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Department of Health Care Services



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DATE: April 1, 2016

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: **REVISED APL 15-005: PRIOR AUTHORIZATION FOR INTRAVENOUS SEDATION AND GENERAL ANESTHESIA SERVICES**

The purpose of this All Plan Letter (APL) is to revise instruction previously provided in APL 15-005, which was released on September 11, 2015. This revised APL supersedes the original APL 15-005 released on September 11, 2015.

The Department of Health Care Services (DHCS) has developed consistent criteria and guidelines for intravenous sedation and general anesthesia services for dental procedures that was implemented across all delivery systems and programs. As of November 1, 2015, providers are required to submit Treatment Authorization requests (TARs) for the provision of intravenous sedation and general anesthesia services.

Submission and criteria requirements outlined in the Manual of Criteria will not be updated until the implementation of Current Dental Terminology (CDT) 15 occurs; however, providers are required to abide by the updated requirements outlined in this APL.

**INTRAVENOUS SEDATION AND GENERAL ANESTHESIA
GUIDELINES FOR DENTAL PROCEDURES**

Patient selection for conducting dental procedures under intravenous sedation or general anesthesia utilizes medical history, physical status, and indications for anesthetic management. DHCS expects that the dental provider will work collaboratively with an anesthesia provider to determine whether a Medi-Cal beneficiary meets the minimum criteria necessary for receiving intravenous sedation or general anesthesia. The need for intravenous sedation or general anesthesia should be evaluated using the clinical judgement of the provider(s) based on the criteria indication delineated below. The anesthesia provider must submit documentation outlining the patient's need for intravenous sedation or general anesthesia based on the criteria indication delineated below through a TAR, and must receive approval prior to delivering the requested sedation or anesthesia services.

TARs for intravenous sedation and general anesthesia services can be submitted by:

- Dental anesthesiologists enrolled as billing providers;
- If a dental anesthesiologist is not enrolled as a billing provider, an enrolled billing provider rendering the dental services may submit TARs on behalf of the dental anesthesiologist;
- If a dental anesthesiologist is part of a group practice, the group practice may submit TARs on behalf of the dental anesthesiologist.

Please note that a TAR is not required prior to delivering intravenous sedation or general anesthesia as part of an outpatient dental procedure for a beneficiary who resides in a state certified skilled nursing facility (SNF) or any category of intermediate care facility (ICF) for the developmentally disabled. Additionally, the dental provider must meet the requirements for chart documentation, which include a copy of a complete history and physical examination, diagnosis, treatment plan, radiological reports and images, the indication for intravenous sedation or general anesthesia, and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure pertinent to the request.

CRITERIA INDICATIONS FOR INTRAVENOUS SEDATION OR GENERAL ANESTHESIA

Behavior modification and local anesthesia shall be attempted first; conscious sedation shall then be considered if this fails or is not feasible based on the medical needs of the patient.

If the provider provides clear medical record documentation of both number one (1) and number two (2) below, then the patient shall be considered for intravenous sedation or general anesthetic:

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient.
2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient.

If the provider documents any one of numbers three (3) through six (6) then the patient shall be considered for intravenous sedation or general anesthetic:

3. Use of effective communicative techniques and the ability for immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient.

4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
5. Patient has acute situational anxiety due to immature cognitive functioning.
6. Patient is uncooperative due to certain physical or mental compromising conditions.

If sedation is indicated then the least profound procedure shall be attempted first. The procedures are ranked from low to high profundity in the following order: *conscious sedation via inhalation or oral anesthetics, intravenous sedation, then general anesthesia.*

Patients with certain medical conditions such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias and significant bleeding disorders (i.e. continuous anticoagulant therapy such as Coumadin therapy) should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.

