

**BLUE CROSS BLUE SHIELD OF ARIZONA HEALTH CHOICE  
DENTAL CLINICAL REVIEW CRITERIA**

<b>Department</b>	<b>Utilization Management</b>
<b>Policy Number</b>	<b>D0019</b>
<b>Subject</b>	<b>Space Maintainers</b>
<b>Attachments</b>	<b>None</b>

**Overview**

This clinical policy provides guidance regarding dental and medical necessity determinations related to member benefits. These criteria support consistent benefit administration and do not guarantee payment or specific outcomes. All coverage decisions are governed by the member’s benefit plan, including applicable terms, conditions, exclusions, limitations, and state and federal regulations. The policy is intended for informational purposes and does not replace professional medical or dental judgment.

Space maintainers are considered medically necessary for eligible pediatric members when premature loss of a primary posterior tooth is likely to result in loss of arch length, crowding, or malocclusion, and when placement is intended to preserve space for normal eruption of permanent teeth.

**Definitions**

- **Space Maintainer:** A fixed or removable dental appliance used to preserve arch space following premature loss of a primary tooth.
- **Premature Tooth Loss:** Loss of a primary tooth prior to its normal exfoliation.

**Criteria**

Space maintainers are covered when all of the following criteria are met:

1. Services are limited to members ages 0 through 14 years at the time of service.
2. There is documented premature loss of a primary posterior tooth.
3. Clinical and/or radiographic evaluation confirms:
  - Risk of space loss that would adversely affect the eruption or alignment of the permanent dentition, and
  - Presence of sufficient bone over the underlying erupting permanent tooth (or as determined by the Blue Cross Blue Shield of Arizona Health Choice Dental Director).
4. The space maintainer is medically and/or dentally necessary, non-cosmetic, and included in a documented treatment plan intended to prevent future orthodontic or restorative complications.
5. There is adequate space to be maintained.

### **Contraindications**

Space maintainers are not covered and are considered not medically or dentally necessary when any of the following conditions apply:

1. The permanent successor tooth has erupted or is erupting in a position that does not require space preservation.
2. Insufficient space is present to be maintained, or the space has already been lost.
3. Clinical and/or radiographic evaluation demonstrates insufficient bone over the erupting permanent tooth, indicating the tooth (or teeth) is close to eruption.
4. Placement to maintain space following loss of an anterior tooth.
5. The member has poor oral hygiene that would compromise appliance effectiveness or maintenance.
6. Severe crowding already exists, and space maintenance would not prevent future orthodontic complications.

### **Required Documentation**

1. Diagnostic-quality radiographs are required to show the area of premature tooth loss for which a space maintainer is requested.
2. Clinical documentation must include the rationale for space maintainer placement and supporting information demonstrating medical and/or dental necessity (e.g., risk of space loss affecting eruption/alignment of permanent dentition).

### **Limitations and Exclusions**

1. Blue Cross Blue Shield of Arizona Health Choice will not reimburse a provider or provider group for the replacement of a lost or damaged space maintainer when the replacement is billed by the same provider or provider group that originally placed the appliance.
  - Per the AHCCCS Uniform Warranty List, space maintainers carry a lifetime warranty.
2. Prior authorization is required for space maintainers except when the service is billed on the same date of service as an emergency extraction of a primary posterior tooth and when all applicable dental criteria are met.
3. If a member is missing primary molar teeth in more than one quadrant within the same arch, coverage will default to a bilateral space maintainer instead of multiple single-tooth appliances. An exception applies when posterior primary molars are absent in multiple quadrants and the permanent molars have not erupted, or when medical necessity supports an alternative.

### **Coding/Billing**

The codes listed in this policy are for reference purposes only. Listing a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by dental necessity criteria and specific benefit plans or other regulatory conditions. This list of codes may not be all inclusive.

## CDT codes

Key:

C.....Covered service

N.....Non-covered service

Code	Description	Medicaid Age 0-20	Medicaid Age 21+	Medicare HCP
D1510	Space maintainer-fixed unilateral	C	N	N
D1516	Space maintainer - fixed - bilateral, maxillary	C	N	N
D1517	Space maintainer - fixed - bilateral, mandibular	C	N	N
D1520	Space maintainer-removable unilateral	C	N	N
D1526	Space maintainer - removable - bilateral, maxillary	C	N	N
D1527	Space maintainer - removable - bilateral, mandibular	C	N	N
D1551	Re-cement or re-bond bilateral space maintainer-maxilla	C	N	N
D1552	Re-cement or re-bond bilateral space maintainer-mandible	C	N	N
D1553	Re-cement or re-bond unilateral space maintainer-per quadrant	C	N	N
D1556	Removal of fixed unilateral space maintainer- per quadrant	C	N	N
D1557	Removal of fixed bilateral space maintainer-maxillary	C	N	N
D1558	Removal of fixed bilateral space maintainer-mandibular	C	N	N
D1575	Distal shoe space maintainer - fixed unilateral	C	N	N

## References

- AHCCCS Medical Policy Manual Chapter 400 – Maternal and Child Health 431- Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment Aged Members.
- American Dental Association. CDT 2026 Current Dental Procedures (2026).
- American Academy of Pediatric Dentistry. Management of the developing dentition and occlusion in pediatric dentistry. The Reference Manual of Pediatric Dentistry. Chicago, IL: American Academy of Pediatric Dentistry; 2025:497-515.
- Tunison W, et al. Dental arch space changes following premature loss of primary first molars... (2008)

### Policy History/Review Date

Developed Date	05/01/2026
Last Review Date	05/2026
Next Review Date	05/2027

**This policy will be reviewed on an annual basis.**