

September 2, 2022

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1770-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

To Whom It May Concern:

On behalf of our 162,000 members, the American Dental Association (ADA) is pleased to provide comments on the dental and oral health services included in the Calendar Year (CY) 2023 Proposed Rule: Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. The following comments pertain to Section II.L of the proposed rule, "Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services."

## **Section II.L.2: Proposals to Clarify the Interpretation of Section 1862(a)(12) of the Act and Codify Current Payment Policies for Certain Dental Services and Request for Comment**

### **a. Proposed Payment for Inpatient Hospital Dental Services and Request for Comment**

*Proposed Rule: "We believe that there are instances in which a Medicare beneficiary may require dental services that are in direct connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth such that the application of the Medicare Part A payment exception would apply when hospitalization is required because of: (1) a patient's underlying medical condition and clinical status; or (2) the severity of the dental procedure. We are interested in receiving public comments on what professional services, including, but not limited to dental services, may occur during and prior to the patient's hospitalization or procedure requiring hospitalization under this exception. We may consider finalizing, based on our review of public comments, additional payment policies in this area."*

Nonventilator hospital-acquired pneumonia (NVHAP) occurs in ~1 in 100 hospitalized patients,<sup>1,2</sup> has an associated crude mortality of 15%–30%, is associated with increases in antibiotic usage, intensive care unit utilization rates, readmission rates, and it is the most common pathway to sepsis.<sup>3</sup> Presence of pathogenic

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<sup>1</sup> Giuliano, KK, Baker, D, Quinn, B. The epidemiology of nonventilator hospital-acquired pneumonia in the United States. *Am J Infect Control* 2018;46:322–327. [CrossRef](#) [Google Scholar](#) [PubMed](#)

<sup>2</sup> Baker, D, Quinn, B. Hospital-Acquired Pneumonia Prevention Initiative-2: incidence of nonventilator hospital-acquired pneumonia in the United States. *Am J Infect Control* 2018;46:2–7. [CrossRef](#) [Google Scholar](#) [PubMed](#)

<sup>3</sup> Munro, SC, Baker, D, Giuliano, KK, et al. Nonventilator hospital-acquired pneumonia: a call to action. *Infect Control Hosp Epidemiol* 2021;42:991–996. [CrossRef](#) [Google Scholar](#) [PubMed](#)

bacteria in the mouth has a critical relationship with NVHAP,<sup>4,5,6,7</sup> and comprehensive, evidence-based oral care is an effective, proven intervention.<sup>8,9</sup> Providing oral care including simple brushing with the right products can improve outcomes for hospitalized patients. We urge CMS to support training of nursing staff and paying for oral care services including purchase of necessary supplies to reduce the incidence of pneumonia in hospitalized patients. We note that the ADA has approved oral care protocol for patients in acute care setting<sup>10</sup>.

#### **b. Proposal to Clarify the Interpretation of Section 1862(a)(12) of the Act and Codify Current Payment Policies for Certain Dental Services**

*Proposed Rule: “Specifically, we propose to include as examples the following dental services for which payment is permitted under our current policy: (1) dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery; (2) reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor; (3) wiring or immobilization of teeth in connection with the reduction of a jaw fracture; (4) extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and (5) dental splints only when used in conjunction with medically necessary treatment of a medical condition. We further propose that Medicare payment would be made for these dental services regardless of whether the services are furnished in an inpatient or outpatient setting, and we propose that payment can also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, use of an operating room, other facility services.”*

As such, the ADA supports and applauds CMS for including a dental benefit for Medicare beneficiaries who require:

- Dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery
- Reconstruction of a ridge when it is performed as a result of and at the same time as the surgical removal of a tumor
- Wiring of teeth when done in connection with the reduction of a jaw fracture
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease
- A dental splint when performed in conjunction with treatment that is determined to be a covered medical condition

The ADA suggests that benefit coverage for reconstruction of a ridge should be available in all instances when the reconstruction of the ridge “is incident to” the surgical removal of a tumor. Also, reconstruction of the ridge does not, alone, return the patient to a condition of health. Without the subsequent replacement of teeth on that ridge to facilitate the intake of nutrition, phonetics necessary for communication and social interaction, the patient is left crippled after the surgical tumor removal. There are clinical circumstances wherein reconstruction may not be an appropriate option at the “same time” as surgical removal of a tumor. We also suggest that “wiring of teeth” be instead identified as “stabilization of teeth” to align with current terminology.

