REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Dental Services Rendered in a Hospital or Ambulatory Surgery Center- OH MCD-PY-1244	06/01/2024-08/31/2025
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. These policies are designed to assist providers and facilities submitting claims to CareSource. The policies are routinely updated to promote accurate coding and clarification. These proprietary policies are not a guarantee of payment. 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.

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 any 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 must meet the standards of good clinical practice in the local area, are the lowest cost alternative, and are not provided 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. Prior authorization is required for certain services. If authorization is not obtained prior to performing the service, CareSource may not reimburse for the procedure.

Health care providers and their office staff are encouraged to use the self-service channels to verify a member's eligibility. It is the responsibility of the submitting provider to submit the most accurate and appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code(s) for the medical product or service being provided and the appropriate Current Dental Terminology (CDT) code(s) for the dental product or service. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee for a submitted claim payment.

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 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 long-term 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)** – Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization that meets all criteria of Ohio Administrative Code (OAC) 5160-22-01.
- **Enhanced Ambulatory Patient Groups (EAPGs**) – A patient classification system designed to explain the amount and type of resources used during an ambulatory visit. Each EAPG have similar clinical characteristics, resource use, and cost.
- **Inpatient Hospital** – A nonpsychiatric facility 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.
- **Medical Necessity** – Procedures, items, or services which 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 its use 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 OAC 5160-1-01.
- **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.

- **Outpatient Hospital** – A facility which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require admission or an overnight stay.
- **Place of Service (POS) Codes** – Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.
- **Sedation Continuum** – When patients undergo procedural sedation/analgesia, they enter a sedation continuum. Several levels have been formally defined along this continuum: minimal sedation/anxiolysis, moderate sedation, deep sedation, and at the deepest level, general anesthesia.
    - **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 cardiac 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).

CareSource Dental Benefits for Ohio Medicaid are administered through our partnered delegated vendor DentaQuest. Coverage for professional services performed by the dentist/oral surgeon in the POS (ASC or OR/SPU) and reimbursement for these services may be provided through the dental benefit once approved via the DentaQuest process of dental utilization review for medical necessity of services and requested place of service. Medical necessity criteria and clinical policies are in the respective Dental Office Reference Manual (DentaQuest). 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 that could be performed effectively and safely in an ambulatory state, unless patient characteristics and cooperation do not allow it. .

CareSource Medical Benefits for Ohio Medicaid are administered directly through CareSource. Coverage and reimbursement for facility charges (eg, operating room, anesthesia) related to dental services performed in POS (ASC or OR/SPU), are eligible for coverage and reimbursement under the member's medical benefit when the dental services have been approved via the DentaQuest Utilization Management process.

The two-step process for dental services and facility services should be followed for obtaining authorization prior to submitting claims for reimbursement:

A. Step 1 - Dental authorization for services to be performed in a (OR/SPU or ASC)
   1. Requests for dental services in POS (19, 21, 22, 24) are submitted by the treating dental provider to the CareSource Ohio Medicaid dental vendor, DentaQuest. The provider must include POS on dental claim and add in authorization notes request is for hospital or ASC setting.
   2. The dental vendor reviews for appropriate medical necessity requirements [listed in the DentaQuest Office Reference Manual Section 14.05 Criteria for Authorization of Operating Room (OR) Cases].
   3. If the dental authorization is approved, the dental vendor will send an automated fax approval letter to the requesting dentist which can additionally be viewed in the DentaQuest provider portal.
   4. If the dental authorization request is not approved, a Notice of Adverse Benefit Determination (Denial Notice) will be issued by the dental vendor to the submitting provider.

