Policy on Third-Party Reimbursement of Medical Fees Related to Sedation/General Anesthesia for Delivery of Oral Health Care Services

Latest Revision

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Purpose

The American Academy of Pediatric Dentistry (**AAPD**) wants to ensure that all children have access to the full range of oral health delivery systems. It advocates that if sedation or general anesthesia and related facility fees are payable benefits of a healthcare plan, these same benefits shall apply for the delivery of oral health services.

Methods

This policy was developed by the Dental Care Committee, adopted in 1989[1], and last revised by the Council of Clinical Affairs in 2016[2]. This document is based on a review of the current dental literature related to guidelines for sedation and general anesthesia, as well as issues pertaining to medically-necessary oral health care. The update included a PubMed®/MEDLINE search using the terms: general anesthesia/sedation costs, general anesthesia/sedation reimbursement, general anesthesia/sedation insurance coverage, general anesthesia and medically necessary dental care, and general anesthesia/oral health-related quality of life and limit: within the last 10 years, as well as relevant articles from dental and medical literature. The search returned 300 articles. Relevant policies and best practices of the AAPD and the American Dental Association (**ADA**) are included. Additionally, expert opinions and best current practices were relied upon when clinical evidence was not available.

Background

For some infants, children, adolescents, and persons with special health care needs, treatment under sedation/general anesthesia in a hospital, outpatient facility, or dental office or clinic represents the optimal method to deliver necessary oral health care.[3-5] The patient's age, dental treatment needs, limited abilities, medical conditions, or acute situational anxiety may preclude the patient from being treated in a traditional outpatient setting.[5-10] These patients may be denied access to oral health care when insurance companies refuse to provide reimbursement for sedation/general anesthesia and related facility services. When oral health care is not accessible, the health implications, effects on quality of life, and societal costs are enormous.[11]

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction. Medically necessary care includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care.[3] Some medical insurance plans may not view dental care and adjunctive services requiring hospital/anesthesia related fees as medically necessary. Although medical policies often provide reimbursement for sedation/general anesthesia and facility fees related to myringotomy for a three-year-old child, these benefits may be denied when related to treatment of dental disease or infection for the same patient. This determination at times appears to be based on inconsistent and poorly-defined criteria.[12-14] While states or third-party payors may require prior authorization for such procedures in an effort to control healthcare expenditures, this can be a time-consuming burden for practitioners. By establishing well-defined criteria (e.g., patient's age, treatment requirements, behavior, and medically-compromising condition; failed attempts at in-office treatment) and a streamlined preauthorization process, the dental practitioner is provided an opportunity to justify the need for anesthesia services and all parties can be assured of transparency, access to the full range of services available through a patient's benefits plan, and improved timeliness of treatment and reimbursement.

Delays in care can result in needless pain and suffering, infection, loss of function, and increased health care costs. Additionally, indiscriminate prescription of antibiotics for infections contributes to antibiotic resistance, and chronic use of acetaminophen for pain control can lead to hepatotoxicity. Less-effective management of these patients may result in a higher disease burden for the patient (i.e., more teeth requiring treatment and more invasive treatment needs)[15] as well as

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **ACA:** Affordable Care Act. **ADA:** American Dental Association. **ECC:** Early childhood caries. **QOL:** Quality of life.

the patient's avoidance of oral health professionals in the future and increased likelihood of seeking care in the emergency department[7]. Furthermore, this could also place an increased demand on practitioners, emergency departments, and hospitals to treat patients with urgent and emergent dental needs. In the event the insurer denies the preauthorization or claim citing lack of medical necessity, an appeals process to allow the practitioner to advocate on the patient's behalf through peer-to-peer conferences is essential.

