following indications (*may not be an all-inclusive list*):
   a. When a member has a healthy periodontium with no history of periodontitis, periodontal maintenance is not indicated, and routine prophylaxis is appropriate instead;
   b. When a member is edentulous, periodontal maintenance is not indicated because there are no natural teeth or supporting structures to maintain;
   c. When a member has active but untreated periodontitis, periodontal maintenance is not indicated until appropriate initial therapy is completed;
   d. When a member is in a short-term post-surgical healing phase, periodontal maintenance is not indicated until healing has progressed and the maintenance phase begins;
   e. When a member is non-compliant with oral hygiene or recommended appointments, periodontal maintenance may be ineffective and is not indicated until compliance improves;
   f. When a member presents with systemic conditions that temporarily or permanently contraindicate dental treatment, periodontal maintenance may not be indicated until medical clearance is obtained.
3. Periodontal Maintenance Benefit Limit:
   a. Coverage is limited to once every 3-months with a maximum of 4 visits per policy year. Prophylaxis procedures are not covered during the same period as periodontal maintenance.

K. **Scaling and Root Planing:**

Scaling and Root Planing (SRP) is a fundamental non-surgical periodontal procedure used to treat and manage active periodontal disease. It involves the meticulous removal of plaque, calculus (tartar), and bacterial toxins from the root surfaces of the teeth. Unlike prophylactic cleanings, SRP is a therapeutic procedure indicated for members with a diagnosis of periodontitis and may serve as either a definitive treatment in early stages or as part of pre-surgical therapy in more advanced cases. The process begins with scaling, which targets mineralized deposits above and below the gumline that contribute to gum inflammation and the formation of periodontal pockets from bone loss. This is followed by root planing, where rough or contaminated root surfaces are smoothed to eliminate bacterial retention sites, promote reattachment of gum tissue, reduce inflammation, and help reduce periodontal pockets. SRP is also known to alter and reduce the oral biofilm and promote periodontal healing and stability. Due to the thoroughness required, the procedure typically demands a significant amount of time per quadrant and often necessitates the use of local anesthesia for patient comfort.

1. PEHP may consider scaling and root planing (SRP) medically necessary when all of the following criteria are met:
   a. A formal diagnosis of periodontitis, , a chronic inflammatory disease affecting the gums and supporting bone either in specific areas (localized to <4 teeth) or throughout the mouth (generalized 4+ teeth), is documented (See Appendix B: Stages of Periodontitis); and
   b. Periodontal examination, including detailed charting at six points per tooth, reveals pocket depths of $\geq$ 4 mm accompanied by bleeding on probing—findings indicative of active gum inflammation and periodontal infection; and
   c. Radiographic documentation must include full-mouth radiographs or digital images that demonstrate alveolar bone loss (the deterioration of bone supporting the teeth), crestal bone heigh reduction or loss in the lamina dura (the dense bone lining the tooth socket), visible root surface calculus (hardened plaque deposits below the gumline), all of which are consistent with chronic periodontal disease.
2. PEHP considers scaling and root planing (SRP) not medically necessary for the following indications (*may not be an all-inclusive list*):
   a. When clinical or radiographic evidence of attachment loss or bone loss is absent, indicating no periodontitis;
   b. When inflammation or gingival irritation is present but lacks evidence of disease progressing to hard tissue or alveolar crest;
   c. When periodontal pockets are shallow (typically $\leq$ 3 mm) and can be managed with routine dental cleaning or prophylaxis;

d. When poor oral hygiene and non-compliance make improvement unlikely without first addressing plaque control;
e. When scaling and root planing is being considered solely for cosmetic purposes, without clinical justification;
f. When systemic health conditions contraindicate non-surgical periodontal therapy, unless medically cleared by the member's healthcare provider.

3. Scaling and Root Planing Benefit Limit:
   a. Coverage is limited to once per quadrant within a 24-month period;
   b. Pocket measurements greater than 4 mm are required for the benefit to be eligible for payment. Localized therapy is defined as 1–3 teeth per quadrant, and generalized therapy as more than 4 teeth in the quadrant;
   c. All four quadrants may be treated on the same day.

