Clinical Policy: Dental Anesthesia

Reference Number: CA.CP.MP.61
Effective Date: 09/15
Last Review Date: 08/17

Coding Implications
Revision Log

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

Description
Medical necessity guidelines for dental anesthesia in the inpatient or ambulatory surgery setting.

California Health & Wellness (CH&W) covers medically necessary services administered in connection with dental services that are **not** provided by dentists or dental anesthesiologists **(See Attachment 1)**.

I. Intravenous sedation and general anesthesia services including the following:
   A. Services related to dental procedures that require intravenous sedation or general anesthesia and are provided by individuals other than dental personnel, including any associated prescription drugs, laboratory services, physical examinations required for admission to a medical facility, outpatient surgical center services, and inpatient hospitalization services required for a dental procedure;
   B. CH&W shall reimburse facility fees for services provided in any hospital, ambulatory surgery center, that meet the requirements set forth in this policy provided by either dental personnel or individuals other than dental personnel; and
   C. CH&W must coordinate all necessary non-anesthesia covered services provided to a member.

II. Members may receive treatment for a dental procedure provided under general anesthesia by a physician anesthesiologist in the settings listed below only if CH&W determines the setting is appropriate and according to the criteria outlined under Policy/Criteria:
   A. Hospital;
   B. Accredited ambulatory surgical center (stand-alone facility);
   C. Dental office; and
   D. A community clinic that:
      a. Accepts Medi-Cal dental program (Denti-Cal or DMC plan) beneficiaries;
      b. Is a non-profit organization; and
      c. Is recognized by the Department of Health Care Services as a licensed community clinic or a Federally Qualified Health Center (FQHC) or FQHC look-alike.

III. Authorization for general anesthesia provided by a physician anesthesiologist to a beneficiary during an inpatient stay must be part of the authorization for the inpatient admission.
IV. Authorization is not required prior to delivering intravenous sedation or general anesthesia as part of an outpatient dental procedure in a state certified skilled nursing facility (SNF) or any category of intermediate care facility (ICF) for the developmentally disabled.

Providers must be qualified and appropriately trained individuals in accordance with state regulations and professional society guidelines. All locations that administer general anesthesia

must be equipped with anesthesia emergency drugs, appropriate resuscitation equipment, and properly trained staff to skillfully respond to anesthetic emergencies. Locations covered under this policy are hospitals, ambulatory medical surgical settings, and dental offices.

Policy/Criteria

V. It is the policy of California Health & Wellness that requests for *general anesthesia or IV sedation in an inpatient setting, ambulatory surgery center, or dental office* are considered **medically necessary** when the use of local anesthesia or conscious sedation to control pain failed or is/was not feasible based on the medical needs of the patient.
   A. Use of local anesthesia or conscious sedation (oral or inhalation) to control pain ***failed***:
      a. The documentation provided must support and justify the need for the consideration of using IV sedation or general anesthesia **(Attachment 2)**.
   B. Use of local anesthesia or conscious sedation (oral or inhalation) to control pain ***is/was not feasible.*** Documentation in the clinical record must support *any* of the following **(Attachment 2)**:
      a. Effective communicative techniques and the ability for immobilization failed or is/was not feasible based on the medical needs of the patient. The documentation provided must support and justify the need for the consideration of using IV sedation or general anesthesia.
      b. Requires extensive or complex dental restorative treatment or surgical treatment that cannot be rendered under local anesthesia or conscious sedation. The submitted documentation must outline the extensive treatment or surgical treatment plan based on radiographs or visual exam (if unable to obtain radiographs from the referring dentist). Extensive or complex treatments are multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions, or any combination of these or other dental procedures. In a child three (3) years of age or younger, "multiple" includes treatments in two (2) or more quadrants or multiple teeth in one quadrant. In a child older that three (3) years of age, "multiple" includes treatments in three or more quadrants or multiple teeth in two quadrants.
      c. Patient has acute situational anxiety due to immature cognitive functioning. Submitted documentation must indicate that the patient is uncooperative due to cognitive immaturity whereby they are unable to follow commands from the provider rendering the needed dental/surgical interventions. This includes situations in which the member is extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude or clinically apparent and functionally threatening to the well-being of the individual that treatment should not be postponed or deferred, and the lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity or mortality,
      d. Patient is uncooperative due to certain physical or mental compromising conditions. Documentation provided must support and justify the need for the consideration of using IV sedation or general anesthesia. This includes situations in which the member exhibits physical, intellectual, or medically-compromised conditions, for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a humane and successful result and which, under general anesthesia, may be expected to produce a superior result.

e. Member needs local anesthesia with dental treatment but the local anesthesia is/will be ineffective because of acute infection, anatomic variation, or allergy.
f. Member has sustained oral-facial and/or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.

