REIMBURSEMENT POLICY STATEMENT
Nevada Medicaid

Policy Name & Number	Date Effective
Dental Services Rendered in a Hospital or Ambulatory Surgery Center- NV MCD-PY-1702	01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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 agreements, 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan 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 or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we 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 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 patient 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 covered service.

I. Prior Authorization (PA) Process Inpatient Hospital Admission
   A. Prior authorization for inpatient hospitalization for a dental procedure is necessary for Medicaid reimbursement.
      1. For Medicaid recipients of all ages, if PA is required for the dental procedure (CDT code), the dentist rendering the service must obtain prior authorization from Nevada Medicaid's state Dental Plan administrator <Liberty Dental Plan>
      2. PA must be obtained from Member's Managed Care Organization (MCO) CareSource to certify the necessity for the recipient to be hospitalized for the performance of the inpatient dental procedure. The certification must be done before or on the date of the admission.
      3. For certification, the provider (hospital or ASC) may submit the request on the CareSource Provider Portal at CareSource.com or by calling CareSource directly at <800.488.0134> and select option to "Request an Authorization", noting "Hospital Admission Request".

II. Prior Authorization (PA) process for an outpatient/ASC facility
   A. Requests Prior authorization for dental procedures performed in an outpatient/surgical center setting may require prior authorization.
      1. For Medicaid recipients of all ages, if PA is required for the dental procedure (CDT code), the dentist rendering the service must obtain prior authorization from Nevada Medicaid's state Dental Plan administrator <Liberty Dental Plan>
      2. For Medicaid recipients ages 5 and below, prior authorization is required for the outpatient facility. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason, including medical necessity, that the recipient is unable to have the services completed in the office.
      3. For Medicaid recipients ages 6 to 20, specific authorization is not required for the anesthesiologist and/or outpatient facility. Procedures done as outpatient services for recipients less than 21 years of age in a hospital or surgical center must be identified. The provider must write "Outpatient Facility Services" at the top of the of the claim form (eg, CMS-1500, UB-04).
      4. For Medicaid recipients 21 years of age and older, the outpatient facility services must be prior authorized. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason that the recipient is unable to have the services completed in the office.
      5. All dentists providing surgical center services to Medicaid recipients must retain in-office copies of x-rays, intra-oral preoperative photographs (when necessary) and documentation necessary to substantiate service need. The substantiating evidence must be retained and remain readily available for no less than 6 years.

B. For the above outpatient facility requests, the provider (hospital or ASC) may submit the request on the CareSource Provider Portal at CareSource.com or by calling CareSource directly at <800.488.0134> and select option to “Request an Authorization”. The requestor must note “Outpatient Facility Services””. Include:
   - A letter of medical necessity signed by the provider that clearly identifies why the procedure(s) could not be completed in an office setting. This letter must also include the name and National
   - Provider Identifier (NPI) of the outpatient facility.
   - A completed American Dental Association (ADA) form listing all dental procedures (CDT codes) to be performed.

C. Once the PA is reviewed and approved, CareSource will transfer the prior authorization number to the outpatient facility.

A. 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)**
  - **Enter Current Procedural Terminology (CPT) code 41899 or (HCPCS) G0330 into the service details, as well as applicable dates and Medical Justification.**
    - 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 CareSource 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.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	09/10/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

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7. Medicaid Services Manual Changes Chapter 1000 – Dental. Medicaid Services Manual Transmittal Letter (MTL) 29/23. December 26, 2023. Accessed September 9, 2025. dhcfp.nv.gov
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