Providers shall adhere to all regulatory requirements (Federal, State, Licensing Board, etc.) for:

- Preoperative and perioperative care
- Monitoring and equipment requirements
- Emergencies and transfers
- Monitoring guidelines

References:

- American Academy of Pediatric Dentistry (AAPD) -- www.aapd.org
- American Dental Board of Anesthesiology -- www.adba.org
- American Dental Society of Anesthesiology -- www.adsahome.org
- American Society of Anesthesiologists – www.asahq.org
- American Association of Nurse Anesthetists - www.aana.com/resources2/professionalpractice
- Dental Board of California – www.dbc.ca.gov/licensees/dds/permits_ga.shtml
- National Network for Oral Health Access - www.nnoha.org/nnoha-content/uploads/2013/07/White-Paper-Health-Centers-and-Hospital-Based-Dentistry.pdf
- Cochrane Database of Systematic Reviews 2012 – www.update-software.com/BCP/WileyPDF/EN/cd006334.pdf
- National Guideline Clearinghouse - www.guideline.gov/content.aspx?id=15258&search=General+Anesthesia
- US National Library of Medicine National Institutes of Health NIH www.ncbi.nlm.nih.gov/pubmed/23152234

Please forward this information to your dental plan providers. All materials developed by the DMC plans for the purposes of notifying their contracted providers of their options shall be submitted to dmcdeliverables@dhcs.ca.gov for DHCS review and approval prior to distribution. If you have any questions with respect to this letter, please contact DHCS at dmcdeliverables@dhcs.ca.gov.

Sincerely,



Alani C. Jackson, MPA
Division Chief
Medi-Cal Dental Services Division
Department of Health Care Services

Attachments:

- 1- Intravenous Sedation and General Anesthesia: Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios
- 2- Medi-Cal Dental Provider General Anesthesia/Intravenous Sedation Policy FAQs
- 3- Instructions for IV Sedation and General Anesthesia Prior Authorization Documentation Requirements for Dental Services

**Attachment 1: Intravenous Sedation and General Anesthesia:
Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios**

Scenario 1 – Dental Office

Beneficiary Enrolled in:	DMC Plan + MCMC	Medi-Cal Dental FFS + MCMC	DMC Plan + Medi-Cal Medical FFS	Medi-Cal Dental FFS + Medi-Cal Medical FFS
Medical Anesthesiologist	MCP pays anesthesiologist	MCP pays anesthesiologist	Medi-Cal Medical FFS pays anesthesiologist	Medi-Cal Medical FFS pays anesthesiologist
Submit Prior Authorization/Treatment Authorization Request to:	MCP for anesthesia fees	MCP for anesthesia fees	CAASD Field Office (ETAR) for anesthesia fees	CAASD Field Office (ETAR) for anesthesia fees
Dental Anesthesiologist	DMC Plan pays anesthesiologist	Denti-Cal pays anesthesiologist	DMC Plan pays anesthesiologist	Denti-Cal pays anesthesiologist
Submit Prior Authorization/Treatment Authorization Request to:	DMC Plan for anesthesia fees	Denti-Cal for anesthesia fees	DMC Plan for anesthesia fees	Denti-Cal for anesthesia fees

