Maximizing Periodontal Surgery Insurance Reimbursement

This document, along with the attached "Procedure Information" and "Insurance Carrier Reimbursement" grids will provide you with a tool to maximize your patient's insurance benefits and ensure you get paid for the treatment they need. This is not meant to advise you on the diagnosis or treatment of your patients, nor does it take a position on the "rightness" of any carrier's reimbursement strategy.

For periodontal surgery or any related periodontal procedures, if there is any doubt on what the carrier or plan will pay, pre-authorize the treatment. If the carrier or plan will not authorize reimbursement and the treatment is clinically necessary or the patient understands it's cosmetic, you may charge the patient. This is common for many procedures such as membranes (GTR), implants, and sinus augmentations. Similarly, if there are other limitations, such as the number of soft tissue or bone graft sites a carrier or plan will reimburse, you may also charge the patient for these procedures using the same guidelines. When emergency situations occur and it is not possible to pre-authorize treatment that should be pre-authorized, it is strongly recommended to have the patient pay for the treatment and, if reimbursed by the carrier, refund the appropriate amount back to the patient.

What pre-operative steps and documentation are crucial to secure reimbursement from the insurance carriers?

- Non-surgical attempts (SRP/PMT) and timelines, as required by each carrier, have been followed – Refer to Carrier Grid
- Periodontal checklist including full breakdown of benefits. Various plans within same carrier provide vastly different benefits.
- Accurate and complete referral form. This is a straightforward but often missed requirement to secure HMO supplemental.
- Pre-authorize whenever necessary and on any large cases, whenever possible – Refer to Carrier Grid.

What general documentation are carriers looking for in order to pay for periodontal procedures?

- FMX within past 3 years and continuing care x-rays less than 6 months old or newer if needed to support clinical necessity
- X-rays must be "text book," showing undeniable clinical necessity.
- Intraorals both pre- and post-op are crucial to get paid when x-rays don't fully support clinical necessity (i.e., soft tissue grafts).
- As applicable, pocket charting recorded baseline, post SRP and pre-op. Pre-op should generally be done by surgical provider.

Will carriers pay for consultation and periodontal surgery performed on the same day? Refer to Carrier Grid.

- For certain specific carriers, yes. This is a significant opportunity for additional reimbursement.

For the most frequently provided periodontal procedures, what are the essentials to ensure you get paid?

- Refer to the attached "procedure information" and the "carrier reimbursement" grids for specific details on gingivectomy (4210), crown lengthening (4249), osseous surgery (4260,4261), bone graft (4263,4264), membrane/GTR (4266,4267), soft tissue grafts (4271,4273,4275), and implants (6010).

Will plans reimburse for Emdogain (4265)? If not, can I charge the patient?

- Many plans do not reimburse even though many PPO carriers have a fee on the fee schedule. Expect zero reimbursement.
- You may charge the patient for this. If the plan reimburses and patient has paid, refund the patient appropriate amount.

How about sinus augmentation (7951)?

- Not a benefit on most plans. Patient may be charged as long as it is not considered inclusive in other procedure.
- Plans with implant rider may provide a benefit. Always pre-authorize or have patient initially pay.

When will bone graft for ridge preservation (7953) be reimbursed?

- Reimbursement is plan-specific and heavily correlated to the plan having implant coverage.
- Some carriers require bone graft be billed with the extraction and others for it to be billed with the implant. ALWAYS verify.

What criteria are carriers looking for to reimburse for a frenectomy (7960)?

- Pre-op intraorals showing the location of a frenum and its impact on the surrounding gingiva and teeth.
- This is not paid if other surgical same site, same service date, such as vestibuloplasty, gingivectomy, or alveoplasty.

Should we expect reimbursement for occlusal adjustments (9951)?

- Most PPO plans do reimburse. Some HMOs will reimburse as well; however, many have a zero fee.

What do most carriers consider standard post-operative care? Will a carrier reimburse for a later surgery on the same area?

