MEDICAL NECESSITY AUTHORIZATION CRITERIA FOR PERIODONTAL SERVICES

The following medical necessity authorization criteria for select dental procedures have been developed by a panel including practicing periodontists, Department of Public Welfare dental consultants, a consumer representative and a representative from the Pennsylvania Dental Association.

Literature references used include, but were not limited to, the following:

American Academy of Periodontology (AAP). Parameter on comprehensive periodontal examination. *J Periodontol* 2000 May (Suppl): 71:847-8.

American Academy of Periodontology (AAP). Parameter on periodontitis associated with systemic conditions. *J Periodontol* 2000 May (Suppl): 71(5):876-8.

American Academy of Periodontology (AAP). Position paper: Treatment of gingivitis and periodontitis. *J Periodontol* 1997 Dec: 68(12):1247-53.

American Academy of Periodontology (AAP). Position paper: Supportive periodontal therapy. *J Periodontol* 1998 Apr: 69(4):502-6.

PROCEDURE CODE	DESCRIPTION	MEDICAL NECESSITY CRITERIA	DOCUMENTATION
D4210	gingivectomy or gingivoplasty – per quadrant	The procedure is medically necessary for the correction of severe gingival hyperplasia or hypertrophy associated with drug therapy. Severe gingival hyperplasia interferes with or restricts the ability to perform effective daily oral hygiene procedures.	If the following criteria are met in the professional judgment of the reviewer, this service will be approved: • Comprehensive periodontal evaluation (e.g., description of periodontal tissues, pocket depth chart, tooth mobility, mucogingival relationships); and • Pertinent medical and dental history (e.g., medications); and • Objective evidence of severe gingival hyperplasia restricting the ability to perform effective daily oral hygiene procedures; or • Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria. • Exceptions to established limits may be granted if documentation presented indicates recurrence of severe gingival hyperplasia within a two-year period due to inability to alter medications.

PROCEDURE CODE	DESCRIPTION	MEDICAL NECESSITY CRITERIA	DOCUMENTATION
D4341	periodontal scaling and root planing – per quadrant	The procedure is medically necessary to: 1. reduce clinical inflammation as evidenced by edema, erythema of the gingiva, generalized bleeding on probing, spontaneous bleeding reported by patient, or by purulent gingival discharge; 2. effectuate microbial shifts to a less pathogenic, subgingival flora; 3. reduce probing depths when pocket depth is equal to or greater than 5mm or in the presence of clinical inflammation (see #1 above) following routine prophylaxis; and/or 4. gain clinical attachment.	If the following criteria are met in the professional judgment of the reviewer, this service will be approved: • Comprehensive periodontal evaluation (e.g., description of periodontal tissue, pocket depth chart, tooth mobility, mucogingival relationships); and • Current diagnostic radiographs demonstrating evidence of bone loss; and • Narrative/documentation of clinical information, including pocket depth(s) of 5mm or greater except in cases of medication related gingival hyperplasia or persistent inflammation characterized by generalized bleeding on probing (multiple bleeding points present per tooth on at least ½ of remaining dentition per quadrant); or • Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria. • Exceptions to established limitations will not be granted due to lack of patient compliance and/or continued poor oral hygiene.

PROCEDURE CODE	DESCRIPTION	MEDICAL NECESSITY CRITERIA	DOCUMENTATION
D4355	full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	The procedure is medically necessary for removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an oral evaluation. A preliminary procedure that does not preclude need for other procedures.	If the following criteria are met in the professional judgment of the reviewer, this service will be approved: • Radiographs for diagnostic purposes demonstrating evidence of gross calculus buildup (radiographically visible calculus involving at least 75% of remaining dentition); or • In lieu of radiographs, documentation is presented indicating treatment was provided under general anesthesia or intravenous sedation, or radiographs were not obtainable due to the patient's medical status; or • Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria. • Exception to established limitations may be granted if objective evidence is presented indicating patient is unable to perform effective daily oral hygiene procedures due to medical status.

PROCEDURE CODE	DESCRIPTION	MEDICAL NECESSITY CRITERIA	DOCUMENTATION
D4910	periodontal maintenance procedures following active treatment (excluding procedure code D4355)	The procedure is medically necessary to: 1. Prevent or minimize the recurrence and progression of periodontal disease in patients who have been previously treated for periodontitis; 2. Prevent or reduce the incidence of tooth loss by monitoring the dentition and any prosthetic replacements of the natural teeth; and 3. Increase the probability of locating and treating, in a timely manner, other diseases or conditions found within the oral cavity.	If the following criteria are met in the professional judgment of the reviewer, this service will be approved: • Documentation of previous periodontal treatment; and • Continuous documentation of significant hard and soft tissue changes (e.g., changes in pocket depth greater than or equal to 2mm); or • Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria. • Exceptions to established limitations will not be granted due to lack of patient compliance and/or continued poor oral hygiene.