



Dental Policy

Subject: Periodontal Maintenance

Guideline #: 04-901

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Description

This document addresses periodontal maintenance.

Note: Please refer to the following documents for additional information concerning related topics:

- Prophylaxis: 01-101
- Scaling and Root Planing: 04-301
- Gingivectomy or Gingivoplasty: 04-202,
- Mucogingival Surgery and Soft Tissue: 04-204
- Osseous Surgery: 04-205

Clinical Indications

Periodontal maintenance is a nonsurgical treatment considered appropriate, following periodontal therapy, that continues for the life of the dentition or any implant replacements 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

As it applies to appropriateness of care, dental services are:

- provided by a Dentist, exercising prudent clinical judgment
- provided to a patient for the purpose of evaluating, diagnosing and/or treating a dental injury or disease or its symptoms
- in accordance with the generally accepted standards of dental practice which 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
 - any other relevant factors
- clinically appropriate, in terms of type, frequency and extent
- considered effective for the patient's dental injury or disease
- not primarily performed for the convenience of the patient or Dentist
- Not more costly than an alternative service.

- Dependent on group contract provisions, cosmetic services may not qualify for benefit coverage even though the services may be clinically appropriate.

A periodontal maintenance procedure is not appropriate when there is no history of periodontal disease requiring definitive periodontal treatment.

Use of Localized Delivery of Antimicrobial (LDA) Agents via a Controlled Release Vehicle into Diseased Crevicular Tissue, per Tooth:

Sustained or controlled release local delivery antimicrobial agents (LDAs) are available for use as adjuncts to scaling and root planing (SRP) in the treatment of periodontitis. These products are placed into periodontal pockets in order to reduce subgingival bacterial flora and clinical signs of periodontitis. Use of LDAs as a first line defense does not clinically improve pocket depth recordings. While the improvement in pocket depth recordings may be statistically significant, the improvement is not clinically significant to justify use.

A thorough hand scaling and root planing procedure has been demonstrated as the most effective treatment for patients diagnosed with mild to severe periodontitis. According to the literature, including a position statement by the American Academy of Periodontics (AAP), the use of locally delivered antibiotics may be effective in patients who have chronic conditions but only after initial treatment by hand scaling and root planing. Other methods of treatment should be considered when periodontal disease demonstrating pocket depth recordings greater than or equal to 5mm are noted such as; when the use of LDAs has failed to reduce periodontal disease; or when anatomical defects are present.

The existing evidence based literature is inconclusive to conclude that LDAs can either reduce the need for surgery or improve long-term tooth retention, or is cost effective. The use of LDAs is appropriate when periodontal disease has been determined to be refractory after definitive non-surgical or surgical therapy.

A refractory diagnosis is typically determined 3 months post definitive therapy where there has been no improvement in pocket depth recordings.

NOTE:

A group may define covered dental services under either their dental or medical plan, as well as to define those services that may be subject to dollar caps or other limits. The plan documents outline covered benefits, exclusions and limitations. The health plan advises dentists and enrollees to consult the plan documents to determine if there are exclusions or other benefit limitations applicable to the service request. 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 health plan. Some plans exclude coverage for services that the health plan considers either medically or dentally necessary. When there is a discrepancy between the health plan’s clinical policy and the group’s plan documents, the health plan will defer to the group’s plan documents as to whether the dental service is a covered benefit. In addition, if state or federal regulations mandate coverage then the health plan will adhere to the applicable regulatory requirement.

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.

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
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth after oral exam
- 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

CPT

- 40804 Removal of embedded foreign body, vestibule of mouth, simple
- 40805 Complicated
- 41899 Unlisted procedure, dentoalveolar structures

ICD-10

Diagnosis

- K03.6 Deposits [accretions] on teeth
- K05 Gingivitis and Periodontal diseases
- K05.0 Acute Gingivitis
- K05.1 Chronic Gingivitis
- K05.2 Aggressive Periodontitis
- K05.3 Chronic Periodontitis
- K05.6 Periodontal Disease unspecified
- Z72.0 Tobacco Use
- Z91 Personal Risk Factors, not elsewhere classified

Discussion/General Information

Periodontal maintenance constitutes a program of supportive follow-up care for patients who have received active periodontal therapy which may or may not have included dental implant placement. The objective of periodontal maintenance is the continued preservation of the health of the bone and soft tissue surrounding the teeth, which has been attained with definitive periodontal therapy. Patients who have been treated for periodontal disease are at high risk for re-infection and progression of periodontal bone loss.

Research shows periodontal maintenance to be an essential element in the long-term stability of the dentition for periodontal patients. Maintenance programs are initiated following completion of periodontal scaling and root planing (initial therapy), as well as after any indicated periodontal surgical procedure and is continued at varying, but specific intervals. Maintenance intervals are evaluated and determined by continual assessment of clinical findings relative to the periodontal disease status and health of the periodontal tissues. Periodontal maintenance schedules may be altered or interrupted as additional treatment needs become evident, and are usually continued for the life of the affected dentition which may or may not include dental implants.

Recommendations for specific maintenance intervals are generally based on studies showing that following periodontal scaling and root planing, the improvement in clinical parameters such as periodontal attachment loss,

bleeding upon probing, and gingival inflammation begin to maximize at about three months. It has also been shown that these parameters may begin to return to baseline levels as early as seven to eight weeks post-therapy (8). Additionally, treatment induced changes of the subgingival microflora (bacteria) which are considered positive for periodontal health show similar reversion to bacterial types considered to be periodontally pathogenic within weeks to months. Studies suggest that most patients should be treated with periodontal maintenance at three month intervals, as this schedule results in a decreased likelihood of disease progression when compared to patients treated at longer intervals. Factors influencing the decision when to provide periodontal maintenance intervals include the patient's compliance with treatment recommendations, the patient's ability to control plaque deposits (a correlation related to self-improvement of oral health maintenance), severity of disease, and the specific nature of a particular patient's disease process. Clinicians need to adapt maintenance schedules to the individual needs of each patient.