- Most have 90-day/3-month post-operative care.
- Most have 3-year limitation to pay for surgical re-entry. May waive with strong clinical justification – Refer to Carrier Grid.

As with previous guidelines, there will be exceptions to the recommendations provided. Carriers often will change their positions on when they will or will not reimburse treatment. Periodontal Surgery has very close links with hygiene and with oral surgery.

Under the guidelines published by the American Academy of Periodontology

Procedure	X-rays	Intraorals	PCH	Narrative (in addition to documentation x-ray, intraoral, PCH, etc.)	Procedure Includes	Generally Not Paid If	Other Important Information
Gingivectomy (4210)	FMX or pre-operative x-rays of the area being treated.	Showing gingival defects supporting need for treatment (CRUCIAL)	Baseline & post-SRP showing pocket depth of 5+mm recession, mobility, attached gingiva, sulcus depth, and width of keratanized gingiva	Suprabony pocket depth w/ firm fibrotic walls following root instrumentation (SRPs). Improvement of soft tissue architecture, such as elimination of soft tissue craters, irregular gingival margins, altered passive eruption and/or for gingival hyperplasia treatment.	Distal wedge/gingival flap same area/same DOS	Provided with crown prep, crown lengthening, frenectomy, other restoration same provider/ same office. Osseous same quad/same DOS.	Delta/DeltaCare SRP must precede by 4 weeks or SRP inclusive. UCCI HMO 24 months SRP to 4210.
Crown Lengthening (4249)	FMX including well-taken, current periapical showing decay reaching below the bone level and insufficient crown for retention (< 4mm retention / 2mm biological width)	Any visible signs of decay reaching below the bone level	Pre-op showing measurements on treated tooth	Include documentation of coronal fracture/ caries below periodontal attachment; to further expose clinical crown to allow proper crown prep and placement; removal of hard tissue in otherwise periodontally healthy mouth; overall perio condition of area/mouth	Distal wedge same area/same date	Same day as crown/ restorative procedure; when osseous on same area; removal of diseased bone; soft tissue removal; inadequate crown root ratio; cosmetic; "closed" hard tissue laser procedure without reflection of flap; more than once/tooth/ lifetime	6-week healing period strongly recommended. Should be healthy tooth w/o perio involvement. GP should rough prep tooth for caries control. If treatment plan changes from crown lengthening to osseous, discuss w/ GP and BC/SBC regarding the change.
Osseous Surgery (4260/4261)	FMX including well-taken periapical and bitewings showing bone levels, horizontal and vertical defects, furca involvement, increasing loss of attachment (moderate to severe bone loss)	Any visible signs of disease, including receding gums, inflammation, suppuration, and bleeding during probing	Baseline and post-SRP showing pocket depth of 5+mm (Guardian / MDG advise 6+ mm), mobility, recession, attached gingiva, sulcus depth, and keratanized gingiva	Document other essentials. Also, include periodontal classification, area/tooth numbers, need to gain access to achieve more effective removal of calculus/plaque in pockets. Necessity for surgical management due to non-response to previous therapy.	