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TOOLKIT

Hospital and ASC Coding and Payment for Dental Cases

3rd Edition, updated January 2024

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

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WHAT'S NEW?

Overview for dentists and oral surgeons regarding Payment to hospitals and ASCs for dental cases.

Beginning on January 1, 2023, as the result of an initiative undertaken by AAPD, ADA and AAOMS, the Medicare Program significantly modified coding and increased Medicare payment to hospitals for the facility services incurred by hospitals for dental cases, such as, for example, Operating Room (OR) expenses, overhead, and administrative costs. Beginning on January 1, 2024, the Medicare program also extended Medicare coverage to certain dental cases (including dental rehabilitation (G0330) performed **in Ambulatory Surgical Centers (ASCs)**. While hospitals and ASCs will be responsible for the submission of claims for dental cases that use their facilities, we anticipate that hospitals and ASCs may look to dentists or other specialists who perform these surgical cases for assistance in assuring that the coding is accurate.

It is important to understand that these changes address the amounts payable to hospitals and ASCs for the facility costs they incur in making ORs available for dental procedures including, for example, the costs associated with equipping and staffing ORs, hospital/ASC administrative costs and overhead costs. Dentists' professional fees are separately billable and are not affected by these changes.

Effective on **January 1, 2023**:

- Medicare adopted a new HCPCS code—HCPCS Code G0330—for hospitals to use to report dental rehabilitation.

  G0330: Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room.

- Medicare established a national average Medicare payment rate of **$1,722.43** for dental rehabilitation (G0330) (APC 5871), which was substantially higher than the payment rate applicable prior to 2023.

Effective on **January 1, 2024**, also as the result of an AAPD-ADA-AAOMS advocacy initiative:

- The AAPD ADA-AAOMS coalition successfully fought a Medicare proposal that would have reduced hospital payment for dental rehabilitation (G0330) by over 45%. Instead, the Medicare program increased the facility fee payable to hospitals for dental rehabilitation (G0330) to **$3,070.81** (APC 5164), beginning January 1, 2024. (This hospital facility payment includes all dental procedures as well as other services that

may be performed in conjunction with the dental rehabilitation, such as dental evaluation and imaging.)

- The Medicare Program for the first time approved Medicare payment for ASC facility costs for dental cases, and established an ASC facility rate of **$1,318.93** for dental rehabilitation (G0330), a tremendous boost from CMS' original proposal**,** which would have allowed only $495.52.

- The Medicare Program established facility rates for 243 CDT codes performed in hospital outpatient departments and 26 new CDT codes performed in ASCs, and restricted hospital and ASC billing of dental rehabilitation (G0330) to dental cases that do not involve the performance of a separately billable CDT code.

IMPORTANT FACTS FOR DENTISTS, ORAL SURGEONS, AND DENTAL ADVOCATES

Professional Fees

- The new Medicare rules govern payment to the hospital or ASC for **facility services only**. 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.

- The dentist or other professional does not necessarily need to participate in the Medicare program in order for the hospital or ASC to receive payment for the costs they incur. However, a dentist or surgeon who provides services in a hospital or ASC OR will be required to provide his or her NPI to the hospital for billing purposes and will be required to obtain hospital or ASC staff privileges.

- Under the Medicare program, anesthesia professional fees are billed separately from hospital and ASC facility fees. Likewise, in most non-Medicare cases, the anesthesiologist's professional service fees will be separately payable.

Medicare Coverage and Payment

- Remember that Medicare is not just for the elderly. Some of your disabled pediatric and adult patents may be eligible for Medicare. When a patient is eligible for both Medicare and Medicaid, Medicare is primary.

- Medicare pays for hospital outpatient services under a different methodology than for inpatient services. Medicare payment for hospital outpatient services is based on a procedure's Ambulatory Payment Classification (APC), and Medicare payment for ASC facility services depends on the amount paid to hospitals.

- Under the CY 2024 rule, dental rehabilitation (G0330) is billable for hospitals only if no other dental procedure that is separately payable is performed. The list of CDT codes included in HOPPS is provided as **Addendum 1** of this Toolkit. Note that in hospital settings, only CDT codes with status indicator "S" or "T" are separately payable to the hospital, and "T" codes are separately payable only if they are not included on the same claim as an "S" procedure.

> For typical pediatric dental cases, the total amount billable by a hospital for their facility costs for cases billed based on individual CDT codes will be significantly greater than the amounts payable prior to CY 2023, when far fewer CDT codes were billable. See Appendix 1 for several examples of how the new system will work for dental cases performed in hospital outpatient departments.

