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September 11, 2023

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-1810

Re: CMS–1786–P, CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule

To Whom It May Concern:

On behalf of our 159,000 members, the American Dental Association (ADA) is pleased to provide comments on the dental and oral health aspects in the proposed rule on the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Our comments pertain to two sections, specifically on Healthcare Common Procedure Coding System (HCPCS) codes describing dental services within OPPS and on ASC Addendum AA & BB, Proposed ASC Covered Surgical Procedures and Ancillary Procedure Code Lists for Calendar Year 2024.

Hospital Outpatient Payment for Dental Rehabilitation

The ADA supports the addition of the 229 specific CDT/ Level II HCPCS codes describing dental services to clinical Ambulatory Payment Classification (APC's) in the OPPS facility fee schedule.

While we believe these are the appropriate codes to include in the OPPS fee schedule, we have concerns about the mechanism for assigning the APC weights and the associated facility payment rates for some of these procedures.

Payment rate for "D" codes in the OPPS schedule: We understand that CMS consulted with clinical experts for new codes with no cost information available to assign APCs using crosswalk code analyses. We also understand that CMS looks for parity in clinical intensity, resource utilization and supply costs when making APC determinations. However, based on available market fee data which are typically inclusive of and reflect relative clinical complexity and resource use, we believe that some of these determinations remain incorrect. For example, a gingivectomy procedure (D4210) is weighted (APC: 5164) and paid at $3087.88 while a gingival flap with root planning (D4240) is weighted (APC: 5163) and paid at $1465.59. The clinical intensity, resource utilization and supply costs for a D4240 would be expected to be greater than D4210.

Similarly, a surgical extraction of a tooth requiring a mucoperiosteal flap (D7210) is weighted (APC: 5871) and paid at $938.69 would be expected to be similar in clinical intensity and resource use compared to an alveoloplasty (D7310) weighted (APC:5163) and paid at $1465.59. We request clarification on what crosswalks were used to determine APC classification and data on validation of these crosswalks in assigning the payment rate.

We appreciate CMS having tried to obtain cost information from external sources and acknowledging that claims experience was insufficient to establish objective payment rates. We applaud the agency for clarifying that Medicaid rates were inappropriate for use this establishing these payment rates. The ADA is available to offer the necessary clinical input to improve the validity for some of these determinations until claims data is more widely available.

Packaging payment of specific Level II HCPCS/ CDT codes with primary procedures. We have reviewed the codes with the “N” and “Q1” status indicators and believe that for the purposes of determination of facility fees, the codes identified to be packaged with a primary service are appropriate.

Payment rate for G0330 in the OPPS schedule: It appears that the payment rate assigned to G0330 has been lowered from $1722.43 in 2023 to $938.69 in 2024. We question such a reduction and strongly suggest that CMS revisit the payment rate for G0330. We understand that this change may have resulted from inclusion of specific CDT/ Level II HCPCS codes that are now priced separately and the use of the G0330 code may be limited to situations where ancillary services are billed. We are not confident, however, that there were in fact enough claims experience to support a reduction of the payment rate for G0330. We suggest that the agency revisit the payment rate and reconsider the analysis once sufficient claims volume is available for future analysis.

ASC Payment for Dental Rehabilitation

The ADA supports the addition of specific CDT/ Level II HCPCS codes describing dental services in the ASC facility fee schedule in addition to G0330 to support payment for ancillary services.

While we believe these are the appropriate codes to include in the OPPS fee schedule, we have concerns about the mechanism for assigning the APC weights and the associated facility payment rates for some of these procedures.

Payment rate for “D” codes in the ASC schedule: Similar to our comments on the OPPS schedule, we question the validity of the APC assignments and the associate payment rates for dental procedures on the ASC schedule. The table below provides a sample of codes that we believe are misclassified. We request clarity from CMS on the crosswalks used to determine these APC classifications.

Addendum BB: Proposed “Ancillary” Procedure list

We strongly disagree with the list of dental procedures included in Addendum BB: “Ancillary” Procedure list. While there are no safety issues with any of these procedures, it is vital for CMS to recognize that dental “surgery” includes procedures performed on hard tissues (teeth) as well as the soft tissues (surrounding periodontium and oral mucosa). It is inappropriate to classify “surgical procedures” as only those performed on soft tissues.

In dentistry we use specialized instrumentation to physically reach into a patients’ body in order to investigate or treat pathological conditions such as a disease or injury, to alter bodily functions, to improve appearance, or to remove/replace unwanted tissues or foreign bodies. Teeth are considered a body part similar to bones. Setting a broken arm and placing pins to repair or stabilize the bone is considered a surgical procedure. It is much the same with restoring a damaged or pathological tooth. The area must be locally anesthetized, the tooth is

actually cut into using sterilized surgical dental instruments and a dental material is placed to restore/stabilize the tooth. Also tooth decay is often below the gums (subgingival). Removal of the subgingival decay results in management of the gingival tissue involved, including hemostasis of the affected tissue. Tooth restorations artificially modify dentition.

