EXPLORING POLICY SOLUTIONS THAT SUPPORT THE DELIVERY OF GENERAL ANESTHESIA SUPPLEMENTAL SERVICES ASSOCIATED WITH DENTAL CARE

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Medicaid Medicare CHIP Services Dental Association

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ABSTRACT

With support from the Delta Dental Foundation (DDF), the Medicaid Medicare CHIP Services Dental Association (MSDA) conducted a 2024 national research initiative titled Exploring Policy Solutions that Support the Delivery of General Anesthesia for Dental Services. The project examined how state Medicaid programs regulate, reimburse, and ensure the safe delivery of general anesthesia (GA) for dental procedures—particularly for children as well as individuals with intellectual and developmental disabilities and those who are medically compromised. The primary aims were to (1) **assess whether Medicaid policy promotes access to GA-supported dental care, (2) identify policies that ensure safety and effectiveness, (3) highlight best practices, and (4) document alternatives that reduce access barriers.**

An advisory panel guided the research through four specialized policy domains—**Scope of Practice, Location of Services, Medical Necessity, and Reimbursement**—each exploring statutory, regulatory, and administrative frameworks across states. Using mixed-methods analysis of Medicaid policy manuals, federal regulations, peer-reviewed literature, and professional guidelines (ADA, AAPD, ASA), the study integrated qualitative and quantitative data to identify state variation and emerging trends.

Findings reveal a highly heterogeneous policy landscape. Most states authorize anesthesiologists, dental anesthesiologists, and oral surgeons to independently administer GA in multiple settings, whereas general dentists and anesthesiology assistants face narrower scopes and supervision requirements. Medicaid coverage most commonly extends to GA provided in hospitals or ambulatory surgical centers (ASCs) when medically necessary, with office-based anesthesia subject to the most restrictions. Medical necessity determinations typically require separate justification for both the dental procedure and anesthesia service; however, states differ markedly in criteria specificity and documentation requirements. Reimbursement methodologies and administrative controls—particularly prior authorization—further shape access and timeliness of care.

The study concludes that variations in provider authorization, service location rules, and medical necessity criteria collectively influence the availability, safety, and cost of GA-supported dental services. **Recommendations** include promoting standardized definitions of medical necessity, harmonizing provider credentialing and supervision policies, expanding access through office-based settings, and enhancing data collection on anesthesia-related outcomes. Strengthening these policy levers can improve

safety, reduce wait times, and expand equitable access to comprehensive dental care for Medicaid members.

BACKGROUND

Access to general anesthesia (GA) for dental services has become a significant problem in recent years as hospitals nationwide have decreased the availability of operating rooms to dental providers.[i] Despite meeting the criteria for Medical Necessity, vulnerable patients have experienced extended waiting times that can exceed years. Several factors contribute to the growing challenges in accessing hospital operating rooms for dental care. Among these include financial constraints, limiting hospital operating room access particularly for pediatric dental care. Hospitals often prioritize surgical procedures that generate higher revenue, as medical surgeries typically receive greater reimbursement rates than dental procedures. This financial disparity incentivizes hospital administrators to allocate operating room time to medical rather than dental cases. Additional barriers include complex pre-authorization requirements, inconsistent insurance coverage, and more stringent definitions of “Medical Necessity,” all of which make it challenging for dentists to secure hospital operating room time. The COVID-19 pandemic further intensified these limitations, as hospitals continue to operate with reduced availability and stricter scheduling protocols.[ii]

Limited access to hospital operating rooms for dental care for children and individuals with intellectual and developmental disabilities (I/DD) can lead to significant consequences for these individuals and their families. Delays or cancellations of necessary procedures often result in untreated dental problems progressing over time, causing increased pain, infection, and potentially serious medical complications. These untreated conditions frequently drive families to seek care in emergency departments, which may only provide temporary relief rather than definitive treatment. Beyond the physical impact, ongoing dental pain and disease can interfere with an individual’s ability to eat, sleep, learn, and engage in normal social activities, ultimately affecting their overall health and well-being. Dental providers also face ethical challenges when they are unable to provide timely and appropriate care due to systemic barriers beyond their control.[iii]

The American Academy of Oral and Maxillofacial Surgeons’ (AAMOS) statement on Medical Necessity warns that *failure to intervene in these instances could result in significant medical/dental health consequences.*[iv] With support from the Delta Dental Foundation (DDF), the Medicaid Medicare CHIP Services Dental Association (MSDA) led a research initiative in 2024 entitled, *Exploring Policy Solutions that Support the Delivery of General Anesthesia for Dental Services*. The aim of the study was to investigate recent trends in dental associated GA; examine existing Medicaid policy; identify unique factors that potentially contribute to timely and effective access to GA; create a summary of promising state Medicaid policies and practices; and develop recommendations for policy consideration by Medicaid dental program administrators. This paper describes the work of the research team; existing state *Medicaid policies* associated with the use of GA for dental care; recent practice trends associated with GA for dental care services; a summary of promising practices that support access to sedation services for dental care; and recommendations for policy considerations by Medicaid dental program administrators.

STUDY QUESTIONS

Researchers were interested in answering the following key questions.

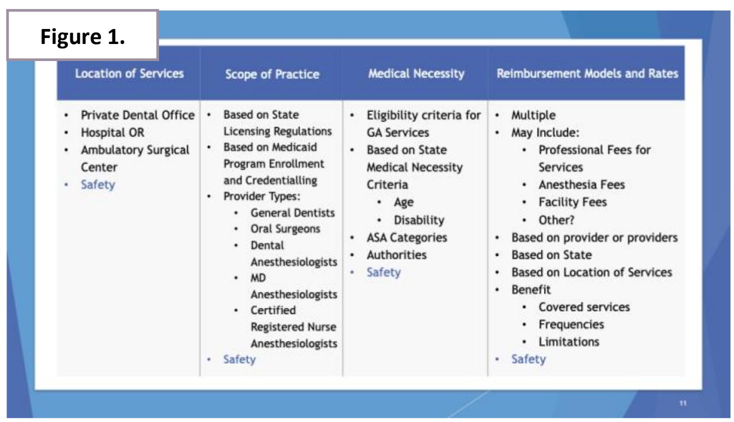
1. Does Medicaid policy promote and support access and use of GA for dental care for Medicaid members?
2. What Medicaid dental policies exist that promote and support safe and effective use of GA for dental care among Medicaid members?
3. What best practice approaches exist that promote and support safe and effective use of GA for dental care among Medicaid members?
4. What alternatives have state Medicaid agencies and/or providers identified that reduce access barriers and facilitate dental care for members/patients requiring GA?

METHODOLOGY

To guide the study, the Medicaid Medicare CHIP Services Dental Association (MSDA) convened a multidisciplinary advisory panel composed of national experts in medicine, dentistry, and health policy. The panel included medical and dental anesthesiologists, pediatric and general dentists, oral and maxillofacial surgeons, dental researchers, managed care and Medicaid administrators, and health policy professionals. This group provided scientific and technical oversight throughout the research process.

The advisory panel was organized into four specialized subcommittees, each assigned to one of the study's primary policy domains: Scope of Practice**,** Location of Services**,** Medical Necessity**,** and Reimbursement**.** Each subcommittee was tasked with identifying and analyzing relevant Medicaid statutes, regulations, and policy documents governing the use of general anesthesia (GA) for dental services. **Figure 1** illustrates the four domains and related subtopics explored. Both qualitative and quantitative data were collected, synthesized, and integrated into the findings presented in this report.

Figure 1.



Each subcommittee conducted a targeted literature and policy review to identify key trends and regulatory considerations associated with its assigned domain. The review included peer-reviewed publications, federal and state Medicaid policy manuals, professional guidelines from recognized authorities (e.g., ADA, AAPD, ASA), and relevant academic and governmental reports.

This process validated the original four policy domains and revealed two additional areas warranting further consideration: safety and pharmaceutical use. For analytic consistency, the research team incorporated *safety* as a cross-cutting fifth domain applied across all areas of inquiry. The sixth domain, pharmaceutical use, was identified but excluded from detailed analysis due to the limited scope of this project. Consequently, this report focuses on findings derived from the four core domains and the integrated safety dimension, which together form the foundation for the study's comparative policy analysis.

All four subcommittees convened independently on a monthly basis over a ten-month study period, providing regular progress updates to the full advisory panel during joint meetings. Each subcommittee systematically collected and cataloged a comprehensive library of source materials, including federal and state regulations, Medicaid policy manuals, professional guidelines and standards of care, best-practice frameworks, network adequacy standards, quality measures, access and utilization data, emergency care protocols, provider credentialing and privileging requirements, market and reimbursement trends, and documented safety considerations related to the administration of GA for dental treatment.

Building on insights from the literature and policy review, the research team developed a structured set of survey instruments designed to capture state-level Medicaid program information. Four distinct survey tools were created, each aligned with one of the study's primary policy domains: Scope of Practice, Location of Services, Reimbursement, and Medical Necessity. The instruments included targeted questions addressing factors influencing access to GA-supported dental care, such as provider type, facility setting, payment methodologies, benefit design, and coverage limitations. Data on the frequency, duration, and service restrictions associated with GA benefits were collected from Medicaid dental program administrators in all participating states, enabling cross-state comparison and policy mapping.

Researchers made up to three attempts to collect survey data directly from each state Medicaid program administrator. For states that did not respond, subcommittee members conducted independent policy reviews and documented publicly available GA policies within the research database. All data were organized by state within a master Microsoft Excel file, allowing for consistent documentation and comparative analysis. Once all state policies were compiled, MSDA conducted virtual validation meetings with program administrators to verify the accuracy and completeness of the information collected.

To assess potential variations in Medicaid policy across the states, the research team analyzed the aggregated state survey responses and qualifying comments to identify trends, implementation differences, and potential gaps in Medicaid coverage or regulatory alignment. The following section presents a summary of findings and analyses generated by each of the four subcommittees.

