Dental Policy

Subject: **Implants**
Guideline #: **06-101** **Publish Date:** **03/15/2018**
Status: **Revised** **Last Review Date:** **02/05/2018**

Description

This document addresses the clinical aspects of dental implant placement.

Note: Please refer to the following documents for additional information concerning related topics:

- Bone Grafts for Dental Surgical Services – 07-901; 04-201
- Mucogingival Surgery and Soft Tissue Grafting – 04-204
- Osseous Surgery – 04-205
- Scaling and Root Planing -04-301
- Removal of Teeth - 07-101
- Crown and Fixed Partial Dentures – 02-701 ; 06-701

Clinical Indications

Dental Services using dental implants to replace missing teeth may be considered appropriate as a result of accidental traumatic injuries to sound, natural teeth from an external blow; loss of teeth as a result of the removal of pathologic disorders or unrestorable teeth; congenitally missing teeth as a component of a genetic disorder; and congenital disorders of teeth.

As it applies to appropriateness of care, dental services are:

- provided by a Dentist, exercising prudent clinical judgment
- provided to a patient for the purpose of evaluating, diagnosing and/or treating a dental injury or disease or its symptoms
- in accordance with the generally accepted standards of dental practice which means:
    - standards that are based on credible scientific evidence published in peer-reviewed, dental literature generally recognized by the practicing dental community
    - specialty society recommendations/criteria
    - any other relevant factors
- clinically appropriate, in terms of type, frequency and extent
- considered effective for the patient's dental injury or disease
- not primarily performed for the convenience of the patient or Dentist
- Not more costly than an alternative service.
- Dependent on group contract provisions, cosmetic services may not qualify for benefit coverage even though the services may be clinically appropriate.

The replacement of multiple teeth by dental implants in the same arch is not appropriate (unless specified by group contract) when other less costly dental services are capable of adequately restoring the occlusion to function. The prosthetic restoration of dental implants may be subject to alternate benefit plan provisions.

Note: Whether a service is covered by the plan, when any service is performed in conjunction with or in preparation for a non-covered or denied service, all related services are also either not covered or denied.

Note:

A group may define covered dental services under either their dental or medical plan, as well as to define those services that may be subject to dollar caps or other limits. The plan documents outline covered benefits, exclusions and limitations. The health plan advises dentists and enrollees to consult the plan documents to determine if there are exclusions or other benefit limitations applicable to the service request. The conclusion that a particular service is medically or dentally necessary does not constitute an indication or warranty that the service requested is a covered benefit payable by the health plan. Some plans exclude coverage for services that the health plan considers either medically or dentally necessary. When there is a discrepancy between the health plan's clinical policy and the group's plan documents, the health plan will defer to the group's plan documents as to whether the dental service is a covered benefit. In addition, if state or federal regulations mandate coverage then the health plan will adhere to the applicable regulatory requirement.

General Criteria

1. Prior to implant placement, an evaluation of the functional occlusion of the entire dentition (mouth-oral cavity) must be completed.
2. Dated, properly oriented, diagnostic full mouth, panoramic, and/or other appropriate radiographic images must be provided that documents the bone levels and quality. A panoramic image or full mouth images must reveal all existing and missing teeth in both upper and lower arches.
3. A comprehensive treatment plan may be requested including periodontal status. This may include documentation of a history of definitive periodontal treatment, including maintenance, for the remaining teeth related to any periodontal conditions must be provided.
4. In the absence of multiple missing teeth and active infection, single tooth replacement by a dental implant may be considered regardless of the need for full crown coverage of the teeth adjacent to the implant site.
5. In the absence of multiple missing teeth within the same arch, implant placement for a second molar tooth may be considered if a functional opposing first or second molar tooth is present. The molar opposing the implant must be periodontally sound and healthy and dependent upon the proposed implant for prevention of passive eruption.
6. For a completely edentulous arch, replacement of teeth and restoration of the occlusion can be adequately restored with four dental implants per arch unless variations are specified by group contract.
7. A patient's sensitivity (allergy) to denture restorative materials may be considered a qualification for dental implant placement. This condition must be documented by a physician and dental provider's letters of medical/dental necessity as well as a copy of the laboratory analysis of the allergy.
8. A patient's inability to wear a removable appliance due to severe alveolar ridge atrophy may be considered a qualification for implant placement. This condition must be documented by a letter of dental necessity from the treating provider and supported by appropriate radiographic evidence.
9. Implant placement will not be considered for correction of developmental or congenital defects (congenitally missing teeth unless covered by group contract) or for spacing due to migration/drifting of teeth.
10. The guidelines related to bone grafting for dental implants is included in a separate clinical policy.
11. Immediate placement of dental implant bodies in tooth extraction sites is an acceptable procedure. Immediate placement of a dental implant should only be done at the time of atraumatic tooth removal.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CDT

