REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Dental Services Rendered in a Hospital or Ambulatory Surgery Center- MP-PY-1407	06/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):			
☒ **Georgia**	☒ **Indiana**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Dental Services Rendered in a Hospital or Ambulatory Surgery Center

B. Background

The decision to perform dental care in a particular place of service is based on a wide variety of factors, including the age and special health care needs (physical, intellectual, and developmental disabilities or chronic medical conditions) of the individual, in addition to the type, number, and complexity of procedures planned. These factors also determine the type of anesthesia used during the procedure.

Most dental care can be provided in a dental office setting with local anesthesia or local anesthesia supplemented with non-pharmacological behavior guidance (basic to advanced techniques) and/or pharmacological options. Basic non-pharmacological behavior guidance includes communication guidance, positive pre-visit imagery, direct observation, tell-show-do, ask-tell-ask, voice control, non-verbal communication, positive reinforcement and descriptive praise, distraction, and desensitization. Pharmacological options may include nitrous oxide, oral conscious sedation and intravenous (IV) sedation (mild, moderate, or deep), or monitored general anesthesia by trained certified individuals in each level of sedation dentistry. As noted by the American Academy of Pediatric Dentistry (AAPD) and the American Society of Anesthesiologists (ASA), there are certain situations where appropriate candidates may require the use of general anesthesia as medically necessary in a healthcare facility, such as an ambulatory surgical center, hospital operating room, or short procedure unit (SPU).

C. Definitions

- **Ambulatory Surgical Center (ASC)** – A distinct entity that operates exclusively to furnish outpatient surgical services to patients who do not require hospitalization and are typically discharged less than 24 hours following admission.
- **Hospital** – An institution primarily engaged in providing, by or under the supervision of physicians, diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation.
- **Monitored Anesthesia Care (MAC)** – A specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure.
- **Sedation Continuum** – When patients undergo procedural sedation/analgesia, a sedation continuum is entered. Several levels have been formally defined along this continuum, as follows:
  - **Minimal Sedation (Anxiolysis)** – A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.
  - **Moderate Sedation (Analgesia) (Conscious Sedation)** – A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No

interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

- **Deep Sedation (Analgesia)** – A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- **General Anesthesia** – A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Note: Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering moderate sedation should be able to rescue patients who enter a state of deep sedation, while those administering deep sedation should be able to rescue patients who enter a state of general anesthesia. Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper than intended level of sedation, such as hypoventilation, hypoxia, and hypotension and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

- **Short Procedure Unit (SPU**) – A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic, or medical services.

D. Policy

This policy is intended to provide guidance on the process for obtaining authorization and reimbursement for dental services performed in a place of service (ASC or hospital OR/SPU) and reimbursement for related facility charges (eg, operating room, anesthesia, medical consults).

Dental services are only covered in a hospital setting when the nature of the surgery or the condition of the patient precludes performing the procedure in the dentist's office or other non-hospital outpatient setting, and the inpatient or outpatient service is a Health Insurance Marketplace covered service. As such, it would exclude any diagnostic or preventive dental services delivered in a hospital setting, if these services cannot be performed in office.

I. Dental Prior Authorization Process
   A. A review of medical necessity is required for all dental services performed in a hospital inpatient or outpatient facility or ambulatory surgery center facility.
   B. Dental services authorization for an outpatient/ASC setting
      1. Requests for dental services should be handled through the member's dental plan. Claims submitted for professional dental services should be submitted using the appropriate CDT codes and applicable ADA form.
      2. If the member does not have a stand-alone dental plan, the member will be responsible for the costs of the dental services.
   C. Facility process
      Facility service claims should be submitted to CareSource using the applicable claim form (eg, CMS-1500, UB-04).

E. State-Specific Information

All states follow any state-specific regulations regarding coverage of dental services. Refer to current state laws, regulations, and administrative code for age restrictions, diagnosis restrictions, and other requirements for coverage of dental services in a hospital or ambulatory surgery center.

- Georgia: Coverage of general anesthesia and hospital or ambulatory surgical facility charges for certain dental care. GA CODE § 33-24-28.4 (2024).
- Indiana: Dental care provisions required. IN CODE § 27-13-7-15 (2024).
- West Virginia: Required coverage for dental anesthesia services. WEST VIRGINIA CODE § 33-15-4j (2009).

F. Conditions of Coverage

The fact that a physician, dentist or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment for it. Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

The following information is provided as a reference. This list may not be all inclusive and is subject to updates.

- **Outpatient Hospital Facility (SPU) POS (19, 22); Ambulatory Surgical Center POS (24)**
  - **Use HCPCS code G0330 as the facility fee code**
    - Paid according to CareSource contract and the Medicare Physician Fee Schedule (PFS).
    - Dental-related facility charges must be billed on an institutional claim (UB-04 claim form, portal institutional claim, 837I transaction).
  - **Use CPT 00170 for anesthesia for intraoral treatments, including biopsy**
    - Paid according to CareSource contract and the Medicare PFS.

- All associated professional services, such as radiology and anesthesia, as well as ancillary services related to the dental services, must be billed on a professional claim (CMS-1500 claim form or electronic equivalent).

- **Inpatient Hospital Facility POS (21)**
  - All services as well as any additional Room and Board fees would have to be pre-certified and receive medical necessity review. Services are subject to benefit provisions and criteria for dental hospital admissions for both adult and pediatric members in accordance with clinical guidelines.

- **Dental/Oral Surgery Professional Services**
  - The scope of this policy is limited to medical plan coverage of the facility and/or general anesthesia services provided in conjunction with dental treatment, and not the dental or oral surgery services.

G. Related Policies/Rules

NA

H. Review/Revision History

	DATE	ACTION
Date Issued	11/30/2022	
Date Revised	08/28/2024 09/10/2025 03/11/2026	Annual review: updated background, reorganized definitions, removed facility PA process and DentaQuest information, updated references. Approved at Committee. Review: updated references, approved at Committee. Review: added state specific regulations. Approved at Committee.
Date Effective	06/01/2026	
Date Archived		

I. References

1. Ambulatory surgical centers. Centers for Medicare and Medicaid Services. Updated April 22, 2025. Accessed Feburary 5, 2026. www.cms.gov
2. American Academy of Pediatric Dentistry. Management of dental patients with special health care needs. *Reference Manual of Pediatr Dent.* 2025-2026:364-371. Accessed Feburary 5, 2026. www.aapd.org
3. American Academy of Pediatric Dentistry. Policy on hospitalization and operating room access for oral care of infants, children, adolescents, and individuals with special health care needs. *Reference Manual of Pediatr Dent.* 2025-2026:180-182. Accessed Feburary 5, 2026. www.aapd.org
4. American Academy of Pediatric Dentistry. Policy on third-party reimbursement for management of patients with special health care needs. *Reference Manual of Pediatr Dent.* 2025-2026:193-196. Accessed Feburary 5, 2026. www.aapd.org
5. Committee on Quality Management and Departmental Administration. *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia.* October 23, 2024. Accessed Feburary 5, 2026. www.asahq.org

6. Hospitals. Centers for Medicare and Medicaid Services. Updated January 29, 2026. Accessed Feburary 5, 2026. www.cms.gov