Scenario 2 – Dental Only Surgery Center

Beneficiary Enrolled in:	DMC Plan + MCMC	Medi-Cal Dental FFS + MCMC	DMC Plan + Medi-Cal Medical FFS	Medi-Cal Dental FFS + Medi-Cal Medical FFS
Medical Anesthesiologist OR Certified Registered Nurse Anesthetist	<ul style="list-style-type: none"> MCP pays anesthesiologist MCP pays facility fee 	<ul style="list-style-type: none"> MCP pays anesthesiologist MCP pays facility fee 	<ul style="list-style-type: none"> Medi-Cal Medical FFS pays anesthesiologist Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider 	<ul style="list-style-type: none"> Medi-Cal Medical FFS pays anesthesiologist Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider
Submit Prior Authorization/Treatment Authorization Request to:	MCP for anesthesia and facility fees	MCP for anesthesia and facility fees	CAASD Field Office (ETAR) for anesthesia and facility fees if DOSC is an enrolled Medi-Cal provider	CAASD Field Office (ETAR) for anesthesia and facility fees if DOSC is an enrolled Medi-Cal provider
Dental Anesthesiologist	<ul style="list-style-type: none"> DMC Plan pays anesthesiologist MCP pays facility fee 	<ul style="list-style-type: none"> Denti-Cal pays anesthesiologist MCP pays facility fee 	<ul style="list-style-type: none"> DMC Plan pays anesthesiologist Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider 	<ul style="list-style-type: none"> Denti-Cal pays anesthesiologist Medi-Cal Medical FFS pays facility fee if DOSC is an enrolled Medi-Cal provider
Submit Prior Authorization/Treatment Authorization Request to:	<ul style="list-style-type: none"> DMC Plan for anesthesia fees MCP for facility fees 	<ul style="list-style-type: none"> Denti-Cal for anesthesia fees MCP for facility fees 	<ul style="list-style-type: none"> DMC Plan for anesthesia fees CAASD Field Office (ETAR) for facility fees if DOSC is an enrolled Medi-Cal provider 	<ul style="list-style-type: none"> Denti-Cal for anesthesia fees CAASD Field Office (ETAR) for facility fees if DOSC is an enrolled Medi-Cal provider

**Attachment 1: Intravenous Sedation and General Anesthesia:
Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios**

Scenario 2 – Ambulatory Surgery Center and General Acute Care Hospitals

Beneficiary Enrolled in:	DMC Plan + MCMC	Medi-Cal Dental FFS + MCMC	DMC Plan + Medi-Cal Medical FFS	Medi-Cal Dental FFS + Medi-Cal Medical FFS
Medical Anesthesiologist OR Certified Registered Nurse Anesthetist	<ul style="list-style-type: none"> MCP pays anesthesiologist MCP pays facility fees 	<ul style="list-style-type: none"> MCP pays anesthesiologist MCP pays facility fees 	<ul style="list-style-type: none"> Medi-Cal Medical FFS pays anesthesiologist Medi-Cal Medical FFS pays facility fees 	<ul style="list-style-type: none"> Medi-Cal Medical FFS pays anesthesiologist Medi-Cal Medical FFS pays facility fees
Submit Prior Authorization/Treatment Authorization Request to:	MCP for anesthesia fees and for facility fees	MCP for anesthesia fees and for facility fees	CAASD Field Office (ETAR) for anesthesia fees and for facility fees	CAASD Field Office (ETAR) for anesthesia fees and for facility fees
Dental Anesthesiologist	<ul style="list-style-type: none"> DMC Plan pays anesthesiologist MCP pays facility fees 	<ul style="list-style-type: none"> Denti-Cal pays anesthesiologist MCP pays facility fees 	<ul style="list-style-type: none"> DMC Plan pays anesthesiologist Medi-Cal Medical FFS pays facility fees 	<ul style="list-style-type: none"> Denti-Cal pays anesthesiologist Medi-Cal Medical FFS pays facility fees
Submit Prior Authorization/Treatment Authorization Request to:	<ul style="list-style-type: none"> DMC Plan for anesthesia fees MCP for facility fees 	<ul style="list-style-type: none"> Denti-Cal for anesthesia fees MCP for facility fees 	<ul style="list-style-type: none"> DMC Plan for anesthesia fees CAASD Field Office (ETAR) for facility fees 	<ul style="list-style-type: none"> Denti-Cal for anesthesia fees CAASD Field Office (ETAR) for facility fees

Attachment 1: Intravenous Sedation and General Anesthesia: Prior Authorization/Treatment Authorization Request and Reimbursement Scenarios

Acronym List:

CAASD – Clinical Assurance and Administrative Support Division
Medi-Cal Dental FFS or Denti-Cal – Medi-Cal Dental Fee-For-Service
DMC Plan – Dental Managed Care Plan
DOSC – Dental Only Surgery Center
DHCS – Department of Health Care Services
ETAR – Electronic Treatment Authorization Request
MCP – Medi-Cal Managed Care Health Plan
Medi-Cal Medical FFS – Medi-Cal Medical Fee-For-Service
MCMC – Medi-Cal Medical Managed Care

