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

Re: CMS-1784-P, Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

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 services included in the; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. The following comments pertain to proposals on Medicare Parts A and B payment for dental services inextricably linked to specific covered services and requests for information on dental services integral to certain specified conditions as well as implementation of payment for dental services.

Policies Permitting Payment for Dental Services Inextricably Linked to Other Covered Services

We note that the proposed rule would permit payment under Medicare Parts A and Part B for: (1) Dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to Medicare-covered: chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and the administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer; and (2) Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with: chemotherapy when used in the treatment of cancer, CAR T-cell therapy when used in the treatment of cancer, and the administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer. Further, the proposal also permits payment under the applicable payment system for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, and use of the operating room.

The ADA supports payment under Medicare Parts A and B for dental services for Medicare beneficiaries who require treatment of cancer through chemotherapy, Chimeric Antigen Receptor T- (CAR-T) Cell therapy, and the use of high-dose bone modifying agents (antiresorptive therapy) as well as for medically necessary diagnostic and treatment services to eliminate oral/dental infections prior to or contemporaneously with such treatments.

The impact of high-dose bone modifying agents can result in deterioration of oral health well after discontinuation of active therapy. We seek clarification from CMS as to whether payment would be made for dental services throughout a patient's lifespan or at least for a limited period post treatment such as at least for a year after active therapy. We believe it is reasonable to conclude that reducing the potential for immune system complication stemming from inflammatory or infectious disease within the oral cavity would be beneficial to maintenance of both oral and overall health.

The ADA agrees that payment for dental services should be made for patients receiving chemotherapy regardless of whether it is used with or without other therapy types.

With regards to payment for dental services related to head and neck cancer therapy, the ADA appreciates the clarification that payment for dental services for patients undergoing treatment for head and neck cancer will be allowed "prior to the initiation of, or during" head and neck cancer therapy.

With regards to coverage of specific dental procedures that may be covered in instances where CMS has determined that dental treatment is substantially and inextricably linked to the success of the medical procedures, the proposed rule notes the following:

> *"We provided as examples of dental services that could be furnished to eradicate infection services such as, but not limited to, diagnostic services, evaluations and exams (for example, CDT codes payable with D0120, D0140 or D0150), extractions (for example, CDT codes payable with D7140, D7210), restorations (removal of the infection from tooth/actual structure, such as filling procedures - for example, CDT codes payable with D2000-2999), periodontal therapy (removal of the infection that is surrounding the tooth, such as scaling and root planing - for example, CDT codes payable with D4000-4999, more specifically D4341, D4342, D4335 and D4910), or endodontic therapy (removal of infection from the inside of the tooth and surrounding structures, such as root canal - for example, CDT codes payable with D3000-3999). However, we continue to believe that additional dental services, such as a dental implant or crown, may not be considered immediately necessary to eliminate or eradicate the infection or its source. Therefore, we reiterate that such additional services would not be inextricably linked to the specific covered services.* ***As such, no Medicare payment would be made for the additional services that are not immediately necessary to eliminate or eradicate the infection****. We further clarify that we did not in CY 2023 nor are we proposing in CY 2024 to adjust any payment policy for services involving the preparation for, or placement of dentures, and maintain that these services are not payable under Medicare Parts A and B."*

While the ADA appreciates the recognition of the need to eliminate dental infection, we would like to reiterate that, without the subsequent replacement of teeth to facilitate the intake of nutrition, phonetics necessary for communication and social interaction, the patient is left crippled after certain medical procedures like surgical tumor removal. 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.

Further, certain maxillofacial protheses such as feeding aids, obturator prosthesis, radiation cone locators, and radiation shields are integral to the medical procedures identified in the proposed rule. We note that the Physician Fee Schedule (PFS) RVU files identify the relevant CDT/ Level II HCPCS codes related to these dental procedures with a status indicator of "R" (Restricted Coverage. Special coverage instructions apply. If covered, the service is contractor priced.). We urge CMS to provide clear guidance to the Medicare Administrative Contractors that such services, although not directly related to "elimination of dental infection", should also be considered covered services.

Implementation of Payment for Dental Services

We appreciate that CMS is pursuing the adoption of the 837D - dental claim form and look forward to working with CMS on its implementation for the successful processing of dental claims.

However, we note that the Medicare Part B program and various regulations that have been promulgated over the years were designed to address the needs of patients seeking care in a physician's office, not a dental office. Currently, 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 800+ 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.

We note that the payment indicators as outlined in the Physician Fee Schedule (PFS) RVU files DO NOT align with existing dental billing and coding conventions. In fact, we believe that none of the flags introduced against the CDT codes are appropriate for the following reasons:

1) Modifier (Spreadsheet Column B "MOD"): According to the HIPAA standard electronic dental claim transaction (837D) implementation specifications (837D and associated ASC X12 Type 3 Technical Reports) the only source for CDT modifiers is the ADA.