L. **Soft Tissue Graft Procedures:**

Soft tissue graft procedures in periodontics are surgical techniques used to repair or rebuild gum tissue around the teeth, primarily to treat gum recession, cover exposed tooth roots, increase tissue thickness, and improve both the appearance and health of the gums. These procedures protect teeth from root decay and sensitivity while enhancing oral hygiene and gum function. Common types include free gingival grafts, where tissue is taken from the palate and transplanted to the affected area; subepithelial connective tissue grafts, which involve placing connective tissue harvested beneath the palate under existing gum tissue; and pedicle grafts, where adjacent gum tissue is repositioned to cover exposed roots. Overall, these grafts promote tissue regeneration and restore the natural contour and durability of the gums.

1. PEHP may consider soft tissue graft procedures medically necessary when all of the following criteria are met:
   a. When adequate donor tissue is available from the member's palate or another intraoral site, or when an appropriate alternative graft material is used; and
   b. When clinical evidence shows root exposure associated with documented gingival recession and inadequate attached gingiva (typically < 2 mm); and
   c. When documentation includes periodontal charting, clinical photographs, and radiographs supporting the medical necessity of the graft; and
   d. When gingival recession is associated with dentinal hypersensitivity, root caries, or progressive attachment loss compromising periodontal stability; and
   e. When the defect involves a localized area where natural healing or non-surgical treatment would be insufficient to restore tissue integrity; and
   f. When the procedure is intended to improve periodontal health and function, not solely for cosmetic purposes.
2. PEHP considers soft tissue graft procedures not medically necessary for the following indications (*may not be an all-inclusive list*):
   a. When adequate attached gingiva is present, and there is no clinical evidence of sensitivity, root exposure, or attachment loss;
   b. When documentation is insufficient to support the medical necessity of the graft procedure;
   c. When gingival recession is generalized or not localized and better treated with alternative periodontal therapies;
   d. When the procedure is performed solely for cosmetic reasons or esthetic enhancement without associated functional or health impairment.
3. Soft Tissue Graft Procedures Benefit Limit:
   a. A pedicle soft tissue graft is allowable once per retained natural permanent tooth, excluding third molars, within a twelve (12)-month period when performed during eligible periodontal surgery, with a maximum of three per lifetime of the tooth;
   b. Free soft tissue graft is allowable once per treated site in a 24-month period when clinically indicated and performed during eligible periodontal surgery, with a maximum of twice per site. A treated site is defined as a specific natural retained permanent tooth, a dental implant (identified by the corresponding permanent tooth number), or an edentulous site (identified by the corresponding permanent tooth number) requiring surgical intervention, excluding third molars.

M. **Surgical Revision:**

Surgical revision in periodontal surgery refers to a corrective procedure performed on a tooth or site that has already undergone periodontal treatment but requires additional intervention due to complications or inadequate healing. Unlike routine post-operative care, it involves significant corrective measures such as addressing persistent infection, flap separation, or the need to recontour tissue or bone, and is undertaken to restore proper periodontal health and function rather than for cosmetic purposes.

1. PEHP may consider surgical revision medically necessary for any of the following indications:
    a. Flap dehiscence (separation of tissue): This refers to the unintended opening or breakdown of a surgically repositioned gum flap, which exposes underlying bone or tooth structures and requires corrective surgery to restore proper healing; or
    b. Irregular or inadequate bone/tissue healing: This occurs when the bone or soft tissue does not regenerate or repair as expected after periodontal surgery, leading to uneven contours or insufficient support that necessitates surgical correction; or
    c. Need to recontour gingival or osseous structures for proper function: Gingival recontouring involves reshaping the gum tissue, and osseous recontouring involves reshaping the supporting bone; both are required when irregularities interfere with oral function, periodontal stability, or restorative needs; or
    d. Persistent infection or inflammation after initial surgery: This refers to ongoing periodontal disease activity, such as continued swelling, bleeding, or bacterial infection at the surgical site, which indicates that additional surgical intervention is necessary to achieve resolution.
2. PEHP considers surgical revision not medically necessary for the following indications (*may not be an all-inclusive list*):
    a. Cosmetic revisions without clinical disease or functional impairment: These are procedures performed solely to improve appearance, such as reshaping healthy gum tissue for esthetics, which do not meet the criteria for medical necessity;
    b. Routine post-operative care (e.g., minor adjustments, suture removal): These are standard follow-up measures after surgery, such as trimming tissue edges or removing stitches, which are considered part of normal healing and not separate medically necessary surgical revisions.
3. Surgical Revision Benefit Limit:
    a. Coverage is limited to once per retained natural permanent tooth, excluding third molars, in a 12-month period with a maximum of 3 procedures per lifetime of the tooth.

