CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12047	**Date: May 18, 2023**
	Change Request 13190

SUBJECT: Educational Instructions for the Implementation of the Medicare Payment Provisions for Dental Services as Finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide further clarity to and directs the A/B MACs to develop educational materials to aid in the implementation of the Medicare payment policies for dental services as described in Section II.L of the CY 2023 PFS final rule (87 FR 69663-69688). This guidance is intended to facilitate a consistent application of this payment policy nationally, with MACs providing payment for more types of dental services associated with a broader set of medical services than before CY 2023.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 9, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-02	Transmittal: 12047	Date: May 18, 2023	Change Request: 13190

SUBJECT: Educational Instructions for the Implementation of the Medicare Payment Provisions for Dental Services as Finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule

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I. GENERAL INFORMATION

A. Background: Section 1862(a)(12) of the Social Security Act generally precludes payment under Medicare Parts A or B for any expenses incurred for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth. That section of the statute also includes an exception to allow payment to be made for inpatient hospital services in connection with the provision of such dental services if the individual, because of their underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services. Our regulation at 42 Code of Federal Regulation 411.15(i) similarly excludes payment for dental services except for inpatient hospital services in connection with dental services when hospitalization is required because of: (1) the individual's underlying medical condition and clinical status; or (2) the severity of the dental procedure.

Medicare Parts A and B also makes payment for certain dental services in circumstances where the services are not considered to be in connection with dental services within the meaning of section 1862(a)(12) of the Act or our regulation at § 411.15(i). CMS makes payment when a physician, including a doctor of dental medicine or dental surgery, furnishes dental services (within their applicable scope of practice) that are an integral part of the covered primary procedure or service furnished by another physician treating the primary medical illness. Prior to the CY 2023 PFS finale rule policies, there were a limited number of circumstances listed as examples for when Medicare payment could be made for dental services. These specific circumstances included, but were not limited to, the wiring of teeth when done in connection with a reduction of a jaw fracture, the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease, and/or an oral or dental examination on an inpatient basis performed as part of a comprehensive workup prior to renal transplant surgery. (See Medicare Benefit Policy Manual (Internet Only Manual (IOM) Publication (Pub 100-02, Chapter 15, Section 150); and Medicare National Coverage Determinations Manual Chapter 1, Part 4 (IOM Pub 100-03, Chapter 1, Part 4, Section 260.6)).

B. Policy: On November 1, 2022, CMS issued regulation number CMS-1770-F, Medicare and Medicaid Programs; CY 2023 Payment Policies Under the PFS and Other Changes to Part B Payment Policies (the CY 2023 PFS Final Rule). This CR intends to provide further clarity to and directs the A/B MACs to develop educational materials to aid in the implementation of the Medicare payment policies for dental services as described in Section II.L of the CY 2023 PFS final rule (87 FR 69663-69688). This guidance is intended to facilitate a consistent application of this payment policy nationally, with MACs providing payment for more types of dental services associated with a broader set of medical services than before CY 2023.

There are instances where dental services are so integral to other medically necessary services that they are inextricably linked to the clinical success of that medical service(s), and, as such, they are not in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth within the meaning of section 1862(a)(12) of the Act. Rather, these dental services are inextricably linked to

the clinical success of an otherwise covered medical service, and are payable under Medicare Parts A and B.

However, consistent with existing statutory authority, MACs should make payment under Medicare A and B in circumstances where the dental services are in direct connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth because the patient's underlying medical condition and clinical status, or the severity of the dental procedure, requires hospitalization (in compliance with section 1862(a)(12) of the Act). MACs should not deny payment for dental services just because the medical service is not provided in the list of examples under § 411.15(i). These are examples of circumstances where CMS believes there is a clear inextricable link between the dental and medical services, but it is not an exhaustive list of instances where dental and medical service are inextricably linked.