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<sup>4</sup> Gomes-Filho IS, Passos JS, Seixas da Cruz S. Respiratory disease and the role of oral bacteria. *J Oral Microbiol.* 2010; 2: 5811

<sup>5</sup> Scannapieco FA, The oral microbiome: its role in health and in oral and systemic infections. *Clin Microbiol Newsl.* 2013; 35: 163-169

<sup>6</sup> Scannapieco FA, Shay K, Oral health disparities in older adults: oral bacteria, inflammation, and aspiration pneumonia. *Dent Clin North Am.* 2014; 58: 771-782

<sup>7</sup> Heo SM, Haase EM, Lesse AJ, Gill SR, Scannapieco FA, Genetic relationships between respiratory pathogens isolated from dental plaque and bronchoalveolar lavage fluid from patients in the intensive care unit undergoing mechanical ventilation. *Clin Infect Dis.* 2008; 47: 1562-1570

<sup>8</sup> Baker, D, Quinn, B. Hospital-Acquired Pneumonia Prevention Initiative-2: incidence of nonventilator hospital-acquired pneumonia in the United States. *Am J Infect Control* 2018;46:2–7.[CrossRefGoogle ScholarPubMed](#)

<sup>9</sup> Quinn B, Giuliano KK, Baker D. Non-ventilator health care-associated pneumonia (NV-HAP): Best practices for prevention of NV-HAP. *Am J Infect Control.* 2020 May;48(5S):A23-A27. doi: 10.1016/j.ajic.2020.03.006. PMID: 32331561.

<sup>10</sup> American dental association—approved protocol for the use of evidence-based oral care in the acute care setting. <https://www.ajicjournal.org/action/showFullTableHTML?isHtml=true&tableId=tbl0001&pii=S0196-6553%2820%2930129-2>

We note that CMS intends to expand access to these services by allowing a benefit in both the in-patient as well as the out-patient settings. While the ADA appreciates the value of such expanded access to care for Medicare beneficiaries, the ADA would like clarification regarding certain claims and payment policies in order to ensure the dentists in the out-patient setting can address the needs of these patients.

Specifically, we request clarification on the following:

- (1) Will dentists be able to continue to use the 837D form for filing claims with the Medicare contractors?
- (2) Would CDT/ Level II HCPCS “D” codes be the mandated code set for reporting oral evaluation services?
- (3) If ICD diagnostic codes are required on claim submissions, will CMS be issuing guidance for reporting the medical diagnosis that triggers eligibility for a Medicare benefit on the applicable claim form as well as guidance for reporting dental diagnosis associated with the care provided?
- (4) Will CMS issue clear National Coverage Determinations (NCD) to assure equitable access across the Medicare population with these conditions? We request clarification regarding NCD policies and preclusion or exception with MAC eligibility determinations of dental services and coordination of benefits. Additional guidance will be required regarding administration of dental services frequency limits, supporting documentation, and authorization processes.
- (5) How will CMS ensure there is an adequate network of dentists available to treat patients in these categories?

### **c. Proposed Update to Current Payment Policies for Dental Services**

*Proposed Rule: “We are proposing to amend § 411.15(i) to include examples of payable services under Medicare Parts A and B, as: (1) the dental or oral examination as part of a comprehensive workup prior to an organ transplant, cardiac valve replacement, or valvuloplasty procedure; and (2) the necessary dental treatments and diagnostics to eliminate the oral or dental infections found during a dental or oral examination as part of a comprehensive workup prior to an organ transplant, cardiac valve replacement, or valvuloplasty procedure. We believe that clinical practice is such that these services can occur within the inpatient hospital or outpatient setting, and we further propose that Medicare Parts A and B would make payment for these dental services, as applicable, regardless of whether the services are furnished in an inpatient or outpatient setting. Furthermore, we propose that payment under the applicable payment system could also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, and use of the operating room.... “Medicare Administrative Contractors (MACs) may determine on a claim-by-claim basis whether a patient’s circumstances do or do not fit within the terms of the preclusion or exception specific....DDS/DMD should be considered “physicians,” as they are in statute.”*

For individuals scheduled for organ transplant, cardiac valve replacement, or valvuloplasty procedure, the ADA supports a dental benefit in Medicare covering dental or oral examination as well as necessary dental treatments and diagnostics to eliminate the oral or dental infections prior to surgery.

