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September 5, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1786-P
P.O. Box 8010
Baltimore, MD 21244-1810

Submitted online via www.regulations.gov

Re: File Code CMS-1786-P Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Proposed Rule

Dear Administrator Brooks-LaSure:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States. AAOMS appreciates the opportunity to comment on the proposed 2024 revisions to the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems Proposed Rule, published in the July 31, 2023, *Federal Register* (*Vol. 88, No. 145, pages 49552-49921*).

AAOMS commends CMS on efforts to improve access to high-quality and affordable health care, specifically, the proposals aimed at ensuring Medicare beneficiaries have access to medically necessary and essential dental services in hospitals and ambulatory surgery centers.

Through this letter, we provide recommendations and seek clarification on select aspects of the proposals impacting payment for dental services under both the OPPS and ASC payment system.

Prefatory Comment

We understand that, while CMS had opted for a catch-all approach with the introduction of the G0330 code in the hospital outpatient setting in 2023, CMS has taken a different approach for 2024 by proposing the addition of numerous individual dental procedures with their own facility rates for both hospital and ASC settings, relegating 2024 use of the G0330 code to when other covered and payable codes are inapplicable. Our comments provided herein are not intended to recommend one approach over the other as AAOMS recognizes that each has its merits and challenges. Rather, our comments are intended to work with the direction that CMS has proposed for 2024 by

providing guidance for more accurate assignment of codes and to seek clarity for provisions of the proposal that may be unclear.

Hospital outpatient payment for dental services

Assignment of CDT©[1] codes to clinical Ambulatory Payment Classifications

As indicated in prior comments, we support Medicare coverage and payment for dental services furnished to identify, diagnose and treat oral or dental infections linked to certain acute conditions and Medicare-covered therapies. This includes the clinical scenarios outlined in the CY 2023 Medicare Physician Fee Schedule (MPFS) final rule[1] and those proposed by CMS in the CY 2024 MPFS proposed rule[2]. OMSs routinely evaluate and safely treat patients ranging in complexity across a variety of care settings, therefore AAOMS continues to support Medicare coverage of such dental services in both inpatient and outpatient hospital settings.

Assigning additional dental procedure codes to clinical APCs would allow hospital outpatient departments to receive facility payment for dental services that meet the threshold for Medicare coverage, if finalized. This is consistent with the coverage and payment policies for inextricably linked dental services CMS has established under the MPFS to date. As such, AAOMS appreciates CMS's proposal to assign 229 CDT© codes to clinical APCs, permitting Medicare payment to be made for medically necessary dental services furnished in the hospital outpatient setting when all Medicare coverage and payment criteria are met.

Request for additional dental surgical procedures to be payable in the hospital outpatient setting

In addition to the dental procedures outlined in the CY 2024 OPPS/ASC proposed rule, AAOMS continues to believe there are additional dental surgical procedures that may be medically necessary to treat oral or dental infections for patients with certain acute conditions and therefore may meet the threshold for Medicare coverage and payment. Further, these procedures are appropriate for payment under the OPPS, as they may be furnished safely in the hospital outpatient setting.

Consistent with our prior recommendations, AAOMS encourages CMS to consider the following dental surgical procedures for coverage in the hospital outpatient setting:

- **Coronectomy as described by CDT© code D7251.**
- **Surgical procedures to facilitate tooth eruption as described by CDT© codes D7280 and D7283.**
- **Alveoloplasty or ridge preparation procedures as described by CDT© codes D7320 and D7321.**
- **Excision of benign soft tissue lesions as described by CDT© codes D7410, D7411 and D7412**.
- **Excision of malignant soft tissue lesions as described by CDT© codes D7413, D7414 and D7415.**
- **Excision of malignant intra-osseous lesions as described by CDT© codes D7440 and D7441.**
- **Excision of benign intra-osseous lesions as described by CDT© codes D7450 and D7451.**
- **Removal of lateral exostosis of the jaws as described by CDT© code D7471.**
- **Surgical removal of foreign body from mucosa, skin, subcutaneous alveolar tissue or the musculoskeletal system as described by CDT© codes D7530 and D7540.**

[1] *CDT© is a registered trademark of the American Dental Association.*

If the above procedures are included for coverage in the hospital outpatient setting, AAOMS requests that they be assigned to clinical APCs as provided in Appendix A.