- As in hospital outpatient settings, dental rehabilitation (G0330) is payable in ASC settings only if no separately billable service is performed. The list of dental procedures that are separately payable (i.e. included on the ASC Covered Procedures List (CPL)) is included in this Toolkit as **Addendum 2**. Because fewer services are separately payable in ASC settings than in hospital outpatient settings, dental rehabilitation (G0330) is likely to be billable more often in an ASC than in hospital outpatient settings. Dental rehabilitation (G0330) performed in ASC settings is payable only if an ancillary service identified on **Addendum 3** is also performed.

- All of the hospital and ASC rates included in this Toolkit are national average rates. The actual amounts paid to the hospital or ASC will vary based on the facility's geographic location and other factors and will be subject to a patient copayment.

- The Medicare payment rates for hospitals that are set forth in Addendum 1 are not applicable in Maryland, which has its own system for paying for hospital services.

- While Medicare coverage of dental services was expanded in 2023 and expanded further in 2024, Medicare's dental coverage remains limited to specific services that are considered integral to other Medicare-covered services. **Medicare will cover hospital and ASC facility services for specific indications only when Medicare coverage requirements are met, as provided under Medicare regulations**.

- The multiple procedure payment reduction (MPPR) for facility fees means that if a healthcare provider performs multiple procedures during a single patient encounter, Medicare (and many commercial insurers) typically will pay "full price" for only the highest-valued procedure.

- Packaged payment policy for facility fees is a reimbursement term referring to the practice of making a single payment that includes payment for a significant procedure as well as for the minor ancillary services associated with the procedure. CMS frequently uses this term to define the services for which it will not provide separate payment.

Medicaid and Other Non-Medicare Payers

- **These new regulations cover Medicare, but Medicare coverage and payment rules may be followed/adopted in full or part by state Medicaid agencies (SMAs) as well as private insurers.**

- The use of HCPCS Code G0330 is not limited to Medicare and may be adopted by state Medicaid programs and other governmental and private payers, based on their own coverage and coding criteria.

- Medicaid, especially for children, covers a much broader range of dental services as compared to Medicare. Hence, any changes in facility fee policies for dental operating room cases under Medicaid should apply to most patients.

- Private payers are not required to follow Medicare's coverage or payment policies, but they have the option to do so. Historically, private insurers tend to adopt changes made by Medicare to the ASC CPL.

- Medicare's new coverage and payment policies for hospital outpatient and ASC facility services may affect state Medicaid policies. Many state Medicaid programs utilize the Medicare HCPCS system and base state Medicaid payment for hospital outpatient services on Medicare rates. However, because each state Medicaid program is different, it is impossible to say whether, and to what extent, the new Medicare coverage and payment policies for hospital and ASC facility services will impact Medicaid in your state. See Appendix 2 for information about Medicaid policies relating to State Medicaid Agency (SMA) implementation of facility payment for dental rehabilitation services provided in hospital outpatient departments and ASCs.

Other Billing and Coding Issues

- You may be required to identify the appropriate ICD 10 diagnostic code on the hospital or ASC clinical record. Some electronic health records and electronic dental records have algorithms built into their software that pre-populate the ICD-10 diagnostic code based on the CPT or CDT code or that provide a short list from which to choose the appropriate ICD-10 diagnosis code. While this streamlines the administrative process, it is important for you to pay close attention to the diagnostic code selected or pre-populated. There are a wide variety of diagnoses – both medical and dental – that could predicate having dental treatment under monitored anesthesia in a hospital outpatient operating room or ASC setting. For example, the need for this treatment could be due to the patient having an intellectual or developmental disability (e.g. ICD F70-79 series)[1] or a behavioral or emotional disorder (e.g. F98 series), or it could be because of the complexity of the dental treatment (K series). We recommend that you consult with the 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 dental rehabilitation (G0330) and other CDT codes.

- Hospitals have the option to have their outpatient surgical services certified as an ASC. If a surgical service is organized and billing as an ASC, ASC payment rules will apply regardless of hospital ownership.

[1] Autistic disorder - F84 series, cerebral palsy - G80 series, Down syndrome - Q90 series, as examples.

