

**Delta Dental of Virginia Clinical Policy # 407**
**Subject**

Scaling and Root Planing

**Originating Department**

Clinical Professional Services

**Signature Authority**

Dental Director

**Type:**       New                       Replacement                       Revision                       Clarification

**Date:**              11/15/2009                      **Revision Date:**              11/15/2011

**Preamble:**

The Clinical Policy Bulletin is an expression of Delta Dental of Virginia's (DDVA) determination regarding whether certain services or supplies are medically or dentally necessary. DDVA bases its conclusions on a review of currently available clinical literature. This includes, but is not limited to, clinical outcome studies published in the peer-reviewed medical and dental literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians and dentists practicing in relevant clinical areas, and other relevant factors. DDVA reserves the right to revise these policies as new clinical information is available and we welcome submission of further relevant information.

Each group defines covered dental services under their dental plan, as well as those services that may be subject to dollar caps or other limits. The plan documents outline covered benefits, exclusions and limitations. DDVA 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 DDVA. Some plans exclude coverage for services that DDVA considers either medically or dentally necessary. When there is a discrepancy between DDVA's clinical policy and the group's plan documents, DDVA is to 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 DDVA will adhere to the applicable regulatory requirement.

**History:**

Periodontal scaling and root planing is a technically demanding and time-consuming procedure involving instrumentation of the tooth crown and root structures. The instrumentation attempts to remove plaque and biofilm, adherent calculus deposits, and cementum (root tooth structure) that may be permeated with calculus, microorganisms and microbial toxins. The periodontal scaling and root planing procedure is considered therapeutic, rather than prophylactic, and constitutes definitive treatment for periodontal patients. The therapeutic objective of scaling and root planing is to reduce or eliminate causative factors responsible for initiating a host inflammatory response(1).

The beneficial effects of scaling and root planing include improvement with the clinical parameters of periodontal disease such as inflammation, bleeding, and loss of the periodontal attachment(2,3,4,5,6,7), shifts of subgingival microorganisms (bacteria) to populations considered less pathogenic (harmful) to periodontal tissues(8,9), and a possible improved host immune response to the selected bacterial species(21). Some soft tissue removal is commensurate with the treatment process, but studies show no additional beneficial effect of an additional procedure such as gingival curettage when compared to scaling and root planing

	<p>alone(10,11). Limitations of the effectiveness of scaling and root planing include the presence of furcation involvements (exposure of the space between the roots of molar teeth)(14,15), variations in root morphology(16,17) and areas of deep pocket depth(1,1819,20).</p> <p>The positive clinical response of patients to this treatment, in conjunction with supportive therapy, often precludes the need for surgical intervention. Long-term studies show that periodontal scaling and root planing, when combined with a program of continued periodontal maintenance, can stabilize the periodontal disease process for many patients over long periods of time(22,23,24,25,26,27,28). Research shows that, following scaling and root planing, healing begins immediately and clinical improvements begin to maximize at about three months post-therapy(3,4,5,12,13). Consequently, evaluations for the necessity of later surgical procedures must allow time for an appropriate healing response to determine need.</p>
<b>Policy:</b>	<p>DDVA Guidelines:</p> <ol style="list-style-type: none"> <li>1. Documentation of the need for this procedure must include a current periodontal charting and full mouth periapical X-rays.</li> <li>2. Teeth to be treated must have at least 4 millimeter probing pocket depths.</li> <li>3. Periodontal scaling and root planing requires administration of local anesthesia by intramucosal injection.</li> <li>4. Topical anesthetics and other anesthetic preparations injected or placed subgingivally do not qualify as local anesthesia for scaling and root planing procedures.</li> <li>5. Documentation of the duration of treatment times for periodontal scaling and root planing may be required for individual cases. In general, treatment times for periodontal class III patients with 4-6 millimeter pocket depths, bleeding on probing, and detectable subgingival calculus deposits require minimally 30 to 45 minutes per quadrant, dependent on the numbers of affected teeth in the quadrant.</li> <li>6. Other than 4 millimeter pocket depths, parameters for periodontal therapy with scaling and root planing include clinically evident inflammation and/or bleeding.</li> </ol>
<b>Codes(29):</b>	<p>4341 – Four or more diseased teeth per quadrant</p> <p>4342 – Less than three diseased teeth per quadrant</p>
<b>References:</b>	<ol style="list-style-type: none"> <li>1. American Academy of Periodontology. Treatment of gingivitis and periodontitis (position paper). J Perio;1997;12:1246-1253.</li> <li>2. Morrison EC, Ramfjord SP and Hill RW. Short-term effects of initial non-surgical periodontal treatment (hygienic phase). J Clin Perio 1980;7:199- 211.</li> <li>3. Garrett JS. Effects of non-surgical periodontal therapy on periodontitis in Humans. A review. J Clin Perio 1983;10:515-523.</li> <li>4. Badersten A, Nilveus R and Egelberg J. Effect of non-surgical periodontal therapy. I. Moderately advanced periodontitis. J Clin Perio1981;8:57-72.</li> <li>5. Badersten A, Nilveus R and Egelberg J. Effect of non-surgical Periodontal</li> </ol>

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