



## Anesthesia for Dental Services

### I. Policy

University Health Alliance (UHA) will reimburse for anesthesia services for dental services when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

### II. Criteria/Guidelines

- A. UHA considers general anesthesia and monitored anesthesia care medically necessary for dental or oral and maxillofacial surgery services if any of the following criteria is met:
1. The member is a child, up to 6 years old, with a dental condition (such as baby bottle syndrome) that requires repairs of significant complexity (e.g., multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions, or any combinations of these noted or other dental procedures); or
  2. Members who exhibit 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 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
  3. Members who are extremely uncooperative, fearful, unmanageable, anxious, 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; or
  4. Members for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations or allergy); or
  5. Members who have sustained extensive oral-facial and/or dental trauma, for which treatment under local anesthesia would be ineffective or compromised; or
  6. Members with bony impacted wisdom teeth.

#### NOTE:

*This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.*

*Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.*

*UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation through direct peer communication.*

### III. Limitations/Exclusions

- A. Administration of any type of anesthesia service must be provided by qualified and appropriately trained individuals.
- B. Monitored anesthesia care/general anesthesia services provided in conjunction with dental treatment may be impacted by benefit plan language and governed by state mandates. Please refer to the applicable plan benefit document to determine benefit availability and the terms and conditions of coverage.
- C. Anesthesia services are to be provided in an ambulatory/ASC setting.

### IV. Administrative Guidelines

- A. Prior authorization is required.
- B. To request prior authorization, please complete the PA form specific to psychological and neuropsychological testing and submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.
- C. This policy only reviews UHA coverage for anesthesia services and does not include coverage of dental procedures. Dental procedures should be billed to the dental plan.
- D. UHA reserves the right to perform retrospective review using the above criteria to validate those services rendered met payment determination

#### CPT codes covered if selection criteria are met:

CPT Code	Description
00170 - 00176	Anesthesia for intraoral procedures, including biopsy; not otherwise specified, or repair of cleft palate, or excision of retropharyngeal tumor, or radical surgery
00190 - 00192	Anesthesia for procedures on facial bones or skull

### V. Policy History

**Policy Number:** MPP-0137-211209

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