Periodontic Procedures
DEN-003

Iowa Medicaid Program	Prior Authorization	**Effective Date**	08/01/2009
Revision Number	10	**Last Reviewed**	04/18/2025
Reviewed By	Dental Consultant, DDS	**Next Review**	04/17/2026
Approved By	Medicaid Clinical Advisory Committee	**Approved Date**	06/22/2017

Criteria

Prior authorization is required.

Periodontal Scaling and Root Planing

Periodontal scaling and root planing are considered medically necessary when the request is accompanied by **ALL** the following:

1. A completed copy of a current periodontal probe chart; **AND**
2. A previous periodontal history; **AND**
3. A panoramic with four bitewings or full mouth series of radiographs depicting bone level.

Periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident on radiographs, radiographic bone loss, or probing depths are 4mm or over. Third molars are excluded unless rationale made for function when determining between D4341 or D4342.

Osseous Surgery and Osseous Allograft

Osseous surgery and osseous allograft are considered medically necessary when the request is accompanied by **ALL** the following:

1. A plan for treatment; **AND**
2. A completed copy of a current periodontal probe chart; **AND**
3. Previous periodontal history; **AND**
4. A panoramic or full mouth series of radiographs.

Osseous surgery and osseous allograft procedures may be approved after scaling and root planing has been provided, the member has had 1 year of periodontal maintenance at reasonable intervals, and the member has

demonstrated reasonable oral hygiene unless the member is unable to demonstrate reasonable oral hygiene because of physical or mental disability.

Gingivoplasty and Gingivectomy

Periodontal surgical procedures which include gingivoplasty and gingivectomy are considered medically necessary when the request is accompanied by **ALL** the following:

1. A plan for treatment; **AND**
2. A completed copy of a current periodontal probe chart; **AND**
3. Previous periodontal history; **AND**
4. A panoramic or full mouth series of radiographs/photographs where appropriate such as to show recession or other soft tissue that would not otherwise be depicted on radiograph.

Gingivoplasty and gingivectomy may be approved when there is evidence of gingival hyperplasia or when there is a deep carious lesion that cannot be otherwise accessed for restoration.

Pedicle Soft Tissue Graft and Free Soft Tissue Graft

Pedicle soft tissue graft and free soft tissue graft are considered medically necessary when the tooth has a favorable prognosis and the request is accompanied by a written narrative describing medical necessity. Periapical radiograph is required.

Coding

The following list(s) of codes are provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT/CDT code is inappropriate.

CDT	Description
D4341	Periodontal scaling and root planing - per quadrant.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant.

CDT	Description
D4260	Osseous surgery, including flap entry and closure, 4 or more contiguous teeth or tooth bounded spaces per quadrant.
D4261	Osseous surgery 1-3 contiguous teeth or tooth bounded spaces per quadrant.

CDT	Description
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant.
D4211	Gingivectomy or gingivoplasty – 1-3 contiguous teeth or tooth bounded spaces per quadrant.
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.

CDT	Description
D4270	Pedicle soft tissue graft.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing providers in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version
[mm/dd/yyyy]			[#]
Signature			

Change Date	Changed By	Description of Change	Version
04/18/2025	CAC	Annual consultant review.	10
Signature William (Bill) Jagiello, DO			

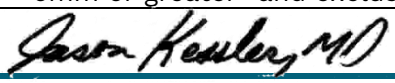
Change Date	Changed By	Description of Change	Version
01/19/2024	CAC	Annual consultant review.	9
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
01/20/2023	CAC	Annual consultant review.	8
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
01/21/2022	CAC	Annual review. Minor criteria wording changes. Formatting changes.	7
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
10/16/2020	CAC	Annual review.	6
Signature William (Bill) Jagiello, DO			

Change Date	Changed By	Description of Change	Version
09/27/2019	Dental consultant	Removed CDT code D4910 and D4381 and their instructions due to no longer requiring prior authorization for these codes. Added 'Periapical radiograph required' to instructions for CDT code D4270.	5
Signature Mark E. Randleman, DO			

Change Date	Changed By	Description of Change	Version
05/06/2017	Dental consultant	Under periodontal scaling and root planing and periodontal maintenance, added panoramic "with four bitewings." Added narrative on third molar exclusion. Under periodontal surgical procedures, added maintenance "at reasonable interval." Under pedicle soft tissue graft added "when tooth has a favorable prognosis." Under localized delivery of antimicrobial agents, added depth definition of "6mm or greater" and exclusion of third molars.	4
Signature Jason Kessler, MD			

Change Date	Changed By	Description of Change	Version
04/17/2015	Medical Director	Added paragraph in References.	3
Signature			

Change Date	Changed By	Description of Change	Version

Criteria Change History

03/06/2015	Dental consultant	Added paragraph on antimicrobial therapy.	2

Signature

Change Date	Changed By	Description of Change	Version
03/27/2014	Dental consultant	Under Criteria, in paragraph 3 removed “gingivoplasty.” In paragraph 4 removed “periodontal surgical” and added “osseous surgery and osseous allograft.” Removed “reevaluation exam and gingival hyperplasia resulting from drug therapy” and added “1 year of periodontal maintenance and reasonable oral hygiene.” Added paragraphs 5 and 6 regarding gingivoplasty and gingivectomy. Last paragraph added “3 months.”	1

Signature

CAC = Medicaid Clinical Advisory Committee