

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

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**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](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

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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](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](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:

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[http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume\\_31\\_Number\\_18a.pdf](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?**

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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](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 anesthesiologist 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.*

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**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.