

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

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