Given this, we believe Addendum BB (ancillary services) should be limited to exam and imaging codes (i.e., D0XXX series of codes) and should not include any other CDT codes involving procedure on hard or soft tissues in the mouth. All other procedures (D1XXX – D7XXX) should be included in Addendum AA as covered procedures. We note that the ancillary list of covered medical procedures is limited to examination, imaging and several drug/vaccine codes setting the precedent for what should be considered “ancillary” for dental services.

We request that the following codes be transferred from Addendum BB into Addendum AA and be assigned a D2 indicator. We do not believe there are any safety issues with these procedures, but we believe this will better align the ASC ancillary procedure list with those procedures that have a status indicator of Q1 (packages codes) on the OPPS schedule.

HCPCS Code	Short Descriptor
D2140	Amalgam one surface permanen
D2150	Amalgam two surfaces permane
D2160	Amalgam three surfaces perma
D2161	Amalgam 4 or > surfaces perm
D2330	Resin one surface-anterior
D2331	Resin two surfaces-anterior
D2332	Resin three surfaces-anterio
D2335	Resin 4/> surf or w incis an
D2390	Ant resin-based cmpst crown
D2391	Post 1 srfc resinbased cmpst
D2392	Post 2 srfc resinbased cmpst
D2393	Post 3 srfc resinbased cmpst
D2394	Post >=4srfc resinbase cmpst
D2740	Crown porcelain/ceramic
D2750	Crown porcelain w/ h noble m
D2751	Crown porcelain fused base m
D2752	Crown porcelain w/ noble met
D2791	Crown full cast base metal
D2799	Interim crown
D2920	Re-cement or re-bond crown
D2929	Prefab porc/ceram crown pri
D2930	Prefab stnlss steel crwn pri
D2931	Prefab stnlss steel crown pe
D2932	Prefabricated resin crown
D2933	Prefab stainless steel crown
D2934	Prefab steel crown primary
D2940	Protective restoration
D2941	Int therapeutic restoration
D2950	Core build-up incl any pins
D2951	Tooth pin retention
D2952	Post and core cast + crown
D2954	Prefab post/core + crown
D3220	Therapeutic pulpotomy

D3222	Part pulp for apexogenesis
D3230	Pulpal therapy anterior prim
D3240	Pulpal therapy posterior pri
D3310	End thxpy, anterior tooth
D3320	End thxpy, premolar tooth
D3330	End thxpy, molar tooth
D3460	Endodontic endosseous implan
D3910	Isolation- tooth w rubb dam
D4341	Periodontal scaling & root
D4342	Periodontal scaling 1-3teeth
D4346	Scaling gingiv inflammation
D4355	Full mouth debridement
D4910	Periodontal maint procedures

Addendum AA: Proposed covered procedure list

We appreciate CMS including specific additional CDT codes in Addendum AA, covered procedure list, however, we are unclear why services that can be safely performed in an ASC are not included in Addendum AA even though they are included in the OPPS schedule. For example, the D4261 (osseous surg 1 to 3 teeth) or D4266 (Guided tiss regen resorble) are covered in OPPS but not in the ASC schedule.

We understand that reimbursement will be based on coverage determinations by the Medicare Contractors based on the dental procedure being inextricably linked to outcomes of the covered medical procedures. We believe that to ensure equal access for both in-patient and out-patient settings, a similar list of CDT procedures barring any valid safety concerns should also be covered in the ASC setting. We request CMS review the list of covered CDT procedures in the OPPS schedule to recognize them in the ASC schedule.

HCPCS code G0330 in the ASC schedule: Regarding code G0330, first we appreciate CMS recognizing G0330 on the covered procedure list for ASC payment. We understand that the facility rate for the G code is computed as 50% of the OPPS fee schedule, but as we noted above, we do not understand the basis for deriving the payment rate within the OPPS fee schedule. Therefore, the ADA questions the validity of this rate for CY 2024, in the OPPS fee schedule which if finalized without changes would drop from $1,722.43 in 2023 to $938.69. Under the proposed rule, the national average ASC payment for these services would be only $495.52 when reported with an ancillary code. We urge the agency to revisit this rate calculation.

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In summary, the ADA appreciates CMS willingness to work with dentistry on dental coding issues as applied to facility fee payment rate for hospital out-patient and ambulatory surgical centers. We would like to assist CMS in developing appropriate APC weights. Without appropriate facility reimbursement, the lack of access to care that our most vulnerable patients face every day will only exacerbate.

Thank you again for the opportunity to offer input and for your many efforts on these issues. Please do not hesitate to contact David Linn at linnd@ada.org with any questions.

Sincerely,

George R. Shepley, D.D.S.
President

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

GRS:RAC:dl