CMS updates include expansion of Medicare-

CMS published two final rules in November that updated physician and healthcare facility payment rates for Medicare-covered services for 2024, including dental services.

In 2023, CMS expanded Medicare coverage and payment for certain dental services necessary to diagnose and treat an oral or dental infection prior to, or during, the following Medicare-covered surgeries:

- Organ transplant, including hematopoietic stem cell and bone marrow transplant
- Cardiac valve replacement
- Valvuloplasty procedures

For 2024, CMS expanded coverage for additional dental services necessary to diagnose and treat an oral or dental infection prior to, or during, the following Medicare-covered cancer treatments:

- Chemotherapy (any cancer)
- Chimeric antigen receptor (CAR) T-cell therapy (any cancer)
- Antiresorptive drug therapy, in limited circumstances (e.g., IV bisphosphonate therapy to treat multiple myeloma and metastatic bone cancer)
- Medicare-covered treatments for head and neck cancer, including surgery, chemotherapy, radiation or any combination of these

Other CMS coverage and payment changes

CMS also expanded coverage and payment for dental care necessary to address oral or dental complications following the direct treatment for head and neck cancer.

According to CMS, dental services that meet the thresholds above – including linked ancillary services (e.g., X-rays, administration of anesthesia, use of an operating room) – may be payable in either the inpatient or outpatient setting when all Medicare coverage and payment criteria are met.

As of the date of publication, CMS has not set a timeframe during which dental services connected to the treatment of head and neck cancer – specifically post-cancer treatment – are eligible for Medicare coverage. Additional guidance is anticipated from CMS and local Medicare contractors.

To be eligible to bill and receive payment for covered dental services, OMSs must be enrolled in the Medicare program and meet all other requirements for billing under the Medicare Physician Fee Schedule. However, note that CMS's dental policy update does not apply broadly to all dental procedures.

Medicare coverage and payment for dental services generally are limited to dental services considered medically necessary and "inextricably linked" to certain covered medical procedures. In other words, dental services must be an integral part of a specific treatment of a Medicare beneficiary's covered medical condition to be covered.

Several Medicare contractors have published articles outlining the requirements for billing dental services, including guidance on the documentation that may be necessary to support Medicare coverage determinations. Further direction from CMS and Medicare contractors is anticipated in relation to the dental policy changes finalized for 2024. OMSs are encouraged to monitor their contractor's website for additional information and resources on coding, billing and payment for Medicare-covered dental services.

Additionally, the final rule:

- Reduces the conversion factor to $32.74 for 2024, a decrease of nearly 3.4 percent from 2023.
- Extends key Medicare telehealth flexibilities, including waiving originating site requirements and continued coverage of certain audio-only services through the end of 2024.
- Maintains CMS's current definition of direct supervision to permit the presence and "immediate availability" of the supervising practitioner through live audio and visual interactive communication through Dec. 31, 2024.
- Reinstates add-on office visit complexity code G2211 as a separately payable service, contributing significantly to the decreased conversion factor due to budget neutrality.
- Aligns the definition of "substantive portion" with CPT^ guidelines for split or shared visits.
- Indefinitely pauses the Appropriate Use Criteria program.
- Establishes a new Healthcare Common Procedure Coding System (HCPCS) code (G0136) to identify and value the work involved in documenting and assessing a patient's social risk factors.
- Maintains the Merit-based Incentive Payment System (MIPS) performance threshold of 75 points for 2024 and adds five new MIPS Value Pathways related to certain select specialties or medical conditions.

covered dental services, facility payments

Billing for facility costs

The Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System rule updates payment rates and regulations affecting Medicare services furnished in hospital outpatient and ASC settings. For 2024, CMS finalized several provisions that allow hospitals and ASCs to bill for facility costs and resources (e.g., surgical equipment and supplies, clinical staff, use of the operating room) associated with certain Medicare-covered dental procedures.

Previously, OPPS payment rates were assigned to a limited number of dental procedure codes, such as G0330 and codes for extraction services. For 2024, CMS assigned facility payment rates to more than 240 additional dental procedure codes, including those for vestibuloplasty, intraoral and extraoral I&Ds, removal of benign odontogenic and nonodontogenic cysts and excision of malignant lesions and tumors.

As of Jan. 1, Medicare payment may be permitted for the facility charges associated with these dental services when rendered in the hospital outpatient setting when all Medicare coverage and payment requirements are met.

Payment rates under the OPPS are determined based on the clinical characteristics and resource costs associated with each procedure. Each dental service, depending on its complexity and the resources required to perform it, is assigned a unique payment rate.

For most covered dental services, the average rate hospitals may receive in 2024 ranges from approximately $839 to over $3,000. Consistent with comments AAOMS submitted to CMS, CMS reassigned G0330 to an ENT Level 4 APC rate, increasing the facility reimbursement for G0330 in a hospital setting to $3,070.81.

The expanded list of dental codes with specific payment rates may allow hospitals to bill for a wider range of dental procedures, potentially increasing total Medicare reimbursements and improving patient access to facility-based dental services.

Changes for ASC

Under the ASC payment system, CMS added nearly 30 dental surgical procedures to the Covered Procedures List (CPL), a list of services deemed safe and eligible for Medicare payment when performed in the ASC setting. This includes dental codes for extraction services, intraoral and extraoral I&Ds and, as requested by AAOMS, dental rehabilitative services described by G0330. Like the OPPS, this means Medicare payment may be allowed for facility fees associated with certain Medicare-covered dental procedures performed in an ASC as of Jan. 1. CMS also added 11 CPT codes to the ASC CPL, including two codes that describe mandibular reconstructive procedures.

For 2024, CMS has set an ASC payment rate of approximately $456 for many – but not all – dental surgical procedures. For example, G0330 carries a 2024 facility payment rate of approximately $1,300 when billed by an ASC for a Medicare-covered dental rehabilitative service.

Additionally, CMS expanded the list of ancillary services covered in an ASC by nearly 80 dental procedures, allowing them to be provided alongside other covered surgeries in the ASC. However, these services are generally bundled with the primary surgical procedure, therefore separate Medicare payment may not be made.

CMS specifies that G0330 can only be billed in an ASC setting alongside a covered ancillary service for which separate payment is not permitted. For instance, an ASC may report a dental exam under anesthesia using the appropriate dental code and G0330. If it meets Medicare criteria, the ASC receives a single payment for G0330, covering the resources for a dental exam requiring anesthesia in a facility setting.

As a reminder, the HCPCS code G0330 is not permitted for use by providers to report professional services rendered in a facility setting. Providers, including OMSs, should continue to report the CDT* or CPT code that most accurately identifies the service furnished to the patient, regardless of place of service. HCPCS code G0330 is used by the facility, not the provider.

The assignment of an individual payment rate under the OPPS or ASC payment system does not guarantee the facility will be reimbursed for any given dental procedure. A facility fee is payable only if the procedure itself meets all Medicare coverage criteria. OMSs and professional coding and billing staff are encouraged to review the current Medicare dental coverage guidelines available at CMS.gov/Medicare/Coverage/MedicareDentalCoverage as well as check their local Medicare contractor's website for guidance on billing dental services. ■