When a provider determines that a beneficiary meets one of the criteria of V.B.a. – V.B.f. it is not automatically considered to be documentation that local anesthesia or conscious sedation was not feasible. The submitted documentation of the criteria that was met must be clearly stated in the patient's records and the submitted documentation requesting IV sedation or general anesthesia must clearly demonstrate the need for this service.

VI. Patients with certain medical conditions, such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias, and significant bleeding disorders (continuous Coumadin therapy) should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.

VII. Providers will adhere to all regulatory requirements (Federal, State, Licensing Board, etc.) for:
A. Preoperative and perioperative care.
B. Monitoring and equipment requirements
C. Emergencies and transfers
D. Monitoring guidelines

Background

Sedation and anesthesia for dental procedures performed on patients in nontraditional settings, such as acute inpatient facility or ambulatory surgery center, have increased over the past several years. Providers must be qualified and appropriately trained individuals in accordance with state regulations and professional society guidelines.

All locations that administer general anesthesia must be equipped with anesthesia emergency drugs, appropriate resuscitation equipment, and properly trained staff to skillfully respond to anesthetic emergencies. Locations covered under this policy are acute care inpatient facilities and ambulatory surgery centers.

General anesthesia allows for the safe and humane provision of dental diagnostic and surgically invasive procedures. General anesthesia is only necessary for a small subset of members but is an effective, efficacious, and safe way to provide necessary treatment. Those included in this subset are individuals who may be cognitively immature, highly anxious or fearful, have special needs, or medically compromised and unable to receive treatment in a traditional office setting.

Withholding of general anesthesia can result in less access to quality oral health care and long term consequences. Less effective management of these members may increase avoidance behaviors of oral health professionals in the future and increase care being sought in the emergency department. Improved diagnostic yield and greater quality of procedures improves the cost-effectiveness of general anesthesia over local anesthesia in some individuals.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT 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.

CPT® Codes	Description
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified
00190	Anesthesia for procedures on facial bones or skull; not otherwise specified
41899	Other Procedures on the Dentoalveolar Structures (facility fees)

HCPCS Codes	Description
D9220	Deep sedation/general anesthesia, first 30 minutes
D9221	Deep sedation/general anesthesia, each additional 15 minutes
D9241	Intravenous conscious sedation/analgesia, first 30 minutes
D9242	Intravenous conscious sedation/analgesia, each additional 15 minutes
D9248	Non-intravenous conscious sedation

Reviews, Revisions, and Approvals	Date	Approval Date
Extensive revisions to comply with CA DHCS APL 15-012	05/15	06/15
Extensive revisions to combine Centene CP with CA DHCS APL 15-012	06/16	06/16
Changed CH&W policy to new template using latest Centene version Updated Policy/Criteria section based on materials and presentation from DHCS and Denti-Cal Added CPT code 41899 Added Attachments from APL and DHCS/Denti-Cal presentation	05/17	
Removed an already approved TAR as one of the criteria for approval based on DHCS/Denti-Cal guidance received via email on 8/2/2017. References reviewed and updated.	08/17	

References

American Academy of Pediatric Dentistry. General Anesthesia. Patient Brochure. Chicago, IL: AAPD; 2011. http://www.aapd.org

American Academy of Pediatric Dentistry. General Anesthesia Legislation. Accessed at: http://www.aapd.org/advocacy/general_anesthesia_legislation/

American Academy of Pediatric Dentistry. Pediatric Oral Health Research & Policy Center, Technical Report 2-2012: An essential health benefit: general anesthesia for treatment of

early childhood caries. Accessed at: http://www.aapd.org/assets/1/7/POHRPCTechBrief2.pdf
American Dental Association Policy Statement: The use of conscious sedation, deep sedation and general anesthesia in dentistry. As adopted by the October 2007 ADA House of Delegates.
American Academy of Pediatric Dentistry. Guideline on use of anesthesia personnel in the administration of office-based deep sedation/general anesthesia to the pediatric dental patient. Adopted 2001, Revised, 2005, 2007, 2009, 2012.
State of California—Health and Human Services Agency Department of Health Care Services, All Plan Letter 15-012, August 21, 2015 Dental Services – Intravenous Sedation And General Anesthesia Coverage. http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-012.pdf

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 medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan 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 medical practice current at the time that this clinical policy was approved. "Health Plan" means California Health & Wellness, a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to 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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members 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 and LCDs 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.