N. **Wedge Procedure:**

The wedge procedure is a periodontal surgical technique used to remove excess or bulky soft tissue and reshape the gingival contours in areas that are difficult to access, particularly around the distal (back) surfaces of the last molars. This procedure is often necessary when conventional flap surgery alone cannot provide adequate access or tissue adaptation, such as in the posterior regions of the mouth where the tissue is thick and causing difficult hygiene practices. The technique involves creating a wedge-shaped incision in the gum tissue, excising the excess tissue, and then repositioning and suturing the remaining tissue to promote proper healing and establish a more functional and maintainable gingival architecture. It is frequently performed in conjunction with other periodontal procedures like osseous surgery or clinical crown lengthening to improve visibility, access, and long-term periodontal health.

1. PEHP may consider a wedge procedure medically necessary for the following indications:
    a. When excess soft tissue impairs adequate adaptation of a surgical flap or limits visibility and access to underlying bone or root surfaces; or
    b. When performed as part of a clinical crown lengthening procedure and need to achieve proper soft tissue contour in hard-to-reach posterior areas; or
    c. When performed in conjunction with periodontal flap or osseous surgery to improve access and visualization in areas with deep periodontal pockets as a result of soft tissue; or
    d. When the procedure is necessary to achieve effective surgical closure and healing in regions where anatomical limitations prevent complete pocket elimination without tissue reduction; or
    e. When there is documented inflammation or tissue overgrowth in the area that does not respond appropriately to non-surgical periodontal therapy.

2. PEHP considers soft tissue graft procedures not medically necessary for the following indications (may not be an all-inclusive list):
    a. When documentation does not support the presence of deep periodontal pockets, excessive tissue, or anatomical limitations requiring surgical modification;
    b. When performed for cosmetic purposes without a functional or clinical indication;
    c. When used solely to reshape gingival contours in the absence of disease, inflammation, or a restorative or surgical need.
3. Wedge Procedure Benefit Limit:
    a. Coverage is limited to once per retained natural permanent tooth, excluding third molars, in an 18-month period when clinical indicated and performed during eligible periodontal surgery.

O. **Documentation Requirements:**

1. The following should be submitted for review if requested and/or when the service requires prior authorization:
    a. A complete periodontal charting that includes detailed measurements of pocket depths, gingival recession—which is the loss of gum tissue exposing the tooth root—bleeding on probing, and tooth mobility, all of which are critical indicators of periodontal health; and
    b. A documented history of any prior periodontal treatments, including non-surgical procedures like scaling and root planing or surgical interventions, to demonstrate previous care and ongoing management of the condition; and
    c. Clinical notes that clearly document the diagnosis of periodontal disease along with a comprehensive treatment plan outlining the recommended procedures and their medical necessity; and
    d. Current radiographic images, such as bitewing X-rays that show the crowns of the upper and lower teeth, or a full-mouth series, providing visual evidence of bone levels and detecting any alveolar bone loss related to periodontal disease.

P. **Non-Covered Services:**

1. The following periodontal services are not covered (*may not be an all-inclusive list*):
    a. Periodontal procedures performed solely for cosmetic purposes, such as reshaping or contouring healthy gum tissue to enhance appearance without addressing clinical disease, are not eligible for coverage as they do not meet the criteria for medical necessity.

