Anesthesia or Sedation for Dental Procedures

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Pediatric patients and occasionally adults can present special circumstances that make routine in-office dental treatment difficult or impossible. In these cases it may be necessary to use controlled anesthesia in order to perform necessary dental procedures safely. Facility charges (free standing or hospital based), licensed medical or dental providers, anesthesiologists, and assistant physicians may be coverable under the member's medical benefit if criteria is met.

This policy pertains to outpatient surgical procedures and settings. The term "hospitalization" as used in this policy shall mean admission to an ambulatory surgical facility whenever possible and appropriate, or to a hospital facility if special clinical circumstances warrant. Additional medical review will determine if a hospital stay is coverable.

Criteria

Commercial

Prior authorization is required.

I. **Pediatric Medical/Dental Benefit:** This benefit is limited to one time per year (calendar or plan per member benefit plan). PacificSource considers pediatric medical/dental benefit medically necessary when **ALL** of the following criteria is met:

- Patient is under the age of seven (7), has a behavioral health diagnosis **OR** has a developmental disorder preventing the child from cooperating with dental treatment;
- Extensive treatment needs involving multiple quadrants (e.g., extraction, root or pulp procedures or deep drilling) are required at one session due to one of the following: severity of disease, acute abscess resulting in pain, infection or near-term jeopardy to dental integrity; **and**

- Clinical documentation of failed treatment attempts utilizing behavioral interventions and/or conscious sedation.

Exclusions

Anesthesia secondary to the patient's apprehension or for convenience of dentist/family is not covered. See member benefit book for contract language exclusions.

II. Hospitalization for Dental Procedures Benefit:

PacificSource considers hospitalization for dental procedures medically necessary when **ALL** of the criteria is met:

- The member has a medical or physical condition that requires monitoring during dental procedures (e.g., coronary disease, asthma, chronic obstructive pulmonary disease (COPD), heart failure, serious blood/bleeding disorder, unstable diabetes/hypertension, or developmental disability/autism).

Exclusions

Hospitalization secondary to the patient's apprehension or convenience is not covered. See member benefit book for contract language exclusions.

Medicaid

PacificSource Community Solutions (PCS) follows Oregon Health Plan (OHP) per Oregon Administrative Rules (OAR) 410-123-1000 to 1640 for coverage of Anesthesia or Sedation for Dental Procedures.

PCS covers facility and anesthesia charges for children and adults as part of Hospital Dentistry cases, in accordance with OAR 410-123-1490 and in coordination with Dental Care Organizations (DCOs). Prior Authorization (PA) is required according to the following process:

1. The dental provider submits a first-level Hospital Dentistry PA request to the appropriate DCO.
2. The DCO reviews the request and any and all clinical documentation to ensure appropriateness and that the request meets the required criteria in OAR 410-123-1490.
3. The DCO then issues to the dental provider an approval or denial notice/letter.
4. The dental provider or facility submits the anesthesia PA, DCO approval notice/letter, and facility PA to PCS for final review.

PCS reviews, makes a decision, and sends the PA Approval notice to the dental provider, the facility, anesthesia group (such as M2), and the DCO. If the PA request from the provider or facility does not include the DCO approval notice/letter, PCS will deny the PA request.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS criteria, evidence-based criteria, and internal policy guidelines, requests are reviewed on an individual basis for determination of coverage and medical necessity.

Appendix

Policy Number:

Effective: 7/1/2020 **Next review:** 6/1/2023

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s):

Commercial Ops: 6/2022

Government Ops: 6/2022