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Part B Overview of Medicare Dental Coverage

9/17/2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenter

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Objective

The purpose of this webinar is to familiarize dental providers with Medicare Part B dental coverage, billing, and enrollment guidance.

Agenda

- Dental Coverage Overview
- Covered and Noncovered Services
- Inextricably Linked Services
- Enrolling In Original Medicare
- Dental Claim Submission Guidelines
- Advance Beneficiary Notice of Noncoverage (ABN)
- Medical Documentation
- Resources

Dental Coverage Overview

Definitions

- Ancillary services
  - Services that include, but not limited to, X-rays, administration of anesthesia and use of the operating room, and other related procedures
- Dental services
  - Refers to dental services 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
  - A doctor of dental medicine or dental surgery, who is legally authorized to practice dentistry in the state which they perform services, and are acting within their scope of license

Background

- Medicare 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
- Prior to 2023, there were a limited number of circumstances listed as examples in regulations for when Medicare payment could be made for dental services
- These specific circumstances included, but were not limited to
  - Wiring of teeth when done in connection with a reduction of a jaw fracture
  - Extraction of teeth to prepare the jaw for radiation of treatment of neoplastic disease
  - Oral or dental examination, on an inpatient basis, performed as part of a comprehensive workup prior to renal transplant surgery
- Reference
  - Change Request 13190: 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

CY 2023 PFS Final Rule

- CMS finalized the following provisions in the final rule related to dental services
  - Clarification and codification of certain aspects of the current Medicare Fee-for-Service payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition
  - 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
  - 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
  - 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
- Resources
  - Change Request 13181: Medicare Policy Updates for Dental Services as Finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (MPFS) Final Rule
  - Dental Services