B. Step 2 - Facility precertification process
Once dental procedure approval has been obtained, providers are required to administer services at CareSource participating hospitals and must obtain facility precertification.
1. For facility precertification**,** the facility provider (hospital or ASC) may submit the request on the CareSource Provider Portal at CareSource.com.
2. The Provider may also request a facility precertification by calling CareSource directly at 800.488.0134 and select the option to "request an authorization."
3. The facility approval request should include the facility services (ie, operating room charges, anesthesia) requested, the DentaQuest Authorization Approval Letter, and authorization number.
4. The CareSource Medical Utilization Management (UM-MM) team will complete **ALL** the following:
   a. Verify that the facility is in network.
   b. Review the DentaQuest pre-determination letter (PDL) or approved dental authorization and complete administrative approval for facility fee and anesthesia.
   c. Determine medical necessity for any other facility-related CPT/HCPCS codes submitted.
   d. Fax a Facility Approval to the hospital/ASC which can also be viewed in the CareSource Provider Portal.

E. Conditions of Coverage
Facility reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate code modifiers, if applicable to CareSource. 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)**
  - Use CPT code 41899 as the facility fee code.
    - Discounting factors - payments shall be multiplied by any applicable discounting factor, rounded to the nearest whole cent.
  - Use CPT code 00170 for anesthesia when performing intraoral treatments, including biopsy.
    - 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 (ie, 75 minutes) 75 = 5 units (of 15 min increments). CMS Base units = 5. Maximum state allowances may be applicable.
    - Payment for an anesthesia service is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by a formula.
- **Inpatient Hospital Facility POS (21)**
  - All services as well as any additional room and board fees need to be pre-certified and receive medical necessity review. Services are subject to benefit provisions.

- **Ambulatory Surgical Center POS (24)**
  - Use code 41899 for facility fee. Payments for dental services will be made in accordance with the discounting factors as determined by the EAPG grouper.
  - Use code 00170 for Anesthesia professional services. CPT 00170 is calculated in CMS base units. The base unit = 5 units. See under Hospital section above.

Dental/Oral Surgery Professional Services
The scope of this policy is limited to medical plan coverage reimbursement codes for facility and/or general anesthesia services provided in conjunction with dental treatment, and not the actual dental or oral surgery services provided. For information on dental benefits and coding, please consult the partnered dental vendor DentaQuest Office Reference Manual for clinical guidelines, policies, and procedures.

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	09/16/2020	New Policy
Date Revised	01/26/2022 02/14/2024	Annual review. Removed dental codes, removed tables, simplified coding information Annual review: adjusted title, updated definitions, policy language, and references, corrected base unit typo. Approved at Committee.
Date Effective	06/01/2024	
Date Archived	08/31/2025	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.

H. References

1. Ambulatory Surgery Center (ASC) Services: Provider Eligibility, Coverage, and Reimbursement OHIO ADMIN. CODE 5160-22-01 (2020).
2. Anesthesia Services, OHIO ADMIN. CODE 5160-4-21 (2017).
3. Committee on Quality Management and Departmental Administration. *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia.* American Society of Anesthesiologists. Updated October 23, 2019. Accessed February 7, 2024. www.asahq.org
4. Conditions and Limitations, OHIO ADMIN. CODE 5160-2-03 (2022).
5. Dental Services, OHIO ADMIN. CODE 5160-5-01 (2022).
6. General Provisions: Hospital Services, OHIO ADMIN. CODE 5160-2-02 (2022).
7. *Hospital Billing Guidelines*. Ohio Dept of Medicaid; 2021. Accessed January 31, 2024. www.medicaid.ohio.gov
8. Management of dental patients with special health care needs. *Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2023:337-344.

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

Accessed February 13, 2024. www.aapd.org
9. Medicaid Medical Necessity: Definitions and Principles, OHIO ADMIN. CODE 5160-1-01 (2022).
10. Outpatient Hospital Reimbursement, OHIO ADMIN. CODE 5160-2-75 (2020).
11. Policy on hospitalization and operating room access for oral care of infants, children, adolescents, and individuals with special health care needs. *Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2023:169-170. Accessed February 13, 2024. www.aapd.org
12. Policy on third-party reimbursement for management of patients with special health care needs. *Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2023:181-184. Accessed February 13, 2024. www.aapd.org

Approved ODM 03/07/2024