Additional DHCS Resources:

- Clinical Assurance and Administrative Support Division: <http://www.dhcs.ca.gov/formsandpubs/laws/CAASD/Pages/default.aspx>
- Dental Managed Care Plan Directory: <http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=ManagedCarePlanDir>
- Medi-Cal Dental Provider Handbook: <http://www.denti-cal.ca.gov/WSI/Publications.jsp?fname=ProvManual>
- Medi-Cal Electronic Treatment Authorization Request (ETAR) webpage: <https://learn.medi-cal.ca.gov/Resources/eTARNewsTips.aspx>
- Medi-Cal Managed Care Health Plan Directory: <http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx>
- Medi-Cal Provider Manuals: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

**Attachment 2: Frequently Asked Questions:
Medi-Cal Dental Provider General Anesthesia and Intravenous Sedation Policy**

1. When do the new guidelines for general anesthesia and intravenous sedation take effect?

In the Medi-Cal Dental Program, prior authorization is required for general anesthesia (D9220/D9221) and intravenous sedation (D9241/D9242) services administered on or after November 1, 2015. The updated Denti-Cal criteria was outlined in the September 2015 Provider Bulletin, Volume 31, Number 13. The Bulletin can be found at the following link:

http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_31_Number_21.pdf

This policy became effective in managed care beginning May 12, 2015, and was later updated on August 21, 2015, via All Plan Letter (APL) 15-012.

2. Why are dental providers required to submit Treatment Authorization Requests (TARs) for general anesthesia and intravenous sedation services now?

This policy was developed to align processes across the medical and dental programs and across delivery systems. A TAR process for medical services has always been in place in managed care.

3. Who is responsible for submitting the TAR?

The TAR for general anesthesia or intravenous sedation can be submitted by:

- Dental anesthesiologists enrolled as billing providers;
- If a dental anesthesiologist is not enrolled as a billing provider, an enrolled billing provider rendering the dental services may submit TARs on behalf of the dental anesthesiologist;
- If a dental anesthesiologist is part of a group practice, the group practice may submit TARs on behalf of the dental anesthesiologist.

Please note that medical Managed Care Plans (MCPs) are not obligated to approve all authorization requests received from providers; approval will be based on meeting medical necessity in accordance with the new policy.

4. In a group practice with multiple anesthesiologists, does the TAR need to indicate the name of the anesthesiologist rendering the general anesthesia or intravenous sedation?

The Notice of Authorization (NOA) is issued to the group practice because the dental anesthesiologist rendering the anesthesia or sedation services can

sometimes be assigned on the date of service (DOS). However, the dental anesthesiologist rendering the treatment must be enrolled in the Medi-Cal Dental Program and must have a valid permit on file with Medi-Cal Dental Program.

5. How long will it take a TAR to be approved or denied?

Although experience has typically been fifteen (15) days, the Medi-Cal Dental contractor(s) have up to thirty (30) days to approve or deny a TAR. Providers should confer with the respective health or dental managed care plan regarding the timelines they employ for rendering prior authorization approvals.

MCPs have up to fourteen (14) calendar days from receipt of request to render a decision, per contract. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the beneficiary or the beneficiary's provider requests an extension, or the MCP can provide justification upon request by the State for the need for additional information and how it is in the beneficiary's interest.

6. Can TARs be submitted for Prior Authorization (PA) for general anesthesia and intravenous sedation prior to November 1, 2015?

Yes. TARs submitted for prior authorization for general anesthesia or intravenous sedation services before November 1, 2015 will be reviewed utilizing existing Medi-Cal Dental criteria for the sedation procedures. The sedation must be rendered within the approved authorization period outlined on the NOA. Extensions cannot be requested for these NOAs. If the approved time period has expired, a new TAR will need to be submitted and the updated criteria will apply if the document is reviewed on or after November 1, 2015.