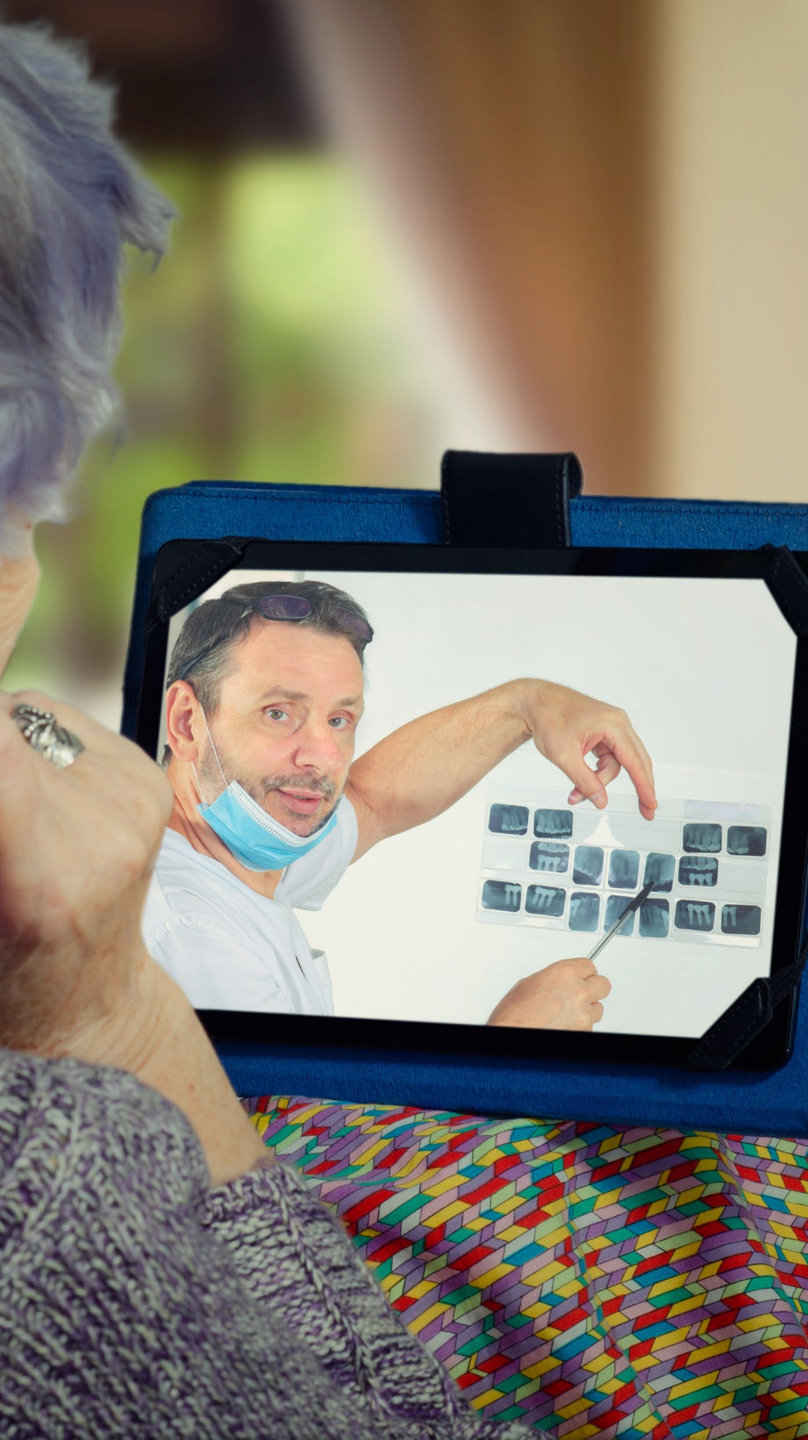
CY 2024 Medicare PFS Final Rule

- CY 2024 finalized
  - To permit payment for certain dental services inextricably linked to other covered services used to treat cancer, prior to, or contemporaneously with
    - Chemotherapy services
    - Chimeric Antigen Receptor T- (CAR-T) Cell therapy
    - Use of high-dose bone modifying agents (antiresorptive therapy)
  - Codification of and amendments to the previously finalized payment policy for dental services prior to, contemporaneously with, and/or after treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these, whether primary or metastatic
- Reference
  - MLN Matters® *MM13452: Medicare Physician Fee Schedule Final Rule Summary: CY 2024*

Covered and Noncovered Services

Medicare Dental Coverage

- Medicare does not pay for items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth except for inpatient hospital services connected to dental procedures if the patient is hospitalized due to
  - The patient's underlying medical condition and clinical status require hospitalization in connection with providing these procedures
  - The severity of the dental procedure requires hospitalization
- Medicare payment can be made under Part A and Part B when dental services are inextricably linked to the clinical success of other medically necessary covered services



Noncovered Services

- Medicare does not cover items and services for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth
  - Structures directly supporting the teeth are the periodontium, which includes
    - Gingivae
    - Dentogingival junction
    - Periodontal membrane
    - Cementum
    - Alveolar bone (alveolar process and tooth sockets)

Noncovered Services (continued)

- Noncovered items and services include, but are not limited to
  - Routine dental care (services for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth)
  - Items and services done primarily to prepare the mouth for dentures, including
    - Alveoplasty
    - Dental ridge reconstruction
    - Frenectomy
    - Removing the torus palatinus
- Dental services related to other noncovered services

Covered Services

- Payment may be made for dental services furnished in the inpatient or outpatient setting. Such services include, but are not limited to
  - 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
  - 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
  - The reconstruction of a dental ridge performed because of and at the same time as the surgical removal of a tumor
  - 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
  - The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease

Covered Services (continued)

- Medicare payment can also be made under Part A and Part B for ancillary services and supplies incident to the covered dental services, such as
  - Administering anesthesia
  - Diagnostic X-rays
  - Operating room use
  - Other related procedures

