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

Space maintainers are indicated for the following:
- Maintaining space due to premature loss of a primary tooth (teeth)
- To regain space

Space maintainers are contraindicated for the following:
- When tooth/teeth is/are close to eruption
- Patient is not compliant or has poor oral hygiene
- Severe crowing already exists
- Space has already been lost
- If sufficient amount of space already exists

Coverage Limitations and Exclusions
- 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

**DEFINITIONS**

**Space Maintainer**: A passive appliance, usually cemented in place, that holds teeth in position (ADA)

**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.

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**DESCRIPTION OF SERVICES**

Space Maintainers are passive appliances designed to prevent tooth movement following premature loss of primary teeth so permanent teeth can erupt into proper position. Additionally, the goal of space maintenance is to prevent loss of arch length, width and perimeter by maintaining the relative position of the existing dentition.

**REFERENCES**


**GUIDELINE HISTORY/REVISION INFORMATION**

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