REIMBURSEMENT POLICY STATEMENT
TrueCare

Policy Name & Number	Date Effective
Dental Services Rendered in a Hospital or Ambulatory Surgery Center-TrueCare-PY-1423	12/01/2025-02/28/2026
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.

Table of Contents

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)** – A publicly or privately owned institution not considered a physical part of a hospital, which provides elective surgical treatment for “outpatients” whose recovery under normal and routine circumstances will not require “inpatient” care.
- **Hospital** – An institution primarily engaged in providing, by or under the supervision of physicians, diagnostic and therapeutic services or rehabilitation services.
- **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.
- **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. Practitioners 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).

TrueCare Dental Benefits for Mississippi Medicaid are administered through the partnered delegated vendor Avēsis. 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 Avēsis process of dental utilization review for medical necessity of services and requested POS. Medical necessity criteria and clinical policies are in the Avēsis Dental Office Reference Manual. 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 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.

TrueCare Medical Benefits for Mississippi Medicaid are administered directly through TrueCare. 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 Avēsis Utilization Management process.

The 2-step process for dental services and facility services should be followed for obtaining authorization prior to submitting claims for reimbursement:

1. 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 TrueCare dental vendor, Avēsis. 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.
    3. If the dental authorization is approved, the dental vendor will send an approval letter to the requesting dentist which can be viewed in the Avēsis 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.
2. Step 2 - Facility precertification process
   Once dental procedure approval has been obtained, providers are required to administer services at TrueCare participating hospitals and must obtain facility precertification.
    1. Avēsis will submit approved prior authorizations to TrueCare, including all essential information corresponding with the prior authorization number.
    2. The TrueCare Medical Utilization Management (UM-MM) team will complete **ALL** the following:
        a. Verify that the facility is in network.
        b. Review the Avēsis 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 TrueCare Provider Portal.

E. Conditions of Coverage

Facility reimbursement is dependent on, but not limited to, submitting approved HCPCS Level II and CPT codes along with appropriate code modifiers, if applicable to TrueCare. 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), Ambulatory Surgical Center POS (24)**

- Hospitals may bill for the same CDT code(s) and units as the dentist for services rendered for the technical portion of the "D code procedure" that would be due to the facility, granted the dentist obtained the appropriate authorization from Avēsis, or
- Use HCPCS code G0330 as the facility fee code.
- 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.

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 Avēsis Dental Office Reference Manual for clinical guidelines, policies, and procedures.

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/09/2025	New market, approved at Committee.
Date Revised	08/27/2025	Review: updated codes to include CDT, clarified facility process with vendor, simplified Conditions of Coverage, approved at Committee.
Date Effective	12/01/2025	
Date Archived	02/28/2026	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. American Academy of Pediatric Dentistry. Management of dental patients with special health care needs. *Reference Manual of Pediatr Dent.* 2024-2025:343-350. Accessed August 7, 2025. www.aapd.org

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

2. 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.* 2024-2025:173-175. Accessed August 7, 2025. www.aapd.org
3. American Academy of Pediatric Dentistry. Policy on third-party reimbursement for management of patients with special health care needs. *Reference Manual of Pediatr Dent.* 2024-2025:186-189. Accessed August 7, 2025. www.aapd.org
4. 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 August 7, 2025. www.asahq.org
5. Dental Services Provided in the Hospital or Ambulatory Surgical Center (ASC) Setting, 23-204 MISS. CODE R. § 1.11 (2019).
6. Dental Services Provided in a Hospital Setting, 23-202 MISS. CODE R. § 5.7 (2019).
7. General, 23-210 MISS. CODE R. § 1.1 (2019).
8. Prior Authorization, 23-204 MISS. CODE R. § 1.6 (2014).

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