Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

***Current Policy Effective Date: 1/1/25**

Title: Dental General Anesthesia

Description/Background

Anesthesia services consist of the administration of an anesthetic agent in one of the following forms:

- General anesthesia means the loss of ability to perceive pain when associated with loss of consciousness produced by intravenous infusion of drugs or inhalation of anesthetic agents. Intravenous and oral sedation (usually supplemented with a local anesthetic) produces a depressed level of consciousness and the patient retains the ability to independently and continuously maintain the airway.
- Regional anesthesia is the use of local anesthetic solution(s) to produce circumscribed areas of loss of sensation. This includes nerve, spinal, epidural and field blocks. Epidural anesthesia is produced by injection of a local anesthetic solution into the epidural space. Spinal anesthesia places the anesthetic agents into the subarachnoid space.
- Local anesthesia is infiltration or topical application of an anesthetic into or onto the operative site.

Most dental care is provided in a dental office setting using local anesthesia or local anesthesia supplemented with oral or intravenous sedation. Under certain circumstances, it may be necessary to perform these procedures in a hospital, an accredited outpatient surgical facility or dental office using general anesthesia.

This policy addresses the medical criteria for coverage for general anesthesia provided for rendering dental services. Even if the anesthesia meets medical criteria for coverage, the surgical procedure itself may be considered dental by the member's contract.

When anesthesia services are provided in any non-accredited facility, all supplies, materials, and equipment are included in the reimbursement for the anesthesia services.

Medical Policy Statement

The safety and efficacy of general anesthesia and/or intravenous sedation for specified dental procedures have been established. They are useful therapeutic options for individuals meeting the appropriate patient selection criteria.

Inclusionary and Exclusionary Guidelines

This policy addresses general anesthesia provided for rendering dental services. General anesthesia services for rendering a dental procedure can be eligible for separate reimbursement if the anesthesia is rendered by a provider **other than** the dental services provider (such as an anesthesiologist or certified registered nurse anesthetist (CRNA). All facility charges incurred in association with the anesthesia charges are covered under the medical/surgical benefit if any **ONE** the following criteria are met.

- For children under age seven (i.e., through the end of the sixth year)
- For older patients (age seven years and older), consider the extent of the procedures required. At a minimum, the individual should require:
  - A total of six or more teeth to be extracted, **or**
  - Procedures that must be performed in two or more quadrants of the mouth on the same date of service.

  In addition, for patients age seven years and older, documentation of **one** of the following conditions must exist:
  - A concurrent hazardous medical or behavioral condition that creates a documented medical necessity for performing the procedure in an accredited facility using general anesthesia or sedation. These conditions may include, but are not limited to, labile hypertension, significant cardiac arrhythmias (more than 5 premature ventricular contractions per minute on EKG), Down's syndrome, cerebral palsy and/or spasticity, morbid obesity, autism, movement disorders, chronic respiratory disease, hemophilia and other bleeding disorders, uncontrolled diabetes, etc. *Note: A history of chronic diabetes mellitus is not considered a concurrent hazardous medical condition under the above criteria*.
  - A statement from the member's primary physician supporting that the member has medical conditions too serious to undergo dental treatment in the dental office setting
  - Significant cellulitis or swelling and associated trismus (a sustained spasm of the jaw muscles, characteristic of the early stages of tetanus) that does not allow the use of local anesthesia.
  - Extensive orofacial and/or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
  - Extremely uncooperative, fearful, unmanageable or anxious, as determined by their primary care physician, or uncommunicative members with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
  - Allergy or sensitivity to local anesthesia

Exclusions:

- All other anesthesia modalities used to perform dental services in the dental provider's office.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established codes:

00170 41899

Rationale

This is a treatment modality to allow for dental services to be provided to a member with a documented medical necessity to require general anesthesia.

Dental Medical - Surgical Treatment Scenarios

Location	Situation	Medical/Surgical Benefit			Dental Benefit	
		Dental services charge	Facility charge	Anesthesia charge	Dental service charge	Anesthesia charge
Inpatient facility	Dental condition negatively impacting medical condition for discharge	Yes	Yes	Yes	No	No
Inpatient or accredited outpatient facility/dental office	Medically compromised condition that prevents treatment in dental office	No	Yes	Yes	Yes	No
Accredited outpatient facility/dental office	Meets anesthesia criteria under BCBSM Dental Anesthesia Policy	No	Yes[4]	Yes[4]	Yes	No
Accredited outpatient facility/dental office	Meets anesthesia criteria under BCBSM Dental Anesthesia Policy	No	Yes[4]	Yes[4]	Yes	No
Dental Office	Meets BCBSM Dental Anesthesia Policy criteria for general anesthesia, IV sedation	No	N/A	Yes	Yes[1]	Yes

