34 out of 50 States Now Mandate Private Medical Insurers Must Pay Charges for Pediatric Dental Sedation

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Introduction: Historically, private medical insurers in the United States have refused to cover sedation and facility charges for dental procedures by insisting that they should be covered by dental insurance. At the same time, the private dental insurers have been refusing to cover the sedation and facility charges on the basis that they are for the practice of medicine and thus not a dental benefit. To resolve the situation where a patient has both medical and dental insurance and still has no coverage, many states starting in the late 1990's passed legislation requiring medical insurers to cover sedation and facility charges for dental procedures for children under 5 to 8 years of age and for other people with disabilities that make them require sedation for procedures which normally would not require sedation. Each state has its own description of the sedation locations covered, ranging from a "dental office" to "surgery center setting" to "hospital." The purpose of this study was to identify which states currently have passed such mandates.

Methods: A search of the internet and public health organizations and state legislature archives therein was the source of all data.

Results: The 34 states listed in the category of "Mandates" in the table are those for which a mandate could be found. There are 16 states in the "No Mandates" category. Classification in the "No Mandates" category does not mean that evidence was found that there is no mandate. It means simply that no evidence of a mandate could be located.

Discussion: Knowledge of the details of a practitioner's particular state statutes may be helpful when submitting a claim to the patient's insurer since the insurer, particularly if it is based out of state, may need to be educated about the laws governing coverage for the sedation. In addition, the preponderance of states with statutes may have caused national insurers for the sake of simplicity to write guidelines applied nationally which provide a form of the mandated benefits to insureds in states that have not in fact passed laws mandating the benefits.

State Laws (nationwide)	
Mandates	**No Mandates**
AK	AL
AR	AZ
CA	DE
CO	HI
CT	MA
FL	MI
GA	NV
IA	NM
ID	OR
IL	PA
IN	RI
KS	SC
KY	UT
LA	VT
MD	WV
ME	WY
MN	
MO	
MS	
MT	
NC	
ND	
NE	
NH	
NJ	
NY	
OH	
OK	
SD	
TN	
TX	
VA	
WA	
WI	

Sample Mandate - California

CALIFORNIA CODES HEALTH AND SAFETY CODE - SECTION 1367-1374.16

1367.71. (a) Every health care service plan contract, other than a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, shall be deemed to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. The health care service plan may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions. (b) This section shall apply only to general anesthesia and associated facility charges for only the following enrollees, and only if the enrollees meet the criteria in subdivision (a): (1) Enrollees who are under seven years of age. (2) Enrollees who are developmentally disabled, regardless of age. (3) Enrollees whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. (c) Nothing in this section shall require the health care service plan to cover any charges for the dental **procedure** itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section shall be subject to all other terms and conditions of the plan that apply generally to other benefits. (d) Nothing in this section shall be construed to allow a health care service plan to deny coverage for basic health care services, as defined in Section 1345. (e) A health care service plan may include coverage specified in subdivision (a) at any time prior to January 1, 2000.