

TO: All Colorado Dental Association Members

The Dentists Professional Liability Trust Board, on 12-9-87, approved requirements for the use of dental implants. The Trust's concern in arriving at these requirements was to provide two types of protection. First, we wished to protect those members who do not work with implants by being fiducially responsible to see that this is a shared risk. Secondly, we would protect the Trust by requiring those dentists who do work with implants to meet some current and ongoing education qualifications, and thereby assure that the liability risk to the Trust would not be as great.

To allow for the use of implants (ceramic or any metallic fixture **surgically** placed in alveolar bone or basal bone excluding periodontal bone grafting materials, ridge augmentation materials and endodontic stabilizer implants), the dentist must meet the following requirements.

- A. Only Federal Drug Administration approved implants will be accepted.
- B. Sixty-four (64) hours of continuing education before coverage will begin. All hours must be completed within the past five years. These 64 hours must be documented to include:
 - 1. Thirty-two (32) hours of general implantology with emphasis on:
 - a. dental anatomy
 - b. pharmacology
 - c. biomaterials and biomechanics
 - d. medical evaluation criteria
 - e. wound healing and repair
 - f. periodontics
 - 2. Sixteen (16) hours in clinical instruction, a portion of which must include hands on experience in the system utilized.
 - 3. Sixteen hours (16) in the restorative phase, a portion of which must include experience in the system utilized. Four (4) hours total can be obtained by video, CD, internet or self-test reviewed articles.
- C. Ongoing continuing education consisting of twelve (12) hours in every twenty-four-(24) month period. May be in any of the areas listed in section B-1 above, but should include coverage of recent research or developments in one or more of these areas. Four (4) hours total can be obtained by video, CD, internet or self-test reviewed articles.

(over)

- D. Peer Review
The Trust Board will have the right to evaluate the implantologist individually as to requirements being met.
- E. \$500.00 increase in premium. This increase in premium will be waived once this coverage has been carried for three (3) consecutive years with no implant claims.

To allow for the use of the **restorative** phase of implants, the dentist must meet the following requirements:

- A. Fourteen (14) hours of continuing education before coverage will begin. All hours must be completed within the past five years. These 14 hours must be documented to include the following:
 - 1. general overview of implantology
 - 2. wound healing and repair of implants
 - 3. restorative design, function, and occlusion
 - 4. restorative technique, i.e., lab support
- B. Minimum of twelve (12) hours in 24 months of continuing education i.e., study clubs, seminars, courses. Four (4) hours total can be obtained by video, CD, internet or self-test reviewed articles.
- C. At this time the Trust will provide coverage of the restorative phase with no additional increase in premium.

SUPPLEMENT

- A. Documentation concerning implants and the restorative phase must include certificates or letters of completion with signatures from course directors. These documents must verify requirements set by the Trust.
- B. A specific informed consent document is no longer required but the use of one is **strongly advised** for both phases of implant coverage.

REPORT FORM

THE DENTISTS PROFESSIONAL LIABILITY TRUST

EDUCATION REQUIREMENTS FOR THE USE OF IMPLANTS

In accordance, with the requirements governing the continued use of dental implants, please submit verification of continuing education courses completed. **Documentation must include certificates of courses completed and/or letters of completion with signatures of course directors. All hours must be completed within the past five years.** Please categorize the contents of the courses as listed below. Copy, if additional report forms are needed.

SURGICAL PHASE EDUCATION REQUIREMENTS

1. General Implantology including anatomy, diagnostic evaluation, pharmacology, wound healing, biomaterials and periodontics.
(32 hrs. required)

Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____

1. Clinical and hands on experience including training in the system utilized. (16 hrs. required)

Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____

2. Restorative phase including training in the system utilized.
(16 hrs. required)

Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____
Course _____	Date _____	Hrs _____

RESTORATIVE PHASE EDUCATION REQUIREMENT

1. General Implantology including a general overview, wound healing and repair, restorative design and function, occlusion and restorative technique and lab support. (14 hrs. required)

Course _____ Date _____ Hrs _____
Course _____ Date _____ Hrs _____
Course _____ Date _____ Hrs _____
Course _____ Date _____ Hrs _____

I am applying for Implant coverage for:

Surgical Phase (complete front side of this form)

Restorative Phase (see above)

Signature _____

Date _____

Approved:

Not Approved:

Reasons:

By _____

Date _____

IMPLANT PATIENT-PROSTHETIC INFORMATION AND CONSENT FORM

Patient: _____

Date : _____

1. I, _____ authorize Dr.(s) _____ to construct a dental prosthesis for use with my surgical implant as indicated by the diagnostic studies and/or evaluations already performed.