Attachment 1: (From Attachment 2 of APL 15-012)

Intravenous Sedation and General Anesthesia: Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios

Acronym List:
CAASD: Clinical Assurance and Administrative Support Division
Medi-Cal Dental FFS or Denti-Cal: Medi-Cal Dental Fee-For-Service
DMC Plan: Dental Managed Care Plan
DOSC: Dental Only Surgery Center
DHCS: Department of Health Care Services
ETAR: Electronic Treatment Authorization Request
MCP: Medi-Cal Managed Care Health Plan
Medi-Cal Medical FFS: Medi-Cal Medical Fee-For-Service
MCMC: Medi-Cal Medical Managed Care

Scenario 1 – Dental Office

Beneficiary Enrolled in:	DMC Plan + MCMC	Medi-Cal Dental FFS + MCMC	DMC Plan + Medi-Cal Medical FFS	Medi-Cal Dental FFS + Medi-Cal Medical FFS
Medical Anesthesiologist	MCP pays anesthesiologist	MCP pays anesthesiologist	Medi-Cal Medical FFS pays anesthesiologist	Medi-Cal Medical FFS pays anesthesiologist
Submit Prior Authorization/Treatment Authorization Request to:	MCP for anesthesia fees	MCP for anesthesia fees	CAASD Field Office (ETAR) for anesthesia fees	CAASD Field Office (ETAR) for anesthesia fees
Dental Anesthesiologist	DMC Plan pays anesthesiologist	Denti-Cal pays anesthesiologist	DMC Plan pays anesthesiologist	Denti-Cal pays anesthesiologist
Submit Prior Authorization/Treatment Authorization Request to:	DMC Plan for anesthesia fees	Denti-Cal for anesthesia fees	DMC Plan for anesthesia fees	Denti-Cal for anesthesia fees