CY 2023 PFS Final Rule Finalized Provisions for Medicare Parts A and B Payment for Dental Services

In the CY 2023 PFS Final Rule, CMS finalized the following provisions related to dental services:

1. Effective for CY 2023, a clarification and codification of certain aspects of the current Medicare FFS payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition;
2. Effective for CY 2023, Medicare Parts A and B payment for dental services, such as dental examinations, including necessary treatment, performed as part of a comprehensive workup prior to organ transplant, or prior to a cardiac valve replacement or valvuloplasty procedures;
3. Effective for CY 2024, Medicare Parts A and B payment for dental services, such as dental examinations, including necessary treatments, performed as part of a comprehensive workup prior to the treatment for head and neck cancers; and
4. Effective for CY 2023, a process to identify for CMS's consideration and review submissions of additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services.

Additionally, effective for CY 2023, payment can be made under Medicare Parts A and B, under the applicable payment system, for such dental services that occur within the inpatient hospital and outpatient setting, as clinically appropriate.

Specifically, under this finalized policy, payment under Medicare Parts A and B can be made for dental services that are inextricably linked to, and substantially related and integral to the clinical success of, a certain covered medical service; payment may be made under Medicare Parts A and B for services furnished in the inpatient or outpatient setting. Such services include, but are not limited to:

1. Dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to Medicare-covered organ transplant, cardiac valve replacement, or valvuloplasty procedures; and, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, the organ transplant, cardiac valve replacement, or valvuloplasty procedure.
2. The reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor.
3. The stabilization or immobilization of teeth in connection with the reduction of a jaw fracture, and dental splints only when used in conjunction with covered treatment of a covered medical condition such as dislocated jaw joints.
4. The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.

Additionally, ancillary services and supplies furnished incident to covered dental services are not excluded for payment under Medicare parts A and B, and Medicare payment may be made under Part A or Part B, as applicable, whether the service is performed in the inpatient or outpatient setting, including, but not limited to the administration of anesthesia, diagnostic x-rays, use of operating room, and other related procedures.

Medicare payment policy related to dental services has historically been further specified within the Medicare Benefit Policy Manual (IOM Pub 100-02, Chapter 15, Section 150); and Medicare National Coverage Determinations Manual Chapter 1, Part 4 (IOM Pub 100-03, Chapter 1, Part 4, Section 260.6). CMS plans to make conforming changes to the Medicare Benefit Policy Manual and Medicare National Coverage Determinations Manual to reflect these CY 2023 PFS final policies.

Definitions

Ancillary Services: For the purposes of Medicare payment under this Medicare payment policy, "ancillary services" are services that include, but are not limited to, x-rays, administration of anesthesia, and use of the operating room, and other related procedures.

Dental Services: For the purposes of Medicare payment under this Medicare payment policy, "dental services" refers to dental and oral examinations and medically necessary diagnostic and treatment services, such as, but not limited to, the elimination of an oral or dental infection.

Dentist: For the purposes of Medicare payment under this Medicare payment policy, a "dentist" refers to a doctor of dental medicine or dental surgery.

Determining Inextricable Linkage

In the CY 2023 PFS final rule, we provided examples where dental and medical services are inextricably linked. We recognize that there are additional circumstances where dental services are inextricably linked to a covered medical service, beyond the list of examples provided under subsection (§) 411.15(i)(3).

Submission of claims containing dental services is considered a certification by the submitter of compliance with the applicable payment policies.

CMS will develop provider education materials to explain that submitting dental claims is a certification that the dental service is inextricably linked to a Medicare covered medical service as specified under § 411.15(i), and could be subject to normal post-pay review in accordance with Medicare policies. When we release the education materials, contractors shall use the national education content to educate providers and supplement with information specific to their jurisdiction.

