IEHP UM Subcommittee Approved Authorization Guidelines

Intravenous Sedation and General Anesthesia Coverage for Dental Services

Policy:

Intravenous sedation and general anesthesia are considered medically necessary for individuals undergoing needed dental procedures who are unable to tolerate the dental procedures using behavior modification or less invasive forms of anesthesia (e.g. local anesthesia and conscious sedation.) Intravenous sedation and general anesthesia are available options based on the medical needs of the individual when certain conditions exist.6

When sedation is being considered, the least profound procedure should be attempted first. The procedures are ranked from low to high profundity in the following order: conscious sedation via inhalation or oral anesthetics, intravenous sedation, then general anesthesia.

A. Intravenous (IV) sedation and general anesthesia shall be considered when the provider provides clear medical documentation of both (1 and 2) of the following: 6:

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient.
2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient.

B. When the above criteria is met, intravenous (IV) sedation and general anesthesia shall be considered for any of the following conditions (1 through 4):

1. Use of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient.
2. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
3. Patient has acute situational anxiety due to immature cognitive functioning.
4. Patient is uncooperative due to certain physical or mental compromising conditions.

C. General anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center will be covered for beneficiaries less than seven years of age.1

Reimbursement must take place for contractually covered prescription drugs, laboratory services, pre-admission physical examinations required for dental offices, admission to ambulatory medical surgical settings or an inpatient hospital for a dental procedure, and facility fees, as
applicable. See Appendix B for reimbursement scenarios.

CPT Coding:
- Intravenous conscious sedation: D9241
- Intravenous analgesia: D9242
- Deep sedation: D9220
- General anesthesia: D9221

**Benefit Coverage:**

*Title XXII Regulation 51303 General Provisions:*
“Health care services which are reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury are covered by the Medi-Cal program and subject to utilization controls.”

**ALL PLAN LETTER 15-012 (August 21, 2015):**
Describes the requirement for Medi-Cal managed care health plans (MCPs) to cover intravenous (IV) sedation and general anesthesia services provided by a physician in conjunction with dental services for managed care beneficiaries in hospitals, ambulatory medical surgical settings, or dental offices. Identifies the information the MCPs must review and consider during the prior authorization process including the criteria indicating the medical necessity for intravenous sedation and general anesthesia.

**Benefit Description:**
Anesthesia care may include but is not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedures. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services; e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry.

Note:
1. May be given by Nurse Anesthetist (CRNA), within the scope of his/her license.
2. General anesthesia (when not covered by the Member’s Dental Provider) and associated facility charges for dental procedures rendered in the hospital or surgery center setting are the health plan’s financial responsibility.
CMS has issued guidelines for children's dental care and Medicaid programs which include both the concepts of "Dental Home" and behavior management.7

“Dental Home”

Primary pediatric oral health care is best delivered in a “dental home” where competent oral health care practitioners provide continuous and comprehensive services. Ideally a dental home should be established at a young age (i.e., by 12 months of age in most high-risk populations) while caries and other disease processes can be effectively managed with minimal or no restorative or surgical treatment. An adequate dental home should be expected to provide children and their parents with:

A. An accurate examination and risk assessment for dental diseases,
B. An individualized preventive dental health program based upon the examination and risk assessment,
C. Anticipatory guidance about growth and developmental issues (e.g., teething, thumb or pacifier habits),
D. Advice for injury prevention and a plan for dealing with dental emergencies,
E. Information about proper care of the child’s teeth and supporting structures,
F. Information about proper diet and nutrition practices,
G. Pit and fissure sealants,
H. A continuing care provider that accomplishes restorative and surgical dental care in a manner consistent with the parents’ and child’s psychological needs,
I. Interceptive orthodontic care for children with developing malocclusions,
J. A place for the child and parent to establish a positive attitude about dental health,
K. Referrals to dental specialists such as endodontists, oral surgeons, orthodontists, pediatric dentists and periodontists when care cannot be directly provided within the dental home, and
L. Coordination of care with the infant/child’s primary care medical provider.