MCPs will continue applying the policy criteria as specified in APL 15-012 and utilizing the TAR process as standard practice for all requests received, including those TARs for PA.

7. Will there be a grace period for patients that are already scheduled for an appointment on or after November 1, 2015?

No. All general anesthesia or intravenous sedation rendered on or after November 1, 2015 should be prior authorized in accordance with the updated criteria.

8. What is the definition for “Medically Necessary?”

Medical necessity is defined in the Welfare and Institutions Code (W&I Code) §14059.5 as follows:

“A service is ‘medically necessary’ or a ‘medical necessity’ when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”

Medical necessity must be demonstrated based on the needs of the individual with respect to the provision of dental services provided under general anesthesia or intravenous sedation. The following link leads to W&I Code §14059.5 citation:

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14059.5.&lawCode=WIC.

[For children under Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\), the Centers for Medicare & Medicaid Services \(CMS\) defines medical necessity as follows:](#)

“Services that fit within the scope of coverage under EPSDT must be provided to a child only if necessary to correct or ameliorate the individual child’s physical or mental condition, i.e., only if ‘medically necessary.’ The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child...[and] all aspects of [the] child’s needs, including nutritional, social development, and mental health and substance use disorders.”

The CMS definition is found at:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

9. What kind of documentation does the provider need to submit for a patient to be considered for general anesthesia or intravenous sedation?

The documentation required is based on the medical necessity for the beneficiary and is reviewed per Denti-Cal criteria outlined in the September 2015, Volume 31, Number 13 Bulletin. A subsequent provider bulletin was published on October 29, 2015, outlining the submission requirements for TARs and claims for

general anesthesia and intravenous sedation services. The provider bulletin can be found at the following link:
http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_31_Number_18a.pdf.
Providers can also confer with the respective health or dental managed care plan regarding documentation requirements for general anesthesia or intravenous sedation.

10. What should a provider do in circumstances where they are unable to perform an evaluation or take radiographs of a patient unless the patient is under sedation?

- When an examination and radiographs cannot be rendered without sedation, only the general anesthesia or intravenous sedation should be requested on the TAR.
- When the examination and treatment can only be rendered under sedation, the rendered treatment should be added to the approved NOA for the sedation when submitting for payment. Prior authorization will be waived for those applicable dental services with the exception of fixed partial dentures, removable prosthetics and implants. The treatment, however, must meet the Manual of Criteria and all required documentation and radiographs will be required for payment.

11. Can a provider of dental services obtain an authorization for general anesthesia or intravenous sedation on behalf of a dental anesthesia provider in a dental office, dental surgery center, or ambulatory surgical center/general acute hospital?

Yes. Refer to question and answer #3.

12. Why aren't consumers of the Department of Developmental Services, exempt from the TAR requirement?

The delineated exclusions are based solely on State law, which do not explicitly reference Regional Centers or Regional Center clients. Also, in accordance with program requirements, we must equitably provide covered benefits in the same scope, duration and frequency across similarly situated coverage groups. Therefore, Regional Centers were not added as an exemption from the TAR requirement. However, pursuant to W&I Code §14132(f), prior authorization is not required for patients residing in a Skilled Nursing Facility (SNF) or any category of Intermediate Care Facility (ICF) for the developmentally disabled.

13. Do beneficiaries under the age of seven (7) automatically qualify for general anesthesia?

Children under seven (7) years old do not automatically qualify for general anesthesia or intravenous sedation. Beneficiaries of all ages must meet the criteria delineated in the policy to qualify for anesthesia or sedation services.

14. Does the general anesthesia procedure need to be rendered at a SNF or ICF for the developmentally disabled?

No. Most ICFs and SNFs are not equipped with all the safety measures required to have general anesthesia and intravenous sedation rendered in the facility. The prior authorization requirement is waived for anesthesiologist services for residents of a certified SNF/ICF. The determination of the most appropriate location to render general anesthesia or intravenous sedation services for SNF/ICF residents is subject to the clinical expertise of the treating provider.

