REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name	Policy Number	Effective Date
Dental Procedures in a Hospital, Outpatient Facility or Ambulatory Surgery Center	PY-1244	01/01/2021-06/30/2022

Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policy Statement: 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.

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A. Subject

Dental Procedures in a Hospital, Outpatient Facility or Ambulatory Surgery Center

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Most dental care can be provided in a traditional dental office setting with local anesthesia and if medically necessary, a continuum of behavior guidance strategies, ranging from simple communicative techniques to nitrous oxide, enteral or parenteral sedation. Monitored Anesthesia Care or Sedation (Minimal, Moderate or Deep) may be a requirement of some patients including those with challenges related to age, behavior or developmental disabilities, medical status, intellectual limitations or other special needs. 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 as a medical necessity, general anesthesia in a healthcare facility such as an Ambulatory Surgical Center or Outpatient Hospital facility.

C. Definitions

- **Ambulatory Surgical Center (ASC) -**
  Eligible ambulatory surgery centers as defined in paragraphs (A)(1) and (B) of Ohio Administrative Code (OAC) rule 5160-22-01 entitled Ambulatory Surgery Center (ASC) services: provider eligibility, coverage, and reimbursement are subject to the enhanced ambulatory patient grouping system (EAPG) and prospective payment methodology utilized by the Ohio department of Medicaid as described in this rule.
  (A) Definitions, for the purposes of this rule the following meanings apply.
  (1) An "ambulatory surgery center (ASC)" is any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.
  (2) "Enhanced ambulatory patient grouping (EAPG)" is a group of outpatient procedures, encounters, or ancillary services which reflect similar patient characteristics and resource utilization and which incorporate the use of international classification of diseases (ICD) diagnosis codes, current procedural terminology (CPT) procedural

codes and healthcare common procedure coding system (HCPCS) procedure codes.

(3) "EAPG grouper" is the software provided by 3M health information systems to group outpatient claims based on services performed and resource intensity.

(4) "Default EAPG settings" are the default EAPG grouper options in 3M's core grouping software for each EAPG grouper version.

(5) "Discounting factor" is a factor applicable for multiple significant procedures or repeated ancillary services designated by default EAPG settings or both. The appropriate percentage (fifty or one hundred per cent) will be applied to the highest weighted of the multiple procedures or ancillary services payment group.

(a) "Full payment" is the EAPG payment with no applicable discounting factor.

(b) "Consolidation factor" is a factor of zero per cent applicable for services designated with a same procedure consolidation flag or clinical procedure consolidation flag by the EAPG grouper under default EAPG settings.

(c) "Packaging factor" is a factor of zero per cent applicable for services designated with a packaging flag by the EAPG grouper under default EAPG settings.

(6) "ASC invoice" is a bill submitted in accordance with Chapter 5160-1 of the Administrative Code, to the department for services rendered to one eligible Medicaid beneficiary on one or more date(s) of service. For an invoice encompassing more than one date of service, each date will be processed separately as an individual claim.

(7) "ASC claim" encompasses the ASC services rendered to one eligible Medicaid beneficiary on one date of service at an ASC facility.

- **Inpatient Hospital -** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **Off Campus-Outpatient Hospital -** A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **On Campus-Outpatient Hospital -** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **Short Procedure Unit (SPU**) - A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic or medical services.
- **Medical Necessity** - Procedures, items or services that prevent, diagnose, evaluate or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person 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 as defined by the Ohio Department of Medicaid OAC 5160-1-01.

- **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.
  Monitored Anesthesia Care ("MAC") - does not describe the continuum of depth of sedation; rather it describes "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."
  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. Hence, 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/Analgesia ("Conscious Sedation") should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia 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.

D. Policy

Most dental care and/or oral surgery is effectively provided in an office setting. However, some members may have a qualifying condition that requires the procedure be provided in a hospital setting or ambulatory surgical center under general anesthesia. The purpose of this document is to provide reimbursement and billing guidance for facility related services when dental procedures are rendered in a in a Hospital or Ambulatory Surgical Center (ASC) Place of Service (POS) under general anesthesia. Hospital Inpatient or Outpatient Facility services and ASC Facility services for the provision of dental care under general anesthesia are addressed in this policy, not dental care or oral surgery in an office setting. Professional dental services are covered only to the extent that the member has dental benefits and guidelines for dental services are provided in the DentaQuest Policy Manual.

