ANESTHESIA
ASSOCIATES OF CENTRAL PENNSYLVANIA

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OFFICE BASED ANESTHESIA GUIDE

The professional fees for your anesthesiologist's services are separate from your dental bill. Our services are available by request through your pediatric dental office. AACP (Anesthesia Associates of Central Pennsylvania) are not providers (out of network) with any insurance company and cannot usually accept insurance assignment, **BUT** your medical insurance may **reimburse you directly** for part of the anesthesia fee.

You are the customer in this situation and your insurance company will be more responsive to your direct claims for reimbursement. We will gladly help patients who have health insurance receive the maximum benefits provided by your insurance company.

Due to its recent introduction within the medical and dental community, many health plans have not formally completed their review of this mode of care or you may find that your specific health plan may not currently consider office based anesthesia (OBA) for pediatric patients as a covered benefit for treatment of dental conditions. As more parents, such as you, request coverage for OBA for procedures such as your child's dental treatment, the reimbursement process will get easier and more health plans will cover this.

This guide provides details on how to find out if your health plan covers office based anesthesia for pediatric patients and for obtaining pre-authorization approval for treatment if need be. It overviews the steps you can follow if you have individual health insurance or group health insurance coverage through your employer.

Step 1: Is your child a candidate for office based anesthesia (OBA) for dental care?
Answer: Your pediatric dentist, upon evaluating your child will determine the best treatment modality to best care for him/her. The office staff will have you fill out a brief medical history form and share the information with the anesthesiologist. If it is determined the child would be best treated with the utilization of anesthesia, you will also be given a medical evaluation form to be filled out by your pediatrician 1-3 days prior to treatment. THIS STEP IS IMPORTANT. Pediatricians routinely allow for a quick check-up/evaluation, are flexible with scheduling, and the appointment is almost always covered by insurance.

Step 2: Is office based anesthesia a covered benefit under your health plan?
Answer: Contact your health plan provider by phone to ascertain if OBA for pediatric dental treatment is a covered benefit under your plan. Provide them with the following OBA procedural codes and Current Procedural Terminology (CPT) codes:

CPT 00170-P – Anesthesia for intraoral procedures, moderate sedation/analgesia
CPT 00190-P – Anesthesia for intraoral procedures, deep sedation/general anesthesia
D9223 – Deep sedation/general anesthesia, each 15 minute unit
D9243 – Intravenous moderate sedation/analgesia, each 15 minute unit

Plans determine this by reference to the above codes used to bill for the treatment in question. If they tell you it is an approved procedure und your covered benefits, ask them to provide you with the details and the steps you need complete to receive coverage/reimbursement. Ask them if you need to obtain pre-authorization of OBA for pediatric dental treatment

If OBA for pediatric patients is not a covered benefit, ask why it is not currently considered a covered service. They may answer that it is not considered a ***"medically necessary"*** procedure for the dental treatment, or it is not considered a covered benefit under your specific plan. Ask them specifically what information and documentation you need to submit to get them to reconsider their decision to deny this service. They may ask for a ***"statement of medical necessity form"*** which your pediatrician and pediatric dentist can help you fill out…record all contact

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information (including the person who you are talking to on the phone and any person they recommend you to contact) and what is discussed on the phone conversation

Step 3: Pre-authorization for office based anesthesia, do I need it?
Answer: When reviewing the plan details of your family health policy, you may find mention of penalties or non-payment of claims for certain procedures that require pre-authorization. Not obtaining this pre-authorization for medical services needed for any family member can dramatically increase your out-of-pocket expenses. Your plan details should clearly outline all procedures that require pre-authorization. It is however, a good idea to contact your insurance provider IN ADVANCE of any scheduled medical/dental procedure to verify that pre-authorization has been given or is not required. Ask for the claims number and request a copy for your records
Remember -- Pre-authorization does not guarantee payment of benefits

The pre-authorization request should include detailed information about your child's medical condition and the need to undergo OBA for pediatric dental treatment (all of which can be furnished by your pediatrician). Your pediatrician may ask the health plan to call him or her with any questions regarding the letter of the office-based anesthesia for pediatric dental care. The following items may be requested on the pre-authorization:

- You child's medical condition with the exact diagnosis and the symptoms associated with your child's condition
- The medical necessity for your child to undergo the dental procedure and the need for office based anesthesia during this procedure
- What health problems could occur if you do not get office based anesthesia for your child's dental treatment
- What other treatments or services you have had for your child's dental treatment, if any, and why these or other alternative treatments did not allow your child's dental treatment to proceed/be completed.

Step 4: Obtaining the decision after submitting the request to your health plan
Answer: You should contact the health plan claims office by phone if you do not receive a reply within two weeks and ask when a decision can be expected. You can offer to provide any additional information that they need/request. It is state law that insurance companies are required to respond within 30 days. Your health plan must provide a clinical reason for their decision, whether they approve or deny the request for coverage.

Your health plan may deny office based anesthesia for pediatric patients for the following:

- The dental procedure is not considered "medically necessary"
- Your child is too old
- They do not offer this service under your health plan to any participants of the plan and OBA for pediatric patients is not a "covered health benefit" under your plan

Whatever the reason for denial, you have the right to appeal the decision and can file an appeal to the decision in order to attempt to have the decision reversed.

Step 5: Appealing a denial, how do I do this?
Answer: If you are denied, this is their first response/answer and it does not mean it is the ultimate decision. You should request a written response, detailing the reasons for denial. You will then have something specific to answer.

The type of insurance you have determines whether state of federal law applies to the appeal process. If your plan is self-funded, then ERISA (federal law) applies and the Department of Labor has jurisdiction. If it is a commercial insurance, state law usually applies and the state Division of Insurance (DOI) has jurisdiction.

Reconsideration of denial (grievance letter) – you can formally request reconsideration by calling, writing or faxing the health plan. Written forms are always better than phone conversations due to record keeping. The health plan

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MUST send you a letter indicating they received your request for reconsideration. In this letter you should express your concern as to why you disagree with the decision made and ask if there is any other documentation you could provide in order for them to reconsider. If they say that there is no coverage because it is not "medically necessary", you can have your pediatrician write/fax a letter of medical necessity on your behalf. In your request include this letter, medical records, and documentation that supports your coverage for the benefit.

Second appeal – If the first appeal is denied, you can and should ask again for the denial in writing. Also, inquire if another appeal is possible to a higher-level person or committee. Be persistent, many claims have been authorized after multiple appeal attempts so it is worth filing.

External independent review of claims – You should, after multiple appeals, check with your health plan to see if you have the right to request an external independent review of their decision to deny coverage of OBA for pediatric patients. Your plan provider can explain to you the necessary steps to take should you proceed with this route. The external independent reviewer is someone who is not employed by the health plan, who reviews your request for OBA for pediatric dental treatment and subsequently makes a decision independent of the health plan. This request must be made within a certain time period following denial and should be a mailed letter.

Recommendations:

- Always contact them in writing. Phone calls can be made, but written communications is more powerful and easier to keep records
- Be sure to follow-up all written communications with a phone call to make sure they received your letters
- Keep a log of all your letters for your records. All phone calls and conversations should be kept track of
- Send important documents by certified mail (return receipt), Federal Express, or by fax with a confirmation sheet