SUBCOMMITTEE FINDINGS

Medical Necessity

Medicaid is a state and federal partnership that allows each state to create policy, rules, coverage criteria, exceptions and limitations. This partnership results in a state defined policy across the states that varies benefits and coverage for vulnerable patients depending upon their state residence. Many states rely upon and use the federal statute defining MN Section 14059.5 - Medically Necessary or Medical Necessity (a) For individuals 21 years of age or older: a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Centers for Medicaid and Medicare Services (CMS) Regulation defines "Medically Necessary" or "Medical Necessity" to mean "health care services that a physician, exercising prudent clinical judgment, would provide to a patient. The service must be for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. Services must be under accepted standards of medical practice and considered to be specific and effective treatment for the patient's condition. The amount, frequency, and duration of the services planned and provided must be reasonable."

The Charge to the Medical Necessity Committee was to identify for GA:

1. Federal legislation that defines MN
2. CMS's definition of MN and associated regulation(s)
3. The impact of the definition of MN upon GA services and coverage
4. Any limitations associated with the definition of MN for GA services
5. Variation of MN definitions across states
6. Notable authorities on the administration and use of GA
7. Criteria states use to develop Medicaid policy, coverage and payment
8. Themes, practices, and strategies most used by states for establishing MN criteria for GA

When evaluating MN, the researchers examined both the MN policies governing the dental services provided and those governing the use of GA as a supporting (supplemental) service to dental care. To assess the extent to which states address these two components independently, the researchers considered three key questions:

1. What MN criteria are used to establish need for dental services?
2. What MN criteria are used to establish need for GA support services?
3. Are these criteria independent of each other or does one take priority over the other?

To answer these questions and gain more detail to fully address the charge of the MN Subcommittee, the group developed a survey tool that incorporated MN as defined by standard essential healthcare diagnostic, billing and reporting code sets: International Classification of Diseases, Tenth Revision (ICD-10), Current Dental Terminology (CDT), Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS**)** codes, and other regulatory language. A copy of the State Survey Questionnaire may be viewed below and in Appendix A.

State Medical Necessity Survey Questionnaire
1. What authority or professional guidelines does your state use to establish MN criteria?
2. Does GA medical necessity criteria differ by age cohort?
3. Does GA medical necessity criteria differ by special needs?
4. What ICD-10 codes are used to document medical necessity for GA?
5. Does your state require prior approval/authorization for GA services; and if so, under what conditions?
6. Does your state have a documented policy outlining medical necessity criteria for the use of general anesthesia support services for dental care?

Upon completion of this task, researchers observed that state Medicaid agencies differ in their process for defining MN and often rely on variable criteria when establishing MN policy. Additionally, MN language varies by procedure code sets such as the ICD-10, CPT, and CDT. These codes are used for diagnosis, billing and reporting purposes and are subject to interpretation by state administrators, as well as clinicians.

Across the eighteen states reviewed—Massachusetts, California, Oregon, Colorado, Texas, Rhode Island, Alabama, Missouri, South Dakota, Florida, Ohio, Washington, Michigan, New Jersey, New York, North Carolina, Rhode Island and Oklahoma—Medicaid policies demonstrate wide variation in how MN for dental services and for the supplemental use of GA are established, authorized, and reimbursed.

Authority or Guidelines for Medical Necessity

Every state ties its MN criteria to state Medicaid regulations or its dental provider manual. Massachusetts and North Carolina use formal state administrative codes— 130 CMR 420.000, NC Clinical Coverage Policy— 1L-1/4A, while California, Texas, and Washington rely on their respective state provider manuals and billing guides. In some states, MN criteria of both dental and GA services are interconnected whereby GA services are covered if a dental service is deemed MN. For example, in Alabama, Missouri, and Florida, MN is grounded in general Medicaid policy rather than with explicit anesthesia guidelines. In other states, independent criteria are established. For example, Texas uniquely employs a 22-point "Criteria for Dental Therapy Under General Anesthesia" scoring tool to quantify MN for GA.

GA Criteria by Age Cohort

Several states with pediatric-specific frameworks reported age as a significant factor in considering MN criteria for GA services. Texas, for instance, embeds age in its scoring tool, giving additional weight to children under seven. Massachusetts and North Carolina distinguish services by age through coverage tables rather than separate criteria. Other states (e.g., Washington, Ohio) apply the same MN standard across ages but have pediatric program addenda.

GA Criteria for Individuals with a Disability

Most states explicitly recognize developmental, behavioral, or medical complexity as justification for GA coverage. Texas, California, Colorado, Oregon, and Ohio include disability-related factors directly in their documentation or scoring tools, while North Carolina and Massachusetts handle them under general MN documentation. Even in states without explicit language (e.g., Alabama, Missouri), clinical documentation supporting behavioral or physical limitations is accepted as evidence of .

ICD-10 Codes for Documenting Medical Necessity

None of the 18 states maintain a fixed or exhaustive ICD-10 list specific to dental GA. Instead, all require that the diagnosis code on the claim substantiate medical necessity in accordance with the state's or managed care plan's guidelines.

Prior Authorization

Most states require prior authorization (PA) for GA in outpatient and particularly in office settings. Massachusetts, California, Texas, Ohio, Oklahoma, and Florida specify PA submission rules and documentation standards. South Dakota is an exception; where anesthesia does not require independent authorization if the associated surgical procedure has already been approved.

The Washington State Health Care Authority (HCA) allows providers to use an Expedited Prior Authorization (EPA) number in place of submitting full documentation for every case. The EPA number is a pre-assigned code indicating that the provider has confirmed the service meets established MN criteria. When all EPA conditions are satisfied, the provider includes the EPA number on the claim or electronic authorization field, allowing it to be processed without manual review. If the criteria are not met or no EPA code applies, a full PA request must be submitted.

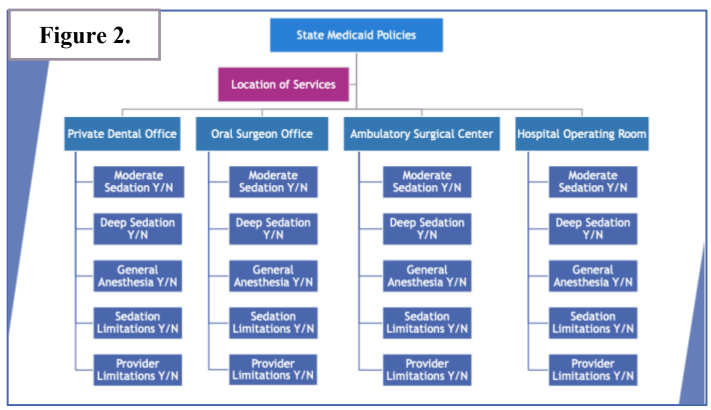
Medical Necessity Criteria Used

All states apply their standard Medicaid MN definition—services must be essential for diagnosis or treatment and consistent with accepted medical standards. Texas and Washington supplement this with quantifiable tools or checklists. Massachusetts and Rhode Island reference CMS and InterQual standards, while California and Oklahoma align with state dental board and managed-care interpretations.

In summary**,** although every state requires documentation of MN, they vary in how precisely they define or operationalize it. States like Texas and Washington employ structured scoring or EPA systems; others, like Florida or Alabama, rely on professional judgment supported by provider documentation. CDT D9222/D9223 codes are nearly universal, and PA remains the main administrative control across the eighteen states.

Location of Services

The main objective for the Location of Services Subcommittee was to evaluate state Medicaid policies for coverage and restrictions on moderate sedation, deep sedation, and GA supplemental services for dental procedures; and to identify specific policy language regarding coverage and/or benefit and payment restrictions based on location of services. To accomplish this, subcommittee members identified four different types of service sites—private dental office, oral surgeon's office, ambulatory surgical center (ASC), and hospital operating room— and cross referenced each type of location by types of services and providers permitted at each site. **Figure 2** depicts the matrix used to assess each of these dependent and independent variables.



For each of the unique service sites, subcommittee members explored Medicaid policies across all 50 states plus the District of Columbia asking state administrators the following key survey questions: 1) Does the state Medicaid program cover moderate sedation, deep sedation and general anesthesia services at each of the various types of service sites noted? 2) Are there any limitations in moderate, deep and GA sedation services by service site? 3) Are there any provider limitations by service site? 4) Are there any dental service limitations by service site? **Figure 3** depicts a sample of the survey tool. A copy of the survey questionnaire related to Location of Services may be viewed in Appendix B.

Figure 3.

Survey Questions	Private Dental Office	Oral Surgeon's Office	Ambulatory Surgical Center	Hospital Operating Room
[illegible] **moderate sedation** services for dental procesures **in this location of services?** [CDT and CPT Codes]				
Does the state Medicaid policy impose any criteria, limitations, or exemptions for **moderate sedation services** for dental procedures **in this location of services**?				
If yes, please explain:				
Does the state Medicaid policy cover **deep sedation services in this type of location?**				
Does the state Medicaid policy impose any criteria, limitations, or exemptions for **deep sedation services** for dental procedures **in this location of services?**				
If yes, please explain:				
Does the state Medicaid policy cover **General Anesthesia services** for dental procedures in this type of location?				
Does the state Medicaid policy impose any criteria, limitations, or exemptions for **General Anesthesia services** for dental procedures in this location of services				
If yes, please explain:				
Are there any **dental service** limitations or conditons **related to each of the locations of services? [Example: GA not permitted in private dental office; similar to mobile dentistry nopt permittted in schools in some states.**				
If yes, please explain:				
Please identify any **code(s)** that may be associated with each specififc **location of service.** (Modifiers?)				
Are there any **dental provider type OR anesthesiologist provider type** limitations specific to location of services?				
If yes, please explain:				

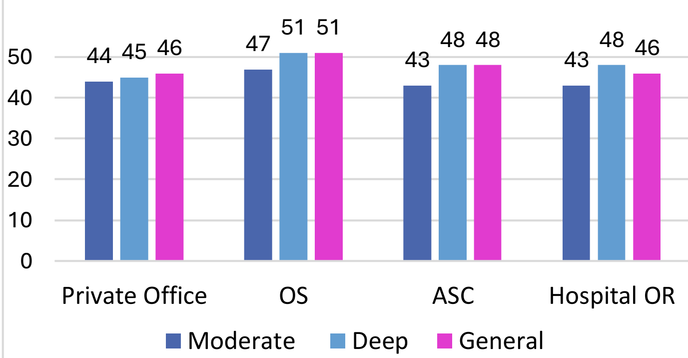
Data Collection and Analysis

"Yes" or "No" responses were collected from all 51 states regarding whether their respective state policies covered moderate sedation, deep sedation, and GA in any of the four noted service locations: private dental office, oral surgery office, ASC, and hospital operating room. "Yes" or "No" responses were also collected regarding anesthesia limitations, provider limitations, and/or dental service limitations. Responses were quantified to assess the extent of each potential limitation type across the state programs.