Evaluation and preparation of pediatric patients undergoing anesthesia is of critical importance in order to assure appropriate utilization of services and quality of care in this vulnerable population. Significant involvement of primary care providers (PCPs) in the medical evaluation and psychological preparation of children for anesthesia is an important prerequisite according to the American Academy of Pediatrics. The PCP’s participation is necessary to insure that the child’s medical issues are clearly defined and that the physiologic impact of general anesthesia, are well delineated.

PCP preoperative evaluation should include but not be limited to:

1. History of present illness (e.g., hemodynamic, respiratory, renal status, etc.);
2. Past and current medical history (e.g., past surgical events);
3. Medications (e.g., aspirin, NSAIDs, etc.);
4. Known allergies;
5. Previous anesthetic experiences;
6. Family history (e.g., anesthetic related complications);
7. Physical examination (e.g., airway, cardiovascular, respiratory, and neurologic systems); and
8. Pertinent laboratory evaluation.

**Behavior Management:**

It has been estimated that 85 percent of children are generally cooperative in dental treatment settings, while the remaining 15 percent require more advanced behavior management approaches in order to provide dental care. Behavior management has been defined as the purposeful application of accepted techniques – both pharmacological and non-pharmacological – to reduce fear and anxiety, enhance cooperation, and effect treatment. Descriptions of common behavior management techniques used in pediatric dentistry can be found in *Appendix A: Clinical Issues* (see attached). A more complete description of techniques, rationale and indications for various approaches can be found in the Reference Manual of the American Academy of Pediatric Dentistry, available on the Internet at [www.aapd.org](http://www.aapd.org).

Behavioral management of anxious children, who are unable to readily accept even routine dental treatment, often require additional time on the part of practitioners and support personnel to provide dental procedures. Dentists may be reluctant to treat very young children and those with disabling conditions. This can contribute to limited access to care for both groups of children. Therefore, it is important that dentists receive adequate training in behavior management to be able to provide care for Medicaid children.

**Examples of Covered Benefits:**

A. Intravenous sedation with or without general anesthesia when behavior management has been unsuccessful or deemed inappropriate due to individual case circumstances.

B. General anesthesia provided in conjunction with dental services for members in a hospital or surgery center, when local anesthesia and conscious sedation have been unsuccessful or deemed inappropriate due to individual case circumstances.

**Effective Date:** January 26, 2006

**Reviewed Annually:** November 9, 2016

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<th>Revised:</th>
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<td>May 11, 2016</td>
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Bibliography:

1. Assembly Bill number 2003, Chapter 790

Disclaimer

IEHP Clinical Authorization Guidelines (CAG) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Authorization Guidelines (CAG) express IEHP's determination of whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. IEHP has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). IEHP makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Authorization Guidelines (CAG). IEHP expressly and solely reserves the right to revise the Clinical Authorization Guidelines (CAG), as clinical information changes.
Behavior Management:

It has been estimated that 85 percent of children can cooperate for dental treatment, while the remaining 15 percent will require behavior management of some type in order to effect dental treatment. While definitions may vary, behavior management can be defined as purposeful application of accepted techniques, both pharmacologic and non-pharmacologic, to reduce fear and anxiety, enhance cooperation and effect treatment. Behavior management is a skill acquired by a provider through training and enhanced with experience. Behavioral management of anxious and children who are unable to cooperate easily in the traditional dental office may require additional time on the part of the provider for a dental procedure that would otherwise be provided in less time.

Techniques:

Communicative (non-aversive) techniques are considered inherent in care of children. These include tell-show-do, voice control, positive reinforcement and distraction. These techniques are used routinely to effect treatment in the pediatric population and are indicated when a child shows mild anxiety, failure to attend, or mild disruptive behavior. It is assumed that a general consent for dental care encompasses the dentist's use of these techniques. The cost of these services is usually assumed within the fee for the service. On occasion, a clearly necessary dental service may be made substantially more difficult because of inability of the patient to easily cooperate in receiving the service as a result of anxiety, inappropriate behaviors, or mental or other disability. Such situations may require the dentist to devote substantially more time than normal to communicative behavioral techniques in an effort to provide the service while avoiding the need for additional, more invasive behavioral management techniques. Since the additional time spent when such situations arise substantially increases the cost of providing the service, state Medicaid programs may wish to consider separate reimbursement for extensive use of communicative behavior management techniques. A separate procedure code ("behavioral management, by report") is available for such use in the American Dental Association's Code on Dental Procedures and Nomenclature, Current Dental Terminology (CDT-3)

Non-communicative techniques include immobilization, analgesia (nitrous oxide), sedation and general anesthesia. These techniques are considered supplemental to routine care and as such require additional consent. These techniques are covered and reported using separate procedure codes in the American Dental Association's Code on Dental Procedures and Nomenclature, Current Dental Terminology (CDT-3). These procedures also are detailed in the Guidelines for Behavior Management of the American Academy of Pediatric Dentistry in the AAPD Reference Manual.