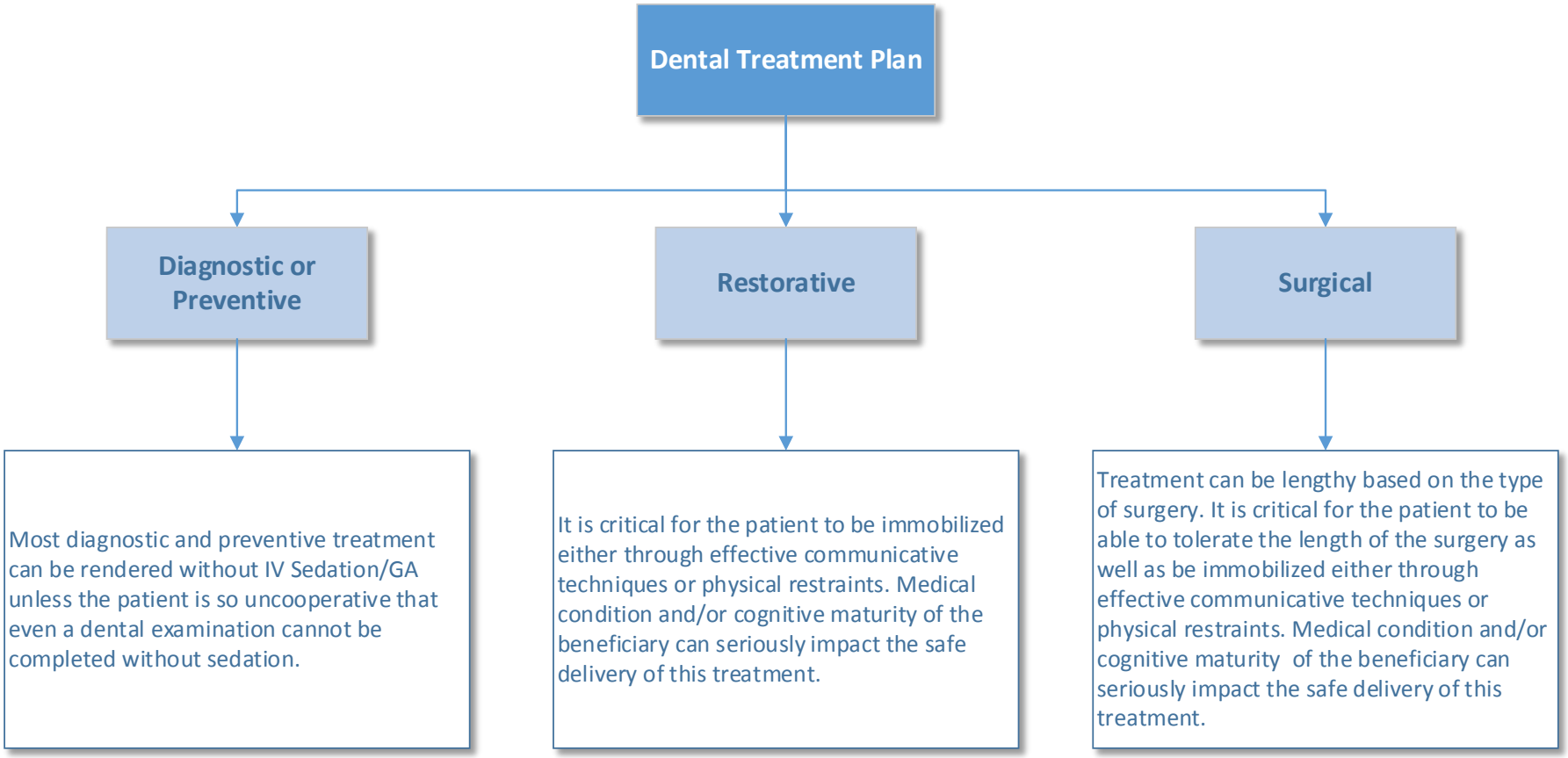
Scenario 2 – Dental Only Surgery Center

Beneficiary Enrolled in:	DMC Plan + MCMC	Medi-Cal Dental FFS + MCMC	DMC Plan + Medi-Cal Medical FFS	Medi-Cal Dental FFS + Medi-Cal Medical FFS
Medical Anesthesiologist OR Certified Registered Nurse Anesthetist	• MCP pays anesthesiologist • MCP pays facility fees	• MCP pays anesthesiologist • MCP pays facility fees	• Medi-Cal Medical FFS pays anesthesiologist • Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider	• Medi-Cal Medical FFS pays anesthesiologist • Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider
Submit Prior Authorization/Treatment Authorization Request to:	MCP for anesthesia and facility fees	MCP for anesthesia and facility fees	CAASD Field Office (ETAR) for anesthesia and facility fees if DOSC is an enrolled Medi-Cal provider	CAASD Field Office (ETAR) for anesthesia and facility fees if DOSC is an enrolled Medi-Cal provider
Dental Anesthesiologist	• DMC Plan pays anesthesiologist • MCP pays facility fees	• Denti-Cal pays anesthesiologist • MCP pays facility fees	• DMC Plan pays anesthesiologist • Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider	• Denti-Cal pays anesthesiologist • Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider
Submit Prior Authorization/Treatment Authorization Request to:	• DMC Plan for anesthesia fees • MCP for facility fees	• Denti-Cal for anesthesia fees • MCP for facility fees	• DMC Plan for anesthesia fees • CAASD Field Office (ETAR) for facility fees if DOSC is an enrolled Medi-Cal provider	• Denti-Cal for anesthesia fees • CAASD Field Office (ETAR) for facility fees if DOSC is an enrolled Medi-Cal provider

