MEDICAL POLICY	Dental Anesthesia Services (Medicare Only)
Effective Date: 12/01/2021  12/1/2021 Medical Officer Date	Medical Policy Number: 328 Medical Policy Committee Approved Date: 10/2021

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

- Please see medical policy "Dental Services: Administrative Guidelines (Medicare Only) – MP # 162" for guidance regarding Medicare coverage of other dental services.

Service	Medicare Guidelines
IMPORTANT NOTE: "Items 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] Thus, dental services, or services rendered in connection to non-covered dental procedure, are statutorily excluded under Original Medicare. In addition, "[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] As a Medicare Advantage Organization (MAO), the Company may offer a Supplemental Dental Benefit Option. However, even with a supplemental Dental Benefit, plan covered dental procedures are limited. The requested item or service must be included in the evidence of coverage (EOC) as a service covered under the supplemental dental benefit **and** must also fall within any established dental benefit limits (e.g., annual maximums). Dental procedures and	

associated services which are ***not*** included as covered dental benefits within the EOC or services rendered that exceed set benefit limits will be considered non-covered. Due to added premium cost for this supplemental benefit, not all Medicare Advantage members may opt to purchase this additional benefit. Dental eligibility will need to be confirmed individually.	
Anesthesia services for dental procedures	Medicare Benefit Policy Manual Chapter 15 - Covered Medical and Other Health Services §150 - Dental Services Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage §140 - Dental Services Exclusion 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…" While a 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, for non-covered dental procedures rendered in an inpatient hospital setting, 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: ➢ 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. ➢ If the primary procedure is determined to be a ***non-covered*** dental 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.

BILLING GUIDELINES

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.

CPT/HCPCS CODES

Medicare Only	
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
41899	Unlisted procedure, dentoalveolar structures

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

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.

MEDICAL POLICY CROSS REFERENCES

Dental Anesthesia Services (All Lines of Business Except Medicare)
Dental Services: Administrative Guideline (All Lines of Business Except Medicare)
Dental Services: Administrative Guideline (Medicare Only)

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 2021. Accessed 09/22/2021.
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 09/22/2021.
3. Medicare Dental Coverage Web page. https://www.cms.gov/medicare/coverage/medicaredentalcoverage?redirect=/medicaredentalcoverage/. Last updated 2013. Accessed 09/22/2021.
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 2017. Accessed 09/24/2021.