Immobilization is used to prevent injury to patient and providers. Immobilization can require additional staff, caretakers and/or devices to safely constrain movement that might be dangerous to patient or staff or affect quality of care.
Indications: Patient is unwilling or unable to control movements and presents a danger to staff or self during treatment procedures deemed necessary.

Contraindications: Immobilization cannot be used as punishment or when it presents risk of injury to the patient.

Analgesia (Nitrous Oxide-Oxygen Analgesia) is an inhalation technique using a combination of nitrous oxide and oxygen in concentrations that relax, but do not render a patient unconscious. Indications: Analgesia can be used for the anxious or obstreperous child, certain CSHN, patients with hyperreflexia of the gag reflex, and for those with inadequate response to local anesthetic. Contraindications: Certain pulmonary conditions, emotional illnesses, drug dependencies, pregnancy may be contraindications to analgesia.

Sedation is administration of a centrally acting pharmacologic agent orally, intravenously, rectally, intranasally, or submucosally to induce a level of consciousness that will permit safe and effective dental care. A complete perspective of the use of sedation in children can be found in guidelines for use of conscious sedation from the American Academy of Pediatric Dentistry. Indications: Children who are anxious or uncooperative for dental care, whose health status permits use of sedative agents, and who, in the judgment of the dentist or from previous ineffective care under other behavioral techniques, are best treated with this technique. Contraindications: Children whose health status precludes use of sedative agents or whose dental disease status requires or permits utilization of alternative methods.

General Anesthesia is a technique in which a child is rendered unconscious with a single or combination of pharmacologic agents. General anesthesia is most appropriately administered in an approved facility by a trained provider. A complete description of general anesthesia and indications for its use can be found in the Guidelines for Behavioral Management of the American Academy of Pediatric Dentistry. Indications: Children whose physical, mental, or medical condition precludes other behavior management choices, who are pre-operative, and whose dental needs merit treatment best performed under general anesthesia. Contraindications: Children whose dental needs are minor and those children whose medical status precludes use of general anesthesia.
# APPENDIX B: Intravenous Sedation and General Anesthesia:

## Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios

### Scenario 1 – Dental Office

<table>
<thead>
<tr>
<th>Beneficiary Enrolled in:</th>
<th>DMC Plan + MCMC</th>
<th>Medi-Cal Dental FFS + MCMC</th>
<th>DMC Plan + Medi-Cal Medical FFS</th>
<th>Medi-Cal Dental FFS + Medi-Cal Medical FFS</th>
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<td>Medical Anesthesiologist</td>
<td>MCP pays anesthesiologist</td>
<td>MCP pays anesthesiologist</td>
<td>Medi-Cal Medical FFS pays anesthesiologist</td>
<td>Medi-Cal Medical FFS pays anesthesiologist</td>
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<td>Submit Prior Authorization/Treatment Authorization Request to:</td>
<td>MCP for anesthesia fees</td>
<td>MCP for anesthesia fees</td>
<td>CAASD Field Office (ETAR) for anesthesia fees</td>
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<td>Dental Anesthesiologist</td>
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<td>Denti-Cal pays anesthesiologist</td>
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### Scenario 2 – Dental Only/Surgery Center

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<th>Beneficiary Enrolled in:</th>
<th>DMC Plan + MCMC</th>
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<tbody>
<tr>
<td>Medical Anesthesiologist OR Certified Registered Nurse Anesthetist</td>
<td>• MCP pays anesthesiologist • MCP pays facility fee</td>
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<td>• Medi-Cal Medical FFS pays anesthesiologist • Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider</td>
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