MAC education shall include information for providers about the existing claims submission processes when providers need a claim denial from CMS so third party payers can pay as primary. MACs should instruct providers to submit claims like they usually do with Healthcare Common Procedure Coding System (HCPCS) modifiers when third party payers need a Medicare claim denial. Using the modifier serves as certification that the provider believes Medicare should not pay the claim. If providers submit the dental claim without one of more of the HCPCS modifiers, they certify the applicable payment policies and

the dental service is inextricably linked to a Medicare covered medical service as described.

MACs should develop supplemental education materials to explain medical review activities to ensure providers understand how the MACs will assess pending medical review claims. For example, if a MAC's data analytics suggests they should conduct a medical review and consult with CMS Division of Medical Review and their assigned Medical Review Business Function Lead, then the MAC shall educate providers on the review necessary to determine if the dental service is inextricably linked to a covered medical service. These education materials should include information about the type of evidence providers should submit, such as at least one of the following examples to support the link between the dental and covered medical services:

1. Evidence to support that the standard of care would be to not proceed with the covered medical procedure until a dental or oral exam is performed to clear the patient of an oral or dental infection, or, in instances where a known oral or dental infection is present, the standard is such that the medical professional would not proceed with the medical service until the patient received the necessary treatment to immediately eradicate the infection. We note that the dental services necessary to immediately eradicate an infection may or may not be the totality of recommended dental services for a given patient.
2. Literature to support that the provision of certain dental services leads to improved healing, improved quality of surgery, or the reduced likelihood of readmission and/or surgical revisions, because an infection has interfered with the integration of the implant and interfered with the implant to the skeletal structure. Examples of literature include:

- Relevant peer-reviewed medical literature and research/studies regarding the medical scenarios requiring medically necessary dental care
- Evidence of clinical guidelines or generally accepted standards of care for the suggested clinical scenario
- Other supporting documentation to justify the inclusion of the proposed medical clinical scenario requiring dental services

1. Evidence that is clinically meaningful and demonstrates that the dental services result in a material difference in terms of the clinical outcomes and success of the medical procedure.
2. Clinical evidence that is compelling to support that certain dental services would result in clinically significant improvements in quality and safety outcomes, for example, fewer revisions, fewer readmissions, more rapid healing, quicker discharge, and/or quicker rehabilitation for the patient.

<u>Integration and Coordination Between Dental and Medical Professionals</u>

MACs may develop supplemental education materials to explain that for a dental and medical service to be inextricably linked, there must be a level of integration and coordination between the dental and medical professionals. MACs may also develop supplemental education materials to explain how to document inextricably linked services.

Background:

Medicare payment may be made when a dentist furnishes dental services that are an integral part of the covered primary procedure or service furnished by another physician, or non-physician practitioner, treating the primary medical illness. If there is no exchange of information, or integration, between the medical professional (physician or other non-physician practitioner) in regard to the primary medical service and the

dentist in regard to the dental services, then there would not be an inextricable link between the dental and covered medical service within the meaning of our regulation at § 411.15(i)(3).

Integration between medical and dental professionals can occur when these professionals coordinate care. This level of coordination can occur in various forms such as, but not limited, to a referral or exchange of information between the medical professional (physician or non-physician practitioner) and the dentist. This coordination should occur between a dentist and another medical professional (physician or other non-physician practitioner) regardless of whether both individuals are affiliated with or employed by the same entity.

Without both integration between the Medicare enrolled medical and dental professional, and the inextricable link between the dental and covered medical services, dental services fall outside of the Medicare Part B benefit as they would be in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth within the meaning of section 1862(a)(12) of the Act; though they may be covered by types of supplemental health or dental coverage. This is because the medical and dental professionals would not have the necessary information to decide that the dental service is inextricably linked to a covered medical service, and therefore, not subject to a statutory payment exclusion under section 1862(a)(12) of the Act.

Multiple Visits

MACs may develop supplemental education materials to specify how providers should identify when an applicable service under § 411.15(i)(3) occurs over multiple visits.

