
Delta Dental of Ohio Clinical Criteria for Utilization Management Decisions

Clinical Criteria for Gingivectomy

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Introduction

This Delta Dental of Ohio clinical criteria document addresses the gingivectomy procedure. The purpose of this document is to provide written clinical criteria to ensure that Delta Dental of Ohio consistently applies sound and objective clinical evidence when determining the medical necessity and clinical appropriateness of gingivectomy treatment, as well as taking individual patient circumstances and the local delivery system into account.

Gingivectomy is a resective periodontal surgical procedure that performed to eliminate suprabony periodontal pockets, reduce gingiva enlargement or provide access for restorative procedures.

The gingivectomy procedure typically involves a series of steps:

- Depending on the patient's condition, treatment may be performed for initial control of gingival inflammation.
- The surgical procedure begins with mapping of the suprabony pockets by transgingival marking on the gingiva. This may be performed with a probe or pocket marking forceps.
- The resection of gingival tissue is then performed with scalpels, electrosurgery or laser surgery.
- After excised gingival tissue has been removed, further contouring of tissues and scaling and root planing may be carried out.
- A periodontal dressing is placed to cover the wound surface.

Gingivectomy may be performed by general dentists, periodontists and other dental specialists in a variety of healthcare facilities.

Applicable Dental Procedure Codes

The following dental procedure codes defined in the current version of the American Dental Association's Code on Dental Procedures and Nomenclature (the CDT® Code) are applicable to this document and are the appropriate codes to use when documenting gingivectomy procedures. Inclusion of these codes here is for informational purposes only and does not imply benefit coverage or noncoverage of a procedure by a member's dental plan. A determination that a dental procedure is medically necessary and clinically appropriate does not guarantee that the procedure is a covered benefit of a member's dental plan. To determine if gingivectomy is a covered benefit of an individual member's dental plan, please refer to the plan documents in effect on the date of service.

CDT® Procedure Code	Procedure Code Nomenclature
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

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CDT® Procedure Code	Procedure Code Nomenclature
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth

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Clinical Criteria¹

When approval of benefit payment for a gingivectomy by a member's dental plan requires a determination by Delta Dental of Ohio that the procedure is medically necessary and clinically appropriate, the patient's dental record must document a generally accepted indication for performing the procedure. The following conditions are generally considered to be indications for performing a gingivectomy:

- Suprabony pockets with normal underlying bony architecture that are unresponsive to nonsurgical periodontal therapy
- Treatment of gingival abscesses
- Gingival enlargement caused by medications, idiopathic gingival fibromatosis and other conditions resulting in gingival overgrowth
- Gingival enlargement resulting from orthodontic treatment
- provide access for restorative procedures

For patients who do not meet the published qualifying criteria for gingivectomy, Delta Dental of Ohio will consider documentation from relevant clinicians that explains the necessity of covering a gingivectomy procedure for conditions not included in the criteria.

Depending on the clinical circumstances, the performance of a gingivectomy under the following conditions may be considered not medically necessary, inadvisable or deficient in clinical quality and may result in disapproval of benefits based on a professional determination that treatment is not medically necessary or not clinically appropriate:

- Absence of suprabony periodontal pockets or gingiva enlargement
- Insufficient or absent attached gingiva
- Pocket bases at or apical to the mucogingival junction
- Presence of underlying infrabony defects or abnormal bony configuration
- Gingival inflammation that can be effectively controlled through non-surgical periodontal treatment
- Gingivectomy performed on a tooth that has a hopeless periodontal, endodontic or structural prognosis
- Incomplete gingivectomy inadequate to treat suprabony periodontal pockets or gingival enlargement
- Gingivectomy performed solely for cosmetic improvement
- Patient non-compliance with oral hygiene procedures and supportive care
- Patients with medical conditions where periodontal surgery is inadvisable including, but not limited to, a history of bisphosphonate treatment or chemotherapeutic or radiation therapy of the head and neck

¹ Government regulations or the provisions of a member's dental plan that define when a dental procedure may be considered medically necessary and clinically appropriate with respect to benefit coverage may take precedence over these clinical criteria.