We applaud CMS for specifying that services ancillary to dental procedures – such as x-rays, administration of anesthesia, and use of the operating room – will be eligible for payment under the applicable payment system. We applaud CMS for its recent proposal [Hospital OutPatient Payment Rule] to change the Medicare Ambulatory Payment Classification (APC) of CPT code 41899 (unlisted procedure, dentoalveolar structures), which is the code frequently used by hospitals to bill the facility fee for dental operating room (OR) cases. This change significantly enhances the facility fee that an operator may be paid when scheduled for dental services assuring access to these facilities for patients with dental needs. We note; however, that a similar change is necessary to address concerns for Ambulatory Surgical Centers and urge CMS to similarly review the ASC facility fee for CPT code 41899.

The ADA wishes to note that elimination of infection prior to the medical/surgical procedure is critical. As noted in the rule, “if a patient requiring an organ transplant [or other eligible Medicare procedure] has an oral infection, the success of that transplant could be compromised if the infection is not properly diagnosed and treated prior to the transplant surgery.” Further, the proposed rule indicates, “the necessary treatment to eradicate an infection may not be the totality of recommended dental services for a given patient.”

While examination is the first step to identifying and eliminating dental disease, examination alone is not enough for improving health outcomes. Recovery, rehabilitation and maintenance of the patients is equally important. Many studies have established an association between poor oral health, malnutrition /under

nutrition, and reduced quality of life in older adult populations.<sup>11</sup> Further, the first-line treatment that has historically been performed for patients in these clinical scenarios is tooth extraction. However, the ADA believes that tooth extraction should be considered a last resort clinical approach for treating dental disease. We hope the “elimination” of oral infection is not limited to dental extractions when other treatment options are considered appropriate based on the clinical judgment of the care team. Medicare beneficiaries whose teeth can be reasonably preserved should be able to opt for more conservative approaches to care. To this end, we urge CMS to consider coverage of comprehensive services beyond “elimination of infection” prior to medical/surgical procedure. Moreover, even when extraction is the best treatment, extraction without subsequent replacement of the extracted teeth leaves the patient disabled.

We note that CMS intends to expand access to these services by allowing a benefit in both the in-patient as well as the out-patient settings. While the ADA appreciates the value of such expanded access to care for Medicare beneficiaries, the ADA, as previously noted, would like clarification regarding certain claims and payment policies in order to ensure the dentists in the out-patient setting can address the needs of these patients.

*Proposed Rule: “We propose to continue to contractor price the dental services for which payment is made currently, and for the dental services that can be made under the proposed amendments to § 411.15(i)(3) for CY 2023, or until we have further data to establish prospective payment rates”*

We note that CMS proposes to use “contractor pricing” for the dental services payable by Medicare and that prospective payment rates could be established once more data is available. A widely-accepted Resource-Based Relative Value Scale (RBRVS) does not exist for dental procedure codes represented by the “Current Dental Terminology” (“CDT” Code), the named Health Insurance Portability and Accountability Act (HIPAA) standard for representing dental procedures on standard electronic transactions. Recent relevant data must be collected from dentists for over 700+ CDT Codes in order to develop a viable fee schedule using the RBRVS methodology. In addition, other features of the RBRVS-based payment system—including global periods and multiple procedure reduction rules—have to our knowledge never been applied within dental claims and must be evaluated for their applicability and appropriateness.

Further, a dental practice typically has high costs of maintaining and running an office, including dental equipment, supplies, lab costs, staffing needs, anesthesia, sterilization and personal protective equipment (PPE). The weighting of practice expenses, physician work and malpractice insurance used in the development of the relative value units for the physician fee schedule are unfavorable to the practices that are equipment heavy due to the surgical nature of the treatment. An appropriate weighting method must be developed in order for such a system to be used as an indexing method for a dental fee schedule.

The ADA is willing and ready to assist CMS in accurately identifying a process whereby facility fees for care provided in out-patient settings can be adequately accounted for in any payment rate methodology that CMS will develop.

