IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Intravenous Sedation and General Anesthesia for Dental Services	**Guideline #**	UM_DEN 01
		Original Effective Date	01/26/06
Section	Dental	**Revision Date**	09/19/18

COVERAGE POLICY

Intravenous sedation and/or general anesthesia are considered medically necessary for individuals 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/or 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. For Members 6 years of age and younger, intravenous (IV) sedation and/or general anesthesia shall be considered when the provider provides clear medical documentation of the following:
    1. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient.
B. For Members 7 years of age and older, intravenous (IV) sedation and/or general anesthesia shall be considered when the provider provides clear medical documentation of both 1 and 2: [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.
    3. Once criteria 1 and 2 are met, intravenous (IV) sedation and/or general anesthesia shall be considered for any one of the following additional conditions:
        i. 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
        ii. 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.
        iii. Patient has acute situational anxiety due to immature cognitive functioning.
        iv. Patient is uncooperative due to certain physical or mental compromising conditions.

C. Individuals may receive treatment for dental procedure provided under general anesthesia by a physician anesthesiologist in the settings listed below only if the plan determines the setting is appropriate and according to the criteria above:
    1. Hospital;
    2. Accredited ambulatory surgical center (stand-alone facility);
    3. Dental office; and
    4. A community clinic that:
        i. Accepts Medi-Cal dental program (Denti-Cal or DMC plan) beneficiaries;
        ii. Is a non-profit organization; and
        iii. 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.

D. 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 A for reimbursement scenarios.

E. 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

CPT Coding:

Intravenous conscious sedation	D9241
Intravenous analgesia	D9242
Deep sedation	D9220
General anesthesia	D9221

COVERAGE LIMITATIONS AND EXCLUSIONS

N/A

ADDITIONAL INFORMATION

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:

1. An accurate examination and risk assessment for dental diseases,
2. An individualized preventive dental health program based upon the examination and risk assessment,
3. Anticipatory guidance about growth and developmental issues (e.g., teething, thumb or pacifier habits),
4. Advice for injury prevention and a plan for dealing with dental emergencies,
5. Information about proper care of the child’s teeth and supporting structures,
6. Information about proper diet and nutrition practices,

7. Pit and fissure sealants,
8. A continuing care provider that accomplishes restorative and surgical dental care in a manner consistent with the parents' and child's psychological needs,
9. Interceptive orthodontic care for children with developing malocclusions,
10. A place for the child and parent to establish a positive attitude about dental health,
11. 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
12. 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 are provided below*:* 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.

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.

CLINICAL/REGULATORY RESOURCE

Department of Health Care Services All Plan Letter 15-012 (August 21, 2015)
Describes the requirements 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 that MCPs must review and consider during the prior authorization process including the criteria indicating the medical necessity for intravenous sedation and general anesthesia.

In addition, provider shall adhere to all regulatory requirements regarding intravenous sedation and general anesthesia, including:

- Preoperative and perioperative care
- Monitoring and equipment requirements
- Emergencies and transfers
- Monitoring guidelines

DEFINITION OF TERMS

N/A

REFERENCES

1. Assembly Bill number 2003, Chapter 790
2. American Academy of Pediatric Dentistry Reference Manual, Chicago, IL: American Academy of Pediatric Dentistry. 2015.
3. U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U. S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
4. American Academy of Pediatric Dentistry Reference Manual, Chicago, IL: American Academy of Pediatric Dentistry. 2000.
5. U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U. S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000
6. Department of Health Care Services. ALL PLAN LETTER 15-012 (REVISED), "Dental Services – Intravenous Sedation and General Anesthesia Coverage," August 21, 2015.
7. CMS Department of Health and Human Services, "Guide to Children's Dental Care in Medicaid," October 2004.

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.

APPENDIX A: Intravenous Sedation and General Anesthesia:

Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios[6]

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 – 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 fees and for facility fees	MCP for anesthesia fees and for facility fees	CAASD Field Office (ETAR) for anesthesia fees and for facility fees	CAASD Field Office (ETAR) for anesthesia fees and for 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