III. BENEFIT LIMITS

A. Basic Dental Services, including Prosthodontics and Restorations: Maximum of up to $500, $1000, $1500, or $2000 per member per policy year depending on the dental plan and/or employer group.
B. Dental Accident: Maximum of up to $500 per member per policy year.

IV. PEHP DENTAL MASTER POLICY EXCLUSIONS and LIMITATIONS

A. **GENERAL EXCLUSIONS:**

- *Charges for the following circumstances are excluded as benefits under PEHP:*
    - *Administration of enteral minimal or moderate sedation, non-intravenous parenteral moderate sedation, and nitrous oxide are not covered, and local anesthesia, regional block, and trigeminal division block anesthesia are considered inclusive to the procedure and not separately reimbursed.*
    - *Any services or supplies not specifically identified as a covered service.*
    - *Appliance or restorations necessary to increase vertical dimension of teeth or restore or equilibrate the occlusion; occlusal analysis or adjustment.*
    - *Bacteriologic studies, including the collection and analysis of oral samples to identify bacterial presence, are excluded from coverage.*
    - *Care, treatment, operations, or supplies, or any appliances, aids, devices, or drugs, that are not FDA approved.*
    - *Care, treatment, operations or supplies that are illegal, generally considered Experimental, Investigational, Unproven, or for research purposes by the dental profession, that are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted dental practices.*

- *Charges for special equipment, machines, or devices in the Dentist's office used to enhance Diagnostic or therapeutic services in a Dentist's practice.*
- *Dentistry for solely cosmetic reasons, including but not limited to bleaching, bonding, veneers and crowning of peg laterals.*
- *General anesthesia in a dental office is not a covered service under the dental plan, except when medically necessary for eligible complex oral surgeries (e.g., removal of large cysts or tumors, multiple-site implant placement, extensive bone grafting such as ridge augmentation or sinus lift procedures, or impacted third molar removal), for members with special healthcare needs (e.g., developmental disabilities, cognitive impairments, or severe medical conditions who cannot tolerate routine dental care), or when local anesthesia (including regional block and trigeminal division block) or moderate sedation is ineffective or contraindicated. When provided in a dental office, coverage applies only under strict conditions: the dentist or a certified anesthetist must be properly trained and credentialed in anesthesia delivery, the office must be equipped with advanced monitoring devices and emergency management capabilities, and member selection must be appropriate based on medical history and risk assessment. General anesthesia is not covered for routine procedures such as root canal therapy or simple extractions, nor solely for the management of dental phobia or anxiety. General anesthesia administered through an advanced airway is not covered. Services provided in a healthcare facility outside the dental office under the medical benefit requires preauthorization.*
- *PEHP is not responsible to pay any benefits given verbally or assumed except as written in a Pre-authorization.*
- *Unbundling or fragmentation of codes.*
- *Use of monitoring equipment, including pulse oximeters to measure blood oxygen saturation and heart rate, and electrocardiogram (ECG) monitors to assess cardiac rhythm and electrical activity during dental procedures.*