	Including, but not limited to, the following:
D6010	surgical placement of implant body: endosteal implant

D6011	second stage implant surgery
D6012	surgical placement of interim implant body for transitional **prosthesis: endosteal implant**
D6013	surgical placement of mini implant
D6040	surgical placement: eposteal implant
D6050	surgical placement: transosteal implant
D6100	implant removal, by report

CPT Codes

21248	reconstruction of mandible or maxilla; endosteal implant (e.g. Blade, cylinder); partial
21249	reconstruction of mandible or maxilla; endosteal implant (e.g. Blade, cylinder); complete

ICD-10 Diagnosis	*Including but not limited to*
K08.8	exfoliation of teeth due to systemic causes
K08.1	complete loss of teeth
K08.10	complete loss of teeth, unspecified
K08.11	complete loss of teeth due to trauma (note subcategories)
K08.12	complete loss of teeth due to periodontal disease (note subcategories)
K08.13	complete loss of teeth due to caries (note subcategories)
K08.19	complete loss of teeth due to unspecified causes (note subcategories)
K08.4	partial loss of teeth
K08.40	partial loss of teeth (note subcategories)
K08.41	partial loss of teeth due to trauma
K08.42	partial loss of teeth due to periodontal disease (note subcategories)
K08.43	partial loss of teeth due to caries (note subcategories)
K08.49	partial loss of teeth due to unspecified causes (note subcategories)

Discussion/General Information

Note:

A dental implant is a biomedical device made from an inert metallic alloy typically composed of titanium which has demonstrated little to no inflammatory response and therefore improved efficacy. The therapeutic goal is to replace missing teeth to restore comfort, function and esthetics. Dental implants are used to replace single or multiple missing teeth and can serve as anchoring abutments for tooth replacement prosthetic devices such as crowns, fixed partial dentures or complete removable dentures. The implant consists of multiple components: the implant body replaces the tooth root and integrates into the surrounding bone; an abutment head replaces the inner part of the tooth crown and is directly attached to the implant body by a screw; the crown simulates the natural tooth crown (chewing surface).

Dental implants have been proven to be safe, effective and biocompatible. The overall success rate of dental implants is greater than 90% at 10 years post placement. The long-term success rate of dental implants used as bridge abutments is at least comparable or superior to natural tooth supported fixed partial dentures.

The medical and oral health status of patients must be reviewed and considered prior to placement of dental implants. Conditions and habits that may affect the success of a dental implant include oral hygiene habits, history of smoking, bruxism/grinding, periodontal disease, radiation therapy, as well as other causative factors (e.g. – uncontrolled diabetes) that may impair the healing characteristics of bone and soft tissue. It is a well-known fact that patients who smoke must be cautioned to not smoke during the healing phase of dental implant body placement which can affect the long-term success of the dental implant. A clinical assessment of the quality, quantity and contour of the soft tissue and bone into which the implant body will be placed must be made prior to placement. Important anatomic structures, such as sinus cavities and the mandibular nerve must be located using appropriate diagnostic tools.

Dental implants may be placed into edentulous or toothless areas of the lower or upper jaws or they can be immediately placed into extraction sites at the time of tooth removal. Immediate implant placement may help preserve the alveolar anatomy by decreasing loss of bone after tooth removal which therefore decreases the time from extraction to final tooth replacement. Dependent upon the clinical findings at the time of dental implant placement into extraction sites, the use of barrier membranes may be recommended. Barrier membranes prohibit the proliferation or growth of soft tissue into the extraction site which allows blood vessels from the bone walls to inhabit the space between the implant body and the surrounding bone. The blood vessels act as a supporting matrix for

bone regeneration which increases the success of integration of the implant body with bone. Immediate placement of dental implants into extraction sites is typically more successful when the tooth is removed atraumatically allowing close approximation of the dental implant body with the bone walls of the extraction site.

Post-operative management should include periodic evaluation of oral hygiene status, presence of plaque and calculus accumulation, clinical and radiographic appearance of the implant and peri-implant tissue, functional and occlusal status, implant and prosthesis stability, stability of probing depths, and the presence or absence of periodontal pocket exudate (possibly pus or pocket fluids) or bleeding on probing (1,21).

