University of Michigan Health Plan

BENEFIT COVERAGE POLICY

Title: BCP-16 Dental-Related General Anesthesia and Facility Charges

Effective Date: 04/01/2024

Important Information - Please Read Before Using This Policy

The following coverage policy applies to health benefit plans administered by UM Health Plan and may not be covered by all UM Health Plan plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Coverage determinations for individual requests require consideration of:

- The terms of the applicable benefit document in effect on the date of service.
- Any applicable laws and regulations.
- Any relevant collateral source materials including coverage policies.
- The specific facts of the particular situation.

Contact UM Health Plan Customer Service to discuss plan benefits more specifically.

1.0 Policy:

The Health Plan covers general anesthesia for certain dental procedures under the medical benefit when provided by a participating provider (see Section 5.0 for exceptions). Coverage does not include the dental procedure(s) related to the anesthesia and facility charges. Services must be received in a hospital (inpatient or outpatient) or alternative facility.

This policy does not guarantee or approve Benefits. Coverage depends on the specific Benefit plan. Benefit Coverage Policies are not recommendations for treatment and should not be used as treatment guidelines. Refer to member's benefit coverage document for specific benefit description, guidelines, coverage, and exclusions.

2.0 Background:

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, outpatient facility or dental office using general anesthesia.

3.0 Clinical Guidelines:

A. Health Plan considers general anesthesia and facility charges in a hospital or outpatient surgical setting medically necessary for certain dental services when any the following guidelines are met:

   1. The anesthesia must be rendered by a provider other than the provider performing the dental service. All facility charges incurred in association with the anesthesia charges are covered under the medical/surgical benefit if any one of the following criteria are met:

      a. Patients, including infants, exhibiting physical, intellectual, or medically compromising conditions, for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and which, under general anesthesia, can be expected to produce a superior result. Conditions include but are not limited to mental retardation, cerebral palsy, epilepsy, cardiac problems and hyperactivity (verified by appropriate medical documentation); OR

b. The extremely uncooperative, fearful, anxious, or patient 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; OR

c. A total of six or more teeth are extracted in various quadrants, OR

d. Dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation, or allergy, OR

e. The member is a child under the age of seven years old, with a dental condition that requires repairs of significant complexity (e.g., multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions or any combination of these); OR

f. Patients with a concurrent hazardous medical condition; OR

g. Extensive oral-facial and/or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

4.0 Coding:

Prior Approval Legend: Y = All lines of business; N = None required; 1 = HMO/POS; 2 = EPO/PPO; 3 = ASO group L0000264; 4 = ASO group L0001269 Non-Union & Union; 5 = ASO group L0001631; 6 = ASO group L0002011; 7 = ASO group L0001269 Union Only; 8 = ASO group L0002184; 9 = ASO group L0002237; 10 = ASO group L0002193

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified	N	Professional Fees for Medical and Surgical Procedures
D9222	Deep sedation/general anesthesia - first 15 minutes	N	Professional Fees for Medical and Surgical Procedures
D9223	Deep sedation/ general anesthesia, each 15-minute increment	N	Professional Fees for Medical and Surgical Procedures

ICD-10 DIAGNOSIS CODES (Not All Inclusive)	
Code	**Description**
F43.0, 308.3	Acute stress reaction
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	… combine type
F90.9	… unspecified type
F95.2	Tourette's disorder
F70	Mild intellectual disabilities
F79	Unspecified intellectual disabilities
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.8	Other cerebral palsy

ICD-10 DIAGNOSIS CODES (Not All Inclusive)	
Code	**Description**
G80.9	Cerebral palsy, unspecified
G40.A01 – GA40.A19	Absence epileptic syndrome, not intractable
G40.101 – G40.109	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, no intractable
G40.201 – G40.209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable
G40.301	Generalized idiopathic epilepsy and epileptic syndromes
G40.309 – G40.409	Generalized epilepsy and epileptic syndromes
G40.501 – G40.509	Epileptic seizures related to external causes, not intractable
G40.821 – G40.822	Epileptic spasms, not intractable
G40.901 – G40.909	Epilepsy, unspecified, not intractable
K00.0 – K00.9	Disorders of tooth development and eruption
K01.0 – K01.1	Embedded and impacted teeth
K02.3 – K02.9	Dental caries
K03.0 – K03.9	Other diseases of hard tissues of teeth
K04.0 – K04.99	Diseases of pulp and periapical tissues
K05.00 – K06.9	Gingivitis and periodontal diseases
K08.0 – K08.9	Other disorders of teeth and supporting structures
M26.70 – M26.79	Dental alveolar anomalies
M26.81 – M26.82	Soft tissue impingement, anterior or posterior
Q90.9	Down syndrome, unspecified
R56.1	Post traumatic seizures
R56.9	Unspecified convulsions