Request for clarification on the proposed payment rate for APC 5871 Dental Procedures

In the CY 2024 OPPS/ASC proposed rule, CMS notes that it is common for a patient to undergo multiple dental procedures during the same surgical encounter, as well as for dental services to be performed contemporaneously with other medical services. AAOMS agrees. If CMS's proposal to assign over 200 additional CDT© codes to clinical APCs is finalized, it is our understanding that a hospital would be able to bill and receive payment for each Medicare-covered procedure — including covered dental services — assigned a facility payment rate.

However, **AAOMS seeks clarification on the proposed CY 2024 payment rate of $938.69 assigned to APC 5871 Dental Procedures as this represents a decrease of over 45 percent from 2023.** APC 5871 comprises a significant number of dental services, and data presented in the CY 2024 proposed rule indicate that the hospital outpatient claims used in the calculation of the payment rate for APC 5871 include a wide range of geometric mean costs, from approximately $17 to nearly $7,900.

We note that statute requires APCs to be comprised of services comparable in both clinical characteristics and cost. Therefore, based on the broad range of geometric mean costs in the data, we question as to whether the CY 2024 proposed payment rate for APC 5871 is truly representative of clinically similar, cost comparative services. Clarification on how the proposed payment rate was derived would help us and other interested parties engage with CMS on policy-related issues regarding the payment for Medicare-covered dental services under the OPPS.

Request for APC reassignment for select services under the OPPS

Currently, there are several codes payable under the OPPS an OMS may use to report certain types of services for which a hospital outpatient setting is deemed clinically appropriate. This includes both CPT©[2] and CDT© codes, with many of the dental codes assigned to APC 5871. Also, a significant number of the dental codes proposed for coverage under the OPPS for 2024 will be assigned to APC 5871, if finalized.

In particular, we note the dental procedure codes – both currently payable and proposed under the OPPS for 2024 – have comparable medical procedure codes. In many cases, the respective CPT© crosswalks for these dental codes are assigned to other clinical APCs carrying payment rates higher than what is proposed for APC 5871 for CY 2024. If finalized, this means a medical code and a dental code describing the same service could be paid at different rates at the facility level, even though resource costs are equivalent.

An assignment to clinical APC 5871 for dental oral and maxillofacial surgery codes does not accurately capture the clinical complexity and costs associated with these procedures, and CDT© and CPT© codes describing clinically equivalent procedures should not have different facility payment rates under the OPPS. Further, while we understand CMS's methodology generally uses both clinical characteristics and resource costs to assign a service or code to what is deemed an

[2] *CPT © is a registered trademark of the American Medical Association.*

appropriate clinical APC, we note the specific criteria governing how individual levels are determined is unclear.

Based on the above, additional time and information from CMS is needed to suggest accurate APC assignments for dental procedures currently payable under the OPPS and those proposed for assignment to clinical APCs for 2024. In the interim, AAOMS has developed recommendations for APC reassignment for select dental codes, as provided in Appendix B. However, AAOMS recommends continued review for accurate APC assignment.

Request for clarification on the use of clinical experts and crosswalking

In CMS's proposal to assign select dental procedure codes to clinical APCs, the Agency indicates it consulted with clinical experts to discuss the clinical aspects of each dental service, as well as learn about the resources and supplies used to perform them. CMS states this was done to accurately identify crosswalk codes and propose APC assignments for dental services, specifically in the absence of cost data.

We acknowledge the Advisory Panel on Hospital Outpatient Payment (HOP Panel) plays an integral role in the configuration of APCs under the OPPS. Indeed, the Panel is charged with assessing the clinical integrity of APCs and their associated weights. From our review of the proposed rule, we understand this may include evaluating the clinical and procedural details of an item or service, analyzing resource cost and frequency data, as well as crosswalk code analysis.