Crown lengthening, osseous contouring, distal/proximal wedge, SRP, gingivectomy, frenectomy, frenuloplasty, debridements, surgical reduction of fibrous tuberosity, perio maintenance, prophy, anatomical crown exposure, and any flap procedures done on same area/same date	Results in poor crown to root ratio; excessive tooth mobility; advanced attachment loss; poor prognosis; or patients who have demonstrated poor plaque control	SRP quadrants/dates & any prior PMT w/ dates showing increasing probing depth/ loss of attachment. If deep sedation involved, ensure properly recorded/records sent. Prior SRPs/other non-surgical attempts not required in severe cases. If drug induced from meds, recommend pre- auth.
Bone Graft (4263/4264)	Same as osseous with specific focus on bony defects and furcation involvement	Same as osseous with specific focus on bony defects and furcation involvement	Same as osseous with specific focus on bony defects and furcation involvement	Support of osseous/gingival flap, including treatment of vertical bony defects or furcation involvement; natural tooth treated		Provided with ridge augmentation, apicoectomies, extractions, implants, ridge preservation (use 7953), cyst removal, or other non-perio surgical procedures.	Prior non-surgical is the same as osseous with specific focus on bony defects and furcation involvement
Membrane/GTR (4266/4267)	Same as bone graft w/ focus on class II furcation involvement available periodontal ligament	Same as bone graft w/ focus on class II furcation involvement available periodontal ligament	Same as bone graft w/ focus on class II furcation involvement available periodontal ligament	Same as bone graft w/ focus on class II furcation involvement available periodontal ligament		Not paid with bone graft exclusions as well as any soft tissue grafts (4270, 4271, 4273, 4275, 4276)	Many carriers/plans do not pay. Confirm benefits and limitations on all plans.
Soft Tissue Grafts (4271/4273/ 4275) No	No x-rays necessary	Intraorals showing gingival defects VERY IMPORTANT (crucial to prove recession and root exposure). Initial picture and picture when open.	PCH baseline and post-SRP (if periodontally involved) showing pocket depth of 5+mm recession, mobility, attached gingiva, sulcus depth, and width of keratanized gingiva.	If periodontally involved, perio class; tooth treated; patient's symptoms and necessity for surgical mgmt; donor/harvest sites locations/measurements; any frenum involvement	Includes frenectomy, distal wedge, gingivectomy same site/same DOS	Aesthetic purposes; tooth brush abrasion; lack of attached tissue without disease or additional risk factors	UCCI PPO/misc plans consider integral to osseous same area/DOS. UCCI PPO pays 4273 as 4271 – patient responsible for difference. Check coverage on all HMOs – coverage spotty especially on UCCI/Cigna.
Implants (6010)	Full mouth arch or as a complete series. Post-op x- rays after implant but before crown/bridge.			Extraction dates of all of the missing teeth in the arch as well as the type and placement date of any previous prosthesis.		All major HMOs no coverage. PPOs plan specific depending on if they have implant rider. If it is not covered, we can charge patient the entire fee.	Pre-authorize whenever possible. If osseous being done in same area, ensure it is on pre-auth. If not possible to pre-auth, have patient pay fee and refund if covered.