ADVOCACY GUIDANCE FOR DENTISTS AND DENTAL ADVOCATES

- Please notify your hospital(s) and ASC(s) in your area of the expansion in Medicare coverage of dental services and increased rates for dental cases that became effective on January 1, 2024, including especially the new Medicare payment rate for dental rehabilitation performed in hospital outpatient departments of $3080.91; the addition of dental rehabilitation (G0330) and other dental procedures to Medicare's ASC CPL; and the ASC rate for dental rehabilitation (G0330) of $1318.93.

- Additional information regarding changes in Medicare payment for ASC facility services for dental cases is available from CMS[2]**.** In addition, this Toolkit includes Guidance to hospitals and ASCs on coding and payment for dental cases performed in their facilities, which you may wish to provide to your hospital (s) and area ASC (s).

- **Follow up advocacy will be required for private payers and state Medicaid programs to encourage them to follow Medicare's lead**.

- The AAPD, ADA, and AAOMS will be communicating with major private insurers to alert them to the Medicare changes and request the establishment of appropriate facility payment for dental cases performed in hospital outpatient departments and ASCs. It is important to note that if patients have separate medical and dental insurance – as is the most common situation – the facility fee would be billed by the hospital or ASC under the patient's medical insurance. We encourage you to communicate these changes to the major private payers in your area, and to let us know the result of your efforts.

- Since Medicare's recognition of a new code to report dental rehabilitation in 2023, considerable progress has been made in increasing Medicaid payment to hospitals for dental cases. We urge you to notify your SMA of Medicare's 2024 rate increase for dental rehabilitation and the extension of coverage for dental cases performed in ASCs. Included in this Toolkit is a sample letter that you may wish to adapt to the Medicaid program in your state.

[2] https://www.cms.gov/files/document/mm13481-ambulatory-surgical-center-payment-system-january-2024-update.pdf

SAMPLE FOLLOW-UP LETTER TO STATE MEDICAID AGENCIES (SMAS)

Director
State Medicaid Agency

Dear _____:

On behalf of the _____Dental Association, _____ of Pediatric Dentistry, and the _____Society of Oral and Maxillofacial Surgeons, we are writing to request the opportunity to [continue recent discussions concerning] [name of state] Medicaid patients' access to hospital and ambulatory surgical center (ASC) Operating Room (OR) facilities for dental cases. These discussions are particularly timely, in light of the recent issuance of a Medicare rule that addresses the continued lack of Operating Room (OR) access for dental procedures performed under monitored anesthesia for Medicare patients.

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 monitored anesthesia and that therefore requires ORs that meet state and federal safety standards. 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 our state. We 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 faced 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 continued or worsened even as the COVID-19 pandemic has subsided.

The situation is particularly critical in in our state, as there are only an estimated _____ hospitals where dental rehabilitation is performed, and wait times are in the range of _____.

The OR access challenge is attributable in large part to a historical lack of an appropriate billing mechanism and a sustainable payment rate for hospitals and ASCs to obtain payment for dental cases. Effective January 1, 2023, the Centers for Medicare and Medicaid Services (CMS) addressed this issue by establishing a new Healthcare Common Procedure Coding System (HCPCS) G code (**G0330**) for dental rehabilitation performed under monitored anesthesia and by increasing the national average Medicare payment rate for these procedures to $1722.43 . For CY 2024, CMS further increased the Medicare payment rate for dental rehabilitation (G0330) to $3080.91 to align with hospital estimated costs for all of the dental and ancillary

services involved, such as, for example, dental evaluation and imaging. In addition, CMS added many additional dental procedures to its Hospital Outpatient Prospective Payment System.

In addition, the Medicare Program recognized that Ambulatory Surgical Center sites of service should be made available for dental cases by adding dental rehabilitation (G0330) and a number of other dental (CDT) codes to the Medicare Covered Procedures List (CPL). The national average Medicare payment rate for dental rehabilitation (G0330) provided in ASC settings is $1318.93.

We strongly believe that, in light of the significance of the Medicaid program for the affected patient populations, it is critically important that the state Medicaid agency likewise take action in 2024 to remove payment-related obstacles that negatively impact OR access for those needing dental care in hospital outpatient and ASC settings.

In light of this ongoing crisis, we urge you to:

- **Closely monitor the state's Medicaid Managed Care Plans to ensure that they provide OR access for dental cases;**

- **Ensure that hospital outpatient payment for dental rehabilitation (G0330) is in the range reflected by the new Medicare payment rate.**

- **Include dental rehabilitation (G0330) on the list of procedures eligible for Medicaid coverage in an ASC setting and establish an appropriate payment rate for these services, in the range reflected by the new Medicare ASC rate.**

We look forward to hearing from you regarding this important issue.

