UnitedHealthcare

November 2020

policy update bulletin

Dental Clinical Policy & Coverage Guideline Updates

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Clinical Policy Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Application of Desensitizing Medicaments and Resins	Nov. 1, 2020	**Definitions** • Removed definition of "Remineralization" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Non-Surgical Periodontal Therapy	Dec. 1, 2020	**Coverage Rationale** ***Scaling and Root Planing*** • Revised list of conditions for/in which Scaling and Root Planning **is indicated** for the treatment of localized or generalized active Periodontal Disease; replaced: o "Periodontal probing depths up to 6 mm with clinical attachment loss of up to 4 mm; radiographic evidence of bone loss and tooth mobility may be present, in molars, Furcation Involvement should not exceed Class 1" with "periodontal probing depths of 4-6+ mm with radiographic evidence of horizontal or vertical bone loss" o "Periodontal probing depths *greater than 6 mm with attachment loss greater than 4 mm*; radiographic evidence of bone loss *and tooth mobility are present*" with "periodontal probing depths of *4-6+ mm* with radiographic evidence of	<u>**Scaling and Root Planing**</u> **Scaling and Root Planing is indicated for the treatment of localized or generalized active Periodontal Disease characterized by**: • Periodontal probing depths of 4-6+ mm with radiographic evidence of horizontal or vertical bone loss • Refractory or recurrent Periodontal Disease • Periodontal abscess **Scaling and Root Planing is not indicated for the following**: • For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss • Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue) <u>**Localized Delivery of Antimicrobial Agents**</u> **Localized delivery of antimicrobial agents is indicated in cases of Periodontal Disease with probing depths greater than or equal to 5 millimeters with active disease (bleeding upon probing, exudate and inflammation) present.** <u>**Periodontal Maintenance**</u> **Periodontal Maintenance is indicated for the following**: • To maintain the results of surgical and non-surgical periodontal treatment • As an extension of active periodontal therapy at selected intervals **Periodontal Maintenance is not indicated for the following**: • No history of Scaling and Root Planing (SRP) or surgical procedures

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Clinical Policy Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Non-Surgical Periodontal Therapy *(continued)*	Dec. 1, 2020	*horizontal or vertical* bone loss" • Revised list of conditions for/in which Scaling and Root Planning **is not indicated**; removed "as a sole treatment for refractory chronic, aggressive or advanced Periodontal Disease" ***Localized Delivery of Antimicrobial Agents*** • Replaced language stating "localized delivery of antimicrobial agents **is indicated** in cases of *refractory Periodontal Disease and/or residual* Periodontal Disease with probing depths greater than or equal to 5 millimeters with inflammation *still* present *following conventional therapies*" with "localized delivery of antimicrobial agents is indicated in cases of Periodontal Disease with probing depths greater than or equal to 5 millimeters with *active disease (bleeding upon probing, exudate and* inflammation) present" • Removed language indicating localized delivery of antimicrobial agents **is not indicated** on the same day, or immediately following scaling and root planning, before adequate healing has been allowed to occur ***Coverage Limitations*** • Replaced language stating:	• Gingivitis **<u>Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – Full Mouth</u>** Scaling in presence of generalized moderate or severe gingival inflammation is indicated for the removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. **<u>Gingival Irrigation</u>** Gingival Irrigation is unproven due to insufficient evidence of efficacy. **<u>Coverage Limitations</u>** • Scaling and Root Planing is limited to 1 time per quadrant per consecutive 24 months • Localized delivery of antimicrobial agents is limited to 3 sites per quadrant, or 12 sites total • Periodontal Maintenance is limited to 2 times per consecutive 12 months

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Clinical Policy Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Non-Surgical Periodontal Therapy *(continued)*	Dec. 1, 2020	○ "Localized delivery of antimicrobial agents is limited to 3 sites per quadrant, or 12 sites total, *for refractory pockets, or in conjunction with scaling or root planing, by report*" with "localized delivery of antimicrobial agents is limited to 3 sites per quadrant, or 12 sites total" ○ "Periodontal Maintenance is limited to 2 times per consecutive 12 months *following active or adjunctive periodontal therapy, and exclusive of gross debridement*" with "Periodontal Maintenance is limited to 2 times per consecutive 12 months" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence* and *References* sections to reflect the most current information	