Depending on an individual patient's condition and circumstances, the following additional criteria for the gingivectomy procedure may be applied for coverage determinations:

- Unless otherwise established by a dental benefit program, gingivectomy is eligible for benefit coverage for the treatment of natural teeth only.
- Periodontally involved teeth generally qualify for gingivectomy benefit coverage when documented to have at least 5 millimeter suprabony pocket depths.
- Periodontal procedures submitted by quadrant must have at least 4 teeth eligible for treatment.
- The D4212 gingivectomy procedure to allow access for a restorative procedure should only be used when gingival tissue must be removed to expose a tooth surface so that a direct or indirect restoration can be prepared. Gingivectomy performed in conjunction with the preparation of a direct or indirect restoration is generally considered part of the restoration treatment.
- When dental benefit programs have established program-specific criteria that define when gingivectomy is considered medically necessary and eligible for benefit coverage or that place other limitations on gingivectomy coverage, Delta Dental of Ohio will apply that criteria when there is a need to evaluate gingivectomy treatment for medical necessity.

Other Considerations

When the payment of benefits for a dental procedure by a member's dental plan depends on the application of clinical criteria to determine whether the procedure is medically necessary or clinically appropriate, the following additional information will be taken into consideration, if applicable:

- Individual patient characteristics including age, comorbidities, complications, progress of treatment, psychosocial situation and home environment
- Available services in the local dental delivery system and their ability to meet the member's specific dental care needs when clinical criteria are applied

Required Documentation

The decision to perform a gingivectomy procedure on a patient should be based on a thorough clinical and radiographic examination that facilitates the formulation of an appropriate treatment plan. When the payment of benefits for a gingivectomy by a member's dental plan depends on a review of the procedure's medical necessity and clinical appropriateness, the treating practitioner should submit with the claim the following information as applicable from the patient's dental record. If the practitioner is unable to provide this information, benefit payment may be disapproved.

- Preoperative diagnostic quality radiographs including bitewing images showing the teeth in the areas where gingivectomy is planned
- Intraoral photographs of the involved areas when radiographs do not adequately demonstrate the need for the submitted services
- Preoperative six-point periodontal pocket depth charting performed within 12 months of treatment that includes documentation of clinical attachment loss, tooth mobility, bleeding on probing and furcation involvement
- Documentation consistent with the patient record that explains the diagnostic rationale for performing a gingivectomy, including any supporting information from the patient's dental and medical histories

When determining coverage based on medical necessity or clinical appropriateness, Delta Dental of Ohio may request other clinical information relevant to a patient's care if needed to make coverage decisions.

Additional Information

The provision of dental advice and clinical treatment of patients is the sole responsibility of treating dentists, and these clinical criteria are not intended to restrict dentists from carrying out that responsibility or recommend treatment to their patients.

Delta Dental of Ohio's clinical criteria are developed and annually updated by a panel of licensed dental general practitioners and specialists serving on Delta Dental of Ohio's Utilization Management (UM) Committee, including the Dental Director and Utilization Management Director. The criteria are developed in alignment with evidence-based clinical recommendations, guidelines and parameters of care of leading nationally recognized dental public health organizations, health research agencies and professional organizations, credible scientific evidence published in peer-reviewed medical and dental literature, the curriculum of accredited dental schools, the regulatory status of relevant dental technologies, the rules and requirements of the Centers for Medicare and Medicaid Services, Delta Dental of Ohio national processing policies and input from practicing dentists. New and revised clinical criteria must be approved by the Dental Director and adopted by the UM Committee prior to release.

Federal or state statutes or regulations, dental plan contract provisions, local or national claim processing policies or other mandated requirements may take precedence over these clinical criteria.

Delta Dental of Ohio reserves the right to modify or replace this document at any time as appropriate to ensure the soundness, accuracy and objectivity of Delta Dental of Ohio's clinical criteria.

Appendix A

Prior authorization is required for all gingivectomy and gingivoplasty procedures. Gingivectomy and gingivoplasty coverage is limited to correct severe hyperplasia or hypertrophic gingivitis.

Documentation for prior authorization submission:

- Complete radiographs of the mouth, letter of medical necessity and diagnostic photographs must be submitted for review.

References

American Dental Association, CDT 2025: Current Dental Terminology. American Dental Association, Chicago, IL, 2024.

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