Periodontal Surgery - Insurance Carrier Reimbursement Grid *Under the guidelines published by the American Academy of Periodontology*

Plan Type	Carrier	Pre-Auth - *	Consult (9310) & Treat Same Day	Crown Lengthening (4249)	Prior SRP/PMT before Osseous (4260/4261) / Gingivectomy (4210)	Pocket Depth for Osseous	Osseous Quads/ Day - **	Bone Graft (4263/4264) and Membrane (4266/4267)	4263/4266 Sites/Quad	Emdogain (4265)	Soft Tissue Sites/Quad (4271, 4273, 4275)	Implants (6010)	Surgical Re- entry Limitation - +
PPO	Aetna	Over $350	No	6 wk healing; auth > 1 site/quad	Prior attempts; no specifics	5	4	Some pay 4263/4264, rare 4266/4267	> 1 subject to review	Rare coverage	> 1 subject to review	Pre-authorize or pt	3 years
	Blue Cross	None Required	Yes	6 wk healing; auth > 1 site/quad	Prior attempts; no specifics	5	2 (4 on appeal)	4263/4264 only	2	Rare coverage	Lesser 2 sites or osseous	Pre-authorize or pt	3 years
	Cigna	Over $200	Yes	6 wk healing; auth > 1 site/quad	Within 12 months of active therapy	5	4	Pay 4263, 4266 w/ class II furcation	2	Most covered	2	Pre-authorize or pt	No frequency limit
	Delta of AZ	None Required	No	6 wk healing; auth > 1 site/quad	Min of 4 weeks prior	5	4	4263/4264 only	2	Rare coverage	2	Pre-authorize or pt	3 years
	Delta of CA	None Required	No	6 wk healing; auth > 1 site/quad	Min of 4 weeks prior	5	4	Generally both	2	Most covered	2	Pre-authorize or pt	3 years
	Delta of CO	None Required	Yes	6 wk healing; auth > 1 site/quad	30 days prior or 90 days following	5	2 (refer to note)	Generally both	2	Rare coverage	2	Pre-authorize or pt	3 years
	Delta of GA/FL	Suggested over $300	No	6 wk healing; auth > 1 site/quad	Not required; if done, min 4 wk prior	5	4	Generally both	2	Rare coverage	2	Pre-authorize or pt	3 years
	Delta of MN	None Required	No	6 wk healing; auth > 1 site/quad	Not required; if done, min 4 wk prior	5	2 (refer to note)	Generally both	2	Rare coverage	2	Pre-authorize or pt	3 years
	Guardian	None Required	No	6 wk healing; auth > 1 site/quad	Prior attempts; no specifics	Recommend 6	4	Generally both	All subject to review	Not covered	2	Pre-authorize or pt	3 years
	Met Life	Recommend	No	6 wk healing; auth > 1 site/quad	Prior attempts; no specifics	5	4	Whichever considered more comprehensive	2	Most covered	2	Pre-authorize or pt	3 years
	Principal	Recommend	No	6 wk healing; auth > 1 site/quad	Prior attempts; no specifics	5	4	4263/4264 only	2	Not covered	>1 subject to review	Pre-authorize or pt	3 years
	UCCI	Recommend	No	6 wk healing; auth > 1 site/quad	SRP, PMT, eval within 24 mths; min 4 wks prior	5	2 (refer to note)	Generally both - if 4266 denied will deny 4263 & 4260 & require appeal	> 1 subject to review	Not covered	> 1 subject to review (pay 4273 as 4271)	Pre-authorize or pt	2 years
	United Health Care	Mandatory	No	6 wk healing; auth > 1 site/quad	No specifics	5	4	4263/4264 only	> 1 subject to review	Some coverage	> 1 subject to review (reimbursement all plan specific)	Pre-authorize or pt	3 years
HMO	Aetna	Over $350	No	6 wk healing; auth > 1 site/quad	Prior attempts; no specifics	5	4	Not covered	> 1 subject to review	Per pt fee schedule	> 1 subject to review	Not covered	3 years
	Blue Cross	Mandatory	Yes	6 wk healing; auth > 1 site/quad	Min of 4 weeks prior	5	2 (4 on appeal)	Not covered	2	Per pt fee schedule	lesser 2 sites or osseous	Not covered	3 years
	Cigna	Direct Referral	Yes	6 wk healing; auth > 1 site/quad	Within 12 months of active therapy	5	4		2	Per pt fee schedule	2	Not covered	No frequency limit
	DeltaCare	Mandatory	No	6 wk healing; auth > 1 site/quad	Min of 4 weeks prior	5	4		2	Per pt fee schedule	2	Not covered	3 years
	MDG	Direct Referral	No	6 wk healing; auth > 1 site/quad	Min 1 month before surgery; max within 12 months		4	Not covered	All subject to review	Per pt fee schedule	2	Not covered	3 years
	Safeguard	Direct Referral	No	6 wk healing; auth > 1 site/quad	Prior attempts; no specifics	5	4	Not covered	All subject to review	Per pt fee schedule	2	Not covered	3 years
	UCCI	Direct Referral	No	6 wk healing; auth > 1 site/quad	SRP, PMT, eval within 24 mths; min 4 wks prior	5	2 (4 on appeal)	Not covered	> 1 subject to review	Per pt fee schedule	> 1 subject to review	Not covered	3 years

* - All large cases should be pre-authorized.
** - Carriers that indicate only pay 2 quads/day will pay for 4 for patients with systemic health conditions or high risk factors.
+ - Carrier may waive limitation with strong clinical justification. Pre-authorize all instances of such a request.

General Note - When treatment is not covered/not paid, the patient can be charged a fee for the procedure. Always confirm benefits on each patient plan as some plans differ from the overall carrier. As with previous guidelines, there will be exceptions to the recommendations provided. Carriers often will change their positions on when they will or will not pay for treatment.