# Criteria for Dental Therapy Under General Anesthesia

## Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant *Texas Medicaid Provider Procedures Manual* and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ **We Agree**

# Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia is 22 points. Clients in need of general anesthesia who are younger than 7 years of age, or who do not meet the 22-point threshold, by report, will require prior authorization.

**Note:** *Sections marked with an asterisk (*) in the tables below require that a narrative fully describing the circumstances be present in the client's chart.*

| **Age of client at time of examination** | **Points** |
|---|---|
| Less than four years of age | 8 |
| Four and five years of age | 6 |
| Six and seven years of age | 4 |
| Eight years of age and older | 2 |

| **Treatment Requirements (Carious and/or Abscessed Teeth)** | **Points** |
|---|---|
| 1-2 teeth or one sextant | 3 |
| 3-4 teeth or 2-3 sextants | 6 |
| 5-8 teeth or 4 sextants | 9 |
| 9 or more teeth or 5-6 sextants | 12 |

| **Behavior of Client / *Comportamiento del cliente **** | **Points** |
|---|---|
| Definitely negative—unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability<br>*Definitivamente negativo: no puede completar el examen, el cliente no puede cooperar debido a su falta de madurez física o emocional y/o debido a una discapacidad* | 10 |
| Somewhat negative—defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, refusal to take radiographs<br>*Algo negativo: desafiante, reacio a aceptar el tratamiento, desobedece las instrucciones, se estira para agarrar o desviar la mano del operador o se niega a tomar las radiografías* | 4 |
| Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia<br>*Otros comportamientos: los niveles moderados de miedo, el nerviosismo y la aceptación cautelosa del tratamiento deben considerarse respuestas normales y no son indicaciones para que reciba tratamiento con anestesia general* | 0 |

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| Additional Factors * | Points |
|---|---|
| Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention | 15 |
| Failed conscious sedation | 15 |
| Medically compromising of handicapping condition | 15 |

**Certification / *Certificación***

I understand and agree with the dentist's assessment of my child's behavior.

Parent/guardian signature: _____ Date: _____

*Entiendo y estoy de acuerdo con la evaluación del dentista sobre el comportamiento de mi hijo.*

*Firma del padre o tutor:*_____ *Fecha:* _____

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client's chart. The client's chart must be available for review by representatives of TMHP and/or HHSC.

| Performing Dentist's Signature: | Date: |
|---|---|
| License No.: | |

# Medicaid Dental Policy Regarding Criteria for Dental Therapy Under General Anesthesia – Attachment 1

**Purpose:** To justify intravenous deep sedation or general anesthesia for dental therapy, the following documentation is required in the child's dental record.

**Required Elements (**including sections of form which include an asterisk):

- Description of relevant behavior and reference scale
- Other relevant narrative justifying the need for general anesthesia
- Client's demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology
- Proposed Dental Plan of Care
- Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
- Completed Criteria for Dental Therapy Under General Anesthesia form
- The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist's assessment of their child's behavior
- Dentist's attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form

"I attest that the client's condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client's record and is available in my office."

Requesting Dentist's Signature: _____Date: _____