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Northwest Region Utilization Review

UR 56 Dental Anesthesia Policy and Medical Necessity Criteria

Department: Northwest Permanente
Applies to: KPNW Region/NW UM Physician
Review Responsibility: PDA Dental Services Hospital Operating Room Committee; UROC
Subject Matter Expert: Michael Plunkett, DDS

Number: UR 56
Effective: 04/10
Last Reviewed: 10/22, 9/23
Last Revised: 6/23, 7/24, 8/20/24

Medical necessity criteria and policy are applied only after member eligibility and benefit coverage is determined. Questions concerning member eligibility and benefit coverage need to be directed to Membership Services.

PURPOSE

Describe the policy and medical necessity criteria for the provision of general anesthesia (GA) in an operating room (OR) of a hospital or ambulatory surgery center (ASC) or a surgical suite of a dental clinic when GA is required to safely provide necessary dental treatment.

POLICY

It is an accepted community standard to provide necessary dental care under GA when the dental procedures cannot be safely performed in a traditional dental office setting because the member has special needs or because the member is 12 years of age or younger.

The eligibility criteria described herein are NOT intended to be used for patients who require GA in the OR for oral surgery services that are covered under medical benefit and provided by an Oral Surgeon.

DEFINITIONS

- General Anesthesia (GA): A reversible state of controlled unconsciousness produced by intravenous and/or inhaled anesthetic agents which results in the total loss or partial loss of reflexes and absence of pain over the entire body.
- Operating Room (OR): An Operating room or a surgery suite within a hospital or ambulatory surgery center or dental clinic within which surgical operations are carried out.
- General dentistry: The general practice of dentistry
- Pediatric dentistry: The practice of dentistry specializing in patients generally 12 years of age or younger
- Special Needs: Medical, developmental, or mental condition that may impair member's ability to receive dental care in a traditional dental office setting. These conditions may include:
  - Alzheimer's disease
  - Parkinson's disease
  - Autism spectrum disorder
  - Cerebral palsy
  - Down syndrome
  - Intellectual disability
  - Paralysis
  - Seizure disorder
  - Sensory disorder
  - Developmental delay

o Allergy to all conventional local anesthetics (confirmed by documented evaluation by allergist)
NOTE: Dental Phobia in members older than 12 years is not considered to be a special need and does NOT meet the criteria for Medical Necessity of general anesthesia for dental procedures.

MEDICAL NECESSITY CRITERIA

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None
Kaiser Permanente Medical Policy	Due to the absence of a NCD, LCD, or other coverage guidance, Kaiser Permanente has chosen to use their own Clinical Review Criteria, "Dental Anesthesia Policy and Medical Necessity Criteria" for medical necessity determinations. Use the criteria below.

Provision of general anesthesia in operating room of a hospital or ambulatory surgery center or a surgical suite of a dental clinic for dentally necessary dental services may be considered medically necessary when BOTH of the following criteria are met:

Criterion 1:

The pediatric dentist or general dentist or oral surgeon has documented that the member requires dentally necessary care AND clinically appropriate alternatives which can be provided in a traditional dental office setting are not available.

Criterion 2:

The member of any age has a special needs diagnosis which significantly impairs their ability to safely cooperate with dental care in a traditional dental office setting;

OR

The member is 12 years of age or younger and the pediatric dentist or general dentist or oral surgeon has documented that the member's dental care cannot be safely provided in a traditional dental office setting due to factors that include but are not limited to:

- age;
- physical, medical or mental status;
- extent of treatment planned / degree of difficulty of the procedure;
- member's inability to cooperate due to acute situational anxiety /dental phobia;
- exaggerated gag reflex;
- need for immediate comprehensive dental treatment prior to medical treatment;
- allergy to local anesthetic/ inability to achieve local anesthesia;
- protecting the developing psyche of patient and/ or reduce medical risk;
- failed attempt of dental treatment in dental office.

SPECIAL GROUP CONSIDERATIONS

Commercial: This policy applies to all commercial groups

Medicare: This policy applies to Medicare

Washington Medicaid: This policy does not apply, see references below

Oregon Medicaid: This policy does not apply, see references below (Unique criteria FOR OHP Members) ONLY: Health Systems Division: Medical Assistance Programs - Chapter 410, Division 123

REFERENCES

American Academy of Pediatric Dentistry Oral Health Policy 2020, Policy on Hospitalization and Operating Room Access for Oral Care of Infants, Children, Adolescents, and Individuals with Special Health Care Needs

Policy Number: NW.DENTAL.BENEFITS.022.0 - Request for Extra Contractual Services in Operating Room

Oregon Medicaid:

Health Systems Division: Medical Assistance Programs - Chapter 410, Division 123 – Dental/Denturist Services, 410-123-1490 - Hospital Dentistry - Oregon Secretary of State Administrative Rules

(1) The purpose of hospital dentistry is to provide safe, efficient dental care when providing routine (non-emergency) dental services for (Division) members who present special challenges that require the use of general anesthesia or IV conscious sedation services in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting. Refer to OAR 410-123-1060 for definitions.

