I. POLICY

General anesthesia, including associated medical services, as well as a facility admission, either inpatient or outpatient/observation, may be considered medically necessary for the following:

- Patients (adult or children) who have a medically significant condition (e.g. unstable heart disease, severe asthma, severe chronic obstructive pulmonary disease, seizures, hemophilia); OR
- Patients (adult or children) who have a history of severe postoperative complications following oral or dental surgery; OR
- Patients (adult or children) scheduled for dental or oral surgical procedures such as bony impacted teeth extractions which have a high probability of complications. This includes impactions high in the upper jaw which may impinge on the sinuses and those which are deep in the lower jaw; OR
- Patients who are 7 years or younger; OR
- Patients who are developmentally disabled.

Cross-references:
MP-1.101 Orthognathic Surgery
MP-1.004 Cosmetic and Reconstructive Surgery
MP-1.131 Dental Implants
MP-3.015 Office Based Procedures Performed in a Facility

II. PRODUCT VARIATIONS

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

BlueJourney HMO*  BlueJourney PPO*  FEP PPO**
* Refer to Centers for Medicare and Medicaid Services (CMS) Medicare Benefit Policy Manual. Publication 100-02. Chapter 15. Covered Medical and Other Health Services, Dental Services. Payments are made for a covered dental procedure no matter where the service is performed. The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

**Inpatient and outpatient hospital care related to the treatment of children up to age 22 with SEVERE dental caries is covered; NOTE: Inpatient hospitalization is subject to general admission criteria. Hospitalization for other types of dental procedures is covered only when a non-dental physical impairment exists that makes a hospitalization necessary to safeguard the health of the patient. www.fepblue.org

III. DESCRIPTION/BACKGROUND

Occasionally, a patient’s age or health status may require the use of a medical facility to render routine dental care or other covered or non-covered dental and oral surgery procedures. A facility admission may also be required for complex bony tooth extractions when there is a high probability of complications.

The Children and Developmentally Disabled Patient Access to Quality Dental Care Act (Act 94 of 2012) is a PA mandate that requires health insurers to cover general anesthesia and associated medical costs for eligible dental patients when they would fare better under general rather than local anesthesia. Eligible patients are those who are 7 years or younger or developmentally disabled.

General anesthesia is defined in Act 94 as a controlled state of unconsciousness, including deep sedation, that is produced by a pharmacologic method, a non-pharmacologic method or a combination of both and that is accompanied by a complete or partial loss of protective reflexes that include the patient’s inability to maintain an airway independently and to respond purposefully to physical stimulation or verbal command.

IV. DEFINITIONS

ASSOCIATED MEDICAL SERVICES - Hospitalization and all related medical expenses normally incurred as a result of the administration of general anesthesia.

GENERAL ANESTHESIA SERVICES - A means of causing the loss of the ability to perceive pain due to the loss of consciousness produced by the infusion of medications or inhalation of anesthetic agents.
IMPACTED TOOTH is any tooth that is prevented from reaching its normal position in the mouth by tissue, bone, or another tooth.

V. BENEFIT VARIATIONS

The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member’s individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member’s benefit information or contact Capital for benefit information.

VI. DISCLAIMER

Capital’s medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VII. Coding Information

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement

➢ Specific codes do not apply to this policy.

VIII. REFERENCES


IX. POLICY HISTORY

| MP 1.092 | CAC 7/29/03 |
| CAC 8/31/04 |
| CAC 2/22/05 |
| CAC 2/28/06 |
| CAC 2/27/07 |
| CAC 7/31/07 |
| CAC 3/25/08 |
| CAC 1/25/11 Policy statement revised- replaced “retardation” with “intellectual disability”. FEP variation combined into one statement. |
| CAC 10/25/11 Consensus review |
| CAC 10/30/12 Minor revision. Policy revised to add information related to The Children and Developmentally Disabled Patient Access to Quality Dental Care ACT (Act 94 of 2012) PA mandate. House Bill 532-Policy criteria for a facility admission changed from age (6) to age (7). References updated. FEP variation |
MEDICAL POLICY

<table>
<thead>
<tr>
<th>POLICY TITLE</th>
<th>DENTAL AND ORAL SURGERY PROCEDURES PERFORMED IN A FACILITY</th>
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<tbody>
<tr>
<td>POLICY NUMBER</td>
<td>MP- 1.092</td>
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revised regarding dental admissions. Codes reviewed 10/17/12

CAC 11/26/13 Consensus. No changes to policy statements. References reviewed. Changed Medicare variation to reference Centers for Medicare and Medicaid Services (CMS) Medicare Benefit Policy Manual. Publication 100-02. Chapter 15 Dental Services. Payments are made for a covered dental procedure no matter where the service is performed. The hospitalization or non-hospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

Admin. Review 4/1/14, Coding Reviewed and updated. Specific codes not applicable to this policy.

CAC 11/25/14 Consensus review. References updated. No changes to the policy statements. No coding on this policy as it relates to anesthesia and facility only.

CAC 1/26/16 Consensus review. No change to policy statements. References reviewed. Coding reviewed.

5/26/16 Admin change: Updated cross-references.

Admin update 1/1/17: Product variation section reformatted

CAC 3/28/17 Consensus review. No changes to the policy statements. References updated. Policy reviewed and specific codes do not apply to this policy.

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