16.1.25.2 Prior Authorization for Level 4 Deep Sedation and General Anesthesia Provided in Conjunction with Therapeutic Dental Treatment

Notice: MM/DD/YYYY
Effective: July 1, 2017

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Beginning July 1, 2017, all level 4 sedation services by a dentist, procedure code W-D9223, and any anesthesia services provided by an anesthesiologist (M.D./D.O) or certified registered nurse anesthetist (CRNA), procedure code 7-00170, with EP modifier, to be provided in conjunction with dental therapeutic services for Medicaid dental members from ages zero (0) through six (6) years, must be prior authorized. Note: managed care organizations (MCOs) may choose whether to require a modifier on claims for CPT 00170.

The dentist performing the therapeutic procedure is responsible for obtaining prior authorization from the dental maintenance organization (DMO). Prior authorization for both dental services and level 4 sedation/general anesthesia service is mandatory for the reimbursement of either service. The dentist performing the dental therapeutic service is also responsible for providing the anesthesia prior authorization determination from the DMO to the anesthesiology provider. The medical anesthesia provider or facility submits a prior authorization request to the member’s managed care organization (MCO). MCOs must review and prior authorize the medical anesthesiology service subsequent to the prior authorization review performed by the DMO. DMOs will review and make determinations on appropriate dental procedure codes and/or diagnosis codes. MCOs will review and make determinations on appropriate medical procedure codes and/or diagnosis codes.

The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for the age group. Member specific documents and information to be submitted for prior authorization include but are not limited to:

1. The completed Criteria for Dental Therapy Under General Anesthesia form
2. Location where procedures will be performed (in office, or inpatient/outpatient hospital facility)
3. Narrative unique to the member detailing reasons for the proposed level of anesthesia (indicate procedure code W-D9223 or 00170) including:
   a. History of prior treatment
   b. Failed attempts at other levels of sedation
   c. Behavior in the dental chair
   d. Proposed restorative treatment (tooth ID and surfaces)
   e. Urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries
   f. Any relevant medical condition(s)
4. Diagnostic quality radiographs and/or photographs
   a. When appropriate radiographs and/or photographs cannot be taken prior to general anesthesia, the narrative must support the reasons for an ability to perform diagnostic services. For these special cases that receive authorization,
diagnostic quality radiographs/photographs will be required for payment and will be reviewed by the DMO.

Emergency Treatment

In cases of an emergency medical condition, accident or trauma, prior authorization is not necessary. A narrative and appropriate pre- and post-treatment radiographs/photographs must be submitted with the claim. These will be reviewed by the MCO for appropriateness prior to payment.

Coverage Determinations and Appeals Processes

Requirements for prior authorizations, coverage determinations, and appeals processes for services provided through Medicaid managed care are included in Texas Government Code 533 and the Medicaid managed care contracts. Prior authorizations by DMOs and MCOs must be approved within the timeframe prescribed in the managed care contracts and/or the Uniform Managed Care Manual (UMCM). These requirements are listed in section 8.1.9 of the Dental Services Contract, section 8.1.8 of the Uniform Managed Care Contract, section 8.1.9 of the STAR Kids Contract, and section 8.1.8 of the STAR Heath Contract.

DMOs and MCOs use utilization management criteria to evaluate the need for medically necessary covered services. Appeals for denials of medical necessity follow standard provider appeals provisions of the DMO and MCO contracts. Providers should contact the MCO or DMO for requirements for reconsideration of denied prior authorization requests. In the case of a denial of prior authorization of medical necessity by the MCO when the dental services have been prior authorized by the DMO, the MCO and DMO are responsible for coordinating to resolve the issue and appropriately notify the respective providers.

All MCOs and DMOs will accept the Texas Department of Insurance (TDI) Standard Prior Authorization form. Each MCO and DMO may have its own forms and methods for submission for prior authorizations. Providers should contact the DMO and/or MCO for specific requirements.

OPERATIONAL GUIDANCE FOR DMOS/MCOS

Once the DMO has approved a dental provider’s request for prior authorization for either level 4 deep sedation or general anesthesia provided in conjunction with therapeutic dental treatment for members’ ages zero (0) through six (6) years, the DMO must provide proof of approved prior authorization to the dental provider. This proof of approved prior authorization may be delivered to the dental provider using its established provider notification process.

The dental provider must submit the proof of approved prior authorization from the DMO to the anesthesia provider. For general anesthesia administered by a medical anesthesiologist or CRNA, the treating dentist must provide the proof of approved prior authorization from the DMO for dental services to the medical anesthesiology provider or facility. Providers should contact the MCO for specific prior authorization requirements or limitations for level 4 deep sedation and general anesthesia provided in conjunction with therapeutic dental treatment for members’ ages zero (0) through six (6).

