APG Billing for Dental Anesthesia:

Effective with date of service January 1, 2016, providers must utilize new dental procedure codes for the submission of general anesthesia and intravenous sedation. The revisions are a result of the Current Dental Terminology (CDT) 2016 American Dental Association (ADA) code updates.

Providers are required to report the usage of dental anesthesia that was provided in connection with a dental procedure when submitting a claim to Medicaid for reimbursement. The following dental anesthesia codes all group to APG 375, which can be located on the 3M APG Crosswalk located HERE on the NYSDOH website.

Dental Anesthesia Codes Assigned to APG 375:	
Procedure Code:	**Procedure Description:**
D9210 *	Dental anesthesia without surgery.
D9211*	Regional block anesthesia.
D9212 *	Trigeminal block anesthesia.
D9215 *	Local anesthesia
D9223	General anesthesia each 15 min. **(NEW)**
D9243	IV sedation each 15 min. **(NEW)**

Note: Dental anesthesia procedures referenced above with an * all group to the "Never Pay Procedures" list, and are not reimburseable within APGs.

Dental anesthesia procedure codes D9223 and D9243 will be reimbursed via the APG "Procedure Based Weights" file. These procedures will be reimbursed based upon the number of units submitted on the claim. A "Procedure Based Weight" of 1.4127 will be assigned per unit, with a max weight of 5.6508 will be allowed for the submission of up to four (4) units on a claim.

The APG "Procedure Based Weight" file may be found HERE on the NYSDOH website.