Results

Researchers studied the information gathered from all states plus the District of Columbia to evaluate similarities and differences in regulation of moderate sedation, deep sedation and GA in four types of locations: private dental office, oral surgeon's office, ambulatory surgical center and hospital operating room. **Figure 4** shows the number of states with Medicaid policies covering moderate, deep, and GA services by service location.

Figure 4: Number of States Covering Sedation by Location of Servives



Across the 51 state Medicaid programs, Medicaid coverage policy for sedation and GA services varied only slightly by treatment location. Results showed that 45-46 states reported having policies covering moderate, deep and GA sedation services respectively, in private dental offices. All states plus the District of Columbia, reported covering deep sedation and GA services in oral surgeon's offices. Forty-eight states reported having polices supporting deep sedation and GA in ASCs. Forty-eight and forty-six states reported covering deep sedation and GA services respectively in *hospital operating rooms.*

Figure: 5. Number of States Imposing Policy Limitations Regarding Type of Sedation by Location of Services

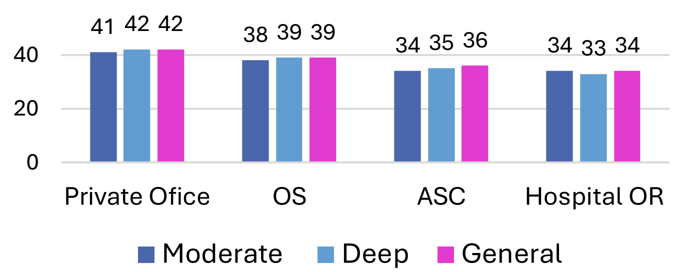
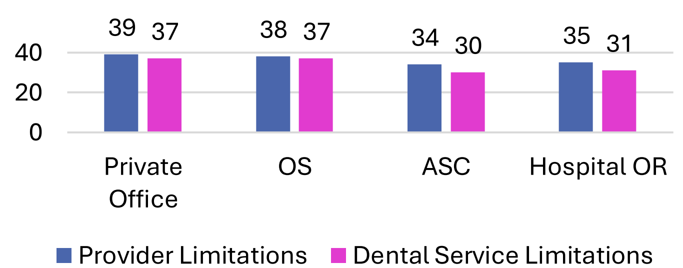


Figure 5 shows the number of states imposing policy limitations regarding type of sedation— moderate, deep, and GA services—based on the location of those services. Of the 50 states plus the District of Columbia, approximately 42 states reported policy limitations in private dental offices. Fewer states, 39, 36, and 34 had policy restrictions on Oral Surgeon's Offices, ASCs and hospital operating rooms suggesting that written policies are not needed due to other required quality and safety standards.

Researchers further explored policy limitations for providers and for specific dental services based on the location of those services. **Figure 6** summarizes the findings—among the 51 state responses, private dental offices had the greatest number of states imposing policy limitations on providers (39 states) and on specific dental services, (37 states) respectively. Oral surgeon's offices had similar policy limitations with 38 and 37 states reporting limitations on providers and dental services. Only 34 states noted provider limitations and 30 states, dental service limitations, when services were delivered in an ASC. Similarly, fewer states had limiting regulations for providers and /or dental services when rendered in hospital operating rooms. Researchers then analyzed Medicaid program administrators' comments as well as state specific policy language to gain understanding of the types of coverage, restrictions, and limitations imposed by various state programs, based on location of services. The following summaries describe general findings and provide state specific examples.

Figure 6. Number of States Imposing Policy Limitations on Providers and Dental Services based on Location of Services



Private Dental Offices and Oral Surgeons' Offices

The Location of Services (LOS) Subcommittee reviewed and analyzed policy language from state program administrators to identify common trends, limitations, and promising practices related to where dental services involving anesthesia may be provided. Findings indicate that Medicaid coverage for deep sedation and GA for dental procedures is generally tightly regulated across states.

In most cases, Medicaid coverage for deep sedation or GA—when paid under a member's medical benefit—is limited to specific populations, such as children, individuals with disabilities, or those with medical or behavioral conditions classified as American Society of Anesthesiologists (ASA) I or II. Coverage applies when anesthesia is deemed medically necessary, typically because the individual cannot tolerate routine dental care. It is rarely available for elective, cosmetic, or routine procedures.

Historically, Medicaid programs have restricted GA coverage to hospitals or ASCs, where advanced medical support is readily available. For example, Iowa does not generally cover GA in private dental offices, while New Hampshire allows it only under exceptional circumstances. When private office settings are permitted, coverage is almost always confined to children under age 21, patients with developmental or physical disabilities, or individuals with severe anxiety or behavioral conditions that prevent standard office-based care.

Most states require PA, except in emergencies. Documentation must clearly demonstrate MN, and claims are often constrained by strict billing codes, time limits, or frequency caps.

Providers offering GA in dental offices must maintain current anesthesia permits from their state dental board and adhere to safety requirements, including proper equipment, trained staff, and emergency protocols. In some states—such as Massachusetts and Virginia—a separate facility permit is also required in addition to individual provider credentials.

Some states—such as Idaho, Illinois, Indiana, Kentucky, Massachusetts, and Virginia—have developed more comprehensive frameworks that require provider permits, restrict GA to complex or high-risk cases, and emphasize rigorous safety compliance. Others, including Kansas and Wyoming, limit coverage to children or special-needs populations and may rely on mobile anesthesia providers to expand access.

More recently, in response to access barriers created by the limited availability of hospital operating rooms, several states—including Ohio, Tennessee, and Washington—have updated their policies to permit GA in private dental offices. For example, in Washington, the policy states,

> *Anesthesiologists or qualified professionals offering mobile anesthesia services in dental offices must 1) hold a current license to practice anesthesia in Washington State; and 2) obtain a separate Mobile Anesthesia Contract with the Health Care Authority (HCA). Dental procedures requiring anesthesia may also be performed in ASCs or hospital settings, depending on the patient's medical needs (Medical Necessity) and the complexity of the procedure.*

Like Washington, other programs require anesthesia be administered by appropriately licensed professionals, such as anesthesiologists, CRNAs, or credentialed dentists, and dental offices must meet strict safety standards with credentialled, and trained staff and emergency equipment in place. These changes aim to reduce backlogs for dental rehabilitation under GA and expand care to non-traditional access points, while maintaining stringent safety and permitting requirements. Such advancements have shown promise in significantly reducing wait times and improving access for populations most in need of complex dental care.

Ambulatory Surgical Centers and Hospital Operating Rooms

Researchers also found that in general, Medicaid covers dental procedures performed in outpatient hospital or ASC settings when treatment cannot be safely provided in a dental office due to the patient's medical condition, such as ASA Levels III and IV, behavioral challenges, or the complexity of the procedure.

Common examples include patients with intellectual and developmental disabilities, those with profound or Level 3 autism spectrum disorder, young children, or individuals requiring extensive dental work under anesthesia.

Like private practice settings, coverage typically requires MN to be clearly documented, and PA obtained, except in emergency situations. ASCs may bill both dental code D9420, often limited to a specific number of times per recipient per year, and surgical CPT codes in the 10000–69XXX range. In addition, deep sedation and GA services must be administered by appropriately licensed professionals, such as anesthesiologists, CRNAs, or credentialed dentists, and facilities must meet strict safety standards with trained staff and emergency equipment in place. (See the Scope of Practice section of this document).

States such as Iowa, Idaho, Illinois, Indiana, New Hampshire, New York, Oklahoma, Virginia, and Kansas specify additional requirements, including provider permits, ASC licensure, and PA rules. Routine or elective procedures are generally excluded unless MA is demonstrated.

Medicaid coverage for dental procedures using GA performed in hospital operating rooms or ASCs is generally restricted to cases where treatment in a less intensive setting, such as a dental office, is not feasible or safe. Coverage is limited to MN procedures and does not extend to elective or cosmetic dental services, even if performed in a hospital. These services are typically approved when the patient has a documented medical or behavioral condition—such as developmental disabilities, severe anxiety, or significant health concerns—that requires anesthesia for safe and effective care. Coverage may also apply for extensive or complex dental procedures that cannot be completed without sedation. Children under seven, patients with special healthcare needs, and individuals unable to tolerate in-office treatment due to physical, mental, or behavioral challenges are common groups eligible for coverage.

PA is almost always required to establish MN before treatment is provided, unless the procedure is performed in an emergency. Medicaid programs in states such as Iowa, Idaho, Illinois, Indiana, Kansas, New Hampshire, New York, Oklahoma, and Virginia emphasize detailed documentation, prior approval, and strict adherence to MN standards. Providers must be properly credentialed—such as anesthesiologists, CRNAs, or dentists with anesthesia certification—and facilities must meet safety requirements, including emergency equipment and trained personnel.

Billing is limited to approved codes, such as CPT 41899 for dental services and CPT 00170 for anesthesia, and state Medicaid manuals outline specific documentation and reporting rules. Some states, such as Kansas, have recently updated reimbursement policies, including higher payments for hospital-based dental rehabilitation under certain billing codes.