   "A modifier must be from code source 135 (America Dental Association) found in the "Code on Dental Procedures and Nomenclature"."

   The values "TC" (Technical Component) and "26" (Professional Component) listed in this column are applicable only to procedures reported with CPT codes on an 837P/CMS 1500 claim format. Therefore, dentists using the 837D dental claim transaction familiar to them cannot use modifiers associated with the CPT code set.

When using CDT (as Level II HCPCS codes) on the 837P/CMS 1500 form, the RVU file is still flawed in its assignment of these modifiers as it does not recognize that the CDT code set includes distinct CDT codes for 1) image capture ***and*** interpretation procedures, 2) for ***image*** capture ***only*** procedures, and 3) for an image ***interpretation only*** procedure. Examples of these flaws in the RVU file are as follows:

- D0210 has three entries for this image capture and interpretation procedure – the first with no modifier, the second with modifier TC and the third with modifier 26. Only the first line with no modifier would be appropriate.
- D0709 has three entries for this image capture only procedure – the first with no modifier, the second with modifier TC and the third with modifier 26. Only the second line with modifier TC would be appropriate.
- D0391 has three entries for this image interpretation only procedure – the first with no modifier, the second with modifier TC and the third with modifier 26. Only the third line with modifier 26 is appropriate.

There are similar flaws in several of CDT's test and examination codes and lab codes where the file again shows three lines for each entry (D0475, D0478, D0780, D0785, D0605 and so on)

2) Global Surgery (Spreadsheet Column O "GLOB DAYS")**:** We note that CMS has instituted a flag of "YYY" against a number of CDT codes. (YYY=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing).

   Unlike CPT codes, where surveys are used to establish RVU's as well as parameters to refine global periods, there is no survey data that establishes what comprises pre-service and post-operative services that may arise as a consequence of a primary dental procedure, or the duration (e.g., number of postoperative visits) of a reasonable period that could be designated as a global period. We question how each Medicare Administrative Contractor (MAC) would assign global days independently to the myriad of CDT codes without such survey information.

Further, CPT modifier 57 is used along with an E/M CPT code to designate an evaluation resulting in the decision to perform surgery on the day of or day prior to surgery. Since global periods include this "pre-service" period, a physician is allowed to report and be paid for this E/M visit without it being included in the global period for the surgical service. These mechanisms do not exist for dental evaluation procedures.

3) Bilateral Surgery (Spreadsheet Column T "BILAT SURG"): We understand that modifier 50 is applicable when the same procedure is rendered on both sides of the body. As a result, only the first procedure delivered is fully reimbursed when using either of these modifiers.

As noted in "1)" above there are no dental procedure modifiers associated with CDT codes. Further, Bilaterality is established in dentistry via claims with CDT codes that are reported in conjunction with separate codes for area of the oral cavity.

Such procedures include, for example, scaling and root planing (D4341, D4342) and sinus lifts (D7951 and D7953), procedures like restorative and endodontic procedures (e.g., D2140, D2150, D2160, D2161, D2330-D2394, D3310-D3330). These procedures may be delivered to different teeth or different quadrants of the mouth on the same date of service, each delivery being a unique and discreet procedure influenced by both tooth and area of the oral cavity anatomy. The costs associated with anesthesia, restorative materials, etc. are separate for each tooth.

Further, according to Chapter 1 of the National Correct Coding Initiative Policy Manual, the rationale for the multiple surgery payment reduction stems in part from code valuation in relation to the global period:

> "*Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work.*"

As noted earlier, without structured surveys to inform the existence of overlap in pre-procedure and post-procedure work, we believe it is inappropriate to make assumptions to prematurely create these rules. It is inappropriate to assume that the same service on different teeth can be bundled for payment purposes, since these are actually separate and distinct surgical procedures.

It is important to note that fees billed by dentists and reported on claims using the CDT Codes typically includes any dental laboratory charges e.g. space maintainers D1516, fixed prosthodontics D2740, D2750, D2751, D2790-D2792 and removable prosthodontics D5223-D5226, D5282. In dentistry we do not separately bill laboratory fees. We also note that several flags that designate CDT codes as subject to bi-lateral reduction flags are illogical; e.g., space maintainers D1516 and removable prosthodontics D5223-D5226, D5282; wherein the CDT nomenclature clearly states in the procedure is unilateral or bi-lateral. It is unclear how a "bi-lateral procedure" reduction rule can be implemented against a single procedure that happens to be "bilateral" on a given date of service.