With the proposed assignment of over 200 dental procedure codes to clinical APCs, we believe it imperative for the HOP Panel to include a dental practitioner. A dentist or dental surgical specialist may advise on the clinical details and resource costs of dental procedures, which may help to inform appropriate APC assignment and facility payment for these services. As such, **AAOMS requests the inclusion of a dentist or dental specialist on the Advisory Panel on Hospital Outpatient Payment.**

<u>ASC payment for dental services</u>

Addition of CDT© codes to the ASC Covered Procedures List

AAOMS appreciates CMS's proposal to add 26 dental surgical services to the ASC Covered Procedures List (CPL), including HCPCS code G0330. Access to medically necessary dental services may be critical to successful outcomes for patients with certain acute conditions. As OMSs routinely evaluate and safely treat patients ranging in complexity across a variety of care settings, we support Medicare coverage for such dental services in both inpatient and outpatient hospital settings, as well as the ASC.

However, we encourage CMS to consider extending coverage for medically necessary dental services to identify, diagnose and treat oral or dental infections, as outlined under the MPFS when rendered in ambulatory surgery centers.

Services to eliminate an oral or dental infection may include, but are not limited to, the extraction of teeth, intraoral and extraoral incision and drainage procedures and partial ostectomy/sequestrectomy for removal of non-vital bone, all of which are surgical procedures CMS proposes to allow payment when furnished in the ASC, providing all Medicare coverage and payment criteria are met. Currently, coverage and payment under the MPFS for dental services

performed to identify, diagnose and treat oral or dental infections prior to or contemporaneously with Medicare covered organ transplant surgery, cardiac valve replacement and valvuloplasty procedures, as well as covered treatments for head and neck cancer beginning in 2024 and the proposals outlined in the 2024 MPFS proposed rule, is limited to hospital inpatient and outpatient settings.

Permitting Medicare payment in the ASC for inextricably linked and medically necessary dental surgical services furnished to identify, diagnose and treatment oral or dental infections prior to, or at the same time as, select covered medical procedures would help to ensure the consistent application of Medicare dental coverage and payment policies across care settings.

Further, we believe that ASCs have the potential to mitigate many of the external pressures that currently act as barriers in access to care. The lack of and/or limited hospital-based OR access is exacerbated by ongoing medical staffing shortages and industry-wide inflation. Other challenges exist for patients unable to access hospital facilities because of geographic or transportation limitations. Indeed, industry research indicates the health care system as a whole benefits when procedures migrate to less costly care settings. As such, **AAOMS encourages CMS to align coverage policies under the MPFS and the ASC payment system to allow Medicare coverage and payment for dental surgical services to identify, diagnose and treat oral or dental infections, when inextricably linked to the clinical scenarios finalized in the 2023 MPFS final rule and those proposed in the 2024 MPFS proposed rule.**

AAOMS further recommends the following CDT© codes for addition to the ASC CPL:

- **Coronectomy as described by CDT© code D7251.**
- **Surgical procedures to facilitate tooth eruption as described by CDT© codes D7280 and D7283.**
- **Alveoloplasty or ridge preparation procedures as described by CDT© codes D7320 and D7321.**
- **Excision of benign soft tissue lesions as described by CDT© codes D7410, D7411 and D7412**.
- **Excision of malignant soft tissue lesions as described by CDT© codes D7413, D7414 and D7415.**
- **Excision of malignant intra-osseous lesions as described by CDT© codes D7440 and D7441.**
- **Excision of benign intra-osseous lesions as described by CDT© codes D7450 and D7451.**
- **Removal of benign nonodontogenic cysts and tumors as described by CDT© codes D7460 and D7461.**
- **Excision of bone tissue, including exostosis and reduction of osseous tuberosity as described by CDT© codes D7471 and D7485, respectively.**
- **Surgical incision and drainage of extraoral soft tissue (complicated) as described by CDT© code D7521.**
- **Surgical removal of foreign body from mucosa, skin, subcutaneous alveolar tissue or the musculoskeletal system as described by CDT© codes D7530 and D7540.**

We believe it can be demonstrated[3] these procedures:

- Do not generally result in extensive blood loss.
- Do not require major or prolonged invasion of body cavities.
- Do not directly involve major blood vessels.
- Are generally not emergent or life threatening.
- Do not commonly require systemic thrombolytic therapy.

- Are not designated as requiring inpatient care.
- Are not limited to a CPT unlisted surgical procedure code.
- Are not other excluded by current regulation.