Overall, Medicaid covers GA and sedation in hospital operating rooms or ASCs only when MN is demonstrated**,** ensuring that such services are carefully monitored, provided by qualified professionals, and delivered in accredited facilities with strict safeguards to promote patient safety and cost-effective care**.**

Scope of Practice

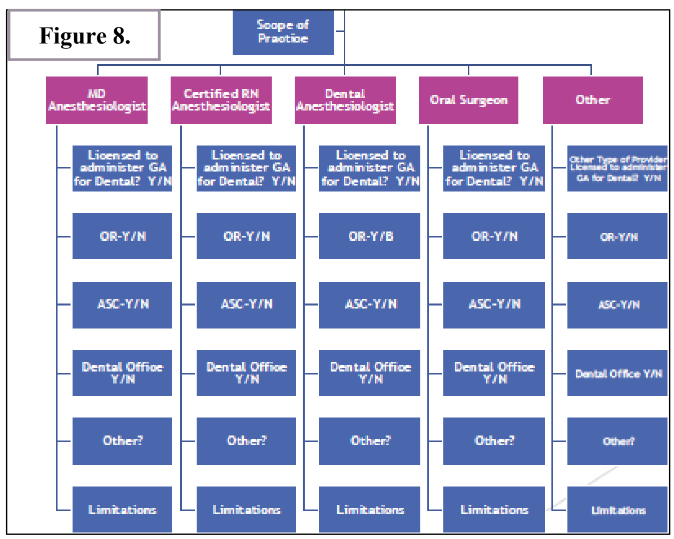
The Scope of Practice Committee was charged with assessing state Medicaid policies governing sedation and general anesthesia services by specific provider types—medical anesthesiologists (MA), dental anesthesiologists (DA), oral surgeons (OS), dentists (DMD/DDS), certified registered nurse anesthetists (CRNA), and certified anesthesiology assistants (CAA) across various service settings—private dental offices, oral surgery offices, ASCs, and hospital operating rooms. Note that this probe, while like the Location of Services inquiry, prioritized scope of practice as the dependent variable instead of location of services.

Figure 7.

Survey Questions	MD Anesthesiologist	Certified RN Anesthesiologist	Dental Anesthesiologist	Oral Surgeon	Dentists	Certified Anesthiologist Assistant
Licensed/Certified to administer sedation/GA in State for Dental Procedures?						
Licensed/certified to administer Sedation/GA services in Hospital Operating Room? Is supervision required to administer Sedation/GA services in Hospital Operating Room?						
Licensed/certified to administer Sedation/GA services in an Ambulatory Surgical Center? Is supervision required to administer Sedation/GA services in an Ambulatory Surgical						
Licensed/certified to administer Sedation/GA services in Private Dental Office? Is supervision required to administer Sedation/GA services in Private Dental Office?						
Licensed/certified to administer Sedation/GA services in an Oral Surgeon's Office? Is supervision required to administer Sedation/GA services in an Oral Surgeon's Office?						
Are there any other noitable scope of practice limitations relatd to the administration of GA for dental procedures?						

A Scope of Practice Survey Tool shown in **Figure 7** was developed to help committee members examine Medicaid policy for provider licensure, certification, and practice limitations—particularly by service location. The review assessed whether each provider type was permitted by Medicaid policy to administer sedation or GA for dental procedures in hospital operating rooms, ASCs, private dental offices, or oral surgery offices. In addition, states were asked to indicate if supervision for the various provider types, in each of the different practice settings, was required.

Figure 8 depicts the matrix for the survey questionnaire that captures the complex nature of these questions and the potential impact on Medicaid policy.



Data Collection and Analysis

"Yes" or "No" responses were collected from each state regarding whether each provider type was permitted by Medicaid policy to administer sedation or general anesthesia for dental procedures in the various practice settings, and whether supervision was required.

Results

All 50 states plus the District of Columbia recognized licensure and/or certification to administer GA for dental procedures by MAs, DAs and OSs. CRNAs were recognized by 48 states, dentists were recognized in 33 states, and certified anesthesiology assistants in 22 states. **Figure 9** illustrates how many states explicitly recognize licensure or certification to administer GA for dental procedures across six provider types.

Figure 9. Number of States Recognizing Licensure, or Certification to Administer GA

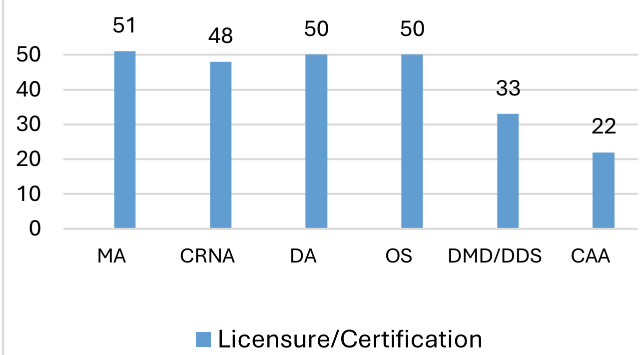
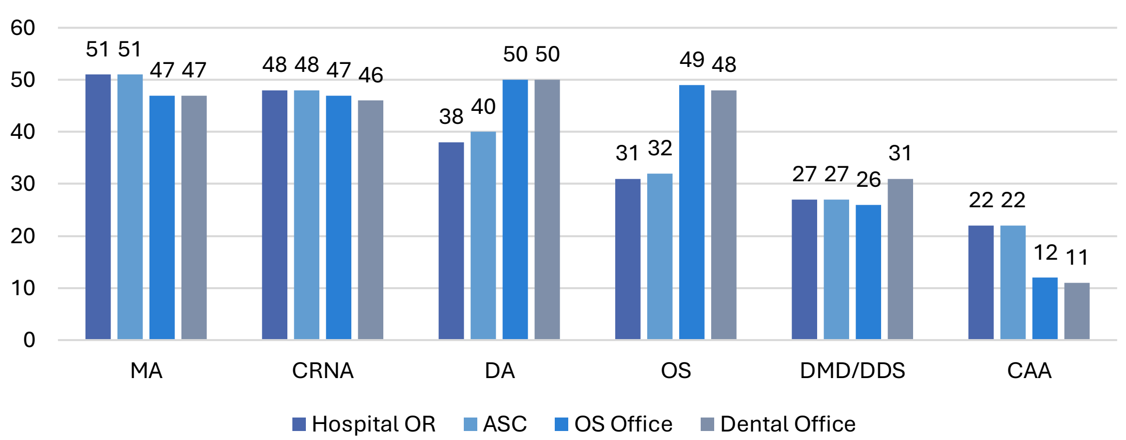


Figure 10 below compares the number of states that recognize different provider types as eligible to deliver general anesthesia across four main settings—hospital operating room (OR), ASC, oral surgery office, and dental office. Across all provider types, the highest number of states recognize licensure or certification for GA administration in hospital and ACS settings, while far fewer extend that recognition to dental office settings. This pattern reflects a common regulatory approach in which hospitals and ASCs are seen as more controlled environments for deep sedation or anesthesia.

Figure 10. Number of States Requiring Licensure/Certification to Administer GA by Location of Services



Provider Scope of Practice Comparisons

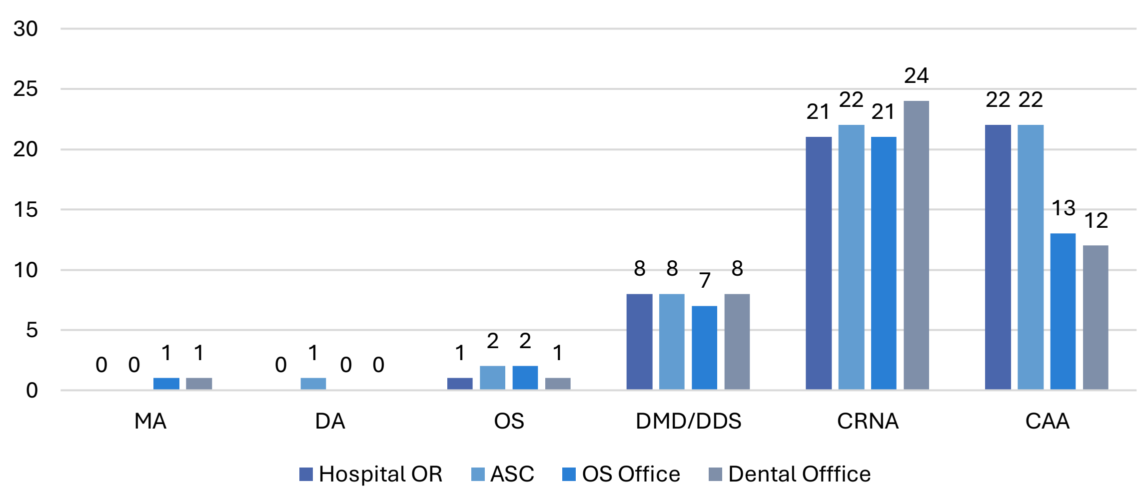
- Medical Anesthesiologists (MA) and CRNAs are recognized most broadly, with 51 and 48 states, respectively, authorizing GA administration in hospitals and ASCs. Nearly the same number (47–48 states) also recognize these providers in oral surgery and dental offices, indicating almost universal acceptance of their role in all settings.

- Dental anesthesiologists (DA) are recognized by 38 states in hospital ORs and 40 states in ASCs, but recognition rises to 50 states for both oral surgery and dental office settings—demonstrating strong alignment of licensure with dental-specific environments.
- Oral surgeons (OS) follow a similar pattern, with 31–32 states recognizing them for GA in hospital or ASC settings and up to 49–48 states in office-based environments, confirming that oral surgeons are primarily credentialed to provide anesthesia within dental and oral surgery offices.
- General dentists (DMD/DDS) are licensed in 27 states to provide GA in hospital or ASC settings, and 26–31 states in dental offices, suggesting a moderate but variable regulatory recognition depending on training and local board rules.
- Certified anesthesiologist assistants (CAAs) are the least widely recognized, with only 22 states authorizing GA in hospitals or ASCs and roughly 11–12 states doing so in office settings, indicating significant regulatory limitations on their independent or supervised practice scope outside institutional environments.

In summary, nearly all states authorize anesthesiologists and CRNAs to administer GA in any clinical setting, while recognition for dental and oral surgery specialists is strongest in office-based contexts. In contrast, general dentists and anesthesiologist assistants face the narrowest scope of authorization, underscoring the uneven regulatory landscape across provider types and service locations.

Figure 11 illustrates how many states mandate supervisory oversight for different provider types administering GA across the same four primary practice settings. Supervision requirements vary significantly by provider type, reflecting differences in training, licensure scope, and regulatory authority. The data show that CRNAs and CAAs face the highest number of state-level supervision mandates, while MAs, DAs, and OSs operate almost universally without supervision requirements.

