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Deep Sedation and General Anesthesia for Dental Services

Policy Number: MM.12.034	**Current Effective Date:** January 1, 2022
Lines of Business: PPO; HMO; QUEST Integration	**Original Effective Date:** January 1, 2022
Place of Service: Inpatient; Outpatient	**Precertification:** Yes

I. Description

Deep sedation or general anesthesia may be medically necessary to render dental services in patients who have special challenges related to their age, behavior, medical comorbidities, developmental disabilities, or intellectual limitations. However, in the vast majority of cases, dental care may be performed without deep sedation or general anesthesia. Guidelines exist for use of non-pharmacologic measures such as behavior guidance techniques and protective stabilization. Pharmacologic treatments may include nitrous oxide. Administration of any type of anesthesia service must be provided by qualified and appropriately trained individuals.

Dental disease is usually not life threatening, though when left untreated, can result in loss of function, infection, and pain. Deep sedation and general anesthesia itself is an intervention that is not without risks, as such, should be reserved as an option of last resort when patient's demonstrated uncooperative behavior makes the delivery of a critical therapy unsafe or impossible, and all alternate therapeutic options and modalities have been considered with priority . The purpose of this policy is to help ensure patient safety, minimize patient risk, and reserve these services for patients and situations that appropriately warrant the risk.

This policy does not address deep sedation or general anesthesia for oral surgery.

II. Policy Criteria

Deep sedation or general anesthesia for dental services is covered (subject to Limitations and Administrative Guidelines) when anesthesia and dental care is provided in an approved setting by a credentialed anesthesiologist or properly trained and permitted dentist and when all of the following criteria are met:

A. Temporizing agents (e.g., silver diamine fluoride, interim therapeutic restoration, fluoride varnish, antibiotics) and/or treatment deferral are not options,
B. The patient has a risk score of 22 or higher on "Criteria for Dental Therapy Under General Anesthesia" as described in the chart in Appendix A,
C. The patient has tried and failed, or has contraindications, to nitrous oxide, see Appendix B ,
D. The patient has tried and failed at least 3 behavior guidance techniques, see Appendix C,
E. The patient or representative (parent/guardian) must be informed of the risks, benefits, and alternatives to deep sedation/general anesthesia prior to all dental procedures,
F. Anesthesia is administered by a credentialed anesthesiologist or properly trained and permitted dentist in accordance with applicable state laws/regulations.

Appendix A
Appendix B
Appendix C

III. Limitations

A. 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.

B. The following dental anesthesia services are not covered as they are not known to be effective in improving long term health outcomes:

1. Dental and oral surgery services of a cosmetic nature defined as services primarily intended to improve a member's appearance but do not restore or materially improve a physical function, or are prescribed for psychological or psychiatric reasons
2. Associated services for all cosmetic procedures are non-covered, e.g. facility, anesthesia
3. Services performed for the convenience of the patient or the dentist
4. Deep sedation/general anesthesia associated with removal of asymptomatic, non-pathologic (non-impacted), third molars
5. Services submitted by more than one provider or facility, including Ambulatory Surgical Centers (ASCs) that are the same services performed on the same dates for the same patient
6. Local anesthesia billed separately from dental anesthesia services on the same date of service for the same patient
7. Exploratory services performed to determine if a patient has dental pathology.

IV. Administrative Guidelines **Appendix A; Appendix B; Appendix C**

A. Precertification is required. To precertify, complete HMSA's Precertification Request and mail or fax the form or use iExchange as indicated. Include the following information if applicable:

1. Documentation must include a thorough description for all elements used in Appendix A: Criteria for Dental Therapy Under General Anesthesia
   a. Fully narrative description of circumstances regarding "definitely" or "somewhat" negative behavior
   b. For patient's <18 years of age, documentation that parent/guardian agree with dentist's assessment of child's behavior
   c. If used, documentation of failure of conscious sedation including agents and dosage or nitrous oxide
   d. Documentation of a medically compromising of handicapping condition (i.e. pertinent medical, neurodevelopmental, and/or psychiatric conditions)

2. Additional documentation must include a thorough description of the following, as applicable:
   a. Patient's age, conditions matching Policy Criteria in II.
   b. Failure or contraindications to nitrous oxide as outlined in Appendix B
   c. Acknowledgement of discussion about risks, benefits, and alternatives to deep sedation/general anesthesia
   d. At least three behavior guidance techniques that were tried and failed, see Appendix C
   e. Tooth specific clinical diagnosis and intended treatment plan
   f. Rationale for immediate need of anesthesia/procedures
   g. Signed and dated Parental General Anesthesia Acknowledgement

B. Precertification is required for QUEST Integration. This policy does not replace any existing requirements set forth by Med-QUEST Division regarding prior authorization process requirements for pediatric dental services requiring general anesthesia.