15. Does a TAR for a developmentally disabled individual need to be submitted only the first time general anesthesia or intravenous sedation is being requested, or do they have to complete the process every single time?

Providers must submit a TAR each time sedation services are being requested. Providers may use the same patient history information when completing multiple TARs. The Provider should document the medical necessity for general anesthesia or intravenous sedation services based on the scope of dental treatment being rendered (degree of difficulty, length of time, etc.)

16. What constitutes “immature cognitive functioning?”

Per the criteria listed in the Provider Bulletin, a patient shall be considered for general anesthesia or intravenous sedation if a provider documents that the patient has acute situational anxiety due to immature cognitive functioning. Examples of immature cognitive functioning include, but are not limited to, a lack of psychological or emotional maturity that inhibits the ability to appropriately respond to commands in a dental setting.

17. What must a provider do in the event that a “less profound” method of sedation is not appropriate for a patient?

Providers must document why a less profound method of sedation was not appropriate, or an attempt was made and failed, and submit that documentation with the TAR.

18. What are some “effective communicative techniques?”

For additional information regarding effective communicative techniques, refer to the guidelines established by the American Academy of Pediatric Dentistry at the following link: http://www.aapd.org/media/policies_guidelines/g_behavguide.pdf.

19. If a provider pre-authorizes for general anesthesia for three (3) hours and actually rendered three (3) hours and thirty (30) minutes, would the provider get paid for the additional time?

Yes. Providers must add the additional time to the approved NOA. Regardless of the time authorized, payment of general anesthesia and intravenous sedation is based on the submitted anesthesia report that documents the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.

When billing MCPs, please check with your particular MCP for specifics regarding billing practices, as billing practices may vary from MCP to MCP.

20. Are there any scenarios where the PA for general anesthesia or intravenous sedation will be waived? If so, what are they?

Other than the exceptions delineated in W&I Code §14132(f) as explained in question and answer #12, PA can be waived when general anesthesia or intravenous sedation is medically necessary to treat an emergency medical condition. An “Emergency medical condition” is defined in Title 22 of the California Code of Regulations as:

A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- a. *Placing the patient's health in serious jeopardy.*
- b. *Serious impairment to bodily functions.*
- c. *Serious dysfunction of any bodily organ or part.*

21. If general anesthesia or intravenous sedation has been deemed medically necessary and authorized, can a provider use this authorization to render treatment on a different DOS (crown prep/cementation, quadrant dentistry, etc.)?

If general anesthesia or intravenous sedation was authorized for the current treatment series, the general anesthesia or intravenous sedation services can be rendered on a different DOS without a new TAR request. Add the additional general anesthesia or intravenous sedation services rendered to the approved NOA.

22. What is the compensation to the referring provider for the failed attempts to treat the patient?

- If the referring provider was able to do an exam but not render treatment, the provider can bill for the exam procedure. If the referring provider was unable to do an exam or render treatment, the provider can bill the Office Visit for Observation (D9430). Documentation must be submitted stating the patient was uncontrollable or uncooperative for the scheduled appointment.
- If the referring provider rendered Nitrous Oxide (inhalation of nitrous oxide/anxiolysis, analgesia - D9230) or Non-intravenous Conscious sedation (D9248) but was unable to render treatment, the provider can bill the D9230 or D9248. Documentation must be submitted stating the patient was uncontrollable or uncooperative and treatment could not be rendered.

Department of Health Care Services
Instructions for IV Sedation and General Anesthesia
Prior Authorization Documentation Requirements for Dental Services

Certain medical or dental procedures and services under Medi-Cal are subject to prior authorization (PA) before reimbursement can be provided. A Treatment Authorization Request is synonymous to PA for the purposes of this guidance. Submission of a PA request is required for approval of medically necessary intravenous (IV) sedation and general anesthesia. The *IV Sedation and General Anesthesia Prior Authorization Documentation Requirements for Dental Services* contains a comprehensive list of **all** of the information and materials required to adjudicate a request for medically necessary IV sedation and general anesthesia for dental services. Each of the items listed on the *IV Sedation and General Anesthesia Prior Authorization Documentation Requirements* is necessary to adjudicate the PA request.