Incident To

- Definition
  - Services that are furnished incident to a physician's professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home
- Providers not enrolled in Medicare could perform services incident to the professional services of a Medicare enrolled physician
- The services must meet the requirements for incident to services
  - "Incident to" Services
  - "Incident to" Office Guidelines
  - Incident to Quick Reference Chart

Inextricably Linked Services

Inextricably Linked Services

- Payment under Medicare Parts A and B is only permitted for dental services that are inextricably linked to, and substantially related and integral to the clinical success of a certain covered medical service
- Integrated and coordinated level of care to ensure the dental services are an integral part of the Medicare covered primary procedure or service. Integrated and coordinated care requires
  - Exchange of information (or referral) between the medical professional (physician or other nonphysician practitioner) and the dentist regarding the need for dental services to support the primary medical service(s)

Coordination of Care

- Without care coordination, health care providers will not have the information they need to decide whether a dental service is inextricably linked to a Medicare covered service
- If the health care provider does not coordinate care, Medicare will not cover and pay for dental services
- Examples of care coordination may include a referral or exchange of information between a medical doctor and a dentist
- Coordination of care must be documented in the medical record
- Reference
  - MLN® Fact Sheet *Collaborative Patient Care is a Provider Partnership*

Without Coordination of Care

- 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
    - Though they maybe 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
    - Not subject to a statutory payment exclusion

Multiple Visits

- It may not be clinically appropriate to receive the totality of dental services that are inextricably linked to the covered medical services within one visit
- Medicare can make payment for multiple visits if it is clinically necessary to provide dental services that are inextricably linked to other Medicare covered services in more than one visit
  - Example
    - Medicare may pay for multiple visits for dental services to eliminate a patient’s dental infection before an organ transplant

Modifier KX for Dental Services

- Inextricable Linkage
  - The dental services are integral to the clinical outcome and success of the covered medical procedure
  - Requires an integrated and coordinated level of care to ensure the dental services are an integral part of the Medicare covered primary procedure or service

Enrolling in Original Medicare

Who Can Provide Dental Services

- You must be a Medicare enrolled provider to bill and be reimbursed for providing Medicare covered dental services
- Covered when provided by
  - Physicians, including a dentist or dental surgeon
  - Nonphysician practitioner
  - Auxiliary personnel such as a dental technician, dental hygienist, dental therapist, or registered nurse, when
    - They are directly supervised by a doctor or dentist
    - The services meet the requirements for incident to services

Enrolling

- To enroll in the Medicare program, medical professionals and dentists must complete the CMS-855I application for physicians and nonphysician practitioners
- You can enroll through the
  - Medicare Provider Enrollment, Chain and Ownership System (PECOS) on-line system
  - Complete the Medicare Enrollment Application Physicians and Nonphysician Practitioners CMS-855I paper application
    - Submit by mail
    - YouTube Video: Completing the CMS-855I Paper Application

New Specialty Codes

- CMS has established new provider specialty codes for dentists
  - E3 - Dental Anesthesiology
  - E4 - Dental Public Health
  - E5 - Endodontics
  - E6 - Oral and Maxillofacial Pathology
  - E7 - Oral and Maxillofacial Radiology
  - E9 - Oral Medicine
  - F1 - Orofacial Pain
  - F2 - Orthodontics and Dentofacial Orthopedics
  - F3 - Pediatric Dentistry
  - F4 - Periodontics
  - F5 - Prosthodontic
- Reference
  - Change Request 13323: New Dental Specialty Codes for Medicare

Provider Enrollment Resources

- National Government Services offers several resources and articles to help you with completing the Medicare enrollment application
- Provider enrollment resources
  - Initial Provider Enrollment Process
  - Introducing PECOS 2.0
- Contact Information
  - J6 (IL, MN, WI)
    - 877-908-8476
  - JK (CT, MA, ME, NH, NY, RI, VT)
    - 888-379-3807