CPT Codes	Description
00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified
41899	Unlisted procedure, dentoalveolar structures – This code does not require precertification but does suspend for review before payment

ICD-10 Codes	Description
K02.3	Arrested dental caries
K01.1	Impacted teeth
K02.51	Dental caries on pit and fissure surface limited to enamel
K02.52	Dental caries on pit and fissure surfc penetrat into dentin
K02.53	Dental caries on pit and fissure surface penetrat into pulp
K02.61	Dental caries on smooth surface limited to enamel
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K02.9	Dental caries, unspecified
K03.7	Posteruptive color changes of dental hard tissues
K03.81	Cracked tooth
K04.1	Necrosis of pulp
K04.6	Periapical abscess with sinus
K04.7	Periapical abscess without sinus
K05.00	Acute gingivitis, plaque induced
K05.10	Chronic gingivitis, plaque induced
K08.3	Retained dental root
K08.52	Unrepairable overhanging of dental restorative materials
K08.530	Fractured dental restorative material w/o loss of material
K08.531	Fractured dental restorative material with loss of material
K08.539	Fractured dental restorative material, unspecified
K08.55	Allergy to existing dental restorative material
K08.89	Other specified disorders of teeth and supporting structures
K08.9	Disorder of teeth and supporting structures, unspecified
R68.84	Jaw pain
S02.5XXA	Fracture of tooth (traumatic), initial for closed fracture
S02.5XXB	Fracture of tooth (traumatic), initial encounter for open fracture
Z01.20	Encounter for dental exam and cleaning w/o abnormal findings

Z01.21	Encounter for dental exam and cleaning w abnormal findings
Z13.84	Encounter for screening for dental disorders
Z46.3	Encounter for fit/adjst of dental prosthetic device
Z91.842	Risk for dental caries, moderate
Z91.843	Risk for dental caries, high
Z98.810	Dental sealant status
Z98.811	Dental restoration status
Z98.818	Other dental procedure status

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4) or for QUEST members under Hawaii Administrative Rules (HAR 1700.1-42), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA's determination as to medical necessity in a given case, the physician may request that HMSA consider the application of this Medical Policy to the case at issue.

VI. Scientific Background

Definitions

The American Society of Anesthesiologists (ASA) provides the following definitions of deep sedation and general anesthesia:

- **Deep Sedation/Analgesia:** A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (NOTE: reflex withdrawal from a painful stimulus is NOT considered a purposeful response) following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- **General Anesthesia:** A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

- **Moderate Sedation/Analgesia ("Conscious Sedation")** is a drug-induced depression of consciousness during which patients respond purposefully (NOTE: reflex withdrawal from a painful stimulus is NOT considered a purposeful response) to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Benefit of deep sedation/general anesthesia for dental procedures

In the American Academy of Pediatric Dentistry "Use of Anesthesia Providers in the Administration of Office-based Deep Sedation/General Anesthesia to the Pediatric Dental Patient ", the use of behavior guidance techniques is highlighted to allow most pediatric dental patients to receive treatment in the dental office with minimal discomfort and without expressed fear. Use of minimal to moderate sedation allows those less compliant to receive treatment. Deep sedation/general anesthesia is described for use in "Some children and individuals with special care needs who have extensive oral healthcare needs, acute situational anxiety, uncooperative age-appropriate behavior, immature cognitive functioning, disabilities, or medical conditions". These guidelines reference "Special Care Dentistry Association consensus statement on sedation, anesthesia, and alternative techniques for people with special needs ", which references other professional guidelines.

Lim and Borromeo reviewed literature regarding use of general anesthesia to facilitate dental treatment in adult patients with special needs. Multiple questions were unanswered per authors, including "in patients with special needs who require general anesthesia to facilitate treatment, what constitutes an effective recall strategy for repeat procedure? Is it appropriate and safe for general anesthesia to be an ongoing part of their oral healthcare management? Likewise, is this form of management in the best interest of all patients who require a procedure under general anesthesia or are other sedation modalities safer and more amenable to the patient's care?"

Risks of deep sedation/general anesthesia

Deep sedation and general anesthesia are not benign procedures without an element of risk.

Vutskits and Davidson reviewed experimental and clinical research literature regarding adverse long-term impact of general anesthesia on the developing brain. Single exposure to sevoflurane anesthesia decreased synaptic density in adult rats that were exposed in the early prenatal period. Nonhuman primate behavioral follow-up studies following early-life anesthesia exposure found increased anxiety, long-term impairments affecting both motor and socioemotional aspects of behavior. Findings from human studies were mixed but varied in study populations, exposures, and outcome measurements, and also were confounded by children who underwent anesthesia often have other problems which in themselves put the child at risk of poor neurodevelopmental outcome.

