Dental Clinical Policy

Subject: Periodontal Maintenance
Guideline #: 04-901
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Description

This document addresses periodontal maintenance.

The plan performs review of periodontal maintenance due to contractual requirements that necessitate benefits for dental services meet specific contract requirements. For example, plan contract(s) may require the provision of benefits for services that meet generally accepted standards of dental care at the lowest cost that properly addresses the patient's condition. The conclusion that a particular service is medically or dentally necessary does not constitute an indication or warranty that the service requested is a covered benefit payable by the dental plan.

Clinical Indications

Periodontal maintenance is a nonsurgical treatment considered appropriate, following therapeutic periodontal treatment, that continues for the life of the dentition or any implant placement and provides treatment and continuing care of patients with a history of/and ongoing periodontal disease. Periodontal maintenance is considered therapeutic, rather than prophylactic, and constitutes continuing treatment for patients with a diagnosis of periodontal disease. The therapeutic objective of Periodontal Maintenance is to reduce or eliminate causative factors responsible for initiating host inflammatory responses. The desired outcome should result in maintenance of the periodontal health status attained as a result of active periodontal therapy. Periodontal Maintenance is:

1. A demanding and time-consuming procedure involving instrumentation of the tooth crown and root structures.
2. A procedure to remove etiological factors such as plaque and biofilm, adherent calculus deposits, and diseased cementum (root structure) that may be permeated with calculus, microorganisms and microbial toxins.
3. A procedure that involves hand instrumentation
4. A phase of periodontal therapy during which periodontal disease and conditions are monitored

Dental review as it applies to accepted standards of care means dental services that a Dentist, exercising prudent clinical judgment, provides to a patient for the purpose of evaluating, diagnosing or treating a dental injury or disease or its symptoms, and that are: in accordance with the generally accepted standards of dental practice; in terms of type, frequency and extent and is considered effective

for the patient's dental injury or disease; and is not primarily performed for the convenience of the patient or Dentist, is not cosmetic and is not more costly than an alternative service.

For dental purposes, "generally accepted standards of dental practice" means:

- Standards that are based on credible scientific evidence published in peer-reviewed, dental literature generally recognized by the practicing dental community
- specialty society recommendations/criteria
- the views of recognized dentists practicing in the relevant clinical area
- any other relevant factors from credible sources.

Criteria

1. History of periodontal therapy and continuous care not exceeding 12 months.
2. Prior history of definitive periodontal therapy with dates and specific treatment rendered.
3. For use of locally administered chemotherapeutic agents (LACA), a letter of medical necessity is required.
4. Post-initial therapy evaluations and treatment planning recommendations following completion of periodontal maintenance are considered integral components of this procedure.
5. A periodontal maintenance procedure is not appropriate when there is no history of periodontal disease requiring definitive periodontal treatment.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CDT *Including, but not limited to, the following:*

D4341 Four or more teeth per quadrant
D4342 Less than three teeth per quadrant
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 Periodontal maintenance
D4999 Unspecified periodontal procedure, by report

IDC-10 CM Diagnoses for Dental Diseases and Conditions: See the current CDT code book for details

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History

Revision History	Version	Date	Nature of Change	SME
	initial	3/14/17		Kahn
	Revision	2/5/18	Related Dental Policies, Appropriateness and Medical necessity	M Kahn
	Revised	11/10/2020	Annual Review	Committee
	Revised	12/05/2020	Annual Review	Committee

Federal and State law, as well as contract language, and Dental Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Clinical Policy Committee are available for general adoption by plans or lines of business for consistent review of the medical or dental necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical or dental necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical or dental necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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