UnitedHealthcare®

UnitedHealthcare® Dental
Coverage Guideline

FULL MOUTH DEBRIDEMENT

Guideline Number: DCG001.04 **Effective Date**: December 1, 2018

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Related Dental Policy

- Non-Surgical Periodontal Therapy

INSTRUCTIONS FOR USE

This Dental Coverage Guideline provides assistance in interpreting UnitedHealthcare dental benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Dental Coverage Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Dental Coverage Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Dental Coverage Guideline. Other Clinical Policies and Coverage Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Dental Coverage Guideline is provided for informational purposes. It does not constitute medical advice.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group health plans (inside and outside of Exchanges) to provide coverage for Pediatric Dental Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for Pediatric Dental EHBs. However, if such plans choose to provide coverage for benefits which are deemed Pediatric Dental EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute Pediatric Dental EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Indications for Coverage

Full mouth Debridement is a covered dental service and indicated when the following criteria have been met:

- Heavy calculus is present on teeth and usually visible on radiographs
- Due to the amount of calculus, plaque and debris, a comprehensive examination and diagnosis is not possible

Coverage Limitations and Exclusions

- Limited to once every 36 months

DEFINITIONS

Debridement: Removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an evaluation.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Clinical Policies and Coverage Guidelines may apply.

CDT Code	Description
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit

DESCRIPTION OF SERVICES

Full mouth debridement is a dental procedure indicated when the amount of deposits present is extensive and prevents the dentist from being able to conduct a complete examination. The need for this procedure would be considered infrequent and typically only indicated in patients who have not received dental care in many years. Full mouth debridement is not considered therapeutic or preventative, and is followed by definitive procedures such as prophylaxis or scaling and root planing.

REFERENCES

American Dental Association (ADA); CDT 2018 Dental Procedure Code Book.

American Dental Association Glossary of Dental Clinical and Administrative Terms.

UnitedHealthcare 2012 Dental Certificate of Coverage.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description

12/01/2018	• Revised coverage rationale/list of coverage limitations and exclusions; removed language indicating this service is:
	  ○ Not to be billed on same day as any exam code or non-surgical periodontal therapy code
	  ○ Not to be billed within 12 months of prophylaxis or periodontal maintenance
	  ○ Not to be used as a therapeutic or preventive procedure such as scaling and root planing or prophylaxis
	• Updated supporting information to reflect the most current references
	• Archived previous policy version DCG001.03