Figure 11. Number of States Requiring Supervision of Providers by Location of Services



Provider Supervision Comparisons

- MAs have no states requiring direct supervision in any setting, confirming their autonomous authority to administer GA across hospital, ASC, and office environments.
- DAs are required to practice under supervision in only one state, and only in the dental office setting. This near-universal independence aligns with their specialty certification and training in dental anesthesia.
- OSs encounter supervision requirements in just one or two states—one for hospitals and two for ASCs—indicating that they are largely authorized to self-regulate anesthesia delivery within both medical and dental environments.
- General dentists are required to have supervision in about seven to eight states across all settings. This pattern suggests greater oversight for general dentists relative to specialists, likely tied to differences in advanced anesthesia training or sedation permits.
- CRNAs face the highest number of supervision mandates, with 21-24 states requiring oversight in all four settings. This reflects ongoing state-level variation in opt-out status from the federal physician supervision rule, with roughly half of states allowing independent CRNA practice and half requiring oversight by a physician or dentist. See more on the federal Opt-Out regulation below.
- Certified anesthesiologist assistants are almost universally supervised, with 22 states requiring supervision in hospitals and ASCs, and 12-13 in office settings of the 22 states that recognize their licensure and/or certification. This consistent supervision requirement underscores their dependent practice model, which mandates physician direction regardless of location.

In summary, the chart underscores a clear regulatory gradient of autonomy. Anesthesiologists, dental anesthesiologists, and oral surgeons operate with broad independent authority, while CRNAs and CAAs are subject to extensive supervision requirements that vary by state and setting. General dentists fall in between—permitted to deliver GA in many states but often under specific supervisory or collaborative conditions. This distribution reflects the balance states seek between ensuring patient safety and maintaining access to anesthesia care across both medical and dental practice environments.

Certified Registered Nurse Anesthetists – Scope of Practice and Opt-Out vs. Opt-In

In 2001, the Centers for Medicare & Medicaid Services (CMS) revised its *Conditions of Participation* to give states the option to "opt out" of the federal requirement that CRNAs be supervised by a physician when providing anesthesia services to Medicare patients. Under the default or "opt-in" framework, states that have not opted out must ensure CRNAs practice under physician supervision—typically by an anesthesiologist or the operating surgeon—at least for Medicare cases. However, individual states may still have more flexible rules for non-Medicare patients depending on their licensing statutes. States that have formally opted out submitted a letter from their governor to CMS, confirming that the exemption aligns with state law, the recommendations of the state's medical and nursing boards, and the public interest. In these states, CRNAs may independently administer anesthesia under Medicare. Conversely, opt-in states remain bound by federal physician-supervision requirements regardless of what their own practice acts might otherwise permit.

As of 2025, 25 states, along with Washington, D.C. have formally opted out of the federal physician-supervision requirement. These include Alaska, Arizona, Arkansas, California, Colorado, Delaware, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah (partial), Vermont, Washington, Wisconsin, and Wyoming (partial). Utah and Wyoming have limited their opt-out status to critical access or rural hospital settings. Approximately 26 other states remain "opt-in," meaning they must comply with Medicare's supervision requirement for CRNAs treating Medicare beneficiaries, even if state law permits greater professional autonomy.

In opt-out *states***,** CRNAs are generally permitted to practice independently in hospitals, ASCs, and, in some cases, dental offices, depending on state law. These arrangements are particularly valuable for addressing anesthesia workforce shortages and improving access to care in rural or underserved regions. In opt-in states***,*** Medicare cases must still involve physician supervision, although the definition of "supervision" may be minimal—sometimes requiring only that the physician be physically available in the facility. Additionally, some state statutes or board regulations impose more stringent supervision mandates for all cases, not just Medicare patients, which can further limit CRNA autonomy.

Medicaid, being state-administered, operates independently from federal Medicare rules, meaning that a state's opt-out status does not automatically extend to its Medicaid program. Even in opt-out states, Medicaid policies governing dental general anesthesia may still require physician supervision, especially in outpatient dental offices or ASCs. California provides a clear example: Although it has opted out of the federal supervision requirement, its state dental board prohibits CRNAs from independently providing anesthesia in dental settings. This kind of dental board restriction is uncommon in other states but demonstrates the variability in how Medicaid and professional boards interpret anesthesia practice authority. Overall, Medicaid scope-of-practice rules for CRNAs vary widely—offering high autonomy in hospital settings but maintaining supervision requirements in community-based environments.

Differences in training among anesthesia providers influence how states and payers perceive pediatric anesthesia competence. CRNAs do not have a nationally standardized pediatric fellowship, and exposure to pediatric cases varies by training program. DAs, in contrast, complete residencies that include extensive pediatric case experience as a core component of their specialty. Medical anesthesiologists receive pediatric exposure during residency and may pursue an additional one-year pediatric fellowship for advanced expertise. CAAs have training structures like CRNAs, with variable pediatric experience but no formal pediatric credentialing pathway. These distinctions are not captured in Medicaid policy language, which may inadvertently equate provider categories without considering pediatric specialization or case experience.

The analysis of the opt-out/opt-in framework has several implications for the Medicaid programs. First, there is a clear federal–state policy disconnect**:** While federal opt-out status allows CRNAs independent practice under Medicare, state Medicaid dental GA policies can still impose supervision requirements in outpatient or ASC settings. Second**,** setting-specific restrictions remain common—hospitals often allow more autonomy, whereas office-based and ASC environments tend to maintain supervision clauses. Third, a potential policy leverage point exists in aligning Medicaid dental GA regulations with existing opt-out frameworks, which could expand access to pediatric dental anesthesia in underserved areas. Finally, this assessment maintains a neutral stance on the safety or efficacy of supervised versus unsupervised CRNA practice, recognizing that those determinations rest with CMS, state law, and the broader medical and nursing professions.

Understanding Provider Scope Under Medicaid General Anesthesia Policy

In their assessment of state Medicaid policies, researchers identified six thematic clusters that describe how Medicaid programs address provider scope of practice related to GA services.

This analysis does **not** measure legal authority, licensure status, or autonomy of practice; rather, it maps how Medicaid manuals and policy documents reference—or fail to reference—specific provider types and settings. The clusters reveal the varied and sometimes inconsistent ways in which state Medicaid programs recognize anesthesiologists, CRNAs, dental anesthesiologists, CAAs, and oral surgeons.

Overall, the findings show that Medicaid language often lags behind professional practice and licensure trends. References to supervision, facility type, or provider recognition are frequently administrative artifacts rather than enforceable clinical mandates. Understanding these patterns helps clarify how Medicaid documentation shapes billing, coverage interpretation, and perceived scope—without necessarily dictating real-world authority or autonomy.

The following six clusters summarize these patterns, illustrating how policy wording, provider recognition, supervision references, facility distinctions, training acknowledgment, and federal-state interactions collectively influence how anesthesia services are represented within state Medicaid programs.

Cluster 1: Explicit Recognition vs. Silence in Medicaid Policy

Researchers identified that state Medicaid manuals vary widely in whether they explicitly name anesthesia providers such as MAs, CRNAs, DAs, CAAs, or OSs. In some states, these provider types are clearly listed in the Medicaid policy, while in others they are absent or unspecified. Importantly, silence in policy does **not** equate to prohibition of practice, it often reflects that Medicaid relies on existing state licensure laws rather than duplicating them. The key takeaway is that explicit recognition in Medicaid policy is primarily about administrative and billing clarity rather than a grant of practice authority. The presence—or absence—of a provider type in Medicaid manuals should therefore be interpreted as a reflection of documentation style, not as a statement of permission or exclusion.

Cluster 2: Uneven Treatment of Provider Categories

Analysis of state Medicaid policies revealed inconsistent treatment across anesthesia provider categories. medical anesthesiologists are the most consistently named, while CRNAs and DAs appear less frequently, and CAAs are the least represented overall. These discrepancies suggest that Medicaid documentation often lags behind state licensure and scope-of-practice realities. In some states, DAs or CAAs are fully licensed and recognized by state boards yet remain absent from Medicaid manuals, leading to confusion about reimbursement and administrative recognition. This uneven treatment underscores the distinction between legal authority to practice and Medicaid policy acknowledgment, highlighting the need for policy modernization to align with current workforce structures and professional roles.

Cluster 3: Conditional Supervision Language

Medicaid policy language also varies in how it addresses supervision requirements, particularly for CRNAs and DAs. Some states explicitly include phrases such as "under the supervision of an anesthesiologist," while others list provider types without qualifiers. These references generally reflect policy phrasing rather than licensure mandates**.** For CRNAs, true autonomy depends on whether the state's governor has formally opted out of the CMS supervision requirement**,** allowing independent anesthesia practice. Even in these opt-out states, Medicaid documents may still reference supervision as a vestige of older language. For DAs, there are no statutory requirements mandating anesthesiologist oversight; thus, any supervision references typically stem from billing conventions or conservative policy drafting rather than enforceable regulations.

Cluster 4: Location of Services Linked Language in Medicaid Policy

Researchers observed notable differences in how Medicaid policies describe provider authority across facility types. Policies referencing hospitals tend to list MAs, CRNAs, and oral surgeons more broadly and without supervision terms, whereas those describing offices or ASCs more frequently include supervision or conditional language. These distinctions generally reflect drafting practices rather than facility licensing law. The trend gives the impression of greater supervision requirements in outpatient settings, though actual autonomy is determined by state licensure statutes, dental board rules, and CMS opt-out provisions. The key insight is that Medicaid manuals may unintentionally signal stricter oversight in office-based environments even when no such restrictions exist in law.

Cluster 5: Training and Specialization

Across all state Medicaid manuals reviewed, none explicitly differentiate anesthesia providers based on pediatric training or specialization. In practice, only medical anesthesiologists may pursue formal pediatric fellowships, while DAs complete residencies with significant pediatric case exposure. CRNAs and CAAs, by contrast, have varied pediatric experiences depending on their educational programs, but no distinct pediatric credential exists. The absence of this distinction in Medicaid policy suggests that training and specialization differences are invisible to policy writers, potentially leading to misunderstandings in coverage or credentialing. This cluster highlights the disconnect between professional training pathways and the way Medicaid documentation represents provider qualifications.