Placing parameters such as bilateral reductions would, in fact, create negative incentives in the system and encourage recalling the patient for multiple appointments for procedures that could potentially be completed on the same date of service.

Lastly, CMS has proposed to continue contractor pricing for all dental services in 2024. In its prior ruling finalized November 2023, the agency urged the MAC's to use publicly available dental fee information to guide payment. We note that both fees charged by dentists as well as amounts paid by commercial carriers under network arrangements do not adjust for any of the parameters such as "global days", "multi-procedure reduction" or "bi-lateral procedure reduction".

A dental practice typically has significant costs of maintaining and running what is essentially a surgical center, including dental equipment, surgical instrumentation, radiology, supplies, lab costs, staffing needs, anesthesia, sterilization and personal protective equipment (PPE). Traditionally, dental fee schedules have included these costs, whereas payment in the medical system accounts for these costs separately from payment to the physician. In order for these costs to be adequately and equitably reimbursed, payment for the surgical center costs must be additive.

For all these reasons, we reiterate that the payment indicators as outlined in the PFS RVU files DO NOT align with existing dental billing and coding conventions. We acknowledge that CMS has removed all flags related to "multi-procedure reductions" in the latest (July release) of the PFS RVU files. We appreciate the agency's continued review and technical corrections of these files. We urge CMS to remove the bi-lateral and global days flags and we look forward to working with CMS in future on a more appropriate payment schedule for dental services.

Finally, in order to promote the correct coding and processing of Medicare claims, we urge CMS to recognize all the following dentist-specific provider codes instead of using two arbitrary specialty codes (oral surgery—dentists only & maxillofacial surgery) to enroll dentists in Medicare.

Dentist-Specific Provider Codes Based on National Uniform Claim Committee - Health Care Provider Taxonomy Code Set	
Code	**Name**
122300000X	Dentist
1223D0001X	Dental Public Health
1223D0004X	Dentist Anesthesiologist
1223E0200X	Endodontics
1223G0001X	General Practice
1223P0106X	Oral and Maxillofacial Pathology
1223X0008X	Oral and Maxillofacial Radiology
1223S0112X	Oral and Maxillofacial Surgery
1223X2210X	Orofacial Pain
1223X0400X	Orthodontics and Dentofacial Orthopedics
1223P0221X	Pediatric Dentistry
1223P0300X	Periodontics
1223P0700X	Prosthodontics
125Q00000X	Oral Medicinist

In addition to specific comments solicited in the proposed rule, we wish to highlight the need to streamline enrollment and credentialing processes for dental providers to assure access to care for Medicare patients. A majority of practicing dentists in the United States currently use the ADA's Credentialing Service powered by CAQH® to manage their profiles for third party credential verification. We understand the Medicare uses the Provider Enrollment, Chain, and Ownership System (PECOS) system to enroll providers into Medicare to enable payment. We believe that CMS should explore opportunities to use the CAQH to reduce administrative burden for dentists wishing to participate in Medicare. Traditionally, dentists have found the PECOS system to be burdensome. We are willing to assist the agency in reviewing the different systems to identify administrative processes that align with existing administrative processes in dentistry.

With regards to coordination of benefits, the proposed rule notes that following:

> *"In these cases where the dental services are not inextricably linked to another specific covered service, dental professionals must include the appropriate HCPCS modifier on the respective dental claim form, which serves as a certification that the professionals believe that Medicare should not pay the claim…... We note that the submission of a claim without one or more of the HCPCS modifier(s) meant to produce a denial shows belief by the enrolled billing practitioner that Medicare, not another payer, should be the primary payer in accordance with all applicable payment policies. As such, submission of a claim for dental services without such a modifier would mean that the billing practitioner believes the dental service is inextricably linked to another Medicare-covered service, or that payment for the service is otherwise permitted under our regulation at § 411.15(i)."*

As we have noted above, according to the HIPAA standard electronic dental claim transaction (837D) implementation specifications (837D and associated ASC X12 Type 3 Technical Reports) the only source for CDT modifiers is the ADA. We acknowledge that issues around coordination of benefits are significant and that there is a need to define efficient approaches to seek Medicare denial when Medicare is the secondary payer for patients with multiple plans and when coordinating with Medicaid payment in cases where the dental procedures are not inextricably linked to the covered medical procedures. The ADA is willing to work with CMS to evaluate the possibility of using HCPCS modifiers on the 837D for the purpose of Medicare denial and coordination of benefits.

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In summary, the ADA supports a defined 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. The ADA would like to partner with CMS to develop an appropriate coding & payment methodology that addresses the shortcomings we have identified and accounts for the unique cost structure in dental offices. 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 David Linn at linnd@ada.org with any questions.

Sincerely,

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President

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

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