Consideration of other surgical procedures for addition to the ASC CPL

As indicated in prior comments, AAOMS supports CMS's overarching commitment to patient safety. However, we reiterate that evolving technology and treatment modalities have allowed for increasingly complex procedures to be performed safely and efficiently across a wide range of care settings, including ambulatory surgery centers. As such, **we again encourage CMS to consider the following procedures for addition to the ambulatory surgery center coverage list:**

- **21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft**
- **21194 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)**
- **21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation**
- **21196 Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation**

The AAOMS Committee on Healthcare Policy, Coding and Reimbursement convened a special panel of surgeons with extensive experience performing orthognathic surgery to evaluate whether certain oral and maxillofacial surgical procedures meet the criteria for addition to the ASC CPL. Through a retrospective case log review and comprehensive search of current scientific literature and perioperative protocols for orthognathic surgery procedures, the panel identified and reached an expert consensus on the recommendation of four codes to the ASC CPL for CY 2024, as indicated above.

Based on the analysis of the expert panel, it was determined these procedures did not violate any of the established patient safety criteria[3] to warrant exclusion from the ASC setting. We note the mitigation of hemorrhage risk associated with certain orthognathic surgical procedures is of fundamental concern to the OMS when treatment planning and furnishing orthognathic surgical procedures. Outlined below, we reiterate the panel's findings as they pertain to blood loss for the recommended surgical procedures of the mandible.

The panel concluded that blood loss for these reconstructive procedures was typically minimal, with an average blood loss of 100cc or 100mL. This is consistent with Chen et al. [4] that reported an average interoperative blood loss of 105.9mL in patients undergoing bilateral vertical ramus osteotomy. A literature review by Lee et al.[5] that found the mean intraoperative blood loss for a typical single-jaw orthognathic case, specifically either a sagittal split ramus osteotomy (SSRO) or intraoral vertical ramus osteotomy (IVRO) ranges from 55 to 167mL and 82 to 104mL, respectively.

Further, implementation of advanced clinical protocols in conjunction with orthognathic surgery has been shown to improve patient outcomes by shortening length of stay, facilitating postoperative pain control and decreasing the incidence of postsurgical complications including nausea and vomiting[6]. Specifically, the Enhanced Recovery After Surgery (ERAS) protocol has been adopted across multiple specialties and represents a systematic, multimodal approach to improving patient outcomes[7]. A retrospective cohort study of 359 patients found the implementation of ERAS

protocols led to a decrease in estimated blood loss and in overall length of stay, allowing for safe and effective same-day discharge for patients undergoing extensive bimaxillary or two-jaw orthognathic surgery[7].

Other factors have contributed to the mitigation of hemorrhage risk associated with certain orthognathic surgical procedures, particularly those described by codes 21193, 21194, 21195 and 21196. For instance, technique advancement by way of efficiencies from virtual surgical planning has allowed surgeons to better anticipate issues intraoperatively, such as predicting bony interferences or the position of the inferior alveolar nerve.

Request to move surgical CDT© codes from the ASC ancillary services list to the CPL

Balancing financial considerations with the goal of providing quality care to patients is an ongoing challenge in the healthcare industry. Although we recognize the necessity of setting coverage and payment restrictions for certain services considered supplemental, integral to or furnished in support of other covered surgical procedures, we believe several of the CDT© codes proposed for addition to the ASC covered ancillary services list may be themselves considered to be primary surgical services as opposed to supportive or ancillary.

The proposed addition of dental surgical procedures to the list of ASC covered ancillary services appears inconsistent with the current structure of the ASC ancillary services list. For example, the 2023 list generally consists of radiology services, examinations and drugs, biologicals and other supplies for which separate payment is not permitted under the ASC payment system as opposed to surgical procedures. For 2024, CMS is not proposing to classify any other surgical procedures as covered ancillary services in the ASC, except for select dental procedures. As indicated by CMS, these services are safely furnished in the ASC and we believe they warrant separate payment. Therefore, **AAOMS asks CMS to reassign all dental surgical procedures described by their respective CDT© codes from the ASC ancillary services list to the ASC Covered Procedures List, as provided in Appendix C.** Dental codes that describe radiologic services, diagnostic imaging, supplies and examinations for packaged payment under the ASC payment system may remain as covered ancillary dental services.