Cluster 6: Federal vs. State Interaction (CRNA Opt-Out as Example)

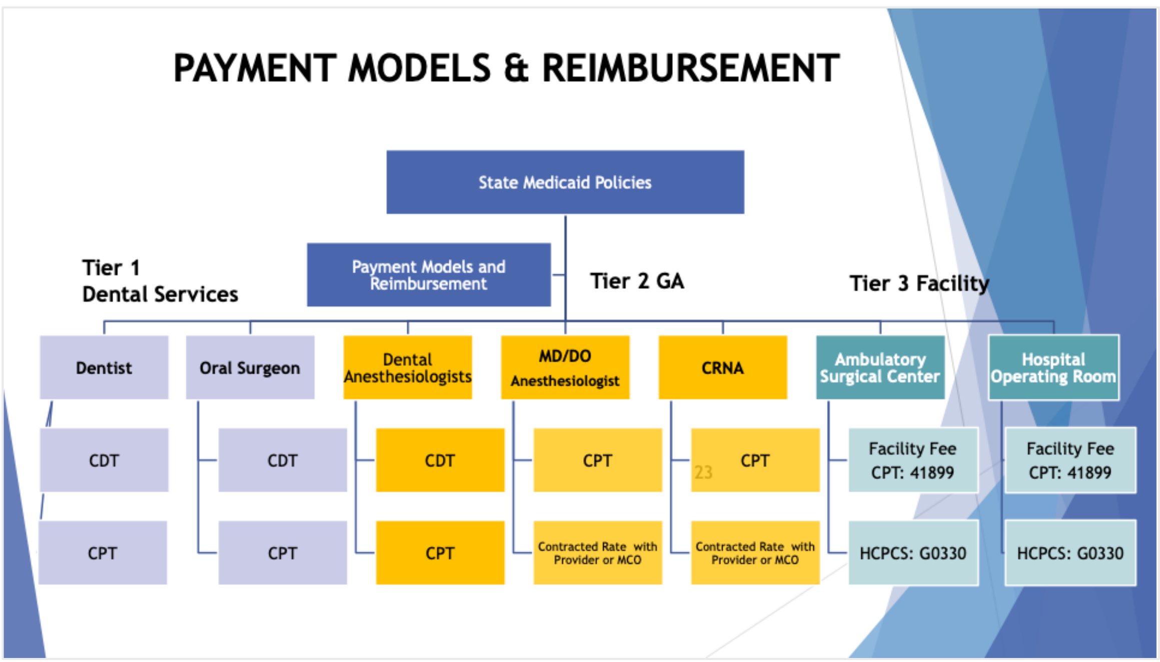
The intersection of federal and state authority further complicates Medicaid policy interpretation. Under federal rules, states that have formally opted out of CMS supervision requirements permit CRNAs to practice without physician oversight. However, state laws or boards may still impose their own restrictions, leading to inconsistencies between legal authority and Medicaid policy language. California serves as a prime example: although it is an opt-out state, its dental board prohibits CRNAs from independent practice in dental settings. Consequently, Medicaid manuals often blur these distinctions, maintaining "supervision" references even when they no longer carry regulatory force. This cluster underscores the tension between federal opt-out authority, state scope-of-practice rules, and Medicaid's administrative interpretation**,** illustrating why policy language does not always align perfectly with clinical or legal realities.

Reimbursement

Variations in provider type, reimbursement methodology, and scope-of-practice policy significantly influence the availability and affordability of anesthesia-supported dental treatment—especially for pediatric, disabled, and medically complex populations. The charge of the Reimbursement Subcommittee was to examine the impact of Medicaid provider reimbursement rates on access to general anesthesia supporting the delivery of dental services.

Researchers explored the types of Medicaid billing providers involved in GA delivery, including dentists, medical anesthesiologists, CRNAs, ASCs, and hospitals, and identify the reimbursement codes, payment models, and policy frameworks governing their participation. Attention was given to scope-of-practice limitations, exemptions, and policy nuances that affect how and where providers may administer GA under Medicaid. **Figure 12** illustrates the various billing providers eligible for payment under Medicaid and associated payment code structure.

Figure 12.



Medicaid reimbursement for GA and dental services operates across three interrelated tiers, reflecting differences in provider type, service setting, and the complexity of care delivery. Each tier aligns with specific CDT, CPT, HCPCS codes, as well as distinct payment mechanisms governed by state Medicaid policies and managed care contracts.

Tier 1: Dental Services

The first tier represents office-based dental services provided by dentists and oral surgeons, where reimbursement is generally based on CDT and CPT codes for procedures and anesthesia time. This tier reflects the most direct, fee-for-service (FFS) payment model, where providers bill Medicaid for specific dental or anesthesia services performed within a private practice or dental office setting. Payment rates at this level are typically lower and tied to individual procedures, making this the most accessible but least resource-intensive environment for GA delivery.

Tier 2: General Anesthesia Providers

The second tier includes specialized anesthesia providers such as DAs, MAs, and CRNAs. These professionals use CPT anesthesia codes and, in some cases, CDT codes when services are performed in conjunction with dental procedures. Reimbursement is often based on a contracted rate negotiated between the provider and the Medicaid agency or Managed Care Organization (MCO). This tier reflects a more flexible model that accommodates multiple anesthesia delivery arrangements—ranging from in-office support to operating room participation—and allows states to adjust payment to reflect provider qualifications, case complexity, and regional anesthesia workforce capacity.

Tier 3: Facility-Based Services

The third tier captures services performed in ASCs and hospital operating rooms —the most resource-intensive settings for anesthesia-supported dental care. Facilities bill Medicaid for facility fees using CPT code 41899 and HCPCS code G0330, which cover the use of the operating room, equipment, and nursing support. These payments are typically separate from the anesthesia provider's professional fee and may vary depending on whether the service occurs in a hospital or ASC. Tier 3 reimbursement represents the highest level of complexity and cost but ensures comprehensive access for patients requiring full surgical capability or advanced monitoring, such as individuals with special health care needs or complex medical conditions or those characterized as ASA Levels 3 and above. See APPENDIX E for summary of the ASA Levels 1-4.

Together, these three tiers illustrate the layered structure of Medicaid's payment ecosystem for dental and anesthesia services

- **Tier 1** supports community-based care and procedural simplicity.
- **Tier 2** bridges dental and medical anesthesia through specialized or contracted providers.
- **Tier 3** delivers comprehensive, facility-based care with distinct reimbursement for both provider and facility components.

This framework underscores how state Medicaid policies balance cost, provider participation, and patient safety by linking payment methodologies to service setting, professional qualifications, and procedural intensity.

Building on this framework, it is useful to identify common themes and practices across states—such as rate-setting strategies, bundled versus fee-for-service models, and site-of-service payment differentials—that shape access to anesthesia-supported dental care.

Across state Medicaid programs, rate-setting strategies for anesthesia services vary widely but follow several recurring patterns. Many states mirror the medical anesthesia model, using a base-plus-time formula derived from CPT codes. When base units or allowable time are capped—often at 60 to 90 minutes—providers treating young children or patients with disabilities face financial disincentives for longer, more complex cases. Other states rely on time-based dental codes (e.g., D9222/D9223), paying a flat amount per 15-minute unit. If these units are undervalued, office-based anesthesia becomes financially unviable. Rate parity also matters, as programs that reimburse medical anesthesiologists, CRNAs, and dental anesthesiologists at comparable levels tend to maintain stronger provider participation than those that favor one group over another.

States also differ in their use of bundled versus FFS payment models. Under a bundled approach, a single rate covers anesthesia, facility, and restorative dental services—streamlining billing and prior authorization while promoting efficiency. However, if the bundled rate is set too low, it can obscure variations in case complexity and undercompensate high-need populations. In contrast, FFS models that reimburse each component separately—professional, facility, and dental—generally support better access when all three elements are adequately valued. Some states have begun piloting episode-based or Diagnosis Related Group, DRG-like payments or case rate bundled model that stabilize revenue for high-volume centers and shorten wait times, provided quality measures are embedded.

Location-of-service payment differentials strongly shape where anesthesia services are delivered. States that reimburse hospitals and ASCs through distinct facility fees (e.g., G0330, 41899) sustain greater procedural capacity. Where ASC facility payments are denied or undervalued, cases cluster in hospital operating rooms, increasing costs and wait times. Enhanced office-based rates or recognition of dental anesthesiologists and mobile anesthesia teams proving GA services in private dental offices can open additional access points, whereas prohibiting in-office anesthesia—despite qualified providers—limits availability for otherwise healthy children.

Several coverage and policy mechanisms further influence access. Clear, evidence-based MA criteria for pediatric patients and for patients with disabilities facilitate timely approval, while vague or inconsistent standards delay care. Rigid age or ASA-status limits and narrow time caps often push cases unnecessarily into hospital settings. Aligning Medicaid coverage rules with state supervision laws—particularly regarding CRNAs, medical anesthesiologists, and dental anesthesiologists—expands provider supply, while misalignment suppresses participation.

Medicaid programs increasingly recognize that a "one-size-fits-all" reimbursement approach cannot meet the needs of rural and disability populations. To address geographic inequities, several states such as Washington, Montana and Alaska, have adopted rural access add-ons or mobile operating room days, offering travel differentials or outreach stipends to extend anesthesia-supported dental services to frontier counties and Title I school districts. Likewise, special-needs multipliers have been introduced in some programs like Kansas and Iowa, to reflect the longer anesthesia and recovery times associated with patients with developmental disabilities or complex comorbidities. These adjustments create a fairer payment environment that rewards the additional time, travel, and coordination required to serve high-need populations. Such a model was recommended by the National Council on Disability in its 2023 Report entitled, *Incentivizing Oral Health Care Providers to Treat Patients with Intellectual and Developmental Disabilities.*[v]

Reducing administrative burden is another key driver of access. States that maintain clean CDT↔CPT crosswalks and claim edits—clearly defining who bills what between dentists, anesthesia providers, and facilities—report fewer denials and stronger provider retention. Similarly, establishing co-billing rules that permit concurrent submission of dental and anesthesia claims, with automated adjudication, shortens payment cycles and improves cash flow. These simplifications make Medicaid participation more sustainable and encourage collaboration between dental and medical anesthesia teams, particularly in high-volume pediatric or special-needs cases.