Some patients may have dental developmental disorders such as dentinogenesis imperfecta, osteogenesis imperfecta, or molar-incisor hypoplasia which require extensive dental treatment that may exceed the capability of the patient to be treated in the normal clinic setting. Dental rehabilitation of early childhood caries (**ECC**) has shown a significant improvement in oral health-related quality of life (**QOL**) in children.[6,16-26] Children undergoing comprehensive dental treatment under general anesthesia exhibited improvement in several areas such as sleeping, eating, and pain.[6,17-20] Parents reported their children to have a better perceived QOL one to four weeks following dental rehabilitation under general anesthesia.[21] Such treatment also has been reported to have a positive impact on the family's quality of life.[16]

ADA Resolution 1989-546 states that insurance companies should not deny benefits that otherwise would be payable "solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure".[27] Recently, the ADA adopted Resolution 3-H (2021) which addressed anesthesia coverage under health plans. It "supports the position that all health plans, including those governed by the Employee Retirement Income Security Act, should be required to cover general anesthesia and/or hospital or outpatient surgical facility charges incurred by covered persons who receive dental treatment under anesthesia, due to a documented complexity, behavioral, physical, mental or medical reason as determined by the treating dentist(s) and/or physician."[28]

A majority of states have enacted legislation requiring medical insurers to reimburse for hospital charges associated with provision of dental care for children in the operating room.[7] Such legislation has resulted in increased access to care, with more children receiving services in an operating room setting after enactment of legislation.[6] However, this increased access has recently come in jeopardy due to multiple factors including the implementation of the Essential Health Benefits package under the Affordable Care Act (**ACA**).[7,29] While most ACA plans included "oral health" as a benefit, oral health was not defined. States play a major role in determining the content of their ACA plans, and fewer states included dental anesthesia (15) than orthodontic care (32) as a benefit for children.[29] Lower reimbursement of hospital facility and anesthesia fees also has reduced access to dental care under general anesthesia.[30]

Per an analysis commissioned by the AAPD, no suitable mechanism for billing rehabilitation services for Medicare or Medicaid beneficiaries having complex dental needs requiring operating room access exists.[31] Coding for dental procedures is limited to a miscellaneous code (CPT 41899) which falls in the Ambulatory Payment Class 5161. The mean reimbursement nationally for this class was less than $250, which is grossly insufficient as this rate does not cover the facility's overhead, equipment costs, or anesthesia services.[31] Therefore, hospitals may have financial incentive to provide operating room time to surgeons whose cases are associated with higher reimbursement levels. Hospital financial and staffing challenges including those caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)/coronavirus disease 2019 (COVID-19) pandemic have limited patient care and severely decreased hospital revenue.[31-33] Due to these obstacles, dental cases reportedly have been delayed as long as six months to a year.[30,31]

Regardless of the insurer and hospital challenges, with dental caries as the most common chronic disease of childhood, access to dental care remains one of the most frequently cited unmet needs.[34] Less availability of the operating room for pediatric dental patients has far reaching implications. Until this situation is rectified, third party payors may be faced with patients seeking medically-necessary oral health care in more expensive locations such as emergency departments.[35-37]

Policy statement

The AAPD encourages all policy makers and third-party payors to consult the AAPD in the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and individuals with special health care needs.

The AAPD strongly believes that the treating dentist determines the medical necessity for sedation/general anesthesia[3] consistent with accepted guidelines on sedation and general anesthesia[9].

The AAPD strongly encourages third-party payors to:

1. recognize that sedation or general anesthesia is necessary to deliver compassionate, quality oral health care to some infants, children, adolescents, and persons with special health care needs.
2. include sedation, general anesthesia, and related facility services as benefits of health insurance without discrimination between the medical or dental nature of the procedure.
3. end denial of reimbursement for sedation, general anesthesia, and facility costs related to the delivery of oral health care.
4. regularly consult the AAPD and the ADA with respect to the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and patients with special care needs.[38]

The AAPD encourages all states to enact legislation that requires third-party payors to reimburse for facility and sedation/general anesthesia costs associated with providing oral health care for children.

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