Thank you for your consideration of these comments. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality and Reimbursement, with any questions at 800-822-6637, ext. 4394 or pserpico@aaoms.org.

Sincerely,

Paul J. Schwartz, DMD
AAOMS President

Joshua E. Everts, DDS, MD, FACS
Chair, AAOMS Committee on Healthcare Policy, Coding & Reimbursement

References

1 Centers for Medicare & Medicaid Services, Health and Human Services. (2022, November 18). Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Final Rule. https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

2 Centers for Medicare & Medicaid Services, Health and Human Services. (2023, August 7). Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule. https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

3 Covered Surgical Procedures, 42 CFR § 416.166

4 Chen, H.S., Lai, S.S.T., Lee, K.T., Lee, H.E. and Hsu, K.J. (2013). Intraoperative blood loss during an osteotomy of the bilateral vertical ramus. *Journal of Dental Sciences, 9*(3). 249-252. https://doi.org/10.1016/j.jds.2013.04.008

5 Lee, K.T., Lin, S.S., Hsu, K.J., Tsai, C.Y., Lee, Y.H., Change, Y.J. and Wu, T.J. (2021). Intraoperative blood loss and postoperative pain in the sagittal split ramus osteotomy and intraoral vertical ramus osteotomy: A literature review. *BioMed Research International, 2021*. https://doi.org/10.1155/2021/4439867

6 Stratton, M., Waite, P.D., Powell, K.K., Scopel, M.M. and Kukreja, P. (2021). Benefits of the enhanced recovery after surgery pathway for orthognathic surgery. *International Journal of Oral & Maxillofacial Surgery,51*(2). 214-218. https://doi.org/10.1016/j.ijom.2021.04.008

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Appendix A

AAOMS recommendations for dental surgical procedures for coverage under the OPPS and ASC payment system and corresponding clinical APCs for CY 2024				
HCPCS Code	**Nomenclature**	**Possible CPT Crosswalk**	**CMS Assigned APC for Crosswalk**	**AAOMS Recommendation for CY 2024**
D7251	coronectomy - intentional partial tooth removal, impacted teeth only			Assign to clinical APC 5871 Dental Procedures
D7280	exposure of an unerupted tooth			Assign to clinical APC 5871 Dental Procedures
D7283	placement of device to facilitate eruption of impacted tooth			Assign to clinical APC 5871 Dental Procedures
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	41874	APC 5164	Assign to clinical APC 5164 Level 4 ENT Procedures
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	41874	APC 5164	Assign to clinical APC 5164 Level 4 ENT Procedures
D7410	excision of benign lesion up to 1.25 cm			Recommend APC 5163 Level 3 ENT, Otherwise, APC 5072 Level 2 Excision/ Biopsy/ Incision and
D7411	excision of benign lesion greater than 1.25 cm			For D7410-D7412: Recommend APC 5163 Level 3 ENT, Otherwise, APC 5072 Level 2 Excision/ Biopsy/ Incision and
D7412	excision of benign lesion, complicated			Recommend APC 5163 Level 3 ENT, Otherwise, APC 5072 Level 2 Excision/ Biopsy/ Incision and Drainage
D7413	excision of malignant lesion up to 1.25 cm			Recommend APC 5164 Level 4 ENT like CPT 40810, Otherwise, APC 5073 Level 3 Excision/ Biopsy/ Incision and Drainage

D7414	excision of malignant lesion greater than 1.25 cm			Recommend APC 5164 Level 4 ENT like CPT 40810, Otherwise, APC 5073 Level 3 Excision/ Biopsy/ Incision and Drainage
D7415	excision of malignant lesion, complicated			Recommend APC 5164 Level 4 ENT like CPT 40810, Otherwise, APC 5073 Level 3 Excision/ Biopsy/ Incision and Drainage
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm			Recommend APC 5164 Level 4 ENT like CPT 40810, Otherwise, APC 5073 Level 3 Excision/ Biopsy/ Incision and Drainage
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm			Recommend APC 5164 Level 4 ENT like CPT 40810, Otherwise, APC 5073 Level 3 Excision/ Biopsy/ Incision and Drainage
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm			Recommend APC 5164 Level 4 ENT like CPT 40810, Otherwise, APC 5073 Level 3 Excision/ Biopsy/ Incision and Drainage
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm			Recommend APC 5164 Level 4 ENT like CPT 40810, Otherwise, APC 5073 Level 3 Excision/ Biopsy/ Incision and Drainage
D7471	removal of lateral exostosis (maxilla or mandible)	41823	APC 5165	Assign to clinical APC 5165 Level 5 ENT Procedures
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	41805	APC 5163	Assign to clinical APC 5163 Level 3 ENT Procedures
D7540	removal of reaction producing foreign bodies, musculoskeletal system	41805	APC 5163	Assign to clinical APC 5163 Level 3 ENT Procedures

