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Toolkit

G0330 Implementation for Dental OR Access

Developed by the American Academy of Pediatric Dentistry, American Dental Association, and American Association of Oral and Maxillofacial Surgeons

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FREQUENTLY ASKED QUESTIONS

Regarding New Hospital Code G0330 for Dental Treatment Under General Anesthesia

Prepared by AAPD, ADA and AAOMS
2nd Edition, updated February 2023

The final Medicare Calendar Year 2023 Hospital Outpatient Prospective Payment System (OPPS) rule was formally published in the Federal Register on November 23, 2022. The OPPS rule addresses payment policies and coding for dental services provided under general anesthesia in hospitals. Of special significance, the **Centers for Medicare & Medicaid Services (CMS) has established a new Healthcare Common Procedure Coding System G code (G0330) and assigned that code to the Medicare Ambulatory Payment Classification (APC) 5871 (Dental Procedures) with a national average Medicare facility payment rate of \$1,722.43.**¹ This facility payment rate is much higher and far more appropriate than what was used in the past.

Changes in Medicare Payment and Coding for HOSPITAL Operating Room and Related Costs (Facility Costs) for Dental Cases

1. I understand that the Medicare program is increasing the amount it pays to hospitals for facility costs incurred in conjunction with dental rehabilitation in hospital OR settings. Does this change the codes I should use or the payment I will receive for my professional services for patients whose procedures are performed in a hospital operating room?

The new HCPCS code G0330 for dental rehabilitation services covers the facility fee and will result in a payment of such fee to the hospital. Payment for dental professional services is billed separately and will be determined based on the type of coverage (and coverage terms) for the patient, whether the patient is covered by public or private insurance, a stand-alone or an embedded dental plan.

2. What code should hospitals report to claim Medicare payment for their facility costs for covered dental rehabilitation cases requiring anesthesia and use of an operating room?

HCPCS code G0330.

¹ For more background on advocacy efforts to obtain this code see:
<https://www.aapd.org/advocacy/legislative-and-regulatory-issues/latest-advocacy-news/aapd-secures-win/>

3. How will hospitals be aware of this new code?²

Hospitals may receive updates from hospital associations and/or CMS. Anyone may sign up for CMS alerts at www.CMS.gov. However, dentists and dental advocates should also be proactive in alerting their department heads and local hospital administrators about the new code.

4. How much will Medicare pay to hospitals for dental rehabilitation facility costs?

The published national average rate for HCPCS code G0330 is \$1,722.43; however, the actual amount will vary based on the hospital's geographic location and other factors.

5. Are the new code and new rate applicable in all states?

The new code and new rate applies to hospital facility fees for patients covered under the Medicare program (except for patients in the state of Maryland, because that state has its own system for paying for hospital services, including hospital outpatient services). It may also be applicable for patients with Medicaid coverage in states where the Medicaid program utilizes the HCPCS system and bases state Medicaid payment for hospital outpatient services on Medicare rates. See response to question 7 below.

6. Will private payers recognize the new code and payment rate?

Private payers are not required to recognize the new code and payment rate, but they have the option to do so. Historically, private insurers tend to adopt changes made in public programs over time. Dental advocates are strongly encouraged to petition for adoption of the new code. The AAPD, ADA, and AAOMS will be communicating with major insurers to alert them to the new code and make this request.

7. Is the new code and payment rate applicable for my Medicaid patients?

Possibly. Because each state Medicaid program is run differently, the adoption of this new code will depend on the state, and it is difficult

² Hospitals may have seen the CMS release *Hospital Outpatient Prospective Payment System: January 2023 Update*: <https://www.cms.gov/files/document/mm13031-hospital-outpatient-prospective-payment-system-january-2023-update.pdf>

There is discussion of G0330 on pages 5-6 under heading "6. Dental Coding Updates."

to generalize in the FAQ. We encourage the dental advocates in each state to work together to advocate for these changes, in the way that best benefits that state.

To assist with this advocacy, the AAPD, ADA, and AAOMS are developing a guide for state dental advocates, starting with a recently released sample letter that should be sent to the SMA. However, advocates should personalize this letter as needed.

While it may be more difficult to persuade those SMAs that do not utilize the HCPCS code or that do not base Medicaid rates on those paid by Medicare, dental advocates still may be able to use CMS's decision to increase facility payment for dental procedures as grounds for beginning a conversation with their SMA.

8. What can I do to get private payers and the state Medicaid program to recognize the new code and to increase the hospital facility payment for dental rehabilitation?

As noted above, follow up advocacy will be required for private payers and state Medicaid programs to recognize the code and to increase hospital facility payment rates. It is important to note that if patients have separate medical and dental insurance – as is the most common situation – G0330 would be billed by the hospital under the patient's medical insurance.

9. How does the new code impact the reimbursement for services provided by physician or dentist anesthesiologists?

Anesthesia fees are typically separate from facility fees. In most cases, the anesthesia fees and an anesthesiologist's professional service fees will not be impacted by the new code and rate change.