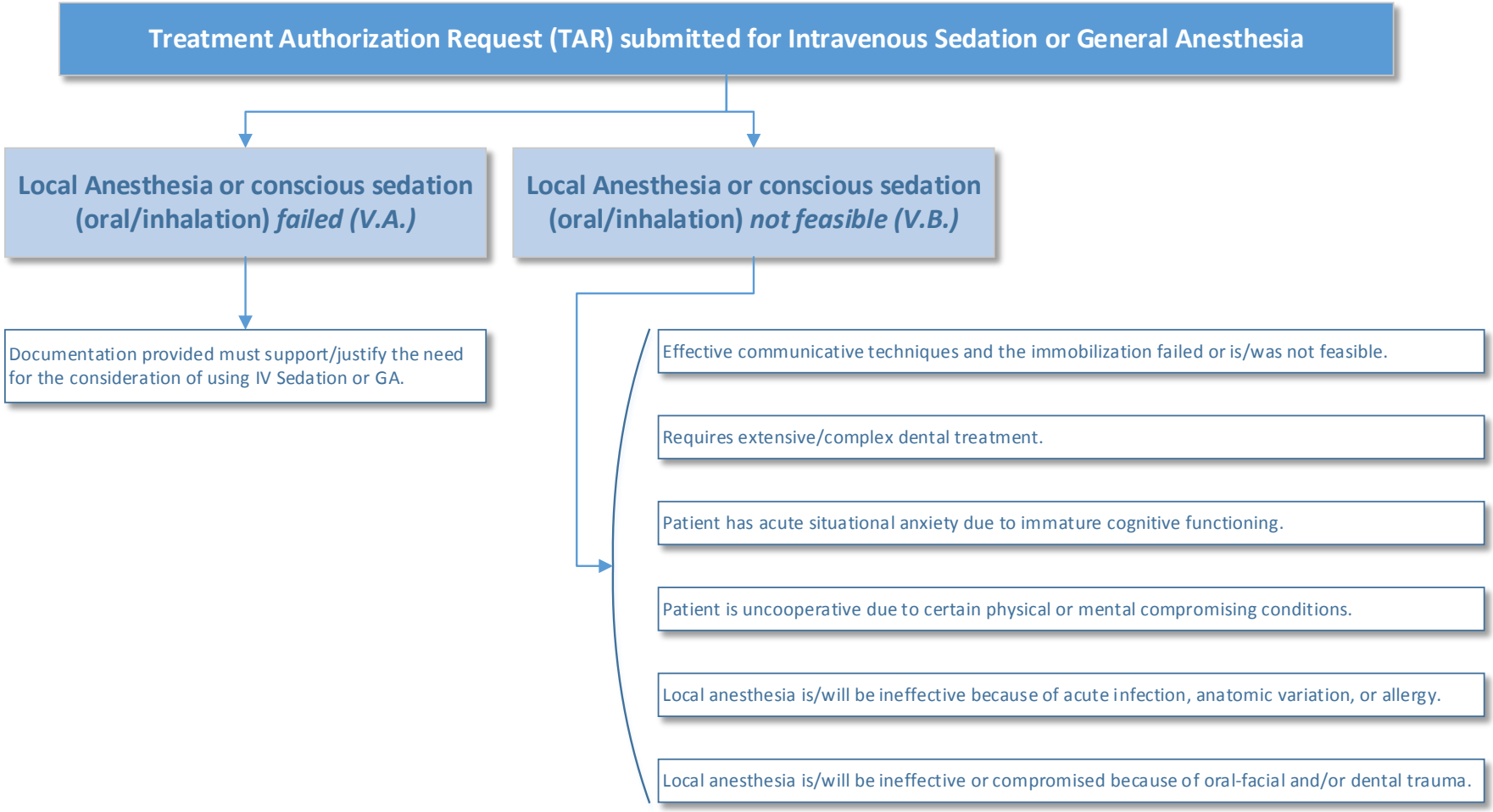
Scenario 3 – Ambulatory Surgery Center and General Acute Care Hospitals

Beneficiary Enrolled in:	DMC Plan + MCMC	Medi-Cal Dental FFS + MCMC	DMC Plan + Medi-Cal Medical FFS	Medi-Cal Dental FFS + Medi-Cal Medical FFS
Medical Anesthesiologist OR Certified Registered Nurse Anesthetist	• MCP pays anesthesiologist • MCP pays facility fees	• MCP pays anesthesiologist • MCP pays facility fees	• Medi-Cal Medical FFS pays anesthesiologist • Medi-Cal Medical FFS pays facility fees	• Medi-Cal Medical FFS pays anesthesiologist • Medi-Cal Medical FFS pays facility fees
Submit Prior Authorization/Treatment Authorization Request to:	MCP for anesthesia and facility fees	MCP for anesthesia and facility fees	CAASD Field Office (ETAR) for anesthesia and facility fees	CAASD Field Office (ETAR) for anesthesia and facility fees
Dental Anesthesiologist	• DMC Plan pays anesthesiologist • MCP pays facility fees	• Denti-Cal pays anesthesiologist • MCP pays facility fees	• DMC Plan pays anesthesiologist • Medi-Cal Medical FFS pays facility fees	• Denti-Cal pays anesthesiologist • Medi-Cal Medical FFS pays facility fees
Submit Prior Authorization/Treatment Authorization Request to:	• DMC Plan for anesthesia fees • MCP for facility fees	• Denti-Cal for anesthesia fees • MCP for facility fees	• DMC Plan for anesthesia fees • CAASD Field Office (ETAR) for facility fees	• Denti-Cal for anesthesia fees • CAASD Field Office (ETAR) for facility fees

Attachment 2. Policy/Criteria (Modified from information provided by DHCS/Denti-Cal)



Extensive dental treatment is not defined by the number of procedures rendered but the treatment that can be reasonably tolerated and rendered in a safe and humane fashion based on cognitive maturity and medical condition of the beneficiary.



When a provider determines that a beneficiary meets one of the criteria of V.B., it is not automatically considered to be documentation that local anesthesia or conscious sedation was not feasible; rather the submitted documentation of the criteria that was met must be clearly stated in the patient's records and the submitted documentation requesting IV sedation/GA must clearly demonstrate the need for this service.