Evidence from multiple states (i.e. Washington, Illinois, and Alabama) shows that certain payment and policy combinations consistently improve access to GA for dental care. Programs that pay all three components—dental, anesthesia professional, and facility—at viable rates and that allow services in both ASC and office-based settings achieve the highest participation. Transparent MN criteria and streamlined PA processes reduce delays for children and patients with disabilities, while aligning Medicaid supervision policies with existing state scope-of-practice laws expands the provider pool. Finally, offering bundled or episode-based options alongside fee-for-service, and incorporating rural or special-needs modifiers, ensures reimbursement reflects true case intensity—helping reduce unmet need and wait times across diverse populations.

Lastly**,** managed care contracting practices can either strengthen or weaken access. Medicaid MCOs that establish contracted anesthesia panels, guarantee minimum payment rates, and expedite authorizations typically achieve higher provider engagement and shorter waiting periods. Some states have designated centers of excellence (COEs) with enhanced bundled rates and performance expectations to reduce pediatric dental GA backlogs. Value-based add-ons tied to timely completion, reduced emergency department reliance, and improved post-operative follow-up are emerging strategies that promote continuity and efficiency.

SAFETY

General anesthesia enables essential dental care for children, individuals with disabilities, and those with severe anxiety or behavioral conditions. However, GA in office-based, ambulatory and hospital-based settings presents significant patient safety challenges that demand both clinical vigilance and policy oversight. The following subsections synthesize key areas of concern and highlight policy options to improve patient safety, reporting, and accountability by state Medicaid programs.

Patient Selection and Preoperative Assessment

Safe anesthesia delivery begins with comprehensive risk assessment. Inadequate preoperative evaluation—including failure to review airway status, comorbid conditions, medication history, or fasting compliance—has been associated with adverse outcomes in pediatric and medically complex patients.[vi] Children, especially those under age six, have higher oxygen consumption and limited cardiopulmonary reserve, magnifying the impact of small errors.[vii] State Medicaid programs can strengthen safety by requiring standardized pre-anesthesia assessments, use of ASA classification, and explicit medical clearance for high-risk populations, consistent with ADA and ASA sedation guidelines and state licensing regulations.[viii]

Provider Qualifications and Team Coordination

Evidence consistently links provider training and team communication with patient safety outcomes. Adverse events often occur when anesthesia is administered by clinicians operating beyond their permit level or without pediatric-specific competencies.[ix] States that require a dedicated anesthesia professional for all GA cases demonstrate fewer critical incidents and improved patient recovery times. Embedding interprofessional team training and communication protocols such as SBAR (Situation–Background–Assessment–Recommendation) or closed-loop response systems promotes situational awareness and rapid intervention.[x]

Medication, Dosing, and Drug Safety

Weight-based dosing errors and inappropriate drug combinations are common contributors to adverse anesthesia events in children. [xi] Variability in local anesthetic use, epinephrine concentration, and sedative selection can lead to hemodynamic instability or local anesthetic systemic toxicity.[xii] Double-check systems, prefilled syringes, and color-coded medication charts are proven strategies to minimize error per the Institute for Safe Medication Practices.[xiii] States and health plans can further reduce risk by requiring documentation of drug reconciliation and periodic pharmacy audit of anesthesia medications.

Emergency Preparedness and Rescue Capacity

Preparedness for emergencies—such as laryngospasm, anaphylaxis, or malignant hyperthermia—is a core safety requirement under both ASA and CMS standards.[xiv] Many office-based dental facilities lack fully stocked emergency kits, updated dantrolene supplies, or established hospital transfer agreements. The presence of expired medications or untrained staff is a recurrent finding in adverse event reviews.[xv] Requiring documented emergency drills, maintaining written rescue protocols, and verifying transfer agreements as part of Medicaid readiness review can strengthen response capacity and reduce mortality.

Post-Anesthesia Recovery and Discharge

Adverse events frequently occur in the post-anesthesia phase when monitoring is reduced. Hypoventilation, airway obstruction, and delayed emergence are common among children and special-needs patients.[xvi] Implementation of standardized discharge criteria—such as the Modified Aldrete Score—and mandatory caregiver education improves outcomes and minimizes post-discharge complications.[xvii] Medicaid managed care contracts can require adherence to such recovery standards to ensure safe and consistent post-procedure care.

Data Reporting, Learning Systems, and Accountability

Currently, dentistry lacks a unified, de-identified national reporting system for anesthesia-related incidents. Existing data are fragmented among malpractice insurers, state boards, and voluntary registries. The Agency for Healthcare Research and Quality (AHRQ) and the National Council on Disability have both emphasized the need for standardized reporting of anesthesia-related adverse events in Medicaid populations.[xviii] Creating a dental Patient Safety Organization (PSO) under AHRQ or integrating dental reporting within the CMS Quality, Safety, and Oversight framework could establish a national repository for incident learning. States can also embed mandatory reporting of serious adverse events—death, hospitalization, or unplanned transfer—into Medicaid managed care contracts or dental state licensing requirements.

In short, airway safety in dental anesthesia is not just a technical issue—it is **a** public policy issue that affects patient safety, access to care, and program accountability. By setting clear expectations for who can provide anesthesia, where it can safely occur, and how adverse events are reported and learned from, Medicaid programs can better protect vulnerable populations—especially young children and individuals with disabilities—while maintaining equitable access to needed dental services.

Airway Management and Ventilation Risks

The shared airway in dental anesthesia presents a unique and preventable source of patient harm that has direct implications for state oversight, facility licensure, and Medicaid contracting. Because both the dentist and the anesthesia provider operate within the same physical space, the potential for airway obstruction, aspiration, or laryngospasm is substantially higher than in other surgical contexts. Children and individuals with special needs are more vulnerable during anesthesia because their oxygen levels can drop quickly and their bodies have less capacity to recover, underscoring the need for careful monitoring and safety precautions. From a policy perspective, these risks underscore the need for explicit regulatory and contractual safeguards that ensure the following:

- Dual-provider Requirements: Medicaid policy should consider stipulating that deep sedation and general anesthesia be administered only when a dedicated, qualified anesthesia provider (e.g. MA, DA, CRNA) is continuously present and not simultaneously performing dental procedures.
- Credentialing and competency verification: State licensure boards and managed care organizations should verify that anesthesia providers possess pediatric airway-management training, current Basic and Advanced Life Support (BLS/PALS/ACLS) certification, and documented competency in airway rescue.
- Equipment, monitoring standards and permitting: Health department policies should require continuous CO_2 monitoring, pulse oximetry, suction redundancy, and emergency airway supplies consistent with ASA and ADA guidelines and consider permitting. Facility inspections and Medicaid readiness reviews should explicitly confirm adherence to these standards.
- Location of service rules: Dental general anesthesia should be permitted only in settings that meet minimum environmental controls—oxygen backup, suction redundancy, and emergency transfer protocols—comparable to ASC standards.
- Incident reporting and quality improvement: All adverse airway events (e.g., obstruction, aspiration, hypoxia, unplanned intubation, or emergency transfer) should be mandatorily reported to the state Health Department, Medicaid agency and a recognized PSO for de-identified investigation, analysis and continuous quality improvement.

CONCLUSION

This research initiative explored how state Medicaid programs regulate, reimburse, and safeguard the delivery of GA for dental services. Through analysis across four domains—Scope of Practice, Location of Services, MN, and reimbursement—the study identified significant variation in how states define provider authority, service settings, and MN criteria and promote safety for GA-supported dental care.

While most states authorize medical and dental anesthesiologists, CRNAs, and oral surgeons to independently provide GA, general dentists and anesthesiology assistants often face narrower scopes of practice and heightened supervision requirements. Medicaid coverage has traditionally focused on hospital and ASC settings, though emerging office-based anesthesia models offer promising opportunities to deliver safe, effective care while reducing wait times and improving access.

Differences in PA, documentation, and reimbursement processes further influence access, timeliness, and cost of care—particularly for pediatric, disability, and medically complex populations who depend on GA to receive essential dental treatment.

The study's findings underscore that the intersection of safety, access, and administrative policy significantly shapes the availability and quality of anesthesia-supported dental services. Moving forward, standardizing MN criteria, aligning provider licensing requirements, expanding access to office-based care, and improving data collection and reporting on anesthesia outcomes represent key policy opportunities. By strengthening these frameworks through collaboration and alignment with existing professional organizations governing dental and anesthesia services (See Appendix F), state Medicaid programs can enhance patient safety, reduce delays in treatment, and ensure equitable access to comprehensive dental care for vulnerable populations.

RECOMMENDATIONS

Medical Necessity

- When establishing MN criteria for dental services and the use of supplemental GA, state policy makers should prioritize determinations based on a documented dental diagnosis and demonstrated treatment need. This approach ensures that the underlying dental condition—rather than administrative or procedural factors—drives the authorization of GA as a supportive service. Aligning MN determinations with clinically verified dental findings promotes equitable access to necessary care, reduces inappropriate utilization controls, and maintains a consistent, evidence-based standard across providers and populations.

Location of Services

- State administrators and contracted health plans should establish a strategic distribution of anesthesia service sites for MN dental care that balances patient safety with equitable access across diverse care settings. Policies should support the integration of accredited office-based anesthesia services alongside hospitals and ASCs to alleviate capacity constraints and reduce wait times for dental procedures requiring anesthesia. This balanced approach should be reinforced through provider credentialing and supervision standards**,** and robust data collection on anesthesia-related outcomes across all settings. By aligning oversight and safety standards while diversifying locations of care, states can expand access to safe, timely, high-quality, and cost-effective anesthesia-supported dental services for Medicaid members.