The new HCPCS G-code is for "facility services for dental rehabilitation procedure(s) furnished to patients who require monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care)) and use of an operating room [emphasis added]." It does not alter the payment rates for dental and anesthesia services provided. The procedures performed – dental and anesthesia – during the case are included on claims *in addition to* G0330 in applicable cases. The primary anticipated impact of the code is that it promotes hospital scheduling and block OR time for dental cases. It makes it financially feasible for hospitals to allocate OR dental time to dental cases.

10. Do I have to be a participating provider in Medicare, Medicaid, or a private insurance plan for a dental OR case involving a patient covered by such insurance plan in order for the G0330 code to be utilized by the hospital?

Not necessarily. Hospitals are considered “providers” just as dentists are considered “providers.” The new code (G0330) pertains to the hospital facility fee, and nearly all hospitals participate in the Medicare and Medicaid programs and other networks. Therefore, the hospital may submit G0330 on the claim form regardless of the dentists’ participation in these networks. However, a dentist who provides services in a hospital OR will be required to provide his or her NPI to the hospital for billing purposes and will be required to meet hospital requirements to obtain staff privileges.

11. Is the new dental code related to CMS’ expansion of Medicare coverage for additional dental procedures that are considered necessary to facilitate medically necessary medical treatment?

No. The dental benefits provided under Medicare to patients who require certain procedures (including organ transplants, cardiac valve replacement, and valvuloplasty) were expanded under the Calendar Year 2023 Physician Fee Schedule rule, which is a separate regulation. The new code described in this FAQ for dental surgeries in a hospital operating room is not limited to patients needing an organ transplant, cardiac valve replacement, or valvuloplasty. However, the expansion of the Medicare dental benefit to patients with those conditions is an additional reason why a hospital should recognize this new code, as patients who are newly eligible for dental treatment may need to have their dental care performed in the hospital’s operating room.

12. Who is responsible for assigning the ICD diagnostic codes that will be necessary in conjunction with CPT procedural code G0330?

Some electronic health records and electronic dental records have algorithms built into their software where ICD diagnostic codes that are commonly associated with the CPT or CDT procedural code populate, either one very commonly associated code or a relatively short list from which the provider selects the most appropriate diagnosis for their patient’s case. While this streamlines the note-taking administrative process, it is important for the dentist provider to pay close attention to the diagnostic code selected or pre-

populated. The diagnostic code is part of the clinical note that is signed by the provider.

There are a wide variety of diagnoses – both medical and dental – that could predicate having dental treatment under general anesthesia in a hospital outpatient operating room setting. The need for this treatment could be due to the patient having an intellectual or developmental disability (e.g. ICD F70-79 series)³ This could be due to a behavioral or emotional disorder (e.g. F98 series). This could also be necessary due to the complexity of the dental treatment needed (K series).

We recommend dental providers consult with their patient’s primary care provider to determine the most appropriate diagnostic code. We also expect that EHR/EDR vendors will soon populate some diagnostic codes that would reasonably and appropriately be submitted with G0330.

Impact on Ambulatory Surgical Centers (ASC)

1. Is the new code on the Medicare Ambulatory Surgical Center (ASC) Covered Procedures List (CPL)?

Not at present. However, the AAPD, ADA, AAOMS and other advocacy partners will strongly urge CMS to include the new code on the ASC CPL in the CY 2024 CMS rule being developed in 2023.

2. Even though the new code is not on the Medicare ASC CPL, can other payers choose to recognize the new code for payment in an ASC?

Yes, and dental advocates should strongly encourage them to do so. Dental advocates may wish to inform any payer (including any state Medicaid program) that has historically provided ASC payment for CPT 41899 (Miscellaneous Dental Procedures, i.e. the CPT code that historically has been reported for dental procedures) that dental procedures requiring general anesthesia are to be reported under HCPCS code G0330 beginning January 1, 2023, and that the national average rate associated with these procedures under G0330 has increased substantially. For example, North Carolina adopted the

³ Autistic disorder - F84 series, cerebral palsy - G80 series, Down’s syndrome - Q90 series, as examples.

G0330 procedure code in NC Medicaid for services provided in an ASC, effective January 1, 2023.⁴

3. As a result of this change in Medicare coding and payment, are Medicaid programs required to cover the facility costs incurred by ASCs for dental rehabilitation or to pay comparable rates?

No. However, if a state Medicaid program has historically recognized CPT 41899 in the ASC setting, dental advocates should inform the Medicaid agency that G0330 should be used instead beginning on and after January 1, 2023, and that Medicare has increased the hospital average facility rate for these procedures under the new code.

4. If a private payer or our state Medicaid program is willing to cover an ASC's dental rehabilitation facility costs, how much should we ask them to pay?

