

Medicare Medical Policy

Dental Anesthesia Services

MEDICARE MEDICAL POLICY NUMBER: 328

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Notes:

- Please see medical policy *Dental Services: Administrative Guidelines (Medicare Only)* (MP162) for guidance regarding Medicare coverage of other dental services, including guidance regarding determinations for “dental vs. medical” coverage.
- This policy does not address dental anesthesia performed in a dental office, which should be reviewed under the member’s dental benefit.
- This policy can be used to address rare circumstances for which dental anesthesia may be potentially eligible for coverage as a medical benefit for select circumstances.

Service	Medicare Guidelines
<p>IMPORTANT NOTE: The CMS references below are intended to provide instruction on how Medicare might categorize a procedure as either medical or dental in nature, as well as CMS coverage (or non-coverage) position statements regarding dental anesthesia services in general. According to Medicare, “[i]tems and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.”^{1,2} In addition, Medicare also states, “[c]overage is not determined by the value or the necessity of the dental care but by the type of service provided and the anatomical structure on which the procedure is performed.”³</p>	
<p><i>Anesthesia services for dental procedures</i></p>	<p style="text-align: center;">Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services §150 - Dental Services</p> <p style="text-align: center;">Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage §140 - Dental Services Exclusion</p> <p>According to both of these Medicare manual references, coverage of services such as the administration of anesthesia, x-rays, and other related procedures are covered “depends upon whether the primary procedure being performed by the dentist is itself covered...” Therefore:</p>

- If the primary procedure is determined to be a **covered** dental service under the member’s plan, then the administration of anesthesia (including general anesthesia) may be eligible for coverage as well when Medicare’s coverage requirements in the aforementioned coverage manual are met and if a covered benefit within the member EOC (note that individual member EOC language may have general dental anesthesia coverage specifically called out).
- If the primary dental procedure is determined to be a **non-covered** service under the member’s plan, then the administration of anesthesia would also be non-covered, even if necessary to successfully perform the non-covered procedure.

See *Policy Guidelines* below regarding services rendered in a hospital setting in connection with a non-covered dental procedure.

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member’s benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (*Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021*)

POLICY CROSS REFERENCES

- [Dental Services: Administrative Guideline](#), MP162

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

BACKGROUND

Medicare payment can be made under Part A and Part B for ancillary services and supplies incident to the **covered** dental services, such as the administration of anesthesia.

In situations when an inpatient hospitalization may be eligible for coverage due to a patient's underlying medical condition and clinical status or the severity of a non-covered dental procedure, other services provided in connection with the non-covered dental service still may not be covered. According to Medicare, “(r)egardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with noncovered dental services are **not covered**. **The services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.**”⁴

Therefore, the need for inpatient hospitalization alone does not make the dental procedure “medically necessary” or covered if it is not a covered benefit under the member’s EOC.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

Dental codes which determine coverage under the supplemental dental benefit and therefore, dental codes should be used to report for dental services.

While for some procedures the use of unlisted code 41899 may be appropriate, a dentist using this code to generically report for "hospital and anesthesia" services is considered incorrect coding. Procedure codes should only be used to report for procedural services performed by a single provider of services. The hospital facility (and anesthesiologist, if a separate provider of services) would submit separate claims for the services they render to an individual and the dentist should not duplicate these services by also trying to report for the hospital and anesthesia services on their dental claim form.

Effective January 1, 2023, the Centers for Medicare and Medicaid Services (CMS) created HCPCS code G0330. Note that Medicare states payment for this code only applies to situations that meet Medicare criteria for coverage of dental services, which are limited. The development and use of this code are **not** meant to imply coverage of all dental services in a facility setting.

CODES*		
CPT	41899	Unlisted procedure, dentoalveolar structures
HCPCS	G0330	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room

*Coding Notes:

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services*)

- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §150 - Dental Services. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>. Last updated 2023. Accessed 08/08/2023.
2. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §140 - Dental Services Exclusion. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf>. Last updated 2014. Accessed 08/08/2023.
3. Medicare Dental Coverage Web page. <https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage>. Last updated 2023. Accessed 08/08/2023.
4. Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A, §70 - Inpatient Services in Connection With Dental Services. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf>. Last updated 2021. Accessed 08/08/2023.
5. Medicare Final Rule; *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID-19*; Available at: <https://public-inspection.federalregister.gov/2022-23918.pdf>. Last updated 2022. Accessed 08/08/2023.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
1/2023	Q1 2023 code updates (converted to new format 2/2023)
10/2023	Annual review; no criteria change