CareSource policy notes the intent of Hospital, Outpatient, and ASC facility requests is the medical necessity of general anesthesia services to perform dental procedures on a member. Requests with the goal of no, minimal, moderate or deep sedation services, will only be considered in extenuating circumstances mandated by systemic disease for which the patient is under current medical management and which increases the probability of complications, such as respiratory illness, cardiac conditions or bleeding disorders. Medical Record and Physician attested letter would be required with authorization requests.

OAC 5160-2-03(A)(2)(h) states that 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 Medicaid covered service.” As such, it would exclude any diagnostic or preventative dental services delivered in a hospital setting.

I. Prior authorization Process
   A. A prior authorization 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 and anesthesia are submitted to the dental vendor: DentaQuest for Ohio Medicaid
      2. Dental vendor reviews for appropriate medical necessity requirements (listed in the [DentaQuest Office Reference Manual] for general anesthesia or for IV sedation in the outpatient hospital or ASC setting
      3. Dental vendor reviews for the medical necessity of the requested procedure and will deny the procedure and anesthesia request if it does not meet medically necessary criteria for that dental procedure. The Notice of Adverse Benefit Determination (Denial Notice) is issued by dental vendor.
      4. If dental procedure(s) and the general anesthesia or sedation in the outpatient hospital or ambulatory surgery center is approved, the Dental vendor will send an automated fax approval letter to the requesting dentist and this can be viewed in the DentaQuest provider portal.
   C. Facility Authorization Process

1. Upon approval, DentaQuest Participating Providers are required to administer services at CareSource participating hospitals. Upon receipt of approval from DentaQuest, Provider should use the information below for facility authorization as applicable.
2. For Medical Prior Authorizations, the Provider (hospital or ASC facility) may submit the request on the CareSource Provider Portal at CareSource.com >Login >Provider Portal.
   a. The Provider may also request a Prior Authorization by calling CareSource directly at: CareSource: 800.488.0134 select option to "Request an Authorization"
   b. The Prior Authorization should Include the facility services requested, the DentaQuest Approval Letter and authorization number
3. The CareSource Medical Utilization Management (UM-MM) team will complete ALL the following:
   a. Verify that facility is in or out of network AND;
   b. Review the DentaQuest pre-determination letter (PDL) or authorization AND;
   c. Determine medical necessity for any other facility- related CPT/HCPCS codes submitted AND;
   d. Fax a Facility Approval to the hospital/ASC which can also be viewed in CareSource Provider portal

Note: 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."

E. Conditions of Coverage

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.

Reimbursement for items assigned to a dental service EAPG type will be paid as follows:

Outpatient Hospital Facility (SPU) POS (19, 22)

Facility	Reimbursement Policy
Children's hospitals, as defined in rule 5160-2-05 of the Administrative Code **Use CPT code 41899 as Facility Fee code**	Will be paid one-thousand sixty-two dollars ($1062.00)

All other hospitals **Use 41899 as Facility Fee code**	Will be paid one-thousand one-hundred ninety-two dollars ($1192.00)
Discounting Factors	Payments shall be multiplied by any applicable discounting factor, rounded to the nearest whole cent.
Anesthesia Professional Services	Reimbursement Policy
CPT Non- Dental Anesthesia Code **00170 Anesthesia for intraoral treatments, including biopsy; not otherwise specified** 00170 is calculated in CMS Base units. The Base unit =5 units. The administration or management of anesthesia as a non-institutional professional service rendered by qualified medical practitioners	Anesthesia Services - Anesthesiology professional Services for intraoral procedures. Time units for physician and CRNA services - both personally performed and medically directed are determined by dividing the actual anesthesia time by 15 minutes or fraction thereof. Since only the actual time of a fractional unit is recognized, the time unit is rounded to one decimal place. Total minutes are listed as the units (i.e. 75 minutes) 75 = 6 units (of 15 min increments). CMS Base units =5. Maximum state allowances may be applicable. 1) Payment for an anesthesia service is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by a formula. (a) The amount is the product of three factors: 1. The sum of the base unit value and the time unit value; 2. The appropriate conversion factor; and 3. The relevant multiplier. Conversion Factors and Multipliers
CDT **Dental Anesthesia Codes** **D9222, D9223 Deep Sedation/General Anesthesia,** **D9239, D9243 Monitored Anesthesia Care**	Payment for intravenous conscious sedation/analgesia services is limited to one unit of the first 15 minutes and up to four units of subsequent 15-minute increments per date of service Payment for deep sedation/general anesthesia services is limited to one unit of the first 15 minutes and up to four units of subsequent 15-minute increments per date of service. Provisions governing payment for anesthesia as a dental service are set forth in Chapter 5160-5 of the Administrative Code

