Dental Clinical Policy

Subject: Scaling and Root Planing

Guideline #: 04-301 **Publish Date:** 01/01/2022

Status: Revised **Last Review Date:** 10/30/2021

Description

This document addresses Scaling and Root Planing.

The plan performs review of scaling and root planing 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

Scaling and root planing is a nonsurgical procedure meeting generally accepted standards of dental care for the treatment of mild to severe periodontal disease. Periodontal scaling and root planing involves instrumentation of the crown and root surfaces of teeth to remove plaque and calculus. This periodontal procedure involves the removal of cementum and dentin permeated by calculus, toxins, and microorganism. It is a non-surgical therapeutic procedure, rather than prophylactic, to treat periodontal disease where migration of the epithelial attachment has caused the formation of periodontal pockets of at least 4 mm.

Periodontal scaling and root planing is:

1. A demanding and time-consuming procedure, which is technique sensitive involving instrumentation of the tooth crown and root structures.
2. Performed to remove plaque and biofilm, adherent calculus deposits, and diseased cementum (root structure) that may be permeated with calculus, microorganisms and microbial toxins.
3. Performed utilizing hand instrumentation and/or ultrasonic scalers.
4. Performed utilizing local anesthetic.

Documentation Criteria #1

In order to perform review of the scaling and root planning service, diagnostic information is required. The following is considered appropriate diagnostic information for scaling and root planing.

- Full mouth radiographic images and/or a panoramic radiographic image including bitewings radiographs; labeled and dated (within 12 months of submitted procedure)
- Periodontal Charting; 6-point periodontal pocket depth charting (labeled and dated (within 12 months of submitted procedure))

Adjunctive Documentation Criteria #7

- Documentation of the duration of treatment times for periodontal scaling and root planing may be required for individual case review.
- Other than 4-millimeter pocket depths, parameters for periodontal therapy with scaling and root planing include clinically evident inflammation and/or bleeding.
- Post-initial therapy evaluations and treatment planning recommendations following completion of scaling and root planing are considered integral components of this procedure.

Criteria

1. See Documentation criteria #1 - above
2. Teeth to be treated must demonstrate at least 4-millimeter pocket depths, bleeding on probing, with demonstrable radiographic evidence of bone loss (either vertical or horizontal) of the alveolar crest. Bone loss is considered to be a bone level that is greater 1.5mm apical to the CEJ (cementoenamel junction).
3. Periodontal scaling and root planing requires administration of local anesthesia by intramucosal injection. Topical anesthetics and other anesthetic preparations placed subgingivally does not qualify as local anesthesia for scaling and root planing procedures.
4. Updated
5. Additional clinical and/or administrative documentation may be requested in cases where more than two quadrants of periodontal scaling and root planing are performed during one appointment.
6. Updated
7. See Adjunctive Documentation criteria #7 - above
8. At least 1 tooth in the quadrant has a pocket depth of 4 mm or more (partial quadrant) or at least 4 teeth in the quadrant have pocket depths of 4 mm or more (full quadrant).
9. The following diagnoses would qualify for payment; chronic periodontitis, localized and generalized aggressive periodontitis, localized and generalized periodontitis as a manifestation of systemic disease, and necrotizing periodontal diseases.
10. Gingival diseases, plaque induced or non-plaque induced would not qualify for payment.
11. Scaling and debridement of implants is considered inclusive with D4341 and D4342.
12. See Adjunctive Documentation criteria #7 - above
13. Updated

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:*

D1110	Prophylaxis – adult
D1120	Prophylaxis – child
D4341	Periodontal scaling and root planing – four or more teeth per quadrant
D4342	Periodontal scaling and root planing – one to three teeth per quadrant
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth after oral exam

References

1. Smiley CJ, Tracy SL, Abt E, et a l. Systematic review and meta - analysis on the nonsurgical treatment of chronic periodontitis by means of scaling and root planing with or without adjuncts. J Am Dent Assoc. 2015 Jul;146(7):508-24. July 2015.
2. Sims T, Takei H. Newman and Carranza's Clinical Periodontology, 13th ed. St. Louis: Elsevier c2019 Chapter 64, Furcation: Involvement and Treatment; p.653-659.
3. American Academy of Periodontology Parameter on chronic periodontitis with slight to moderate loss of periodontal support. 2000.

History

Revision History	Version	Date	Nature of Change	SME
	revision	3-4-19	External facing policy	committee
	Revision	4/22/19	Criteria numbering	Kahn
	Revision	7/23/19	Verbiage	Committee
	Revision	5/20/2020	Annual revision	Committee
	Revised	12/04/2020	Annual Review	Committee
	Revised	10/30/2021	Annual Review	Committee

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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.