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Coverage Guideline Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Full Mouth Debridement	Nov. 1, 2020	**Coverage Rationale** • Simplified content (no change to guidelines) **Supporting Information** • Updated *Description of Services* section to reflect the most current information

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Bacterial and Viral Testing of Oral Infections	Dec. 1, 2020	**Title Change** • Previously titled *Bacterial and Viral Testing* **Coverage Rationale** ***Collection of Microorganisms for Culture and Sensitivity*** • Revised list of conditions for which collection of microorganisms for culture and sensitivity is indicated: o Added "for patients with severe or prolonged infection" o Replaced: ▪ "For *odontogenic* infections that do not respond to *rationale* antibiotic *empiric* therapy and/or incision and drainage in a timely manner" with "for infections *of the oral cavity* that do not respond to antibiotic therapy and/or incision and drainage in a timely manner" ▪ "For *odontogenic* infections in patients with comorbidities including but not limited	<u>Collection of Microorganisms for Culture and Sensitivity</u> **Collection of microorganisms for culture and sensitivity is indicated for the following**: • For infections of the oral cavity that do not respond to antibiotic therapy and/or incision and drainage in a timely manner • For infections of the oral cavity in patients with comorbidities including but not limited to impaired healing response, and compromised immune system • For patients with severe or prolonged infection **Collection of microorganisms for culture and sensitivity is not indicated for the following**: • As a routine procedure for all infections • If infection is small and limited to localized area • If infection is draining on its own with no evidence of spread of infection • For fungal infections • For viral culturing (this procedure has its own reporting code) <u>Viral Culture</u> **Viral culturing is indicated for the presence of oral and perioral vesicles and ruptured vesicles.** **Viral culturing is not indicated for suspected cytomegalovirus (CMV) oral lesions.**

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Coverage Guideline Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Bacterial and Viral Testing of Oral Infections *(continued)*	Dec. 1, 2020	to impaired healing response, and compromised immune system" with "for infections *of the oral cavity* in patients with comorbidities including but not limited to impaired healing response, and compromised immune system" ***Viral Culture*** • Removed language indicating an incisional biopsy and testing is indicated for suspected cytomegalovirus (CMV) oral lesions **Supporting Information** • Updated *Description of Services* and *References* sections to reflect the most current information	
Space Maintenance	Dec. 1, 2020	**Coverage Rationale** • Revised list of conditions for/in which Space Maintainers **are indicated**: o Removed "to regain space" • Revised list conditions for/in which Space Maintainers **are contraindicated**: o Replaced "when tooth/teeth is/are close to eruption" with "when *permanent* tooth/teeth is/are close to eruption" o Removed "if sufficient amount of space already	**Space Maintainers are indicated for maintaining space due to premature loss of a primary tooth (teeth).** **Space Maintainers are contraindicated for the following**: • When permanent tooth/teeth is/are close to eruption • Member is not compliant or has poor oral hygiene • Severe crowding already exists • Space has already been lost **Limitations** • Limited to one per tooth per consecutive 60 months • Any space maintainer adjustments are inclusive for 6 months • Limited to persons under the age of 16

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Space Maintenance *(continued)*	Dec. 1, 2020	exists"	**Exclusions** • Dental services that are not Necessary • Any dental procedure not directly associated with dental disease • Procedures that are considered to be experimental, investigational or unproven. Any treatment, device or pharmacological regimen that is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be an experimental, investigational or unproven service

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General Information

The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Dental Clinical Policy and Coverage Guideline updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria and/or documentation review requirements have been adopted for a health service (e.g., test, drug, device or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria or documentation review requirements; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria and/or documentation review requirements

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

Tips for using the Policy Update Bulletin

- From the table of contents, click the policy title to be directed to the corresponding policy update summary.
- From the policy updates table, click the policy title to view a complete copy of a new, updated, or revised policy.

A complete library of Dental Clinical Policies & Coverage Guidelines is available at **UHCprovider.com** > *Policies and Protocols* > *Dental Clinical Policies and Coverage Guidelines.*