Raghavan et al performed a retrospective study of the Wake-Up Safe (WUS) registry, between January 2010 and December 2017, to investigate the rate and describe the nature, risk factors, severity of outcome, and contributory and causative factors of neurological adverse events (NAEs) occurring during and within 24 hours of general anesthesia in children. The rate of perianesthetic neurological adverse events was 0.49 per 10,000 pediatric anesthetic encounters. The odds of NAE were significantly higher in children who were older than 6 months; had American Society of Anesthesiologists physical status (ASA PS) of 3, 4, or 5; or had American Society of Anesthesiologists Emergency (ASA E) status. Seizures were the most common NAE. Overall, 23 (18.1%) children with neurological adverse events died, and 33 (26%) experienced permanent or

severe permanent harm. The risk of death was higher in infants and in children with ASA PS of 3, 4, or 5; ASA E status; preexisting neurological abnormality; or preexisting neurological deficit and in events associated with cardiac arrest or trauma. Anesthesia contributed to 24 (18.9%) events; patient disease was the primary causative factor in 95 (74.8%) adverse events, and 37 (29.1%) events were preventable, including 2 deaths. Preventable factors broadly included inadequate preoptimization, complications during airway management and central venous catheter placement, and suboptimal patient positioning.

Grabowski et al. performed a systematic review of effects of early anesthesia on neurodevelopment. In total, 493 titles were initially identified, with 56 articles selected for full analysis and 44 included for review. Based on currently available developmental assessment tools, a single exposure to general anesthesia does not appear to have a significant effect on general neurodevelopment, although prolonged or multiple anesthetic exposures may have some adverse effects. Exposure to general anesthesia may affect different domains of development at different ages. Regional anesthetic techniques with the addition of dexmedetomidine and/or some intravenous agents may mitigate the risks of neurotoxicity.

Lee et al. performed a review of media reports in the Lexis-Nexis Academic database and a private foundation website to summarize dental anesthesia-related pediatric deaths due to few data available to quantify pediatric morbidity and mortality related to dental anesthesia. Settings included dental offices, ambulatory surgery centers, and hospitals for US-based children between 1980-2011. Most deaths occurred among 2 – 5-year-olds (n = 21/44), in an office setting (n = 21/44), and with a general/pediatric dentist (n = 25/44) as the anesthesia provider. In this latter group, 17 of 25 deaths were linked with a sedation anesthetic. Note that 7/44 deaths occurred with anesthesiologist as the provider (4 of these occurred in surgery center/hospital), and 10/44 occurred with general anesthesia. 3 of the 44 cases had preexisting medical conditions, 1 of these died on induction of general anesthesia with a volatile anesthetic with autopsy revealing undiagnosed heart defect.

Jooma et al performed a prospective descriptive study on the incidence of emergence delirum of children aged 2-6 years undergoing elective dental surgery under general anesthesia. Emergence delirum (ED) was described as “a disturbance in the child's awareness of and attention to his or her environment with disorientations and perceptual alterations including hypersensitivity to stimuli and hyperactive motor behaviour in the immediate post anaesthesia period”, which is self-limiting but can be unpleasant and also may inflict self-harm. OR for emergence delirum in those with anxiety was 0.3 (95% CI 0.11-0.78), with . Children with emergence delirum required significantly more interventions in the recovery room, namely physical restraint and/or consoling by the parent, pharmacologic agents (fentanyl used in 4.3% patients with ED)) ($P<0.0001$).

Impact of dental outcomes with use of deep sedation/general anesthesia

Oubenyahya & Bouhabba performed a literature review of general anesthesia in the management of early childhood caries. Many children with ECC that are treated under GA exhibit high caries relapse rates. Almeida et al. reported a 79% caries recurrence rate in children who underwent ECC treatment under GA; 17% of these patients required a repeat GA intervention within two years. Similar results were revealed by Kakaounaki et al. 8.9% of 484 children required a re-intervention under GA during a 6-year follow up period. Further, Berkowitz et al. reported that over half the children in their study exhibited new smooth surface caries lesions after 6 months and most parents were unresponsive to later appointments. Similarly, Foster reported that half their patients had new caries within two years and this relapse was more likely when parents failed to attend follow up care. Amin et al. reported a 22% relapse rate in patients attending a

recall appointment within 1 year following surgery compared with a 51% relapse rate in the group attending their first recalls at 13–24 months post-surgery. Correspondingly, an increased relapse rate from 51% in the high attendance patients to 68% in patients with lower attendance rates was reported by El Batawi. The aggressive dental approach of ECC under GA (extractions, pulp therapy, and SSCs) did not decrease caries relapse, which might indicate that this is better explained by a lack of follow up care and persistence of cariogenic habits post rehabilitation. Conclusion by Oubenyahya & Bouhabba (2019) was that an approach that treats the clinical outcome of caries alone without addressing or correcting the underlying risk factors of ECC will fail.