Periodontal maintenance visits include an update of the medical and dental histories, intraoral and extraoral soft tissue examination, a periodontal evaluation noting changes in pocket depth probings and mucogingival tissue, appropriate radiographic reviews, removal of supra and subgingival plaque and calculus, site specific scaling and root planing, tooth polishing, assessment of tooth and dental implant health, and evaluation of the patient's oral hygiene efficiency.

Policy/Therapy Guidelines:

Periodontal Maintenance is not considered an initial procedure in the treatment of periodontal disease. To provide this service, it must be preceded by a history of definitive periodontal treatment, including periodontal scaling and root planing (initial therapy) and/or pocket reduction surgery. Periodontal maintenance therapy must continue on an uninterrupted basis from the time of initial treatment. Periodontal maintenance will not be considered if a period greater than 12 months lapses between appointments for this procedure. Periodontal maintenance will be disallowed if submitted within 90 days of previous definitive therapy with pocket reduction surgery or periodontal scaling and root planing.

Documents Which May Be Required:

1. A current (dated) full mouth periodontal charting.
2. A current (dated) full mouth series of x-rays.
3. A history of periodontal scaling and root planing or definitive periodontal surgery within the preceding 12 month period. The prior history may be documented by submission of treatment notes or a narrative report.

If periodontal maintenance appointments exceed any 12 month period, excluding unusual circumstances, no benefit is available for maintenance therapy as it is a requirement to maintain uninterrupted therapy.

Definitions

Biofilm: any group of bacteria that stick to each other and often adhere to a surface, such as a tooth. These "sticky" cells are frequently embedded within a self-produced matrix of cells.

Calculus: Also known as **tartar** on the teeth is a form of hardened dental plaque caused by the collection of minerals from saliva and gingival crevicular fluid (GCF). The process of precipitation kills the bacterial cells within dental plaque, but the rough and hardened surface that is formed provides an ideal surface for further plaque formation. This leads to calculus buildup, which compromises the health of the gingiva (gums). Calculus can form both along the gum line, where it is referred to as supragingival ("above the gum"), and within the narrow space that exists between the teeth and the gingiva, where it is referred to as subgingival ("below the gum"). Calculus formation is associated with a number of signs and symptoms including bad breath, receding gums and inflamed gingiva. Brushing and flossing can remove plaque from which calculus forms; however, once formed, it is too hard and firmly attached to be removed with a toothbrush requiring removal at the dentist's office.

Dental Plaque: is a biofilm or mass of bacteria that grows on surfaces within the mouth. It is a sticky colorless deposit at first, but when it forms tartar it is brown or pale yellow and is commonly found between the teeth, on the front of teeth, behind the teeth, on chewing surface, along the gum line, and below the gum line. Dental plaque is also known as microbial plaque, oral biofilm, dental biofilm, dental plaque biofilm or bacterial plaque biofilm. While plaque is commonly associated with oral diseases such as caries (cavities) and periodontal disease (gum diseases), its formation is a normal process that cannot be prevented.

Gingiva: The clinical term for gums. The gums are found in the oral cavity or mouth. They consist of mucosal (soft, pink) tissue that covers the alveolar processes (bone) of the maxilla (upper jaw) and mandible (lower jaw) and finish at the neck of each tooth.

Periodontal Disease: Can affect one or more of the tissue/structures associated with teeth (e.g. bone, the ligament that attaches the tooth to bone and gingiva (gums)). While there are many different periodontal diseases that can affect these tooth-supporting tissues/structures, by far the most common ones are plaque-induced inflammatory conditions, such as gingivitis and periodontitis.

Periodontium: Refers to the specialized tissues that surround and support the teeth and maintain the teeth in the upper and lower jaw bones.

Saliva: A watery substance located in the mouth, secreted by salivary glands. Human saliva is 99.5% water with the remainder consisting of several things such as minerals, mucus, protein, enzymes, and bacterial compounds.

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Peer Reviewed Publications:

1. Caton J, Proye M and Polson A. Maintenance of healed periodontal pockets after a single episode of root planing. *J Perio* 1982;53:420-424.
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9. Ramfjord SP, Morrison EC, et al. Oral hygiene and maintenance in the treatment of periodontal disease. *J Clinical Perio* 1982;53:26-30.
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12. Nordland P, Garrett S, et al. The effect of plaque control and root debridement in molar teeth. *J Clin Perio* 1987;14:231-236.
13. Wilson TG, Glover ME, et al. Tooth loss in maintenance patients in a private periodontal practice. *J Perio* 1987;58:231-235
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15. Bostanci HS and Arpak MN. Long-term evaluation of surgical periodontal treatment with and without maintenance care. *J Nihon Sch Dent* 1991; 33:152-159.
16. Badersten A, Nilveus R and Egelberg J. Effect of non-surgical periodontal therapy. VIII. Probing attachment changes related to clinical characteristics. *J Clin Perio* 1987;14:425-432.

Government Agency, Medical Society, and Other Authoritative Publications:

1. American Academy of Periodontology. Treatment of gingivitis and periodontitis (position paper). J Perio;1997;12:1246-1253.
2. American Academy of Periodontology. Position Paper Periodontal maintenance. J Periodontol 2003;74:1395-1401
3. American Academy of Periodontology Statement on Local Delivery of Sustained or Controlled Release Antimicrobials as Adjunctive Therapy in the Treatment of Periodontitis – J Clin Perio August 2006, Vol. 77, No. 8, Pages 1458-1458

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

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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