Dental Claim Submission Guidelines

Claim Submission Options

- There are three ways to submit a claim
  - Electronically
    - 837P
      - Processed in Multi-Carrier System (MCS)
      - CPT and CDT codes accepted
      - All modifiers accepted
    - 837D
      - Only claims with dates of service starting 1/1/2024
      - Processed in Medicare Adjudication Portal (MAP)
      - Only CDT Dental codes accepted
      - Only KX and GY modifiers accepted
      - To submit 837D claims providers are required to sign up for testing
        - Attention Clearinghouses and Vendors
  - Paper
    - ADA 2024 Form
      - Manually entered
    - CMS 1500 Form
      - Processed in MCS
      - All modifiers accepted

EDI Dental Enrollment

- EDI Enrollment is required for testing
- Before electronic dental claims can be submitted the following must test
  - Clearing Houses
  - Billing Services
  - Software Vendors
  - Direct Submitters

Checklist

- Check with clearinghouse, billing service or software vendor if testing has been completed
- Ask if the clearinghouse, billing service, software vendor intend to test for dental claims using the 837D
- If the software vendor is on the Approved Entities List, ask if they tested for 837D
- If yes, submit an EDI Enrollment to update the trading partner id for 837D

EDI Guides and Contact

- Standard Companion Guides
  - Standard Companion Guide Health Care Claim: Dental 837D
  - 837D Edit Spreadsheet
- Please contact the EDI Help Desk at the following numbers for assistance:
- Jurisdiction 6: 877-273-4334
- Jurisdiction K: 888-379-9132

Dental Claim Submission Guidelines

- When you submit a claim for Medicare-covered dental services, you're certifying that the dental service is inextricably linked to a Medicare covered medical service
- Medical and dental providers should bill using Current Dental Terminology (CDT) or Current Procedure Terminology (CPT) codes

Billing the KX Modifier

- Dates of service on or after 1/1/2024
  - Begin using claims submitted on or after 7/1/2024
- Append to procedure code
- 837D or 837P electronic claim
- **NOTE**: KX required for claims received on or after 1/1/2025

KX Modifier

- Used to indicate that the service or item is medically necessary
  - Appropriate documentation included in the medical record
  - Medical record supports or justifies the medical necessity of the service or item
- For example, dental extractions needed before an aortic valve replacement

GY Modifier

- Modifier GY used when submitting a Medicare claim for a statutorily excluded service or does not meet the definition of any Medicare benefit
- Indicates expected denial
  - Appended for purposes of billing the supplemental insurance company **and/or**
  - Beneficiary requested submission
- Informational modifier only
- ABN optional

Claim Processing Tips

- Submit ICD-10 diagnosis code(s) to the highest level of specificity in the
  - Primary and secondary positions related to the dental service(s)provided
  - Secondary positions related to the planned medical condition or surgical procedure that is considered "inextricably linked”
- **NOTE**: ICD-10 required on 837D starting 1/1/2025

Claim Submission Resources

- Claim resources
  - CMS-1500 Claim Form
  - Medicare Part B CMS-1500 Crosswalk for 5010 Ekectronic Claims
  - NGSConnex User Guide
  - Medicare Part B 101 Manual - CMS-1500 Claim Form
- ADA Dental Claim Form
  - Standard Companion Guide Health Care Claim: Dental (837D)

Advance Beneficiary Notice of Noncoverage (ABN)

ABN Overview

- Definition
  - A written notice required by a healthcare provider or supplier to notify a beneficiary in advance of furnishing an item or service when they believe that item or service will likely be denied by Medicare
    - Notice must be in writing
    - Verbally review the ABN with the beneficiary or representative
    - ABN should be given in advance of the service/item
    - A copy of the ABN should be given to the beneficiary or representative
    - Original copy of the ABN must be on file in your office
    - ABNs are limited to use for one year, from the date of signature, for an extended course of treatment
  - Notice is not required in emergency or urgent care situations
- Purpose
  - Allows the beneficiary to make an informed decision about whether to receive the services that they may be financially responsible for paying
  - Serves as proof the patient had knowledge prior to receiving the service Medicare may not cover
- Reference
  - Form Instructions Advance Beneficiary Notice of Non-coverage (ABN)

