

## Dental Care Services in an Operating Room or Ambulatory Surgery Center: Criteria Scoring

### Instructions for Use

This Dental Coverage Form is intended to be used with the Dental Coverage Guideline titled [Dental Care Services in an Operating Room or Ambulatory Surgery Center](#).

Circle the applicable choices from each set of criteria below (age of individual, behavior assessment, co-morbidities, and treatment complexity). Enter the corresponding point value for each criteria set in the *Totals* column. Add the *Totals* column to determine the total points. The total points must be  $\geq 24$  to justify treatment in an OR or ASC.

### Patient Information

Name	Date of Birth
Address	Phone Number

### Scoring Criteria

			Totals
Age of Individual <sup>1,2,3</sup>		Points	Age
0-2 Years		10	
3-5 Years		6	
6-7 Years		4	
8+ Years		2	
Behavior Assessment <sup>1,2</sup>	Description	Points	Behavior
Definitely Negative	Refusal of treatment, crying forcefully, fearful, or any other overt evidence of extreme negativism	10	
Negative	Reluctant to accept treatment, uncooperative, some evidence of negative attitude but not pronounced (i.e., sullen, withdrawn)	5	
Positive	Acceptance of treatment; at times cautious, willingness to comply with the dentist, at times with reservation but patient follows the dentist's directions cooperatively	0	

		Totals	
Subtotal from Page 1			
Co-Morbidities <sup>2,3</sup>		Points	Co-Morbidities
Medically compromising condition – documented by a physician		15	
Behavioral health/disability/special needs condition – documented by a physician		15	
Failure at office-based conscious sedation and/or local anesthetics		15	
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring a surgical procedure		15	
No co-morbidities		0	
Treatment Complexity <sup>3</sup>	Description	Points	Complexity
Highly Complex	10 or more teeth or 5-6 sextants	12	
Complex	6-9 teeth or 4 sextants	9	
Moderate	3-5 teeth or 2-3 sextants	6	
Low	1-2 teeth or 1 sextant	2	
Total Points			

## Agreement

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

\_\_\_\_\_  
 (Signature of Parent/Guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
 (Signature of Performing Dentist)

License #: \_\_\_\_\_

Date: \_\_\_\_\_

Note: When prior authorization is required for dental care under general anesthesia in a hospital operating room or ambulatory surgery center, the following must be included with requests:

- This completed form; and
- The appropriate treatment narrative; and
- Supporting documentation, as indicated in the Dental Coverage Guideline titled [Dental Care Services in an Operating Room or Ambulatory Surgery Center](#).

## References

1. American Academy of Pediatric Dentistry Clinical Affairs Committee – Behavior Management Subcommittee. Guideline on Behavior Guidance for the Pediatric Dental Patient. 2015.
2. American Academy of Pediatric Dentistry Council on Clinical Affairs. Policy on Hospitalization and Operating Room Access for Oral Care of Infants, Children, Adolescents, and Individuals with Special Health Care Needs. 2015.
3. American Society of Anesthesiologists. Statement on Sedation & Anesthesia Administration in Dental Office-Based Settings. 2017.