Appendix B

AAOMS recommendations regarding select dental surgical services for CY 2024					
HCPCS Code	**Nomenclature**	**CMS Proposed Clinical APC for CY 2024**	**Possible CPT Crosswalk**	**CMS Assigned APC for Crosswalk (for CY 2023 and proposed for 2024)**	**AAOMS Recommendation for CY 2024**
CDT Codes with Current APCs/Currently Payable in Outpatient Setting					
D0240	intraoral - occlusal radiographic image	APC 5521 Level 1 Imaging without Contrast	70310	APC 5523 Level 3 Imaging without Contrast	Reassign to APC 5523 Level 3 Imaging without Contrast to align with 70310
D0250	extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	APC 5521 Level 1 Imaging without Contrast	70310	APC 5523 Level 3 Imaging without Contrast	Reassign to APC 5523 Level 3 Imaging without Contrast to align with 70310
D0251	extra-oral posterior dental radiographic image	APC 5521 Level 1 Imaging without Contrast	70310	APC 5523 Level 3 Imaging without Contrast	Reassign to APC 5523 Level 3 Imaging without Contrast to align with 70310
D0272	bitewings - two radiographic images	APC 5521 Level 1 Imaging without Contrast	70310	APC 5523 Level 3 Imaging without Contrast	Reassign to APC 5523 Level 3 Imaging without Contrast to align with 70310
D4264	bone replacement graft - retained natural tooth - each additional site in quadrant	NA (Packaged)			Add to ASC CPL under the ASC payment system
D4268	surgical revision procedure, per tooth	APC 5871 Dental Procedures			Add to ASC CPL under the ASC payment system
D7220	removal of impacted tooth - soft tissue	APC 5871 Dental Procedures			Reassign to APC 5163 Level 3 ENT Procedures
D7230	removal of impacted tooth - partially bony	APC 5871 Dental Procedures			Reassign to APC 5163 Level 3 ENT Procedures
D7240	removal of impacted tooth - completely bony	APC 5871 Dental Procedures			Reassign to APC 5164 Level 4 ENT Procedures
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	APC 5871 Dental Procedures			Reassign to APC 5164 Level 4 ENT Procedures

D7260	oroantral fistula closure	APC 5871 Dental Procedures	30580	APC 5165 Level 5 ENT Procedures	Reassign to APC 5165 Level 5 ENT Procedures to align with 30580
D7261	primary closure of a sinus perforation	APC 5871 Dental Procedures	14040	APC 5054 Level 4 Skin Procedures	Reassign to either: 1.) APC 5054 Level 4 Skin Procedures to align with 14040 2.) APC 5165 Level 5 ENT Procedures to be consistent with clinically similar dental service D7260
D7940	osteoplasty - for orthognathic deformities	APC 5871 Dental Procedures	21208	APC 5165 Level 5 ENT Procedures	Reassign to APC 5165 Level 5 ENT Procedures to align with 21208
G0330	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room	APC 5871 Dental Procedures			Reassign to APC 5164 Level 4 ENT Procedures
CDT Codes Proposed for Assignment to Clinical APCs for CY 2024					
D0321	other temporomandibular joint radiographic images, by report	APC 5521 Level 1 Imaging without Contrast	70332	APC 5523 Level 3 Imaging without Contrast	Reassign to APC 5523 Level 3 Imaging without Contrast to align with 70332 and clinically similar dental service D0320
D0364	cone beam CT capture and interpretation with limited field of view - less than one whole jaw	APC 5522 Level 2 Imaging without Contrast	70486		the CPT crosswalk 70486 is assigned to the same APC as proposed. However, D0330 has APC 5523 Level 3 Imaging w/o contrast, should CBCT be consistent with a pano.
D0365	cone beam CT capture and interpretation with field of view of one full dental arch - mandible	APC 5522 Level 2 Imaging without Contrast	70486		the CPT crosswalk 70486 is assigned to the same APC as proposed. However, D0330 has APC 5523 Level 3 Imaging w/o contrast, should CBCT be consistent with a pano.

D0366	cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	APC 5522 Level 2 Imaging without Contrast	70486		the CPT crosswalk 70486 is assigned to the same APC as proposed. However, D0330 has APC 5523 Level 3 Imaging w/o contrast, should CBCT be consistent with a pano.
D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	APC 5522 Level 2 Imaging without Contrast	70486		the CPT crosswalk 70486 is assigned to the same APC as proposed. However, D0330 has APC 5523 Level 3 Imaging w/o contrast, should CBCT be consistent with a pano.
D0368	cone beam CT capture and interpretation for TMJ series including two or more exposures	APC 5522 Level 2 Imaging without Contrast	70486		the CPT crosswalk 70486 is assigned to the same APC as proposed. However, D0330 has APC 5523 Level 3 Imaging w/o contrast, should CBCT be consistent with a pano.
D0369	maxillofacial MRI capture and interpretation	APC 5522 Level 2 Imaging without Contrast	70540/70542	APC 5523 Level 3 Imaging without Contrast/APC 5572 Level 2 Imaging with Contrast	Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging with Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D0370	maxillofacial ultrasound capture and interpretation	APC 5522 Level 2 Imaging without Contrast	76536		Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging with Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D0371	sialoendoscopy capture and interpretation	APC 5521 Level 1 Imaging without Contrast	70390	APC 5523 Level 3 Imaging without Contrast	APC 5523 Level 3 Imaging without Contrast to align with 70390

D0380	cone beam CT image capture with limited field of view - less than one whole jaw	APC 5522 Level 2 Imaging without Contrast			Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging without Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D0381	cone beam CT image capture with field of view of one full dental arch - mandible	APC 5522 Level 2 Imaging without Contrast			Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging without Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D0382	cone beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	APC 5522 Level 2 Imaging without Contrast			Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging without Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D0383	cone beam CT image capture with field of view of both jaws; with or without cranium	APC 5522 Level 2 Imaging without Contrast			Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging without Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D0384	cone beam CT image capture for TMJ series including two or more exposures	APC 5522 Level 2 Imaging without Contrast			Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging without Contrast 2.) APC 5572 Level 2 Imaging with Contrast

D0385	maxillofacial MRI image capture	APC 5522 Level 2 Imaging without Contrast			Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging without Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D0386	maxillofacial ultrasound image capture	APC 5522 Level 2 Imaging without Contrast			Depending on whether contrast is used, reassign to either: 1.) APC 5523 Level 3 Imaging without Contrast 2.) APC 5572 Level 2 Imaging with Contrast
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	APC 5164 Level 4 ENT Procedures	41823	APC 5165 Level 5 ENT Procedures	Reassign to APC 5165 Level 5 ENT Procedures to align with 41823
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	APC 5163 Level 3 ENT Procedures	41874	APC 5164 Level 4 ENT Procedures	Reassign to APC 5164 Level 4 ENT Procedures to align with 41874
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	APC 5163 Level 3 ENT Procedures	41874	APC 5164 Level 4 ENT Procedures	Reassign to APC 5164 Level 4 ENT Procedures to align with 41874
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	APC 5871 Dental Procedures	41825/41826	APC 5164 Level 4 ENT Procedures	Reassign to APC 5164 Level 4 ENT Procedures to align with 41874 Add to ASC CPL under the ASC payment system
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	APC 5871 Dental Procedures	41825/41826	APC 5164 Level 4 ENT Procedures	Reassign to APC 5164 Level 4 ENT Procedures to align with 41874 Add to ASC CPL under the ASC payment system
D7472	removal of torus palatinus	APC 5871 Dental Procedures	21032	APC 5164 Level 4 ENT Procedures	Reassign to APC 5164 Level 4 ENT Procedures to align with 21032