#### **i. Other clinical scenarios for dental services integral to other covered medical services.**

*Proposed Rule: “We believe there may be other clinical scenarios where dental services may not be in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, but instead are inextricably linked to, and substantially related and integral to the clinical success of, certain other covered medical services. These could include certain dental exams and medically necessary diagnostic and treatment services prior to treatments for head and neck cancers, such as radiation therapy with or without chemotherapy, or the initiation of immunosuppressant therapy, such as those used during cancer treatments, where the standard of care is such that it is clinically advisable to eliminate the source of infection prior to proceeding with the necessary medical care, or the standard of care for the primary medical condition would be significantly materially compromised if the dental services are not performed. As with any assessment of patient health prior to initiating immunosuppressant therapy, it may be necessary to eradicate all sites of infection, including oral infections, prior to suppressing the immune system, regardless of the reason for prescribing an immunosuppressant. We also note some medications may have an immunosuppressant effect, even though*

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<sup>11</sup> Ijaopo E, Ijaopo R. A Review of Oral Health in Older Adults: Key to Improving Nutrition and Quality of Life. OBM Geriatrics 2018;2(3):010; doi:10.21926/obm.geriatr.1803010.

*they are not prescribed principally to suppress the immune system. We believe, in these circumstances, eradicating oral or dental infection prior to beginning a medication that has been found to have a suppressant effect on that part of the immune system required to eradicate infectious agents could be necessary to the clinical success of the medication therapy. Similarly, in joint replacement surgery (such as total hip and knee arthroplasty surgery) we believe there may be risks to the outcome of the procedure if an oral infection is not treated.”*

The comment period does not allow a comprehensive review of the evidence on each of the cited medical conditions. With regards to head and neck cancer, there is low certainty evidence that optimizing oral health may help reduce the need for urgent pre-RT dental treatment, potentially reducing risk of osteoradionecrosis of the jaw and minimizing delay of oncologic treatment in patients with head and neck cancer<sup>12</sup>. A recent systematic review and meta-analysis<sup>13</sup> concludes that survival is significantly higher in those who receive recommended dental care prior to and during cancer therapy compared with those who do not; however, the underlying cause of this relationship remains unknown. This meta-analysis was based on a limited number of studies that did not factor information on comorbidities and frailty into their analyses. The authors call for additional studies to increase confidence in the association.

In terms of joint replacement therapy, as noted in the proposed rule, at this time, evidence regarding a direct relationship between pre-operative dental assessment and improved outcomes following orthopedic surgery is lacking.<sup>14</sup> We look forward to reviewing evidence from other commenters demonstrating that the provision of dental services leads to improved healing, improved quality of surgery, and the reduced likelihood of readmission and/or surgical revisions.

While evidence exists for the effect of immunosuppressant therapy on oral health, we look forward to receiving evidence from other commenters regarding effect of dental clearance on outcomes of immunosuppressant therapy.

*Proposed Rule: “We request comment on whether there are other dental services associated with stabilizing and/or repairing the jaw after accidental injury or trauma and similarly that similarly would not be subject to the exclusion under section 1862(a)(12) of the Act, and for which we should consider providing Medicare payment.”*

With regards to coverage for dental services associated with stabilizing and/or repairing the jaw after accidental injury or trauma, ADA requests consideration of comprehensive coverage to enable reconstruction of post traumatic deformities of facial/jaw bones and soft tissue including restoration of form and function of the dentition.

We appreciate the recognition that, under these circumstances, the dental services may not be provided prior to or contemporaneously with medical services. We support CMS in proceeding with the proposal to allow payment for services furnished after the covered medical procedure or treatment when that is in the patient's best interest for clinical success for situations involving accidental injury or trauma.

