Definition

When a Participating Dentist leaves his office to perform dental services in an Ambulatory Surgical Center or Hospital.

Policy

1. Code D9420 requires predetermination, the required documents will be:

   (a) patient’s diagnostic;
   
   (b) medical condition of the patient, and
   
   (c) the reasons that justify that the patient receives general anesthesia

2. It will be considered for payment one every six months per insured for dental services that are performed in the operating room under general anesthesia or in an ambulatory surgery center where the condition and circumstances of the patient does not allow to perform the services in the dental office and that the anesthesia Considered as a last resort.

3. The fee for code D9420 includes all administrative costs incurred by the participating dentist to perform the service in an operating room or in an ambulatory surgical center; he/she can only charge the insured for non-covered services.
4. If there is a Surgical Doctor predetermination, the same day that dental procedures will be performed, if the code D9420 is covered, it will be part of the fee of the main procedure Surgical Doctor and this cannot be charged to the insured.

5. If you are pre-authorizing dental services that are required to be performed in an outpatient surgery room or hospital under general anesthesia and you are including a Medical Surgical service that may have been performed in an office, you may consider paying the D9420 code to be covered.

6. When a pediatric dentist, oral surgeon or maxillofacial member of the medical faculty of a hospital, licensed by the Government of Puerto Rico, in accordance with Law 75 of August 8, 1925, as amended, determines that the condition or ailment of the patient is significantly complex in accordance with the criteria established by the American Academy of Pediatric Dentistry.

7. When the patient for reasons of age, impairment or disability is unable to resist or tolerate pain, or cooperate with the treatment indicated in dental procedures.

8. When the infant, boy, girl, adolescent or person with a physical or mental impairment has a medical condition in which it is indispensable to perform the dental treatment under general anesthesia in an ambulatory surgical center or in a hospital, and that otherwise it could represent a significant risk to the health of the patient.

9. When local anesthesia is ineffective or contraindicated due to an acute infection, anatomical variation or allergic condition.

10. When the patient is an infant, boy, girl, adolescent, person with a physical or mental impairment, and is in a state of fear or anxiety that prevents to perform dental treatment under the procedures of traditional use of dental treatments and his/her condition is of such magnitude, that delaying or deferring treatment would result in pain, infection, loss of teeth or dental morbidity.

11. When a patient has received extensive and severe dental trauma where the use of local anesthesia would compromise the quality of services or would be ineffective for managing pain and apprehension.

Policy #5 to the #10 belong to Law 352, (Article 1 - Coverage of Anesthesia and Hospitalization in Dental Procedures)
### Codes

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<tr>
<th>CDT</th>
<th>Description</th>
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<tr>
<td>D9420</td>
<td>hospital or ambulatory surgical center call</td>
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<tr>
<th>ICD-10-CM (effective 10/01/15)</th>
<th>Description</th>
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<tr>
<td>ICD-10</td>
<td>Diagnostics according to the Policy</td>
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### Limitation

1. The service code will be paid 1 every 6 months per insured.

2. Insured’s certificate of coverage, exclusions from dental coverage. Every service not included as service covered in the description of the coverage.

3. If there are no dental services contracted with Triple-S Inc., the services of Hospitalization and General Anesthesia will not be honored, according to Law 352. Law 352 of December 22, 1999 clearly establishes: "To require that companies and insurers of health services that provide coverage for **general anesthesia services, hospitalization services and dental services** in the contract of services to a subscriber to honor the coverage of general anesthesia and hospitalization service"...

4. General exclusions of the Basic Coverage;
   a- Expenses for dental services.
   b- Hospital, medical-surgical services and complications associated with these are excluded.

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Executive Medical Director

Rev. 11/28/2016
11/17/2016
References


5. Insured's coverage certificate, General Exclusions of Basic Coverage.