5.0 Unique Configuration/Prior Approval/Coverage Details:

ASO groups L0000264 and L0001269 plans provide coverage for non-network providers (if plan has non-network benefits).

6.0 Terms & Definitions:

Alternate Facility. A freestanding healthcare facility that is:

- Not a Physician's or dentist's office.
- Not a Hospital.
- Not a facility that is attached to a Hospital.
- Is designated by the Hospital as an Alternate Facility
- Can be an ambulatory surgical center or dialysis center, for example.

General Anesthesia. Drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation. The ability to maintain ventilatory function independently often is impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Pediatric Patient. All patients who are infants, children, and adolescents less than the age of majority (18 years old).

Restoration. A surgical procedure that is intended to restore an individual's anatomy to normal function and/or appearance.

7.0 References, Citations & Resources:

1. Journal of Dental Anesthesia and Pain Medicine, "The use of general anesthesia to facilitate dental treatment in adult patients with special needs." 2017 Jun 29. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5564153/
2. American Dental Association (ADA) Guidelines for the use of sedation and general anesthesia by dentists. October 2016. Available at: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/oral-health-topics/ada_sedation_use_guidelines.pdf?rev=b8b34313071d416a99182e8b37add4dd&hash=06A52EC1C4BA50BEA9ABAA5C3A6DD095
3. American Academy of Pediatric Dentistry. Policy on third-party reimbursement of medical fees related to sedation/ general anesthesia for delivery of oral health care services. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:188-91. Available at: https://www.aapd.org/globalassets/media/policies_guidelines/p_3rdsedationga.pdf

8.0 Associated Documents [For internal use only]:

MMP-02 Transition and Continuity of Care

MMP-09 Benefit Determinations

MMS-03 Algorithm for Use of Criteria for Benefit Determinations

MMS-45 UM Nurse Review

MMS-52 Inpatient Case Process in CCA

MMS-53 Outpatient Case Process in CCA

Sample Letter – TCS Approval Letter; Clinically Reviewed Exclusion Letter; Specific Exclusion Letter, Lack of Information Letter.

Form – Request Form: Out of Network/ Prior Authorization.

9.0 Revision History:

Original Effective Date: 07/12/2006

Next Review Date: 04/01/2025

Revision Date	Reason for Revision
2/15	The word "OR" was added to #1-5 of Clinical Determination Guidelines
7/15	Annual review and renewal. Revised to standardized format, combined criteria under Clinical Determination Guidelines and deleted "Issues" section, deleted duplicate criteria. ICD-9 and ICD-10 codes added.
8/15	ICD-10 codes added
7/16	Removed references to Medicaid/DHHS and ICD-9 table
7/17	Annual review – converted from Medical Policy 006 to BCP format; added 4.0.A.4 Mallampati score, 4.0. B. Dental extractions/restorations subject to Dental benefits; "K" and "M" ICD-10 codes; definition of Mallampati score.
10/17	Archive as a medical policy and remove prior approval requirements. Use as a benefit policy.
7/19	No substantive changes upon annual review.
10/19	Annual review; added language regarding benefit exclusions, and updated references.
2/21	Annual review, unlisted code removed, associated documents, and code cost share references updated.
1/22	Annual review approved at BCC on 02-21-2022 with an effective date of 04-01-2022
1/23	Annual review; updated references, D9222 added as a covered code, added MMP-02 Transition and Continuity of Care, MMS-52 and MMS-53 as associated

	documents
1/24	Annual review, updated section 2.0: background, updated section 8.0: associated documents.