## **ii. Establishment of a process to consider additional clinical scenarios for future updates:**

*Proposed Rule: “To facilitate our consideration of interested parties’ recommendations within an annual rulemaking cycle, we would request that interested parties submit this information by February 10th of that year at MedicarePhysicianFeeSchedule@cms.hhs.gov. Submissions received outside of the public comment period for a PFS proposed rule will be considered for possible inclusion in future notice and comment rulemaking cycles. Recommendations received by February, 10th of a calendar year would be reviewed for consideration and potential inclusion within the PFS proposed rule for the subsequent calendar year.”*

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<sup>12</sup> Article in Press

<sup>13</sup> Laryngoscope 2022 Jan;132(1):45-52. doi: 10.1002/lary.29494. Epub 2021 Feb 26. The Impact of Dental Care in Head and Neck Cancer Outcomes: A Systematic Review and Meta-Analysis David Aaron Haynes, Christopher C Vanison, M Boyd Gillespie

<sup>14</sup> Orthop Traumatol Surg Res . 2019 Jun;105(4):761-772. doi: 10.1016/j.otsr.2019.02.024. Epub 2019 May 3. Dental assessment prior to orthopedic surgery: A systematic review Sophie Barrere, Nicolas Reina, Ove A Peters, Lucie Rapp, Jean-Noel Vergnes, Delphine Maret

The ADA appreciates the systematic approach CMS is taking to gather and respond to recommendations on an annual basis, particularly given the rapidly changing health care environment in which we operate. We look forward to providing feedback on the Medicare Physician Fee Schedule by February 10 in forthcoming years.

**iii. Dental services integral to covered medical services which can result in improved patient outcomes:**

*Proposed Rule: “We believe there may be other clinical scenarios, however, where the ongoing disease management of the patient receiving the medically necessary procedure may have an improved outcome or see a clinical benefit from the performance of dental services, but that the dental service may not be inextricably linked to, or substantially related and integral to the clinical success of, the otherwise covered medical service. For example, we believe there may be certain circumstances where the clinical benefit of medical care or treatment of a diabetic patient could be improved if certain dental services are furnished. We are interested in public feedback on whether certain dental services (for example, a dental exam, necessary treatment of a dental condition such as the extraction of an infected and mobile tooth) should be considered so integral to the standard of care for an otherwise covered medical service that the preclusion on Medicare payment under section 1862(a)(12) of the Act does not apply.”*

The ADA acknowledges the positive impact of periodontal care on glycemic control in people with diabetes. Cochrane published a review earlier this year (2022), noting a shift in the evidence that indicates periodontal therapy can improve glycemic control by a clinically significant amount for people with diabetes. The authors state, “Our 2022 update of this review has doubled the number of included studies and participants, which has led to a change in our conclusions about the primary outcome of glycemic control and in our level of certainty in this conclusion. We now have moderate-certainty evidence that periodontal treatment using sub-gingival instrumentation improves glycemic control in people with both periodontitis and diabetes by a clinically significant amount when compared to no treatment or usual care. Further trials evaluating periodontal treatment versus no treatment/usual care are unlikely to change the overall conclusion reached in this review.”<sup>15</sup>

Further, the American Diabetes Association’s Standards of Medical Care in Diabetes (2020) identifies periodontal disease as a common comorbidity that may complicate management of diabetes. The standards note, “In a randomized clinical trial, intensive periodontal treatment was associated with better glycemic control (A1C 8.3% vs. 7.8% in control subjects and the intensive-treatment group, respectively) and reduction in inflammatory markers after 12 months of follow-up.” The recommendations include referrals for “comprehensive dental and periodontal examination.”<sup>16</sup> Recent studies have also shown fiscal offsets in health care costs among people with diabetes associated with enhanced dental care utilization.<sup>17</sup>

To achieve these outcomes for people with diabetes, comprehensive and continuous dental care must be available. We respectfully request CMS conduct a cost analysis of expanding the benefit to the population of people with diabetes such that patients can receive comprehensive ongoing care. Additionally, we request CMS to clarify the impact of such expansion given requirements around budget neutrality parameters in Medicare.

**Section II.L.3: Request for Comment on Other Potentially Impacted Policies.**

*Proposed Rule: “As such, we seek comment on whether our current policies for care management services make clear that time spent by physicians or non-physician practitioners coordinating care with dentists regarding the performance and outcomes of services as proposed under section II.L.2 of this proposed rule, may be counted for purposes of applicable care management codes. We are also*

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<sup>15</sup> Simpson TC, Clarkson JE, Worthington HV, MacDonald L, Weldon JC, Needleman I, Iheozor-Ejiofor Z, Wild SH, Qureshi A, Walker A, Patel VA, Boyers D, Twigg J. Treatment of periodontitis for glycaemic control in people with diabetes mellitus. Cochrane Database of Systematic Reviews 2022, Issue 4. Art. No.: CD004714. DOI: 10.1002/14651858.CD004714.pub4. Accessed 22 July 2022. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004714.pub4/full>

<sup>16</sup> American Diabetes Association; 4. Comprehensive Medical Evaluation and Assessment of Comorbidities: Standards of Medical Care in Diabetes—2020. Diabetes Care 1 January 2020; 43 (Supplement\_1): S37–S47. <https://doi.org/10.2337/dc20-S004>.