B. **PERIODONTICS:**

- *Anatomical crown exposure is allowed once per quadrant within a twenty-four (24)-month period but is not covered when performed for cosmetic purposes and is not eligible for separate reimbursement if performed in conjunction with osseous surgery in the same quadrant.*
- *Apically positioned flap surgery is allowed once per retained natural permanent tooth, excluding third molars, within a twenty-four (24)-month period, provided it is performed during eligible periodontal surgery. Coverage is limited to a maximum of three (3) procedures per lifetime of the same tooth.*
- *Autogenous and non-autogenous connective tissue grafts are allowed once per treated site within a twenty-four (24)-month period, provided they are performed during eligible periodontal surgery. A treated site is defined as a natural retained permanent tooth, a dental implant, or an edentulous site requiring surgical intervention, excluding third molars.*
- *Benefits will be allowable for a full quadrant if there are 5–8 teeth present. Whenever the anatomical quadrant contains fewer than five teeth, the benefit will be calculated as a fraction of the full quadrant fee.*
- *Biologic materials used to aid in soft and osseous tissue regeneration are allowed once per surgical site within a twelve (12)-month period when performed in conjunction with eligible periodontal surgery. A surgical site is defined as a specific natural retained permanent tooth, a dental implant, or an edentulous site requiring surgical intervention. Coverage excludes third molars.*
- *Bone replacement grafts are allowed once per graft site, identified by a retained natural permanent tooth, excluding third molars, within a twenty-four (24)-month period when performed in conjunction with eligible periodontal surgery.*
- *Clinical crown lengthening is allowed once per retained natural permanent tooth, excluding third molars, within a five (5)-year period. Coverage is excluded when performed solely for cosmetic purposes and is not eligible for separate reimbursement if performed in conjunction with osseous surgery in the same quadrant.*
- *Combined connective tissue and double pedicle grafts are allowed once per retained natural permanent tooth, excluding third molars, within a twenty-four (24)-month period when performed during eligible periodontal surgery.*
- *Coronal splinting (intra-coronal and extra-coronal) is allowed under the dental plan only when the condition is caused by an accident and qualifies for the dental accident benefit, subject to plan limits. Coverage of third molars is excluded.*
- *Free soft tissue graft procedures are allowed once per treated site within a twenty-four (24)-month period, provided they are performed during eligible periodontal surgery, with a maximum of two procedures per treated*

site. A treated site is defined as a natural retained permanent tooth, a dental implant, or an edentulous site requiring surgical intervention, excluding third molars.

- *Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit is allowed once within a twenty-four (24)-month period.*
- *Gingival flap procedures, including root planing, are allowed once per quadrant within a twenty-four (24)-month period. Coverage is not eligible for separate reimbursement when performed in conjunction with osseous surgery in the same quadrant.*
- *Gingival irrigation is considered inclusive to scaling and root planing, scaling in the presence of inflammation, full mouth debridement for evaluation, and periodontal maintenance procedures, and is not separately reimbursable.*
- *Gingivectomy/gingivoplasty is allowed once per quadrant within a twenty-four (24)-month period, and for restorative purposes is allowed once per retained natural permanent tooth, excluding third molars, within a three (3)-year period.*
- *Guided tissue regeneration using either resorbable or non-resorbable barrier membranes is allowed once per surgical site and must be performed during eligible periodontal surgery. A surgical site is defined as a natural retained permanent tooth, a dental implant, or an edentulous site requiring surgical intervention, excluding third molars. Coverage is limited to one barrier membrane per site per surgical event within a twenty-four (24)-month period.*
- *Local delivery of antimicrobial agents is allowed once per retained natural permanent tooth, excluding third molars, within a three (3)-month period.*
- *Osseous surgery is allowed once per quadrant within a twenty-four (24)-month period and is limited to a maximum of two full-quadrant osseous surgeries per quadrant per lifetime.*
- *Payment for periodontal surgery includes postoperative care for six months following treatment.*
- *Pedicle soft tissue graft procedures are allowed once per retained natural permanent tooth, excluding third molars, within a twelve (12)-month period when performed during eligible periodontal surgery, with a maximum of three per lifetime of the tooth.*
- *Periodontal charting may be requested for review of claims. No benefits are payable separately for periodontal charting.*
- *Periodontal maintenance, which is a specialized cleaning for patients with gum disease, is allowed once every three (3) months, with a maximum of four (4) visits per policy year. Routine dental cleaning (prophylaxis) is not allowed during any period in which periodontal maintenance is provided.*
- *Periodontal scaling and root planing, whether performed per quadrant or as a full-mouth procedure, is allowed once per quadrant within a twenty-four (24)-month period. All four quadrants may be treated on the same day.*
- *Surgical revision procedures are allowed once per retained natural permanent tooth, excluding third molars, within a twelve (12)-month period, with a maximum of three per lifetime of the tooth. Coverage applies only when medically necessary corrective intervention beyond routine post-operative care is required due to complications or failure of prior periodontal surgery.*
- *Wedge procedures are allowed once per retained natural permanent tooth, excluding third molars, in an eighteen (18)-month period, provided they are performed during eligible periodontal surgery.*