(2) Division reimbursement for hospital dentistry is limited to covered services and may be prorated if non-covered dental services are performed during the same hospital visit:

(a) See OAR 410-123-1060 for a definition of Division hospital dentistry services;

(b) Refer to OAR 410-123-1220 for a definition of covered services.

(3) Hospital dentistry is intended for the following Division members:

(a) Children (18 or younger) who:

(A) Through age three (3): Have extensive dental needs;

(B) Four (4) years of age or older: Have unsuccessfully attempted treatment in the office setting with some type of sedation or nitrous oxide;

(C) Have acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a member with developmental or mental disability, a member that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;

(D) Need the use of general anesthesia (or IV conscious sedation) to protect the developing psyche;

(E) Have sustained extensive orofacial or dental trauma;

(F) Have physical, mental or medically compromising conditions; or

(G) Have a developmental disability or other severe cognitive impairment and one or more of the following characteristics that prevent routine dental care in an office setting:

(i) Acute situational anxiety and extreme uncooperative behavior;

(ii) A physically compromising condition.

(b) Adults (19 or older) who:

(A) Have a developmental disability or other severe cognitive impairment, and one or more of the following characteristics that prevent routine dental care in an office setting:

(i) Acute situational anxiety and extreme uncooperative behavior;

(ii) A physically compromising condition.

(B) Have sustained extensive orofacial or dental trauma; or

(C) Are medically fragile, with a medical or physical condition which requires monitoring during dental procedures (i.e. coronary disease, asthma, or chronic obstructive pulmonary disease (COPD), heart failure, serious blood or bleeding disorder, or unstable diabetes or hypertension), have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the member.

Washington Medicaid:

RCW 48.43.185 - General anesthesia services for dental procedures.

RCW 48.43.185: General anesthesia services for dental procedures. (wa.gov)

(1) Each group health benefit plan that provides coverage for hospital, medical, or ambulatory surgery center services must cover general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such anesthesia services and related facility charges are medically necessary because the covered person:

(a) Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

(b) Has a medical condition that the person's physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's physician.

(2) Each group health benefit plan or group dental plan that provides coverage for dental services must cover medically necessary general anesthesia services in conjunction with any covered dental

procedure performed in a dental office if the general anesthesia services are medically necessary because the covered person is under the age of seven or physically or developmentally disabled.

(3) This section does not prohibit a group health benefit plan or group dental plan from:

(a) Applying cost-sharing requirements, maximum annual benefit limitations, and prior authorization requirements to the services required under this section; or

(b) Covering only those services performed by a health care provider, or in a health care facility, that is part of its provider network; nor does it limit the health carrier in negotiating rates and contracts with specific providers.

(4) This section does not apply to Medicare supplement policies, or supplemental contracts covering a specified disease or other limited benefits.

(5) For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

(6) This section applies to group health benefit plans and group dental plans issued or renewed on or after January 1, 2002.

WAC 182-531-0300 - Anesthesia providers and covered physician-related services. The Medicaid agency bases coverage of anesthesia services on Medicare policies and the following rules:

(1) The agency reimburses providers for covered anesthesia serv-ices performed by:

(a) Anesthesiologists;

(b) Certified registered nurse anesthetists (CRNAs);

(c) Oral surgeons with a special agreement with the agency to provide anesthesia services; and

(d) Other providers who have a special agreement with the agency to provide anesthesia services.

(2) The agency covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) The agency covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC 182-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC 182-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a preanesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) The agency does not allow the anesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or con-current services, other than attending to medical emergencies and other limited services as allowed by Medicare instructions.

(6) The agency requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, the agency reimburses the base anesthesia units (BAU) for the major procedure only.

Certified on 10/25/2019 WAC 182-531-0300 Page 1

WAC 182-500-0070 - Definitions:

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

Molina: 2021Redline_Medicaid_MHWFinalDraft2_forRRD_R (molinahealthcare.com)

"Medically Necessary" ***or*** **"Medical Necessity"** ***means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Enrollee requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).***

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice:

2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and, 3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors. The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.