<sup>17</sup> Nasseh, K., M. Vujicic. “The Relationship Between Education Debt and Career Choices in Professional Programs: The Case of Dentistry,” Journal of the American Dental Association, 148(11): 825–833, November 2017. <https://pubmed.ncbi.nlm.nih.gov/26799518/>

*interested in whether existing care management codes adequately describe and account for time spent coordinating with dentists and their clinical staff.”*

We support the need for physicians and other practitioners to be compensated appropriately for time and resources spent coordinating care with any member of a patient's care team, including dentists. It is equally important to support dentists in the coordination required to manage these complex cases with their physician colleagues. It takes time and resources for health care providers to share relevant details about a patient's case, develop a mutually agreeable treatment plan and sequence, and provide follow-up or post-operative reports as necessary across health care services and specialties. Without administrative – including financial – support in place for care coordination and case management, care teams may operate in a disjointed fashion, potentially compromising patient care and overall health outcomes.

*Proposed Rule: “We are also interested in comments regarding the impact of changes in how health care is delivered, and whether an increased integration and coordination of care among health care providers should also be taken into account in considering dental services that may be inextricably linked to, and substantially related and integral to the clinical success of, a primary medical service.”*

Meaningful integration of medical and dental care for high-need patients with the aforementioned conditions will require not only health care provider coordination, but also the improvement of health IT systems. Interoperability between medical and dental electronic health records is key to coordinating care. These systems must speak readily to one another across disciplines and institutions, facilitate the sharing of relevant health information including clinical and medication information between providers, and not present barriers in administrative processes like scheduling, coding, and billing. We encourage CMS to conduct a review of current regulations and guidance regarding interoperability specifically in regards to the Interoperability and Patient Access final rule (CMS-9115-F) and Interoperability and Prior Authorization proposed rule (CMS-9123-P) as they apply to dental providers and payers. Significant barriers to interoperability, information exchange, and benefits and eligibility verification exist and place an undue burden on dental providers. We would support an effort by CMS to identify, and address these challenges and would be ready to contribute to the process in order to ensure that dentists can participate in the exchange of critical health information.

*Proposed Rule: “Finally, we recognize that many Medicare beneficiaries have separate or supplemental dental coverage, such as through a Medigap plan or other plan offering. If we were to finalize in the CY2023 PFS final rule our proposed policies as described further in section II.L.2 of this proposed rule, we seek comment on how current coordination of dental benefits operates, and where improvements could be provided. Additionally, we seek comment on what aspects of coordinating benefits among supplemental dental providers we should consider if we were to finalize the proposed policies as specified under section II.L.2 of this proposed rule.”*

Currently, dental benefits through a Medigap policy or a dental benefit plan, available through the employer or purchased individually by a Medicare beneficiary, have several policy limitations including annual maximums, frequency limits, etc. The ADA believes that in the best interest of patients, Medicare should pay for the charges of all covered dental benefits, for this targeted group of medically compromised beneficiaries, as the primary payer and not coordinate benefit payment with a limited dental benefit plan.

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In summary, the ADA supports a scope of services necessary to complete a dentist prescribed treatment plan for the targeted population, who are highly vulnerable, to enable management of their medical condition and enhance their quality of life. We urge CMS to clarify the issues we have raised in these comments to ensure that Medicare beneficiaries can gain access to services they need in an outpatient setting.

Thank you again for the opportunity to offer input and for your many efforts on these issues. Please do not hesitate to contact Roxanne Yaghoubi at [yaghoubir@ada.org](mailto:yaghoubir@ada.org) with any questions.

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Sincerely,

Cesar R. Sabates, D.D.S.  
President

Raymond A. Cohlma, D.D.S.  
Executive Director

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