The national average Medicare rate of \$1722.43 would be a starting point for negotiations; however, please note that dental advocates in Michigan have managed to negotiate rates that exceed Medicare's national average payment rate and included both hospitals and ASCs!

⁴ <https://medicaid.ncdhhs.gov/blog/2022/12/21/new-procedure-code-facility-services-dental-rehabilitation-cases-ambulatory-surgical-center>

Suggestions for Dentists and Dental Advocates

- **Please notify your operating room, hospital administrators and state Medicaid agency of the changes that went into effect on January 1, 2023 – the new G0330 code and associated average payment rate of \$1722.43 – regardless of whether dental cases have been reduced in your hospital.**
- **Appropriate coding and fair payment for these services is crucial for the continued allocation of hospital operating room resources to treat those with the most complex cases in need of comprehensive dental care.**
- **Additional information is available from CMS at**
 - <https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2>
 - <https://public-inspection.federalregister.gov/2022-23918.pdf>.

Sample letter to State Medicaid Agencies (SMAs) on G0330

Director
State Medicaid Agency

Dear _____:

On behalf of the [State] Dental Association, _____ of Pediatric Dentistry, and the _____ Society of Oral and Maxillofacial Surgeons, we are writing to alert you to the decision made by the Centers for Medicare and Medicaid Services (CMS) to address the pressing lack of operating room (OR) access for patients whose extensive dental needs must be performed under anesthesia, by modifying coding and increasing payment for hospital outpatient facility services associated with dental rehabilitation. **We would like to request a meeting to discuss options for likewise increasing OR access for those Medicaid beneficiaries whose dental needs must be performed in hospital or ambulatory surgical center ORs.**

In spite of advances in preventive care and reduction in untreated tooth decay, significant oral health disparities exist, including racial and ethnic disparities and geographic disparities. Children, patients of all ages with special needs and disabilities and the frail elderly are especially likely to require extensive dental rehabilitation that must be performed under anesthesia and that therefore require OR facilities for these procedures. The majority of these patients are covered under the Medicaid program.

Unfortunately, there is a critical lack of OR access for these patients, both nationally and in **state**. Our organizations have collectively witnessed a major decrease in OR access for dental procedures over the last decade. The American Academy of Pediatric Dentistry has conducted surveys of the pediatric dental community, finding that in a majority of states, OR access for pediatric dentists is a persistent problem, and in most states – particularly rural states – it can be a severe problem, given fewer access sites and longer scheduling delays. COVID-19 made things far worse as hospitals had to halt elective procedures and then face immense backlogs of medical and dental cases. Too often, pediatric, general dentists and oral and maxillofacial surgeons are seeing dental cases fall to the very back of the line in terms of hospital prioritization as medical procedures are first addressed. In most states this access problem has worsened even as the worst of the COVID-19 pandemic seems to have subsided in many communities.

The situation is particularly critical in [state]. Here, there are only an estimated [] hospitals where dental rehabilitation is performed, and wait times are in the range of [to be supplied].

We believe the operating room access challenge is attributable in large part to a historical lack of an appropriate billing mechanism and a sustainable payment rate for hospitals and ambulatory surgical centers, which are the most appropriate site for providing dental rehabilitation under general anesthesia. In the 2023 Hospital Outpatient Prospective Payment System Final Rule¹, the Centers for Medicare and Medicaid Services (CMS) addressed this issue by establishing a new Healthcare Common Procedure Coding System G code (**G0330**), replacing the prior “miscellaneous” CPT code that historically had been used to bill for the OR and related facility services associated with dental cases (CPT 41899). CMS further assigned the new G0330 code to the Medicare Ambulatory Payment Classification (APC) 5871 (Dental Procedures) with a national average Medicare facility payment rate of \$1722.43 to appropriately cover dental procedures.

We strongly believe that, in light of the significance of the Medicaid program for the affected patient populations, it is critically important that [state’s] Medicaid program likewise take action in 2023 to remove payment-related obstacles that negatively impact OR access for those needing dental rehabilitation and general anesthesia in facility settings.

During our meeting, we would like to strongly recommend and discuss the importance of the following efforts by [state] Medicaid:

- **Understand if and to what extent all Medicaid Managed Care Plans ensure the hospitals and ASCs in their networks provide OR access to Medicaid beneficiaries whose dental needs require facility support for these dental procedures;**
- **Include dental rehabilitation (G0330) on the list of services eligible for Medicaid coverage in an ASC setting and establish an appropriate payment rate for these services²;**
- **Regardless of the payment methodology used by the Medicaid program for hospital outpatient services, ensure that hospital outpatient payment for dental rehabilitation is in the range reflected by the new Medicare payment rate.**

¹ 87 Fed. Reg. 71748.

² Please note that if CPT 41899 is included on the Medicaid Covered Procedure List, the list should be updated to include the successor code G0330.

We would very much appreciate the opportunity to discuss with you the options for addressing this critical problem and look forward to hearing from you regarding a meeting date.

Sincerely yours,

SAMPLE