V. RELATED DENTAL POLICIES

A. Bone Replacement Grafts
B. Fixed Prosthodontics
C. Guided Tissue Regeneration
D. Removable Prosthodontics

VI. APPENDIX

A. **Definitions:**

1. **Alveolar Bone:** The part of the jawbone that surrounds and supports the roots of the teeth.
2. **Attachment Loss:** The destruction of the periodontal ligament and supporting bone, resulting in the detachment of the tooth from its surrounding structures.
3. **Biofilm:** A complex aggregation of bacteria and other microorganisms that adhere to surfaces in the mouth, especially teeth and gums, and play a central role in periodontal disease.

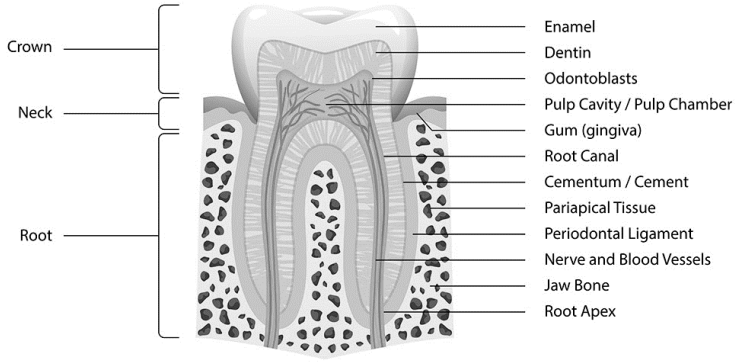
4. **Clinical Attachment Level (CAL):** A measurement used to assess the severity of periodontal disease, determined by the distance from the cementoenamel junction (CEJ) to the base of the periodontal pocket.
5. **Crown-To-Root Ratio (CRR):** Refers to the ratio of the crown length (the part of the tooth above the bone) to the root length (the part of the tooth below the bone). An unfavorable ratio, often defined as a 1:1 or less, can indicate a weak foundation for tooth support and can lead to a poor prognosis for the tooth.
6. **Gingiva:** The gum tissue that surrounds the teeth and covers the alveolar bone.
7. **Gingivitis:** The earliest stage of periodontal disease, characterized by inflammation of the gums without loss of bone or connective tissue attachment.
8. **Periodontal Ligament (PDL):** The fibrous connective tissue that connects the tooth to the alveolar bone, helping absorb forces during chewing.
9. **Periodontal Pocket:** A pathologically deepened space between the tooth and gum, resulting from detachment of the gingiva and destruction of supporting tissue.
10. **Periodontitis:** A chronic inflammatory disease that affects the supporting structures of the teeth, leading to progressive attachment and bone loss if untreated.
11. **Quadrant:** One of the four equal sections of the upper or lower dental arch, beginning at the midline and extending distally to the last tooth, used to organize dental examination and treatment.

B. **Stages of Periodontitis (American Academy of Periodontology):**

1. **Stage I**
   - 1-2mm clinical attachment loss (CAL)
   - Radiographic bone loss of < 15%
   - No tooth loss
   - Complexity
     - Maximum probing depth ≤ 4 mm
     - Mostly horizontal bone loss
2. **Stage II**
   - 3-4 mm interdental clinical attachment loss
   - Radiographic bone loss of 15-33%
   - No tooth loss
   - Complexity
     - Maximum probing depth ≤ 5mm
     - Mostly horizontal bone loss
3. **Stage III**
   - ≥ 5mm clinical attachment loss
   - Radiographic bone loss extends to middle third of root and beyond
   - Loss of ≤ 4 teeth
   - Complexity includes all of criteria for Stage II as well as:
     - Probing depths ≥ 6mm
     - Vertical bone loss ≥ 3mm
     - Class II or III furcation involvement
     - Moderate ridge defects
4. **Stage IV**
   - ≥ 5mm clinical attachment loss
   - Radiographic bone loss extends to middle third of root and beyond
   - Loss of ≥ 5 teeth
   - Complexity includes all of criteria for Stage III as well as:
     - The need for complex rehabilitation due to:
       - Masticatory dysfunction
       - Secondary occlusal trauma (tooth mobility ≥ 2)
       - Severe ridge defects
       - Bite collapse, drifting and/or flaring
       - < 20 remaining teeth (10 opposing pairs)
5. **Note:** The extent and distribution for each stage is described as:
   - Localized (< 30% of teeth involved); or

