Payment Policy | Dental Procedures in the Outpatient Setting

EFFECTIVE DATE: 01|01|2014
POLICY LAST UPDATED: 01|03|2017

OVERVIEW
This policy addresses guidelines relating to facility charges when a dental procedure is rendered in a setting other than the dental office for members with a qualifying medical condition.

PRIOR AUTHORIZATION
Prior authorization is required for BlueCHiP for Medicare and recommended for Commercial products.

POLICY STATEMENT
BlueCHiP for Medicare and Commercial Products
Facility charges (e.g., operating room, anesthesia, medical consults) are eligible for coverage under the member's **medical benefit** when the criteria below are met. Any fees and charges specific to the dental procedure or service performed are eligible for coverage under the member's dental benefit. If the member does not have dental coverage, any resulting charges are the member's responsibility.

MEDICAL CRITERIA
While most dental treatment may be performed in an office setting, some members needing dental treatment may have a qualifying medical condition that requires the procedure be provided at an inpatient/outpatient hospital setting or ambulatory surgical center. Such documented medical conditions are as follows, but are not limited to:

- Heart disease, including congenital defects and prosthetic heart valve that require strict anticoagulation
- Endocrine disturbances, including brittle diabetes and adrenal insufficiency
- Blood dyscrasias, including coagulation defects
- Neuromuscular disease, including spastic paralysis and muscular dystonias
- Pulmonary disease including asthma that cannot safely be managed in an office setting
- Genetic disease, including cystic fibrosis and cleft palate
- Mental retardation complicated by seizure disorders, cerebral palsy, or behavior disorders
- Documented severe emotional disturbance/behavioral disorders
- Rampant caries in a patient less than forty-eight (48) months of age (Baby Bottle Syndrome)
- Extreme apprehension in children with documentation of unsuccessful attempt(s) at office treatment with sedation

BACKGROUND
When a member has a significant qualifying medical condition, a dentist may request preauthorization to perform the dental service in a setting other than the dental office.

COVERAGE
Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage or Subscriber Agreement for applicable Dental and Inpatient/Outpatient/Free-Standing Ambulatory Surgery benefits/coverage.

Coverage for dental services performed by the oral surgeon/dentist will be provided through the dental benefit. If the member has no dental coverage, payments for the dental services are the member's responsibility.

CODING

Note to Facilities: To ensure correct claim processing, **facilities are requested to use the Revenue Codes and HCPCS dental codes listed below:**

Outpatient Surgery Revenue Codes:
0360 Operating Room Services
0361 Operating Room Services: Minor surgery

HCPCS Dental Procedure Codes:
The following is a list of HCPC dental procedure codes **typically** used for dental procedures rendered in the outpatient setting. This is NOT an all-inclusive list.


Dental Svcs in OP Setting HCPCS Codes

RELATED POLICIES

None

PUBLISHED

Provider Update, February 2017
Provider Update, February 2016
Provider Update, August 2014
Provider Update, April 2013
Provider Update, May 2011
Provider Update, December 2011
Provider Update, July 2009
Provider Update, April 2008
Policy Update, January 2008

REFERENCES

Not applicable