Nitrous oxide

The American Academy of Pediatric Dentistry (AAPD) recognizes nitrous oxide/oxygen inhalation as a safe and effective technique to reduce anxiety, produce analgesia, and enhance effective communication between a patient and health care provider. Nitrous oxide/oxygen analgesia/anxiolysis has an excellent safety record. When administered by trained personnel on carefully selected patients with appropriate equipment and technique, nitrous oxide is a safe and effective agent for providing pharmacological guidance of behavior in children. Acute and chronic adverse effects of nitrous oxide on the patient are rare but may include silent regurgitation with subsequent aspiration if pharyngeal-laryngeal reflexes are not intact can be avoided by not allowing patient to go into an unconscious state. Additional usage guidance is detailed in AAPD "Use of Nitrous Oxide for Pediatric Dental Patients".

VII. References

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VIII. Appendices (Back to Criteria)

A. Criteria For Dental Therapy Under General Anesthesia for QUEST members; DHS Form: 1190, (Med-QUEST Forms - Search for 1190)

Total points needed to justify consideration of treatment under general anesthesia = 22

Age of client at time of examination	Points	Select One
Less than four years of age	8	☐
Four and five years of age	6	☐
Six and Seven years of age	4	☐
Eight years of age and older	2	☐

Treatment Requirements (Carious and/or Abscessed Teeth)	Points	Select One
1-2 teeth or one sextant	3	☐
3-4 teeth or 2-3 sextants	6	☐
5-8 teeth or 4 sextants	9	☐
9 or more teeth or 5-6 sextants	12	☐

Behavior of Client (Must be supported in submitted narrative/documentation)	Points	Select One
Behaviors such as expression of fear, crying/screaming, nervousness, and/or cautious acceptance of treatment	0	☐

Somewhat negative – defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, restlessness, refusal to take radiographs willingly	4	☐
Definitely negative – hysterical or combative, unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability	10	☐

Additional Factors (Must be supported in submitted narrative/documentation)	Points	Select All That Apply
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention	15	☐
Failed conscious sedation (Nitrous Oxide is not considered conscious sedation)	15	☐
Medically compromising of handicapping condition	15	☐

Total Points (add the points from each section and document the total here)		

IX. Appendix B (Back to Criteria)

B. Contradictions for use of Nitrous Oxide for Dental Services

1. Some chronic obstructive pulmonary diseases
2. Current upper respiratory tract infections
3. Recent middle ear disturbance/surgery
4. Severe emotional disturbances or drug-related dependencies
5. First trimester of pregnancy
6. Treatment with bleomycin sulfate
7. Methylenetetrahydrofolate reductase deficiency
8. Cobalamin (vitamin B-12) deficiency

Note that whenever possible, appropriate medical specialists should be consulted before administering analgesic/anxiolytic agents to patients with significant underlying medical conditions (e.g., severe obstructive pulmonary disease, congestive heart failure, sickle cell disease, acute otitis media, recent tympanic membrane graft, acute severe head injury). In addition, consultation with the prenatal medical provider should precede use of nitrous oxide/oxygen analgesia/anxiolysis during pregnancy.

REFERENCE: American Academy of Pediatric Dentistry. Use of nitrous oxide for pediatric dental patients. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2020:324-9.

X. Appendix C (Back to Criteria)

C. Behavior Guidance Techniques for Dental Services

Behavior guidance techniques should be used to alleviate anxiety, nurture a positive dental attitude, and perform quality oral health care safely and efficiently for infants, children, adolescents, and persons with special health care needs (SHCN). Selection of techniques must be tailored to the needs of the individual patient and the skills of the practitioner. Behavior guidance is not an application of individual techniques created to deal with children, but

rather a comprehensive, continuous method meant to develop and nurture the relationship between the patient and doctor, which ultimately builds trust and allays fear and anxiety.

1. Positive pre-visit imagery
2. Direct observation
3. Tell-show-do
4. Ask-tell-ask
5. Voice control
6. Nonverbal communication
7. Positive reinforcement and descriptive praise
8. Distraction
9. Memory restructuring
10. Desensitization to dental setting and procedures
11. Enhancing control
12. Communication techniques for parents (and age-appropriate patients)
13. Parental presence/absence

Additional considerations for patients with anxiety or special health care needs

14. Sensory-adapted dental environments (SADE)
15. Animal-assisted therapy (AAT)
16. Picture exchange communication system (PECS)

XI. Policy History

August 17, 2021	Policy reviewed by Dr. Wu
August 17, 2021	Policy approved by Medical Directors
August 18, 2021	Policy approved by UMC
January 1, 2022	Effective Date

XII. Policy Approval

Stephen Lin MD

August 18, 2021

Chair of Utilization Management Committee Date

Brian Wu MD

August 18, 2021

HMSA QUEST Integration Medical Director Date