ADA American Dental Association®

AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

November 17, 2020

Ms. Carol Blackford
Centers for Medicare and Medicaid Services
Hospital and Ambulatory Policy Group
7500 Security Boulevard
Baltimore, MD 21244

Sent via Electronic Mail

Dear Ms. Blackford:

On behalf of the American Academy of Pediatric Dentistry and the American Dental Association, thank you for taking the time to meet with us by phone on November 10 to discuss our concerns regarding pediatric and adult Medicare and Medicaid patient access to dental rehabilitation surgery. As discussed, **we urge CMS to work with the dental community to establish a new HCPCS Level II Category G-Code for dental rehabilitation surgery to address severe dental disease.**

Significance of the Problem Before and During COVID

As we discussed, in spite of advances in preventive care and reduction in untreated tooth decay, thousands of children under five years of age, many adults with special needs and disabilities, and the frail elderly disproportionately suffer from significant dental decay (dental caries). If not treated through dental surgical intervention, this disease can result in emergency department visits and life-threatening infection and hospital admission. Given the time involved for restorative dental surgical procedures, the often-complex equipment and anesthesia required, and the complexity of the services required for high-risk patients, dentists need to provide these services in a hospital or ambulatory surgery center (ASC) operating room to ensure safe, quality care.

Operating room access has been decreasing considerably over a decade in a majority of states. We attribute most of this access challenge to the lack of a sustainable billing mechanism for dental surgical services in both Medicare and Medicaid. This situation has been further exacerbated by COVID as hospitals were and are again being forced to limit elective surgical procedures to address the strain of the pandemic on operating room access.

Medicare/Medicaid Coding Limitations

Dental rehabilitation surgical services for complex dental patient cases that require operating room access do not have specific CPT codes. Coding is limited to an unlisted/miscellaneous code (CPT 41899), and for hospital outpatient payment purposes, have been placed with other miscellaneous codes in an APC (5161) with a national average 2020 APC rate of $203.64. This reimbursement level is grossly under the appropriate cost for complex dental surgery cases, and significantly less than national average geometric mean cost of the procedure being billed to Medicare, which is $2,334.87. The APC rate does not in any way recognize or cover a facility's time, expense, professional surgical services, anesthesia services, or equipment costs, creating a challenge in hospitals agreeing to see Medicare patients in need of dental rehabilitation surgery. ASCs are also limited in seeing these patients for surgery as there is no recognized code to bill for dental surgeries. A majority of state Medicaid programs look to Medicare payment policy and rates as a benchmark for determining Medicaid policies for dental surgical services.

The dental community approached the American Medical Association in the past to explore the creation of a dental surgery-specific CPT code but faced resistance given that dental surgical services are not physician services and no physician time is allocated to the procedures. There is also no present option for a CDT code to address dental rehabilitation surgical procedures given that CDT codes are not covered under the hospital outpatient or ASC payment systems.

CPT Codes Used by Oral Surgeons Do Not Cover Dental Rehabilitation Surgery

During our meeting, Dr. Hambrick asked about the Medicare services provided by oral and maxillofacial surgeons and the difference in procedures from the dental rehabilitation surgery services we seek to address. Existing CPT codes for oral and maxillofacial services do include physician time, work and practice expenses associated with the procedures when rendered in the office and/or a facility. There are CPT codes for services such as surgical repair and/or reconstruction of the jaw after fracture, injury, or removal of a facial tumor. We would like to work with CMS to obtain a Level II HCPCS Code that would indicate that a dental procedure is being rendered in a facility setting.

Conclusion and Next Steps

The AAPD and ADA very much appreciated the questions and feedback provided by you and your staff during our meeting. In follow up to your request, our organizations are working to provide recommendations on a coding descriptor for the HCPCS Level II Category-G Code we

are seeking to establish. We will follow up shortly with our thoughts for your further consideration. In the meantime, for more information or if we can answer any additional questions, please contact Julie Allen at 202-494-4115 or Julie.allen@powerslaw.com. Thank you again for your time and consideration.

Sincerely yours,

American Academy of Pediatric Dentistry
American Dental Association

Cc: Dr. Ryan Howe, HAPG
Dr. Edith Hambrick, HAPG
Dr. Karen Nakano, HAPG
Dr. Perry Alexion, HAPG
Mr. William Robinson, HAPG
Mr. David Rice, HAPG
Mr. Andrew Snyder, CMCS
Dr. Natalia Chalmers, CMCS