Key Tips When Issuing the ABN

- ABN must be issued prior to providing care
- Issuing ABNs on a routine basis or to Medicare beneficiaries receiving services for every procedure is prohibited
- Once a beneficiary signs ABN
  - indicates he or she chose to receive an item or service and accept financial liability
- ABNs are not required for statutorily excluded services that are never a Medicare benefit
- Retention of the signed ABN is five years

ABN Form and Guidelines

- Form: CMS-R-131 with the expiration date of 01/31/2026
- Instructions for completing the form
  - Form Instructions Advance Beneficiary Notice of Non-coverage (ABN)
  - MLN® Educational Tool: *Advance Beneficiary Notice of Non-coverage Tutorial*
    - Guidelines for issuing the ABN can be found in the CMS Internet-only Manual, Publication 100-04, *Medicare Claims Processing Manual, Chapter 30* Section 50

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D.__________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**__________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**______________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.**__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.**__________ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

ABN Modifiers

- Definition
  - Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code
- Purpose
  - They are used to add information or change the description of service to improve accuracy or specificity

Modifier	Modifier Description	When to Use the Modifier
GA	Waiver of liability statement Issued as required by payer policy, Individual case	When you issue a mandatory ABN for a service as required and it is on file
GZ	Item or service expected to be denied as not reasonable and necessary	When you expect Medicare to deny coverage of the item or service due to alack of medical necessity and no ABN was issued

Medical Documentation

Documentation Guidelines

- Documentation should support medical necessity for the service or item provided or ordered
- The documentation should
  - Give a thorough picture of what happened during the patient's visit
  - Tell why services or items you ordered or performed were medically necessary
  - Available upon request
- Remember: If it's not documented it did not happen

General Documentation Requirements

- Documentation supporting medical necessity must be complete, legible, and include
  - Name of person providing the services or items
  - Date of service
  - Patient's signs, symptoms, and any conditions supporting the need for the services or items
  - Details of the services or items you provided
  - Where you provided services or items
  - Signed orders for services or items and the clinical rationale for the orders
  - Rationale for the level of care given
  - Intensity, frequency, duration, and scope of services
  - Legible signature of the person providing the service and the physician ordering and approving treatment plans (if signature is not legible, include a signature log showing name in print and signature)
    - Medical Documentation Signature Requirements
    - MLN® Fact Sheet: *Complying with Medicare Signature Requirements*

Medical Documentation Requirements

- Must include all applicable diagnosis codes to the highest level of specificity to establish the medical necessity of the services provided
  - If you receive an additional documentation request (ADR), make sure you include
    - Lab report/results, including laboratory name, test name, and details of test methodology
    - Office notes that support medical necessity, specifically explaining how the test will be used in the treatment and/or management of the patient
    - Patient history and physical
    - Procedure or operative report
    - Progress or office notes
    - Invoice, when applicable
- Referral information showing the service is inextricably linked to, and substantially related and integral to the clinical success of, a certain covered medical service
- We encourage you to review your documentation prior to submission to ensure that all requested documentation is included in your response, and that the medical records are appropriately authenticated
- Resource
  - Additional Documentation Request

Incomplete Documentation

- Documentation received does not provide enough information to establish medical necessity
- To ensure proper claims processing and payment, you must follow documentation requirements and meet Medicare coverage criteria
- If your documentation is incomplete
  - Medicare may not pay for the services or items you ordered or performed
  - Your patient may have to pay additional costs
- Also, if you do not provide enough information to support medical necessity when you make referrals or write orders, the other provider or supplier may delay or deny care to your patient