Scope of Practice

- State Medicaid agencies should update provider recognition language to explicitly include all licensed anesthesia provider types—MAs, CRNAs, DAs and OSs—as applicable under state law. This ensures administrative clarity, billing consistency, and workforce transparency. Silence or omission in policy should be replaced with affirmative recognition language that aligns Medicaid documentation with state licensure laws and current professional standards, reducing ambiguity and administrative barriers to care.
- State Medicaid programs should require a dual-provider model for the administration of deep sedation and GA in all dental settings, ensuring that a dedicated, qualified anesthesia provider—such as a MAs, DAs—is continuously present and not simultaneously performing dental or

surgical procedures. This separation of clinical roles upholds patient safety, enables immediate airway management, and aligns with national standards for safe anesthesia delivery.

- States that have opted out of CMS anesthesia supervision requirements should ensure Medicaid manuals are updated to mirror this status. Clarifying supervision language promotes consistency, prevents misinterpretation of provider authority, and supports efficient credentialing and contracting processes.

Reimbursement

- Medicaid payment policy should ensure rate parity for the provision of GA services across location sites to support standardized and accredited GA infrastructure and capacity in all service settings. Programs that eliminate reimbursement disparities sustain broader participation and mitigate access gaps, particularly for pediatric and disability populations.
- To balance safety, cost, and access, states should consider site-of-service payment differentials that reflect true resource intensity while encouraging care delivery in the most appropriate setting. This includes maintaining distinct facility payments (e.g., G0330, 41899) for hospitals and ASCs to preserve capacity for complex cases; and introducing essential office-based anesthesia rates for accredited dental offices and mobile anesthesia teams that cover equipment management as well as post-surgical nursing care, in addition to anesthesia services, for lower and moderate-risk patients. This approach reduces reliance on hospital operating rooms, shortens wait times, and expands care availability without compromising patient safety.

Safety

- Medicaid programs and credentialling processes should require adherence to professional and licensing standards for all providers delivering dental care, sedation, and GA services.
- To strengthen patient safety and uphold consistent standards of care, Medicaid policy should require dual providers—that all deep sedation and GA services be administered by a dedicated, qualified anesthesia professional, distinct from the operating dentist.
- Program regulations should further stipulate that contracted anesthesia providers maintain appropriate state licensure and permits, current life-support certifications (BLS, PALS, ACLS), and documented pediatric competency where applicable. In addition, Medicaid agencies and MCOs should embed team coordination and communication protocols within their credentialing, contracting, and performance review processes to ensure safe, coordinated anesthesia delivery across all practice settings.
- Medicaid agencies should establish a statewide anesthesia incident reporting and learning system for health plans, as well as dental and medical providers modeled on PSOs. All anesthesia-related adverse events—such as unplanned transfers, hospitalizations, or deaths—should be mandatorily reported to the state and Medicaid oversight entities. Aggregated, de-identified data should be analyzed to identify systemic risks, inform policy updates, and support quality improvement across managed care networks.
- Federal policy makers should direct CMS or AHRQ to establish a national reporting system for anesthesia-related incidents to drive continuous quality improvement and policy learning in both medical and dental settings.

Appendix A— State Medical Necessity Survey Questionnaire

State Medical Necessity Survey Questionnaire
1. What authority or professional guidelines does your state use to establish MN criteria?
2. Does GA medical necessity criteria differ by age cohort?
3. Does GA medical necessity criteria differ by special needs?
4. What ICD-10 codes are used to document medical necessity for GA?
5. Does your state require prior approval/authorization for GA services; and if so, under what conditions?
6. Does your state have a documented policy outlining medical necessity criteria for the use of general anesthesia support services for dental care?

Appendix B – Location of Services Survey Instrument

Survey Questions	Private Dental Office	Oral Surgeon's Office	Ambulatory Surgical Center	Hospital Operating Room
Does the state Medicaid policy cover moderate sedation services for dental procesures in this location of services? [CDT and CPT Codes]				
Does the state Medicaid policy impose any criteria, limitations, or exemptions for moderate sedation services for dental procedures in this location of services?				
If yes, please explain:				
Does the state Medicaid policy cover deep sedation services in this type of location?				
Does the state Medicaid policy impose any criteria, limitations, or exemptions for deep sedation services for dental procedures in this location of services?				
If yes, please explain:				
Does the state Medicaid policy cover General Anesthesia services for dental procedures in this tyoe of location?				
Does the state Medicaid policy impose any criteria, limitations, or exemptions for General Anesthesia services for dental procedures in this location of services				
If yes, please explain:				
Are there any dental service limitations or conditons related to each of the locations of services? [Example: GA not permitted in private dental office; similar to mobile dentistry nopt permittted in schools in some states.				
If yes, please explain:				
Are there any dental provider type OR anesthesiologist provider type limitations specific to location of services?				
If yes, please explain:				

Appendix C – Scope of Practice Survey Instrument

Survey Questions	MD Anesthesiologist	Certified RN Anesthesiologist	Dental Anesthesiologist	Oral Surgeon	Dentists	Certified Anesthiologist Assistant
Licensed/Certified to administer sedation/GA in State for Dental Procedures?						
Licensed/certified to administer Sedation/GA services in Hospital Operating Room?						
Is supervision required to administer Sedation/GA services in Hospital Operating Room?						
Licensed/certified to administer Sedation/GA services in an Ambulatory Surgical Center?						
Is supervision required to administer Sedation/GA services in an Ambulatory Surgical						
Licensed/certified to administer Sedation/GA services in Private Dental Office?						
Is supervision required to administer Sedation/GA services in Private Dental Office?						
Licensed/certified to administer Sedation/GA services in an Oral Surgeon's Office?						
Is supervision required to administer Sedation/GA services in an Oral Surgeon's Office?						
Are there any other noitable scope of practice limitations relatd to the administration of GA for dental procerdures?						

Appendix D— (ASA) Physical Status Classification System

The American Society of Anesthesiologists (ASA) Physical Status Classification System is used to assess and communicate a patient's pre-anesthesia medical condition and surgical risk. There are six total ASA classes, but when discussing general anesthesia (GA) in dental or medical contexts, the focus is typically on the first four levels (ASA I–IV), which define the range of patients most commonly eligible for routine or medically necessary anesthesia.

ASA Levels:

ASA I – Normal Healthy Patient

- A completely healthy individual with no systemic disease and no physiologic, psychiatric, biochemical, or organic disturbance.
- Examples: Healthy, non-smoking, no or minimal alcohol use.
- Anesthesia Implication: Lowest risk for GA; generally suitable for outpatient or office-based anesthesia.

ASA II – Patient with Mild Systemic Disease

- A patient with a mild, well-controlled systemic condition that does not limit daily activity.
- Examples: Controlled hypertension, mild asthma, well-managed diabetes, obesity (BMI < 30), pregnancy, social alcohol use.
- Anesthesia Implication: Low to moderate risk; often appropriate for GA in office or ambulatory settings with appropriate safeguards.

ASA III – Patient with Severe Systemic Disease

- A patient with significant systemic disease that limits activity but is not incapacitating.
- Examples: Poorly controlled hypertension or diabetes, morbid obesity (BMI ≥ 40), chronic pulmonary disease, stable angina, history of myocardial infarction >3 months ago.
- Anesthesia Implication: Moderate to high risk; GA typically performed in a hospital or ASC setting with advanced monitoring.

ASA IV – Patient with Severe Systemic Disease that is a Constant Threat to Life

- A patient with severe, life-threatening systemic disease or decompensated condition.
- Examples: Recent (<3 months) myocardial infarction, unstable angina, symptomatic COPD, advanced renal or hepatic failure, or ongoing sepsis.
- Anesthesia Implication: High risk; GA should be administered only in a hospital operating room with full resuscitative capability.

ASA V – A moribund patient who is not expected to survive without the operation

- Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.
- Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.
- Uterine rupture

ASA VI — A declared brain-dead patient whose organs are being removed for donor purposes

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Source: American Society of Anesthesiologists (ASA). *ASA Physical Status Classification System.* Approved by the ASA House of Delegates, October 15, 2014. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system

Appendix E—Source Review of Medicaid Policy, Professional Guidelines, Literature and Key Authorities

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Appendix F— Organizations Governing Anesthesia Providers in the United States

Provider Type	Governing / Certifying Organization	Primary Role or Function
Medical Anesthesiologists (MD/DO)	American Society of Anesthesiologists (ASA)	Establishes national standards and guidelines for anesthesia safety, monitoring, and ethics.
	American Board of Anesthesiology (ABA)	Certifies physician anesthesiologists through exams & certification.
	Accreditation Council for Graduate Medical Education (ACGME)	Accredits anesthesiology residency and fellowship training programs.
Dental Anesthesiologists, Oral Surgeons, and Dentists (DDS/DMD)	American Dental Association (ADA)	Develops national policies and clinical guidelines for sedation and anesthesia in dentistry.
	American Society of Dentist Anesthesiologists (ASDA)	Represents dental anesthesiologists and promotes safety & training.
	American Association of Oral and Maxillofacial Surgeons (AAOMS)	Sets anesthesia and surgical standards for oral surgeons, including office-based practices.
	American Dental Society of Anesthesiology (ADSA)	Provides education, research & advocacy for safe dental anesthesia.
Certified Registered Nurse Anesthetists (CRNAs)	American Association of Nurse Anesthesiology (AANA)	Establishes clinical, ethical, and educational standards for nurse anesthetists.
	National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)	Administers certification and ongoing competency assessments for CRNAs.
Certified Anesthesiologist Assistants (CAAs)	American Academy of Anesthesiologist Assistants (AAAA)	Represents CAAs and promotes standardized education and licensure.
	National Commission for Certification of Anesthesiologist Assistants (NCCAA)	Certifies CAAs through national examinations and continuing education.
Cross-Cutting Regulatory and Oversight Bodies	Centers for Medicare & Medicaid Services (CMS)	Establishes federal Conditions of Participation and reimbursement requirements for anesthesia services.
	The Joint Commission (TJC)	Accredits healthcare facilities and enforces safety & monitoring.
	Occupational Safety and Health Administration (OSHA)	Regulates environmental and workplace safety.
	State Health Departments	License, inspect, and regulate healthcare facilities providing anesthesia, including office-based settings.
	State Dental, Medical and Nursing Boards	Define supervision, delegation, and licensure requirements.

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