- Generalized; or
- Molar/incisor pattern.

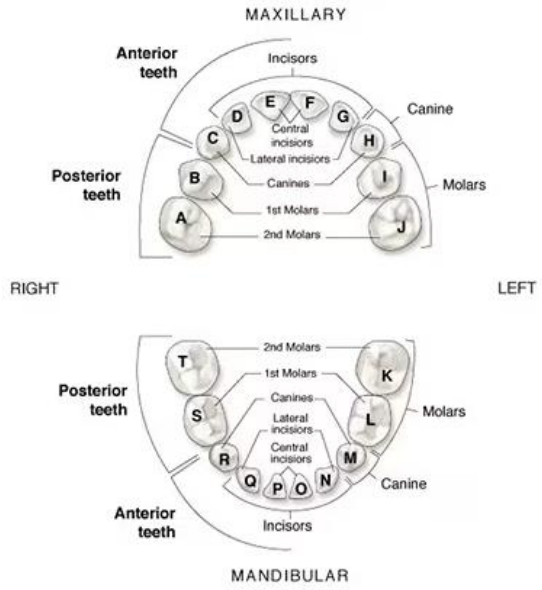
C. **Tooth Anatomy:**



D. **Tooth Chart (Universal Tooth Designation System):**

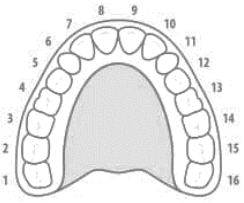
The Universal Tooth Designation System, also known as the Universal Numbering System, is a widely used method for identifying individual teeth in the human mouth. In this system, permanent teeth are numbered 1 through 32, while primary (baby) teeth are assigned letters A through T.

1. **Primary Teeth Chart:**



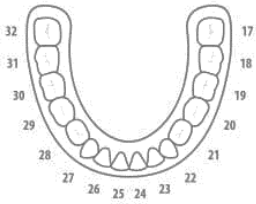
2. **Permanent Teeth Chart:**

1. 3rd Molar (wisdom tooth)
2. 2nd Molar (12-yr molar)
3. 1st Molar (6-yr molar)
4. 2nd Bicuspid (2nd premolar)
5. 1st Bicuspid (1st premolar)
6. Cuspid (canine/eye tooth)
7. Lateral incisor
8. Central incisor



9. Central incisor
10. Lateral incisor
11. Cuspid (canine/eye tooth)
12. 1st Bicuspid (1st premolar)
13. 2nd Bicuspid (2nd premolar)
14. 1st Molar (6-yr molar)
15. 2nd Molar (12-yr molar)
16. 3rd Molar (wisdom tooth)

25. Central incisor
26. Lateral incisor
27. Cuspid (canine/eye tooth)
28. 1st Bicuspid (1st premolar)
29. 2nd Bicuspid (2nd premolar)
30. 1st Molar (6-yr molar)
31. 2nd Molar (12-yr molar)
32. 3rd Molar (wisdom tooth)



17. 3rd Molar (wisdom tooth)
18. 2nd Molar (12-yr molar)
19. 1st Molar (6-yr molar)
20. 2nd Bicuspid (2nd premolar)
21. 1st Bicuspid (1st premolar)
22. Cuspid (canine/eye tooth)
23. Lateral incisor
24. Central incisor

VII. APPLICABLE CODES

A. All claims submitted for processing may be subject to review under McKesson Health Solutions' Clear Claim Connection tool and the Correct Coding Initiative (CCI) guidelines, as established by the Centers for Medicare & Medicaid Services (CMS) and other applicable regulatory authorities. Coding edits may be applied to ensure adherence to national standards, including bundling and unbundling policies as well as code combination restrictions. As a result, claim processing and reimbursement may be adjusted accordingly. All benefit determinations are contingent upon coverage eligibility at the time of service.