Definitions

Atraumatic - not producing injury or damage

Bruxism - the involuntary or habitual grinding of the teeth, typically during sleep

Osseointegration - the process of healing or attachment of the dental implant body into the bone

Titanium - a hard silver-gray metal of the transition series, used in strong, light, corrosion-resistant alloys

References

Peer Reviewed Publications:

Government Agency, Medical Society, and Other Authoritative Publications:

1. Lekholm U, Grondahl K and Jemt T. Outcome of oral implant treatment in partially edentulous jaws followed 20 years in clinical function. Clin Implant Dent Relat Res 2006;8:178-186.
2. Zarb GA. Immediate and early implant loading protocols: a literature review of clinical studies. J Prosthet Dent 2005;94:242-258.
3. Naert I, Koutsikakis G, et al. Biologic outcomes of single-implant restorations as tooth replacements: a long-term follow-up study. Clin Implant Dent Relat Res 2000;2:209-218.
4. Gelb DA. Immediate implant surgery: Three year retrospective evaluation of fifty consecutive cases. Int J Oral Maxillofac Implants;2004;62(Suppl 2):90-105.
5. Dahlin C, Lekholm U and Lindhe A. Membrane-induced bone augmentation at titanium implants. A report on ten fixtures followed from 1 to 3 years after loading. Int J Perio Rest Dent 1991;11:273-281.
6. American Academy of Periodontology. Periodontal maintenance (Position paper). J Perio 2003;74:1395-1401.
7. Becker W, Dahlin C, et al. The use of e-PTFE barrier membranes for bone promotion around titanium implants placed into extraction sockets: A prospective multi-center study. Int J Oral Maxillofac Implants1994;9:31-40.
8. American Academy of Periodontology. Parameter on placement and management of the dental implant. J Perio 2000;71(5 supplement):870-872.
9. Elsubeihi E and Zarb GA. Implant prosthodontics in medically challenged patients: the University of Toronto experience. J Can Dent Assoc2002;68:103-108.
10. American Academy of Periodontology. Bone augmentation. AAP commissioned review. J Perio 2007;78:377-396.
11. American Dental Association. CDT 2013 Dental Procedure Codes;51. (©ADA 2012).
12. Leblebicioglu B, Rawal S and Mariotti A. A review of the functional and esthetic requirements for dental implants. J Amer Dent Assoc 2007;138:321-329.
13. Esquivel-Upshaw J. Dental implants. In: Anusavice KJ, ed. Phillips science of dental materials. 11th ed. Saunders;2003:759-780
14. Parein AM, Eckert SE, et al. Implant reconstruction in the posterior mandible: a long-term retrospective study. J Prosthet Dent 1997;78:34-42.
15. Shenk RK, Buser D, et al. Healing pattern of bone regeneration in membrane-protected defects: A histologic study in the canine mandible. Int J Oral Maxillofac Implants 1994;9:13-29.
16. Lazzara RJ. Immediate implant placement into extraction sites: Surgical and restorative advantages. Int J Perio Rest Dent1989;9:332-343.
17. Lekholm U, Gunne J, et al. Survival of the Branemark implant in partially edentulous jaws: a 10-year prospective multicenter study. Int J Oral Maxillofac Implants 1999;14:639-645.

18. Romeo E, Chiapasco M, et al. Long-term clinical effectiveness of oral implants in the treatment of partial edentulism: seven-year life table analysis of a prospective stud with ITI dental implants system used for single-tooth restorations. Clin Oral Implant Res 2002;13:133-143.
19. Wyatt CC and Zarb GA. Treatment outcomes of patients with implant-supported fixed partial prostheses. Int J Oral Maxillofac Implants 1998;13:204-211.
20. DeLuca S, Habsha E and Zarb GA. The effect of smoking on osseointegrated dental implants. Part I: Implant survival. Int J Prosthodont 2006;19:491-498.
21. Paolantonio M, Dolci M, et al. Immediate implantation in fresh extraction sockets. A controlled clinical and histological study in man. J Perio 2001;72:1560-1571.
22. Johnson PF. Treatment considerations of fixed prosthetic restorations of the compromised dentition vs alternate fixed implant-supported options. J Calif Dent Assoc 2003;20:

History

Revision History	Version	Date	Nature of Change	SME
	initial	12/14/16		Rosen
	Revision	2/5/18	Related Dental Policies, Appropriateness and Medical necessity	M Kahn

Federal and State law, as well as contract language, and Dental Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Clinical Policy Committee are available for general adoption by plans or lines of business for consistent review of the medical or dental necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical or dental necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical or dental necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.