Background:

It may not be clinically appropriate to receive the totality of dental services, which are necessary to immediately eradicate an infection, for example, that are inextricably linked to the covered medical services, within one visit. As such, Medicare can make payment, for example, for the dental services immediately necessary to eradicate the infection if such services require multiple dental services and if it is clinically advisable for those services to occur over multiple visits prior to medical services such as an organ transplant, cardiac valve replacement, or valvuloplasty procedures.

Provider Enrollment

The MACs may develop supplemental education materials to explain Medicare enrollment and how they pay enrolled providers.

Background:

In the CY 2023 PFS final rule, to be eligible to bill and receive direct payment for professional services under Medicare Part B, the medical professional and dentist must be enrolled in Medicare and meet all other requirements for billing under the PFS. Alternatively, a dentist not enrolled in Medicare could perform services incident-to the professional services of a Medicare enrolled physician. In that case, the services must meet the requirements for incident-to services under § 410.26, including the appropriate level of supervision. Payment would be made to the enrolled physician who would bill for the services. Furthermore, the state scope of practice for the medical and dental professional must support the professional performing the specific dental service(s).

Billing and Coding for Dental Services

MACs may provide supplemental education material about billing and coding requirements. These materials could include information on the appropriate billing codes, claim formats, and all other applicable instructions for such professional or institutional claim formats.

Background:

CMS developed and transmitted HCPCS and PFS payment and coding files to include revisions to add other Current Dental Terminology (CDT) codes, and indicated parameters for payment to implement the finalized Medicare Parts A and B payment for dental services provisions of the CY 2023 PFS final rule. Medical and dental providers should bill using CDT or Current Procedure Terminology codes where applicable, and should submit claims using the professional or institutional claim forms.

The indicators included within these payment files are for Medicare purposes, and to the extent that other payers utilize these files that these indicators were intended for Medicare-only purposes. We note that the indicators on the PFS and/or HCPCS payment files are intended to be compatible with existing standing dental billing conventions. If we are notified of any conflicts between standard dental billing conventions, or necessary changes, and payment indicators to the PFS and/or HCPCS file(s), we will make changes via the standard quarterly process.

MACs should make payment under the applicable payment system where the service is furnished. In the CY 2023 PFS final rule we specified that payment can be made under Medicare Parts A and B, under the applicable payment system, for such dental services that occur within the inpatient hospital and outpatient setting, as clinically appropriate. In instances where there are overlapping CDT codes to describe durable medical equipment and supplies, MACs should make payment off of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies fee schedule. MACs shall develop educational materials describing such coding policies.

Advanced Beneficiary Notice (ABN)

MACs may continue to provide education materials about the existing ABN processes.

Background:

The ABN process for this payment policy is consistent with the ABN process for any other Medicare payment policy. For claims submission, the applicable modifier for associated type of ABN (i.e. mandatory, voluntary, etc.) should be used on the claim.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13190.1	Contractors shall develop educational materials to supplement CMS developed national content describing policies related to dental services inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services as specified under § 411.15(i)), with dates of services on or after January 1, 2023.	X	X							
13190.2	MACs should instruct providers to utilize existing claims submission procedures, including the use of HCPCS modifiers, when a Medicare claim denial is sought for submission to third party payers.	X	X							
13190.3	MACs should develop educational materials to explain any medical review activities so that providers are aware of how pending claims under medical review will be assessed	X	X							
13190.4	MACs shall develop educational materials to explain that for a dental and medical service to be inextricably linked, there needs to be a level of integration and coordination between the dental and medical professionals. MACs shall develop educational materials to explain this requirement to providers and instruct them on how it should be documented.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13190.5	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	content releases when you distribute MLN Connects newsletter content per the manual section referenced above.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: MACs may provide education to dental and medical professionals on appropriate and applicable billing and coding requirements.

V. CONTACTS

Pre-Implementation Contact(s): Laura Ashbaugh, 4107861113 or laura.ashbaugh2@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0