B. The following list(s) of procedure codes is provided for reference purposes only and may not be all-inclusive, as Current Dental Terminology (CDT) code updates by the American Dental Association (ADA) may occur more frequently than policy updates. Deleted codes and codes that are not effective at the time the service is rendered may not be eligible for reimbursement. The inclusion of a code within this policy does not imply that the associated service is covered or excluded under any specific health plan. Coverage is determined based on the terms of the member's employer group benefit plan and applicable federal and state laws and regulations. Inclusion of a code does not guarantee claim payment or reimbursement. Other policies or clinical guidelines may also apply.

Anatomical Crown Exposure	Guided Tissue Regeneration (GTR)
Biological Materials	Local Delivery of Antimicrobial Agents (LDAs)
Bone Replacement Grafts	Osseous Surgery
Clinical Crown Lengthening	Periodontal Maintenance
Connective Tissue Grafts	Scaling and Root Planing
Flap Procedures	Soft Tissue Graft Procedures
Full Mouth Debridement	Surgical Revision
Gingivectomy and Gingivoplasty	Wedge Procedure
Anatomical Crown Exposure:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4230	Anatomical crown exposure, 4 or more contiguous teeth or tooth bounded spaces per quadrant
D4231	Anatomical crown exposure, 1 to 3 teeth or tooth bounded spaces
Biological Materials:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site
Bone Replacement Grafts:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4263	Bone replacement graft – retained natural tooth- first site in quadrant **Coverage is subject to the criteria outlined in the "Bone Replacement Grafts" Dental Policy.*
D4264	Bone replacement graft – retained natural tooth- each additional site in quadrant **Coverage is subject to the criteria outlined in the "Bone Replacement Grafts" Dental Policy.*
Clinical Crown Lengthening:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	

D4249	Clinical crown lengthening – hard tissue
Connective Tissue Grafts:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276	Combined connective tissue and double pedicle graft, per tooth
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
Flap Procedures:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant
D4245	Apically positioned flap
Full Mouth Debridement:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
Gingivectomy and Gingivoplasty:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
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
Guided Tissue Regeneration (GTR):	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4266	Guided tissue regeneration – resorbable barrier, per site **Coverage is subject to the criteria outlined in the "Guided Tissue Regeneration" Dental Policy.*
D4267	Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal) **Coverage is subject to the criteria outlined in the "Guided Tissue Regeneration" Dental Policy.*
Local Delivery of Antimicrobial Agents (LDAs):	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue per tooth
Wedge Procedure:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4274	Mesial/distal wedge procedure, single tooth
Osseous Surgery:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant

D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
Periodontal Maintenance:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4910	Periodontal maintenance
Scaling and Root Planing:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant
D4342	Periodontal scaling and root planing – one to three teeth per quadrant
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation
Soft Tissue Graft Procedures:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4270	Pedicle soft tissue graft procedure
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
Surgical Revision:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4268	Surgical revision procedure, per tooth
Wedge Procedure:	
CDT codes COVERED if selection criteria are met (*may not be an all-inclusive list*):	
D4274	Mesial/distal wedge procedure, single tooth
CDT codes NOT COVERED for ANY indication, considered INCLUSIVE to the primary procedure, or COVERED under the Dental Accident benefit only (*may not be an all-inclusive list*):	
D4286	Removal of non-resorbable barrier
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns. Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.
D4323	Splint – Extra-coronal; natural teeth or prosthetic crowns. Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)
D4921	Gingival Irrigation – per quadrant with a medicinal agent
D4999	Unspecified periodontal procedure, by report