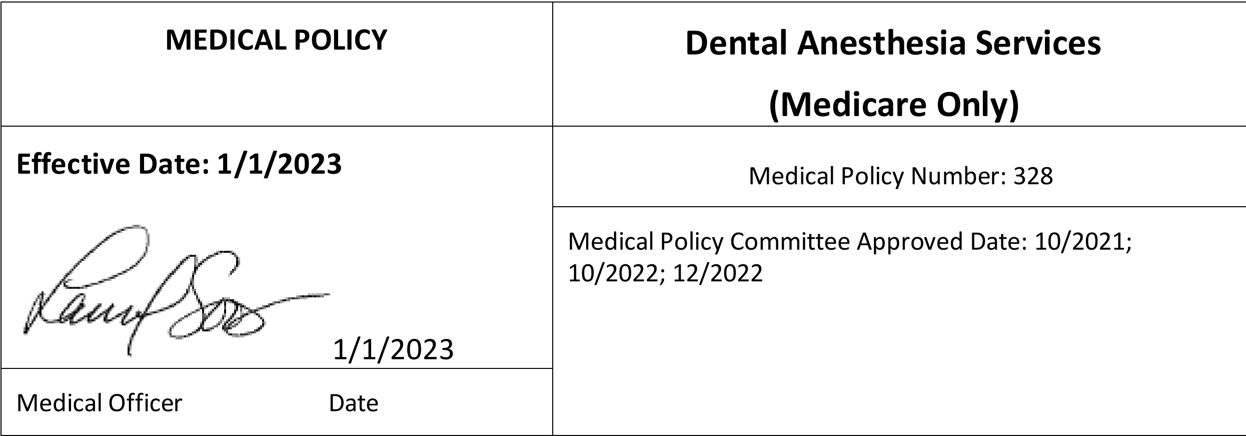

MEDICAL POLICY	Dental Anesthesia Services (Medicare Only)
Effective Date: 1/1/2023	Medical Policy Number: 328
1/1/2023	Medical Policy Committee Approved Date: 10/2021; 10/2022; 12/2022
Medical Officer Date	

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.

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
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]	
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**…" 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.

POLICY GUIDELINES

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

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.

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.

CPT/HCPCS CODES

Medicare Only	
No Prior Authorization Required	
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
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 Services: Administrative Guideline (Medicare Only), MP162

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 2022. Accessed 09/12/2022.
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 09/12/2022.
3. Medicare Dental Coverage Web page. https://www.cms.gov/medicare/coverage/medicaredentalcoverage?redirect=/medicaredentalcoverage/. Last updated 2021. Accessed 09/12/2022.
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 09/12/2022.
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 11/18/2022.