Molina Clinical Policy
Criteria for General Anesthesia and IV Sedation
Policy No. 16.09

Last Approval: 05/23/2025

DISCLAIMER

The clinical criteria outlined is generalized. Services described may not be covered for a particular plan type. In addition, there may be additional plan specific criteria regarding treatment. Therefore, it is essential dental providers review the Benefits Covered Section of the Office Reference Manual (ORM) before providing any treatment.

OVERVIEW

The criteria outlined is based on procedure codes as defined in the American Dental Association's Code Manuals[1]. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for review, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as guidelines for review and payment decisions and are not intended to be all-inclusive or absolute.

It is also recognized that "local community standards of care" may vary from region to region and incorporate generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards.

Prior authorization and post-service review prior to payment are common methods of ensuring medical necessity for payment. Prior Authorization and post-service review are more effective than pay-and-chase processes and preferrable to recoupment.

Clinical review (prior authorization or post-service) is necessary for general anesthesia and IV sedation to protect the program and members by confirming the necessity and appropriateness of the procedure. Member safety, including the possible outcome of death, is of utmost importance. There is also a high potential for abuse with the number of units of anesthesia units billed. General anesthesia and IV sedation services are commonly reviewed by other Medicaid dental insurance programs for necessity/adherence to clinical criteria.

COVERAGE POLICY

Documentation needed for review of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for general anesthesia or IV sedation.
- Treatment rendered under emergency conditions, when review is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by plan) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (i.e. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, intellectual disability, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be performed.

CODING & BILLING INFORMATION

CDT (Current Dental Terminology) Codes

Code	Description	Authorization Required	Frequency Limitations
D9222	deep sedation/general anesthesia first 15 minutes	Prior Auth or Post-Service	Four of (D9222) per Day Per patient.
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	Prior Auth or Post-Service	Four of (D9223, D9243) per Day Per patient.
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	Prior Auth or Post-Service	Four of (D9239) per Day Per patient.
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	Prior Auth or Post-Service	Four of (D9223, D9243) per Day(s) Per patient.
D9248	non-intravenous moderate sedation	Prior Auth or Post-Service	Not allowed in conjunction with D9230 or D9243.
D9610	therapeutic drug injection, by report	Prior Auth or Post-Service	One of (D9610, D9612) per Day(s) Per patient.
D9612	therapeutic drug injection - 2 or more medications by report	Prior Auth or Post-Service	One of (D9610, D9612) per Day(s) Per patient.

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APPROVAL HISTORY

04/02/2025 Policy reviewed and approved.
05/23/2025 Updated policy reviewed and approved.

REFERENCES

1. American Dental Association's Code Manuals (https://www.ada.org/publications/cdt)