Understanding and billing for Medicare-covered

Under general exclusions, items and services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not a covered Medicare benefit. These services include routine dental care, impacted tooth extractions and preparation of the mouth for dentures, such as alveoplasty and dental ridge reconstruction.

In 2023 and 2024, Medicare finalized provisions to expand dental coverage to include medically necessary dental services when inextricably linked and related to the success of certain covered medical treatments. Specifically, these policy updates address dental services required to identify, diagnose and treat oral or dental infections in relation to organ transplants, cardiac valve replacements and repairs, as well as certain cancer treatments (i.e., Medicare-covered chemotherapy, radiation and surgery for the treatment of head and neck cancer). A list of covered services is available at CMS.gov/Medicare/coverage/dental.

Beginning Jan. 1, CMS expanded coverage for dental services required to identify, diagnose and treat oral and dental infections in connection with Medicare-covered dialysis services for beneficiaries with end-stage renal disease. Coverage applies to dental services that meet this threshold, including linked ancillary services (e.g., X-rays, administration of anesthesia, use of an operating room) and may be payable either in the inpatient or outpatient settings, including ambulatory surgical centers (ASCs) and OMS offices, provided that all Medicare coverage and payment criteria are met.

To be reimbursed for Medicare services, CMS requires all physicians and non-physician practitioners who render covered items or services to complete the CMS-855I application and enroll in the Provider Enrollment, Chain, and Ownership System (PECOS). OMSs enrolled in Medicare and providing Medicare beneficiaries with dental services linked to covered medical services may submit claims electronically using the 837D (dental), 837P (professional) or in a paper format using the ADA 2025 or CMS 1500 claim form.

Effective July 1, Modifier KX and ICD-10-CM diagnosis codes will be required on claims to indicate the dental service is linked to a Medicare-covered service. Claims submitted without such information will be processed assuming coverage criteria have not been met and may be denied.

When submitting for Medicare-covered dental services, use the appropriate CDT/CPT code(s) with the appropriate claim form and append modifier KX to indicate the dental service is inextricably linked to a Medicare-covered medical service. Appending the KX modifier certifies the following information to the payer:

- The dental service is medically necessary.
- There is appropriate documentation in the medical record to support the services are inextricably linked to covered medical services.
- Coordination between medical/dental providers has occurred.
- Criteria of the Medicare coverage/payment policy are met.

If submitting a Medicare claim for a denial, to allow for reimbursement by a third-party payer (like Medicaid), append the HCPCS GY modifier on the appropriate CDT/CPT code(s) to:

- Certify the belief that Medicare shouldn't pay for the service.
- Submit statutorily excluded services as non-covered line items on the claim with other covered dental services (like dental services inextricably linked to the clinical success of other Medicare-covered procedures or services).

Note: *Currently, the 837D claim form does not provide a field to append a modifier. Therefore, if appending the KX/GY modifier to a particular procedure or service code, add this information in the remarks section (box 35) of the dental claim form if submitting via a paper format. If submitting electronically, append the appropriate modifier next to the procedure code (box 29). If submitting via the 837P or on the CMS-1500, these modifiers should be added in field 24d as with other medical claims requiring a modifier.*

dental services

OMSs wishing to submit the dental claim form should contact their state's Medicare Administrative Contractor (MAC) to ensure their ability to do so, as the process may involve electronic data interchange enrollment and mandatory claims testing. A list of MACs may be found at CMS.gov/Medicare/coding-billing/medicare-administrative-contractors-macs/who-are-macs.

According to CMS, payment under Medicare is only permitted for dental services that are inextricably linked to and substantially related and integral to the clinical success of certain covered medical services. There also must be coordination between different healthcare providers, such as physicians or other non-physician practitioners and an OMS/dentist. This coordination ensures that:

- Medicare-covered treatments for the illness are provided.
- Dental services essential to the success of the medical treatment are included.

Without this coordination and documented evidence of information exchange between providers, Medicare will not cover dental services. Examples of such coordination include referrals or information sharing between a primary care physician and an OMS.

OMSs and professional coding and billing staff are encouraged to monitor their MAC's website to stay up-to-date on coverage policies and guidance specific to their state or local carrier. Most MACs provide specific guidance and recommendations for claim submission. This information can be found on the individual carrier's website, through specific coding and billing articles released by the MAC or through CMS's Medicare Coverage Database. AAOMS recommends OMSs consult these resources to ensure accurate and compliant billing practices. Additional guidelines on Medicare dental coverage are available at CMS.gov/Medicare/coverage/dental. ■