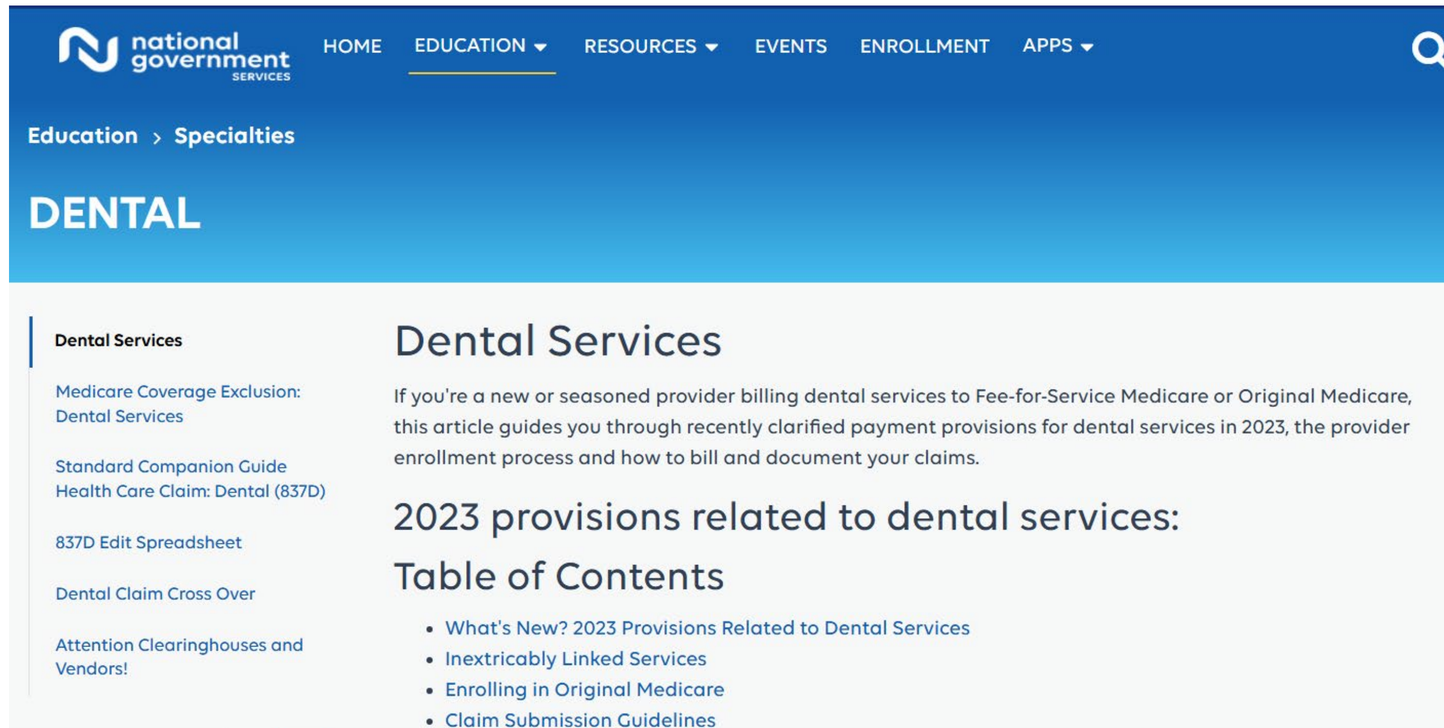
Key Takeaways

- Enroll in Medicare
- Enroll with EDI
- Testing (CH, Vendor, Biller)
- Inextricable Linkage (KX Modifier)
- Integrate/Coordinate Care
- Documentation
- Review Resources

