MEDICAL POLICY

POLICY TITLE	DENTAL AND ORAL SURGERY PROCEDURES PERFORMED IN A FACILITY
POLICY NUMBER	MP- 1.092

Effective Date:	6/1/2023

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:

- Individuals (adult or children) who have a medically significant condition (e.g. unstable heart disease, severe asthma, severe chronic obstructive pulmonary disease, seizures, hemophilia); **or**
- Individuals (adult or children) who have a history of severe postoperative complications following oral or dental surgery; **or**
- Individuals (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**
- Individuals who are 7 years or younger; **or**
- Individuals who are developmentally disabled.

Cross-references:

MP 1.101 Orthognathic Surgery
MP 1.004 Cosmetic and Reconstructive Surgery
MP 3.015 Office Based Procedures Performed in a Facility

II. PRODUCT VARIATIONS

TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO- Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:

https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION/BACKGROUND

TOP

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 for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia.

Per the National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, examples of developmental disabilities include: ADHD, autism spectrum disorder, cerebral palsy, hearing loss, intellectual disability, learning disability, vision impairment, and other developmental delays.

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

TOP

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

DEVELOPMENTAL DISABILITIES - Development disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime.

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

TOP

The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the

applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs for each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VI. DISCLAIMER

TOP

Capital Blue Cross'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. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VII. CODING INFORMATION

Top

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

TOP

1. *Pennsylvania General Assembly. Act 94 of 2012, Children and Developmentally Disabled Patient Access to Quality Dental Care Act.*
2. *American Academy of Pediatric Dentistry (AAPD). Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures. revised 2019.*
3. *American Academy of Pediatric Dentistry (AAPD). Use of Anesthesia Providers in the Administration of Office-based Deep Sedation/General Anesthesia to the Pediatric Dental Patient.; revised 2019.*
4. *American Academy of Pediatric Dentistry (AAPD). Policy on Medically-Necessary Care.; revised 2019.*

5. *Ahmed SS, Hicks SR, Slaven JE, Nitu ME. Deep Sedation for Pediatric Dental Procedures: Is this a Safe and Effective Option?. J Clin Pediatr Dent. 2016;40(2):156-160. doi:10.17796/1053-4628-40.2.156*
6. *Centers for Disease Control and Prevention. Developmental Disabilities. April 29, 2022.*
7. *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; 2022:156-9*

IX. POLICY HISTORY

TOP

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 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.
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies.
	1/31/18 Consensus review. No change to the policy statements. References reviewed. Policy reviewed and specific codes do not apply to this policy.
	2/5/19 Consensus review. No change to the policy statements. References reviewed.
	2/19/20 Consensus review. Policy statement unchanged. References updated.
	2/1/21 Consensus review. Policy statement unchanged. References updated.
	1/25/2022 Consensus review. No criteria changed, References updated.
	2/20/2023 Consensus review. Updated background, definitions and references.

Top