The location for submission of PA requests is determined by provider type, provider location, where the service is being rendered and the Medi-Cal beneficiary's delivery system (i.e., Medi-Cal Fee-for-Service, Medi-Cal Managed Care, and/or Dental Managed Care or Fee-For-Service). Under the fee-for-service delivery system, professional licensed medical personnel (i.e., medical consultants) adjudicate PA requests according to Federal and State regulations and DHCS policy. Adjudication of a PA request may result in one of four decisions: approved as requested, approved as modified, denied or deferred. DHCS communicates the status of the PA's adjudication to the submitting provider through an *Adjudication Response*.

For prior authorization requests that are submitted to Medi-Cal managed care health plans (MCPs), MCPs are required to respond to the provider and the beneficiary with the decision. The decision options are identical to a PA: approved as requested, approved as modified, denied or deferred. The provider will receive a letter from the MCP under each circumstance indicating approval, denial, or request for additional information. If the additional information is not provided when requested, a denial will occur. MCPs can vary supporting documentation requirements for PA. Providers should ask their MCP what type of documentation is needed. Beneficiaries will receive a Notice of Action letter that will outline appeal rights if any decision is rendered other than approved as requested.

Providers shall request authorization before rendering services. Services that require authorization are identified in the policy sections throughout Medi-Cal Part 2 Provider manuals. Outpatient and Medical Services providers also may refer to the *TAR and Non-Benefit List* section of the appropriate Part 2 manual.

➤ **Patient Information**

All PAs must provide beneficiary specific information including: Name, Date of Birth, Age, Client Index Number (CIN)/ Benefit Identification Card (BIC) Number; Parent/Caretaker Name; Home Phone Number; Work Phone Number; and Diagnosis.

➤ **Provider Information**

The PA request must include the following applicable and identifiable information: Referring Provider Name and NPI; Referral Address; Referral Phone; Rendering Provider Name and NPI; and Anesthesia Provider and NPI

➤ **Treatment Requested**

The provider must clearly identify the type of treatment being requested: IV Sedation; General Anesthesia; or Other, with a description of what the requested treatment is.

➤ **Location Where Requested Services to be Provided**

It is imperative that the PA request includes the actual location where services are to be provided, inclusive of a Dentist Office; Ambulatory Surgical Center; Ambulatory (Dental) Surgical Center; or Hospital.

➤ **Methods Attempted**

As part of the PA process, the request must identify and document the methods that were attempted including the number of attempts and/or a description of why the methods were not possible and justification of the medical necessity for IV sedation or general anesthesia. Examples of attempted methods are: Show-Tell-Do Method; Nitrous Oxide; Oral Sedation; and/or Local Anesthetic.

➤ **Reasons for Referral - Must be either 1 and 2 or any one of 3 through 6 as listed below:**

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient,

AND

2. Use of conscious sedation (either inhalation or oral) failed or was not feasible based on the medical needs of the patient.

OR any one of the following:

3. Failure of effective communicative techniques and immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient

4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation

5. Patient has acute situational anxiety due to immature cognitive functioning

6. Patient is uncooperative due to certain physical or mental compromising conditions

➤ **Medical and Dental History**

It is imperative that accompanying each PA is a copy of the beneficiary's medical and dental history to enable the reviewer to make a determination of the appropriateness of the PA. This includes, but is not limited to: copy of dental records; copy of history and physical examination including diagnosis; copy of treatment plan; copy of radiological reports; Indication for IV sedation or general anesthesia; and documentation of perioperative care (preoperative, intraoperative and postoperative).

➤ **Anticipated Billing Codes**

The anticipated billing codes should also be included on the PA and should complement/align with the requested treatment to be rendered, for example, DX (ICD-10) and/or TX (CPT-4).