Each MCO must require prior authorization for general anesthesia (00170) in advance of dental related anesthesia services being performed by its network providers. The MCO may also
require prior authorization for the facility fee (41899). The MCO may request supporting clinical documentation as part of the prior authorization. This must include proof of approved prior authorization for dental services from the DMO.

Upon completion of the services, the dental provider(s) should submit the claim(s) for CDT code D9223 and appropriate CDT codes for payment to the DMO. Claims from medical providers for in-office general anesthesia (00170) should be submitted to the MCO. Claims from medical facilities for outpatient general anesthesia (00170) and/or facility fees (41899) should be submitted to the MCO.

For level 4 deep sedation or general anesthesia performed by a dental anesthesiologist, the dental anesthesia provider must submit the DMO prior authorization number from the treating dentist on the sedation or anesthesia claim. All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance for dental anesthesia. Dental providers must have a current level 4 anesthesia permit issued by the TSBDE to be reimbursed for level 4 deep sedation/general anesthesia services.

The proof of approved prior authorization from the DMO must contain at least the following elements:

1. DMO information
   a. DMO name
   b. DMO address
   c. DMO phone number
   d. DMO fax number
2. Provider information
   a. Provider name
   b. Provider address
   c. Provider phone
   d. Provider NPI
   e. Rendering provider name
   f. Rendering provider NPI (if different from requesting provider)
   g. Treatment location (office or outpatient facility)
3. Member information
   a. Member name
   b. Member Medicaid ID number
   c. Member date of birth
4. Prior Authorization details
   a. Prior authorization/pre-authorization number
   b. Date authorization request received by DMO
   c. Type of authorization request (standard or expedited)
   d. Date of determination by DMO
   e. Determination (approved or denied)
   f. Authorization effective date (if approved)
   g. Authorization end date (if approved)
   h. Procedures authorized (CDT, description, tooth # or area)
5. Comments/Remarks on the Prior Authorization request: Enter reason for denial or additional documentation received, such as x-rays, photographs, type of sedation required, etc.
Dental providers must follow the steps below to obtain prior authorizations for level 4 sedation or general anesthesia to be provided in conjunction with dental therapeutic services for Medicaid dental members ages zero (0) through six (6) years when the place of service is a dental office:

1. The treating dentist determines the level of care needed and submits a prior authorization request and supporting documentation to the member’s DMO.
2. The member’s DMO reviews the request for medical necessity and approves or denies the prior authorization request.
3. If approved, the DMO notifies the treating dentist that the services were approved for the place of service requested. The DMO will provide the treating dentist proof of the approved prior authorization using its established provider notification process.
4. The treating dentist provides a copy of the DMO’s approval to the medical anesthesiologist or provider. To be reimbursed by the member’s MCO, the provider must use the MCO’s contracted anesthesia provider.
5. If the provider administering level 4 sedation or general anesthesia is a dentist, separate prior authorization from the DMO for level 4 sedation or general anesthesia is not required. The dental anesthesiology provider must obtain the prior authorization number from the treating dentist and submit that number on a claim to the DMO after services are rendered. DMOs should ensure that separate claims from the treating dentist and dental anesthesia provider are able to be paid appropriately.
6. The medical anesthesiology provider submits a prior authorization request and supporting documentation to the member’s MCO. This supporting documentation must include the proof of approved prior authorization from the DMO. The supporting documentation must include the proof of prior authorization from the DMO.
7. The member’s MCO reviews the request for medical necessity and approves or denies the medical anesthesiology provider’s prior authorization request.
8. If approved, the MCO notifies the medical anesthesiology provider that the anesthesia services are approved for an in-office setting.
9. The medical anesthesiology provider coordinates with the dental provider to schedule services for the member.
10. Upon completion of general anesthesia and therapeutic dental services, the treating dentist submits a claim for appropriate CDT codes for payment to the DMO, including the prior authorization number. If a dental anesthesiologist is utilized, the dental anesthesiologist submits a claim for D9223 to the DMO, including the prior authorization number from the DMO.
11. The DMO reviews and adjudicates the claim according to the guidelines in its provider manual.
12. Upon completion of anesthesia services, the medical anesthesiology provider submits a claim for payment of anesthesia procedures (00170).
13. Upon receipt of the claim(s), the MCO reviews and adjudicates the claim according to the guidelines in its provider manual.