Dental Office, Inpatient or accredited outpatient facility/dental office	Prophylactic dental extractions before ionizing radiation, cardiac valve replacement, organ transplant surgery or beginning IV bisphosphonate	Yes	Yes	Yes[2]	No	No
Dental Office, ER, inpatient or accredited outpatient facility/dental office	Accidental dental injury	Yes[5]	Yes	Yes	No	No
Dental Office	Medical-surgical procedure (not dental)	N/A	N/A	Yes[3]	N/A	N/A

[1]Anesthesia by provider covered if meets BCBSM Dental Policy anesthesia criteria
[2]Group specific. Check PARS, Availity or Provider Inquiry.
[3]Anesthesia is payable to surgeon if procedure codes 99143 through 99145 (appended with modifier 59) are billed with a procedure code **no**t in CPT Appendix G or with a D dental code or 41899 (unless certificate covers extraction of teeth).
[4]Anesthesia by anesthesiologist or CRNA is payable. Facility charges, supplies, materials and equipment are not payable if anesthesia is performed in a non-accredited facility or dental office setting.
[5]Meets criteria for accidental dental injury and treatment completed within 6 months

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Government Regulations
National:

Article for Review of Dental Services (A41333) 3/13/2008.
Currently, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Medicare will also make payment for oral examination, but not treatment preceding kidney transplantation or heart valve replacement, under certain circumstances.

Statutory Dental Exclusion
Section 1862 (a)(12) of the Social Security Act states, “Notwithstanding any other provision of this title, no payment may be made under part A or B for any expenses incurred for items or services-where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of this underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.”

Coverage Principle
Coverage is not determined by the value or the necessity of the dental care but by the type of service provided and the anatomical structure [defined as the periodontium, which includes the gingivae, periodontal membrane, cementum of the teeth and the alveolar bone, (i.e., alveolar process and tooth sockets)] on which the procedure is performed.

Local:

There is no local WPS coverage determination for dental anesthesia.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

1. Blue Cross Blue Shield of Michigan. Dental Care News, pp.3-4, published January 2008.
2. Center for Medicare and Medicaid Services (CMS), Guide to Children's Dental Care in Medicaid, available at http://www.aapd.org/assets/1/7/Periodicity-DentalGuide.pdf. Accessed September 2024.
3. American Dental Association (ADA) Guidelines for the use of sedation and general anesthesia by dentists. October 2016. Available online at: https://www.ada.org/search-results#q=guidelines%20for%20the%20use%20of%20sedation%20and%20general%20anesthesia%20by%20dentists&sort=relevancy. Accessed September 2024.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through September 2024, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
7/9/02	7/9/02	7/9/02	Joint medical policy established
10/11/04	10/11/04	10/11/04	Policy updated, title changed to "Dental Anesthesia"
5/1/07	2/9/07	2/9/08	Routine maintenance
11/1/07	8/21/07	8/29/07	Revised Inclusionary/Exclusionary Guidelines section, revised CPT code section
11/1/08	8/19/08	10/30/08	Routine maintenance
3/1/12	12/13/11	12/21/11	Routine maintenance
1/1/15	10/24/14	11/3/14	Routine maintenance. No change in policy status.
3/1/16	12/10/15	12/10/15	Routine maintenance
1/1/17	10/11/16	10/11/16	Routine policy maintenance, removed blue cross complete references. No changes in policy statement.
1/1/18	10/19/17	10/19/17	Routine policy maintenance, no change in policy status.
1/1/19	10/16/18	10/16/18	Routine policy maintenance. No change in policy status.
1/1/20	10/15/19		Routine policy maintenance. No change in policy status.
1/1/21	10/20/20		Routine policy maintenance. No change in policy status.
1/1/22	10/19/21		Routine policy maintenance. No change in policy status.
1/1/23	10/18/22		Routine policy maintenance, no change in policy status.
1/1/23	12/20/22		Added changes suggested by Dr. Riley and also a treatment scenario table. Effective date remains 1/1/23.
1/1/24	10/17/23		Additional language included in the inclusion section addressing anxiety, Down's syndrome and other bleeding disorders, also inclusion of allergy or sensitivity to local anesthesia. Vendor managed: N/A (ds)

1/1/25	10/15/24		Routine policy maintenance, no change in status. Vendor managed: N/A (ds)

Next Review Date: 4th Qtr. 2025

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: 8/27/00	Revised: N/A
BCBSM: 6/30/97	Revised: N/A

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: DENTAL GENERAL ANESTHESIA

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply.
BCNA (Medicare Advantage)	See government section
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.