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

Ambulatory Surgical Center POS (24)

CPT Code	Description
Payments for covered dental services may be made for all line items grouping to EAPG grouping code **Use code 41899 for facility fee**	Reimbursement for claims assigned to a dental service EAPG type will be paid as follows: Reimbursement for dental services will be nine-hundred fifty-three dollars and sixty cents. ($953.60) Payments for dental services will be made in accordance with the discounting factors as determined by the EAPG grouper.
Anesthesia Professional Services	Reimbursement Policy
CPT 00170	00170 is calculated in CMS Base units. The Base unit =5 units. See formula under Hospital section above.

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. The professional dental procedure codes listed are for reference only and do not imply coverage of dental procedures. Information on dental benefits, please consult our partnered dental vendor DentaQuest Office Reference Manual for clinical guidelines, policies and procedures

CPT Code	Description
(D0000-D9999) Reimbursed according to provider contractual rate	Dental service charges will be paid directly to the TREATING DENTIST PAYEE GROUP All dental services that require authorization must receive prior authorization via DentaQuest Dental Management. (a) For a service rendered by a provider whose office address (specified in the provider agreement) is in a non-rural Ohio county or a county outside Ohio, payment is the lesser of the submitted charge or the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code. (b) For a service rendered by a provider whose office address is in a rural Ohio county, payment is the lesser of the submitted charge or one hundred five per cent of the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code.

ICD-10 and CPT code for Oral or Maxillofacial region	(2) For a covered dental service that is identified by a current procedural terminology (CPT) code, such as oral surgery, payment is the lesser of the submitted charge or the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code, regardless of whether the service is provided in a rural or non-rural county.
	CPT codes - Follow applicable benefit guidelines in CareSource Provider Manual All medical services of the oral, maxillofacial, head and neck regions performed in the hospital/ASC must receive prior authorization from the CareSource Medical Management team

F. Review/Revision History

	DATE	ACTION
Date Issued	09/16/2020	New Policy
Date Revised		
Date Effective	01/01/2021	
Date Archived	06/30/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

G. References

1. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia. (2018, October 23). Retrieved July 30, 2020, from www.asahq.org
2. American Academy of Pediatric Dentistry. Oral Health Policies and Recommendations. (2019). Retrieved July 20, 2020 from www.aapd.org
3. American Association of Oral and Maxillofacial Surgeons, Ambulatory Surgical Center Coding and Billing. Retrieved April 5, 2019 from www.aaoms.org
4. Ohio Administrative Code. Ambulatory Surgery Center Services 5160- 22. Retrieved from: https://codes.ohio.gov/oac/5160-22-01
   Ohio Administrative Code. Dental Services 5160-5. Retrieved from: codes.ohio.gov/oac/5160-5
5. Ohio Administrative Code. Anesthesia Services. 5160-4-21. Retrieved from: http://codes.ohio.gov/oac/5160-4-21
   Ohio Administrative Code. Hospital Services 5160-2. Retrieved from: http://codes.ohio.gov/oac/5160-2-03
6. Ohio Administrative Code. Outpatient hospital reimbursement 5160-2-75 Retrieved from: http://codes.ohio.gov/oac/5160-2-75
7. Ohio Department of Medicaid. Hospital Billing Guide. Retrieved from: https://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/HospitalBillingGuidelines-20180701.pdf

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.