Dental providers must follow the steps below to obtain prior authorizations for level 4 sedation or general anesthesia to be provided in conjunction with dental therapeutic services for Medicaid dental members when the place of service is an ambulatory surgical center (ASC), hospital ambulatory surgical center (HASC), or hospital.

1. The treating dentist determines the level of care needed and submits a prior authorization request and supporting documentation to the member’s DMO.
2. The member’s DMO reviews the request for medical necessity and approves or denies the prior authorization request.
3. If approved, the DMO notifies the treating dentist that the services were approved for the place of service requested. The DMO will provide the treating dentist proof of the approved prior authorization using its established provider notification process.
4. The treating dentist provides a copy of the DMO’s approval to the medical anesthesiologist or provider. To be reimbursed by the member’s MCO, the provider must use the MCO’s contracted anesthesia provider.
5. The medical anesthesiology provider submits a prior authorization request and supporting documentation to the member’s MCO. This supporting documentation must include the proof of approved prior authorization from the DMO. The supporting documentation must include the proof of prior authorization from the DMO.
6. The member’s MCO reviews the request for medical necessity and approves or denies the medical anesthesiology provider’s prior authorization request.
7. If approved, the MCO notifies the medical anesthesiology provider that the anesthesia services are approved for an in-office setting.
8. The medical anesthesiology provider coordinates with the dental provider to schedule services for the member.
9. Upon completion of general anesthesia and therapeutic dental services, the treating dentist submits a claim for appropriate CDT codes for payment to the DMO, including the prior authorization number. If a dental anesthesiologist is utilized, the dental anesthesiologist submits a claim for D9223 to the DMO, including the prior authorization number from the DMO.
10. The DMO reviews and adjudicates the claim according to the guidelines in its provider manual.
11. Upon completion of anesthesia services, the medical anesthesiology provider submits a claim for payment of anesthesia procedures (00170).
12. Upon receipt of the claim(s), the MCO reviews and adjudicates the claim according to the guidelines in its provider manual.
dental members ages zero (0) through six (6) years when the place of service is an ambulatory surgical center, hospital ambulatory surgical center, or hospital:

1. The treating dentist determines the level of care needed and submits a prior authorization request and supporting documentation to the member’s DMO.
2. The member’s DMO reviews the request for medical necessity and approves or denies the prior authorization request.
3. If approved, the DMO notifies the treating dentist that the services were approved for the place of service requested. The DMO will provide the treating dentist proof of the approved prior authorization using its established provider notification process.
4. The treating dentist provides a copy of the DMO’s approval to the medical anesthesiologist or provider. To be reimbursed by the member’s MCO, the dentist must use the MCO’s contracted facility and anesthesia provider.
5. If the provider administering level 4 sedation or general anesthesia is a dentist, separate prior authorization from the DMO for level 4 sedation or general anesthesia is not required. The dental anesthesiology provider must obtain the prior authorization number from the treating dentist and submit that number on a claim to the DMO after services are rendered. DMOs should ensure that payments from the treating dentist and dental anesthesia provider are able to be paid appropriately.
6. The medical facility submits a prior authorization request and supporting documentation to the member’s MCO. This supporting documentation must include the proof of approved prior authorization from the DMO. The supporting documentation must include the proof of prior authorization from the DMO. MCOs may also require prior authorization of the facility fee (41899).
7. The member’s MCO reviews the request for medical necessity and approves or denies the medical facility’s prior authorization request.
8. If approved, the MCO notifies the medical facility that the anesthesia services are approved for the facility setting.
9. The medical facility coordinates with the dental provider to schedule services for the member.
10. Upon completion of both general anesthesia and therapeutic dental services, the treating dentist submits a claim for appropriate CDT codes for payment to the DMO, including the prior authorization number from the DMO.
11. The DMO reviews and adjudicates the claim according to the guidelines in its provider manual.
12. Upon completion of general anesthesia services, the medical facility submits a claim to the MCO for anesthesia services (00170) and the facility fee (41899) if applicable. 
13. Upon receipt of the claim(s), the MCO reviews and adjudicates the claim(s) according to the guidelines in its provider manual.

References
1. TMPPM. 4.2.25. Dental Therapy Under General Anesthesia; 4.2.24. Dental Anesthesia. Available at: 
2. Medicaid Managed Care Contracts. Available at:
   http://www.hhsc.state.tx.us/medicaid/managed-care/forms.shtml
3. Texas State Board of Dental Examiners. Anesthesia Privileges. Available at: 
   https://www.tsbde.texas.gov/AnesthesiaPrivileges.html