2. I have discussed with Dr. (s) _____ the risks associated with the surgical implant and have consented to that procedure.

3. Alternatives to implant surgery and the implant prosthesis have been explained to me, including their risks. I have tried or considered these alternative treatment methods and their risks, but I desire an implant and an implant prosthesis to secure and/or replace my missing teeth.

4. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant prosthesis and the associated treatment and procedures. I am aware that the implant surgery and/or prosthesis may fail, which may require corrective surgery or the removal of the prosthesis or implant with possible surgery associated with the implant removal.

5. As with any dental prosthesis, there are possible complications of which I should be aware. These include, but are not limited to the following: the presenting conditions may result in compromised bridge work or compromised occlusion requiring additional care and treatment; risk of prosthetic and/or material failure; loss of permanent teeth; allergic reactions to metals; loss of the prosthesis and/or implant if dental disease develops due to improper home care or other reasons; loss of the implant and/or prosthesis if systemic disease develops; and wear or breakage of the implant component and/or prosthesis. The development of any of these aforementioned risks may result in the need for surgical removal of the implant and the use of alternative forms of treatment. I have been advised that bone grafting and /or guided tissue regeneration may be necessary.

6. I have been advised that the use of tobacco, alcohol and/or sugar may affect the implant and the prosthesis and may limit the success of this treatment. I agree that I will follow my dentist's instructions for home care, oral hygiene and agree to follow my dentist's instructions for professional dental cleaning, follow -up care and treatment once the prosthesis has been placed.

IMPLANT PATIENT-PROSTHETIC INFORMATION AND CONSENT FORM

7. I certify that I have read, have had explained to me, and fully understand the foregoing consent to implant prosthesis and that it is my intention to have the foregoing prosthesis constructed as stated. I have been advised that information concerning the longevity of the particular implant and the prosthesis to be used may not be available. However, I have discussed this as well as the nature of the implant product to be used with my doctor and I consent to the procedure knowing its risks and limitations.

Patient

Doctor

Witness (if available)

Parent or Guardian if patient
is minor

Dated:_____

Time:_____

IMPLANT PATIENT - PROSTHETIC INFORMATION AND CONSENT FORM

PATIENT: _____

DATE: _____

1. I, _____, authorize Dr. _____ to construct a dental prosthesis for use with my implant (s).
2. Alternatives to an implant supported and/or retained prosthesis have been explained to me. I have tried or considered these alternative treatment methods and their risks, but I desire implant and implant prosthesis to secure and/or replace my missing teeth.
3. As with any dental prosthesis, there are possible complications of which I should be aware. These include, but are not limited to:
 - Risk of Prosthetic and/or material failure;
 - Loss of permanent teeth;
 - Loss of prosthesis and/or implant due to periodontal disease, other oral disease, or oral manifestations of systemic disease;
 - Compromised bite relationship;
 - Compromised esthetics;

The development of any of these risks may result in the need for surgical removal of the implant and the use of alternative forms of treatment. I have been advised that bone grafting and/or guided tissue regeneration may be necessary.

4. I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of my implant prosthesis. I am aware that the implant surgery and/or prosthesis may fail, which may require corrective surgery or the removal of the prosthesis or implant with possible surgery associated with the implant removal.
5. I have been advised that the use of tobacco or alcohol may affect the implant and/or the prosthesis and limit the success of this treatment. My dentist has provided instructions for home care and oral hygiene and I understand the importance of following my dentist's instructions for professional dental cleaning; as well as follow-up care and treatment.
6. I agree that I have read, had explained to me and understand the consent to implant prosthesis. I have been given the opportunity to ask questions concerning the nature of the treatment and the risks involved. I consent to the procedure knowing its risks and limitations.

PATIENT

DOCTOR

WITNESS (if available)

PARENT OR GUARDIAN (if minor)

DATED:

TIME: