Medicare coverage for dental services: A primer

Medicare statute generally prohibits coverage and payment for any services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. This broad exclusion of dental services from coverage under Medicare has been in place since the establishment of the program in 1965. However, CMS currently interprets this provision to allow payment under Medicare in limited circumstances for which there is appropriate medical justification.

In the 2023 Medicare Physician Fee Schedule Final Rule, CMS finalized select provisions that expand the scope of medically necessary dental services and amend existing regulation to clarify Medicare coverage policy.

It is essential that OMSs participating in the Medicare program become familiar with new and revised CMS policies as these changes may impact how certain services are reported and paid under Medicare. However, regardless of enrollment status, all providers and coders are encouraged to stay abreast of federal policy changes as CMS coverage and claims processing guidelines can also influence commercial payer policies.

Medicare policy has always differentiated between services rendered *in connection with* excluded dental services and those dental services deemed *integral to* an otherwise covered medical procedure. For instance, Medicare will not cover operating room charges or any related facility fees when furnished in connection with a non-covered dental procedure, such as the routine removal of carious teeth. CMS does make an exception and allow payment under Medicare Part A for inpatient hospital services furnished in connection with non-covered dental services when the patient's underlying medical condition or severity of the procedure necessitate hospitalization.

While many limitations will remain in place, the 2023 Final Rule does expand what dental services may be considered integral to otherwise covered medical procedures for patients with certain health conditions.

Integral dental services covered in 2023

Medicare benefit and policy manuals outline those dental services considered to be an integral part of select covered medical procedures, such as the reconstruction of the jaw following accidental injury or extractions done in preparation for radiation treatment of neoplastic disease. Medicare policy also has traditionally allowed for the payment of oral examinations on an inpatient basis preceding kidney transplantation.

In the 2023 Final Rule that took effect Jan. 1, CMS identified other clinical scenarios in which pre-surgical dental exams may be deemed medically necessary, including when part of a comprehensive workup for any type of organ transplant surgery as well as cardiac valve repair (e.g., valvuloplasty) and replacement procedures, and will now cover the hospital's costs regardless of whether these services occur as inpatient status or in an outpatient hospital setting.

Furthermore, CMS indicated that certain dental services may be considered integral to a covered medical procedure when deemed "inextricably linked" or essential to the successful outcome of that procedure. For example, restorative dental services such as a tooth extraction (e.g., CDT© codes D7140 and D7210) to remove or eliminate the source of oral infection prior to organ transplant surgery. Such services may now be considered medically necessary and eligible for Medicare payment as the success of the transplant surgery could be compromised if the oral infection is not properly diagnosed and treated. This coverage provision also extends to ancillary items and services furnished in conjunction with such dental services rendered in the facility, such as X-rays, the administration of anesthesia and use of an operating room.

To affirm these changes, CMS has amended Medicare regulation to include examples of medically necessary dental services that may be deemed inextricably linked or integral to the success of other covered medical procedures, including those originally outlined in policy manuals and national coverage determinations as follows:

- A dental or oral examination as part of a comprehensive workup before an organ transplant, cardiac valve replacement or valvuloplasty procedure.
- The necessary dental treatments and diagnostics to eliminate oral or dental infections found during a dental or oral examination as part of a comprehensive workup before, or occurring at the same time as, an organ transplant, cardiac valve replacement or valvuloplasty procedure.

on integral services, payment policy

- The reconstruction of a dental ridge when performed as a result of and at the same time as the surgical removal of a tumor.
- The wiring or immobilization of teeth when done in connection with the reduction of a jaw fracture.
- The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- A dental splint, but only when used in conjunction with covered treatment of a medical condition.

To clarify, this policy change only applies to certain dental services rendered in the hospital on an outpatient or inpatient basis. It will not apply to office-based procedures or those rendered in an ambulatory surgical center (ASC).

Beginning in 2024, CMS will allow Medicare payment for similar dental services when rendered prior to, or at the same time as, Medicare-covered treatments for head and neck cancers.

Payment policy for dental services

For 2023, CMS will continue to maintain its carrier pricing methodology for medically necessary dental services. This means Medicare Administrative Contractors make coverage determinations on a case-by-case basis as to whether certain clinical scenarios involving dental services meet the parameters for coverage under Medicare policy and price them accordingly.

CMS also released the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule that established a new G-code – G0330 – to describe dental rehabilitation services that require monitored anesthesia and the use of an operating room. This code is billable by hospitals beginning Jan. 1 to report the facility fees associated with covered dental services rendered in a hospital setting. CMS has indicated they may consider making this code payable in the ASC setting in the future. ■

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