D7473	removal of torus mandibularis	APC 5871 Dental Procedures	21031	APC 5164 Level 4 ENT Procedures	Reassign to APC 5164 Level 4 ENT Procedures to align with 21031
D7485	reduction of osseous tuberosity	APC 5165 Level 5 ENT Procedures	41823	APC 5165 Level 5 ENT Procedures	AAOMS agrees with CMS's proposed APC assignment under the OPPS Add to ASC CPL under the ASC payment system
D7510	incision and drainage of abscess - intraoral soft tissue	APC 5071 Level 1 Excision/Biopsy/Incision and Drainage			Recommend APC 5163 like CPT crosswalk 41018. Otherwise, level 1 or 2 Excision, Biopsy, may be more appropriate.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	APC 5071 Level 1 Excision/Biopsy/Incision and Drainage			Recommend APC 5163 like CPT crosswalk 41018. Otherwise, level 1 or 2 Excision, Biopsy, may be more appropriate.
D7520	incision and drainage of abscess - extraoral soft tissue	APC 5071 Level 1 Excision/Biopsy/Incision and Drainage			Recommend APC 5163 like CPT crosswalk 41018. Otherwise, level 1 or 2 Excision, Biopsy, may be more appropriate.
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	APC 5071 Level 1 Excision/Biopsy/Incision and Drainage			Add to ASC CPL under the ASC payment system
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	APC 5871 Dental Procedures	41830	APC 5164 Level 4 ENT Procedures	Reassign to APC 5164 Level 4 ENT Procedures to align with 41830

Appendix C

AAOMS recommendations for dental surgical services to be moved from the ASC Covered Ancillary Services List to the ASC CPL	
HCPCS Code	**Nomenclature**
D1110	prophylaxis - adult
D1354	application of caries arresting medicament-per tooth
D2140	amalgam - one surface, primary or permanent
D2150	amalgam - two surfaces, primary or permanent
D2160	amalgam - three surfaces, primary or permanent
D2161	amalgam - four or more surfaces, primary or permanent
D2330	resin-based composite - one surface, anterior
D2331	resin-based composite - two surfaces, anterior
D2332	resin-based composite - three surfaces, anterior
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2390	resin-based composite crown, anterior
D2391	resin-based composite - one surface, posterior
D2392	resin-based composite - two surfaces, posterior
D2393	resin-based composite - three surfaces, posterior
D2394	resin-based composite - four or more surfaces, posterior
D2740	crown - porcelain/ceramic
D2750	crown - porcelain fused to high noble metal
D2751	crown - porcelain fused to predominantly base metal
D2752	crown - porcelain fused to noble metal
D2791	crown - full cast predominantly base metal
D2799	interim crown-further treatment or completion of diagnosis necessary prior to final impression
D2920	re-cement or re-bond crown
D2929	prefabricated porcelain/ceramic crown - primary tooth
D2930	prefabricated stainless steel crown - primary tooth
D2931	prefabricated stainless steel crown - permanent tooth
D2932	prefabricated resin crown
D2933	prefabricated stainless steel crown with resin window
D2934	prefabricated esthetic coated stainless steel crown - primary tooth
D2940	protective restoration

D2941	interim therapeutic restoration - primary dentition
D2950	core buildup, including any pins when required
D2951	pin retention - per tooth, in addition to restoration
D2952	post and core in addition to crown, indirectly fabricated
D2954	prefabricated post and core in addition to crown
D3110	pulp cap - direct (excluding final restoration)
D3120	pulp cap - indirect (excluding final restoration)
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	pulpal debridement, primary and permanent teeth
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)
D3310	endodontic therapy, anterior tooth (excluding final restoration)
D3320	endodontic therapy, premolar tooth (excluding final restoration)
D3330	endodontic therapy, molar tooth (excluding final restoration)
D3460	endodontic endosseous implant
D3910	surgical procedure for isolation of tooth with rubber dam
D4341	periodontal scaling and root planing - four or more teeth per quadrant
D4342	periodontal scaling and root planing - one to three teeth per quadrant
D4346	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910	periodontal maintenance
D7922	placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site