Resources

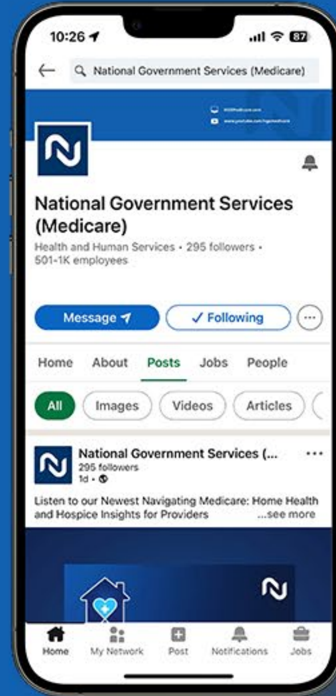
Resources

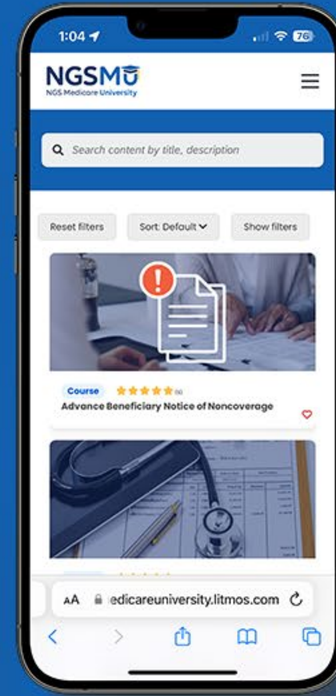
- National Government Services Dental Services
- Subscribe for Email Updates



Related Content

- Dental Services
- Medicare Dental Coverage
- Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule
- Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule
- CMS-1500 Claim Form Completion Instructions
- Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims
- ADA Dental Claim Form Completion Instructions
- MLN® Fact Sheet: *Medicare Billing: 837P & Form CMS-1500*





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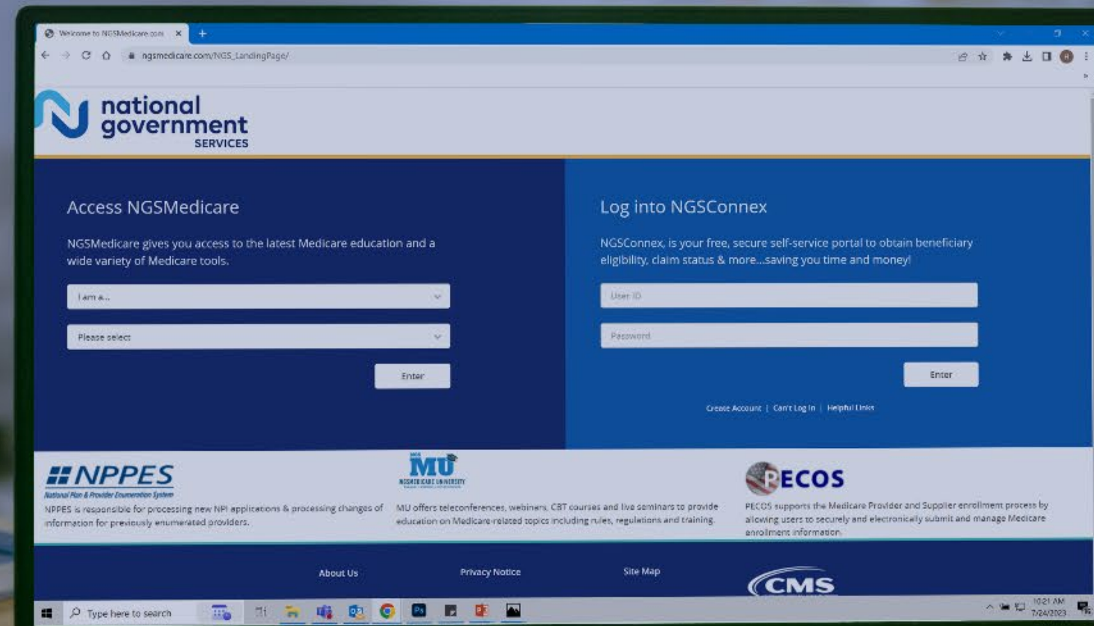

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

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The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

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Thank you!