Dental Clinical Policy: Space Maintainers

Reference Number: CP.DP.38
Last Review Date: 12/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Space maintainers are removable or fixed (cemented in place) appliances used to prevent arch length deficiency due to premature loss of primary teeth. Removable and fixed space maintainers are classified as either unilateral (single quadrant only) or bilateral (both quadrants in the same arch). Bilateral space maintainers are designated by arch (maxillary or mandibular).

Policy/Criteria

I. It is the policy of Envolve Dental Inc.® that space maintainers are **medically necessary** when the following condition is met:

- **A.** When primary teeth are lost prematurely due to caries, trauma, ectopic eruption, or other undesirable tooth movement preventing normal eruption of permanent teeth and/or lead to arch length deficiency;
- **B.** When none of the following contraindications apply:
  1. When time lapse related to premature loss of a primary tooth results in closure of tooth/teeth space(s) to the extent placement of a space maintainer will not facilitate normal eruption of the permanent tooth;
  2. When an erupting permanent tooth is within three (3) months of eruption;
  3. When a patient demonstrates active oral habits or uncooperative ability preventing proper function of a space maintainer;
  4. When the abutment tooth/teeth for the space maintainer has a poor prognosis;
  5. When a patient does not maintain proper oral hygiene;
- **C.** Required documentation to support medical necessity include the following:
  1. Current (within the past six (6) months) bite-wing radiographs clearly showing the eruption progress of the permanent tooth where appliance is proposed; and,
  2. Copy of patient chart or treatment notes documenting conditions supporting medical necessity of a space maintainer; or in the alternative,
  3. Reporting an applicable ICD-10 diagnosis code certifying a condition requiring use of a space maintainer.

II. Coverage Limitation/Exclusions

1. D1510, D1520, D1575 – one per quadrant per 24 months, subject to state-specific regulations; **(If a D1575 – distal shoe space maintainer – is reported and approved but not included in a state benefit plan, it will be benefited and paid as a D1510 unless state-specific laws determine otherwise.)**
2. D1516, D1517, D1526, D1527 – one per arch per 24 months, subject to state-specific regulations; **(If at least one tooth is missing in separate quadrants in the same arch, a bi-lateral space maintainer will become the approved benefit instead of two or more single tooth space maintainers unless medical necessity or state-specific laws determine otherwise.)**

Coding Implications

This clinical policy references Current Dental Terminology (CDT®). CDT® is a registered trademark of the American Dental Association. All CDT codes and descriptions are copyrighted 2023, American Dental Association. All rights reserved. CDT codes and CDT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CDT® Codes	Description
D1510	Space maintainer – fixed, unilateral – per quadrant
D1516	Space maintainer – fixed – bilateral, maxillary
D1517	Space maintainer – fixed – bilateral, mandibular
D1520	Space maintainer – removable, unilateral – per quadrant
D1526	Space maintainer – removable – bilateral, maxillary
D1527	Space maintainer – removable – bilateral, mandibular
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
K08.0	Exfoliation of teeth due to systemic issues
K08.409	Partial loss of teeth, unspecified cause
K08.419	Partial loss of teeth due to trauma, unspecified cause
K08.439	Partial loss of teeth due to caries, unspecified cause
K08.499	Partial loss of teeth due to other specified cause, unspecified cause
S02.5XX	Fracture of teeth

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	10/20	10/20
Policy revised	02/21	02/21
Annual Review	11/21	11/21
Annual Review	12/22	12/22
Annual Review and Format Change	12/23	12/23

References

1. American Dental Association. CDT 2023: Dental Procedure Codes. American Dental Association, 2023.
2. American Academy of Pediatric Dentistry. Pediatric Dentistry: Reference Manual 2022.
3. Ritter, A.V., Boushell, L.W. & Walter, R. Sturdevant's: Art and science of operative dentistry, 7th Edition, Chapter 13, St. Louis: Elsevier, 2018.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed dental/medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Envolve Dental makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. "Envolve Dental" means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Benefit Options, Inc, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Envolve Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Envolve Dental. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Envolve Dental retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute dental or medical advice, dental treatment or dental care. It is not intended to dictate to providers how to practice dentistry. Providers are expected to exercise professional dental and medical judgment in providing the most appropriate care, and are solely responsible for the dental and medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating dentist in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom Envolve Dental has no control or right of control. Providers are not agents or employees of Envolve Dental.

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and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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