

Medicare Medical Policy

Dental Anesthesia Services

MEDICARE MEDICAL POLICY NUMBER: 328

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Next Annual Review: 9/2027

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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 the Medicare medical policy *Administrative Guidelines for Dental Services* (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
<i>Anesthesia services for dental procedures</i>	COVERED SERVICES While dental services are generally excluded under Medicare, there are some services which may be eligible for coverage under limited circumstances. These include: • Inpatient hospital services connected to dental services when the patient requires hospitalization because of one of the following: ○ The patient’s underlying medical condition and clinical status; or ○ The severity of the dental procedure • Dental services, as well as anesthesia, x-rays, operating room use and other related procedures, when inextricably linked to the clinical success of other Medicare-covered procedures or services. Examples include, but are not limited to: ○ Dental or oral exams as part of a comprehensive workup prior to organ transplant, hematopoietic stem cell transplant, or bone marrow transplant. ○ Cardiac valve replacement. ○ Valvuloplasty procedures. ○ Chemotherapy for cancer treatment. ○ Chimeric antigen receptor (CAR) T-cell therapy for cancer treatment.

- Administration of high-dose bone-modifying agents (antiresorptive therapy) when used to treat cancer.
- Dental or oral exams as part of a comprehensive workup prior to, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with, and medically necessary diagnostic and treatment services to address dental or oral complications after, Medicare-covered treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these
- Dental ridge reconstruction done as a result of and at the same time as surgery to remove a tumor.
- Services to stabilize or immobilize teeth related to reducing a jaw fracture.
- Dental splints, only when used as part of covered treatment of a covered medical condition such as dislocated jaw joints.
- Dental or oral examination performed as part of a comprehensive workup prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of ESRD.
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of ESRD.

NOTE: *This potential coverage does **not** extend to services linked to non-covered dental procedures, such as the provision of implants, crowns or dentures, as these remain non-covered as "dental in nature." In addition, this does not extend to dental services prior to immunosuppressant therapy, joint replacement surgeries, or other surgical procedures, nor was it extended to payment for routine dental care for patients with (or at risk of developing) medical conditions such as diabetes, cardiovascular disease, some lung diseases, or physical and cognitive impairments that impact individuals' ability to perform activities of daily living (including tooth brushing). (Source: [CMS 11/18/2022 Final Rule CMS-1770-F](#))*

NON-COVERED SERVICES

Under [Section 1862\(a\)\(12\) of the Social Security Act](#) and [42 CFR 411.15\(i\)](#), Medicare does **not** cover items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. These structures supporting teeth include periodontium, which includes:

- Gingivae
- Dentogingival junction
- Periodontal membrane
- Cementum
- Alveolar bone (alveolar process and tooth sockets)

Under Medicare, these are classified as "dental services," and as such are direct Medicare "coverage exclusions."

Examples of non-covered dental services include, but are not limited to, the following:

- Routine dental care (services for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth).
- Extraction of an impacted tooth.
- Dental services, when performed in connection with excluded services, such as preparation of the mouth for dentures, including:
 - Alveoplasty (surgical improvement of the shape and condition of the alveolar process).
 - Dental ridge reconstruction.
 - Frenectomy.
 - Removing the torus palatinus (a bony growth on the roof of the mouth).
 - Dental services related to other non-covered services
 - Alveolar bone (alveolar process and tooth sockets)

EXCEPTION: *While these services are non-covered under Original Medicare, Medicare Advantage members may have coverage for some of these services when available as a supplemental dental benefit under their specific MAO EOC. Confirm coverage for each individual member before issuing a denial.*

MEDICARE REFERENCES/CITATIONS

- [Medicare Dental Coverage](#) web page
- Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5 – Definitions, [§70.2 - Dentists](#)
- 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](#)
- Medicare Benefit Policy Manual, Chapter 1: Inpatient Hospital Services Covered Under Part A, [§70 - Inpatient Services in Connection With Dental Services](#)
- National Coverage Determination (NCD) for Dental Examination Prior to Kidney Transplantation ([260.6](#))
- Noridian, Jurisdiction F (JF) – [Medicare Part B, Dental Services](#)

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:

- 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

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

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

POLICY GUIDELINES

BACKGROUND

[Effective January 2023, in a Federal Register, CMS finalized a ruling](#) to expand their dental position to recognize that there are instances where dental services are so integral to other medically necessary services that such dental services are inextricably linked to the clinical success of an otherwise covered medical service, and therefore, are substantially related and integral to that primary medical service, making certain dental procedures in select clinical situations also eligible for coverage.

In such situations, Medicare payment can be made under Part A and Part B for ancillary services and supplies incident to the **covered** dental services, including 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. Centers for Medicare and Medicaid Services (CMS). 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 7/15/2026.
2. CMS. 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 2003. Accessed 7/15/2026.
3. CMS. Medicare Dental Coverage. <https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage>. Last updated 2026. Accessed 7/15/2026.
4. CMS. 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 2003. Accessed 7/15/2026.
5. CMS. 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 7/15/2026.

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
10/2024	Annual review; no criteria change
10/2025	Annual review; no criteria change
10/2026	Annual review; no criteria change