Respectfully,

Signatories

GUIDANCE ON CODING AND PAYMENT FOR DENTAL PROCEDURES IN HOSPITAL OUTPATIENT DEPARTMENTS

- Beginning on January 1, 2023, as the result of an initiative undertaken by AAPD, ADA and AAOMS, the Medicare Program significantly modified coding and increased Medicare payment to hospitals under the Hospital Outpatient Prospective Payment System (HOPPS) by adopting a new HCPCS code (G0330) to report dental rehabilitation performed in an OR under monitored anesthesia and providing a national average Medicare APC rate of $1,722.43 (APC 5871).

- Beginning on January 1, 2024, the Medicare Program:

    - Approved 243 dental procedures (including dental rehabilitation (G0330)) as separately payable procedures under HOPPS.
    - Reclassified dental rehabilitation (G0330) into a comprehensive APC 5164, with a national average APC rate of **$3,070.81**.
    - Indicated that dental rehabilitation (G0330) may be reported only when no separately payable dental procedure (CDT) is reported.
    - Provided that virtually all separately payable dental procedures are subject to the multiple surgical procedure reduction.
    - Included many dental procedures under HOPPS that are not separately payable (i.e. accompanied by status indicators other than "S" or "T" (conditionally packaged).

- A list of all dental procedures included in HOPPS, regardless of payment status, is provided at **Addendum 1** of this Guidance.

- Dental cases that are reported using CDT codes may yield aggregate payment amounts that are either more or less than the amount payable for dental rehabilitation (G0330), depending on how many procedures are provided and whether the procedures provided are separately payable. Facility fees for separately reported dental procedures on average range from $840 to $3,071, with a few as high as a $5,585 per service. When multiple procedures are performed, hospitals can bill a facility fee for each procedure performed; however, multiple procedure reductions may apply.

- Examples of coding and payment for typical pediatric and adult dental cases in HOPD and ASCs are provided in **Appendix 1** of this Guidance.

- Private Payers and Medicaid

    - Hospital charges for facility services for dental cases are generally covered under a patient's medical insurance and not under the patient's dental insurance (if any).
    - The use of HCPCS Code G0330 is not limited to Medicare and may be adopted by state Medicaid programs and other governmental and private payers, based on their own coverage and coding criteria.
    - Medicaid payment rules for dental facility services vary by state.

GUIDANCE ON CODING AND PAYMENT FOR DENTAL PROCEDURES IN AMBULATORY SURGICAL CENTERS (ASCs)

- Historically, dental procedures have not been included on the ASC Covered Procedures List (CPL).

- Beginning on January 1, 2024, as the result of an initiative undertaken by AAPD, ADA and AAOMS, CMS took the following actions:

  - Approved 26 dental procedures (CDT codes) for inclusion on the CPL (including a HCPCS code adopted in 2023 for dental rehabilitation (G0330), the descriptor for which reads:

    G0330: Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room.

  - Provided a national average payment rate of **$1,318.93** when dental rehabilitation is provided in the ASC setting.

  - Indicated that dental rehabilitation (G0330) may be reported only when no dental procedure that is identifiable by CDT code and included on the CPL is provided.

  - Indicated that, to be paid, an ASC's claim for dental rehabilitation (G0330) must also include a dental procedure that is on the ASC Ancillary Services List.

  - Provided that all dental procedures on the CPL are subject to the multiple surgical procedure reduction.

  - Required that dental claims include special payment indicators:

    - D1— "Ancillary dental service/item; no separate payment made."
    - D2 – "Non office-based dental procedure added in CY 2024 or later." The "D2" payment indicator would indicate a separately payable dental surgical procedure.

- For separately reported dental procedures in ASCs (CDT codes on the CPL), national average payment rates ranging from $364.98 to $2,760.89.

- The dental procedures on the CPL and on the ASC Ancillary Services List are included as **Addendums 2 and 3** of this Guidance.

- Examples of coding and payment for typical pediatric and adult dental cases in the ASC setting are provided at Appendix 1 of this Guidance.

- Medicare coverage for dental procedures remains limited to certain specific services integral to other Medicare-covered services, as provided by Medicare regulations.

- Private Payers and Medicaid:
    - ASC charges for facility services for dental cases are generally covered under a patient's medical insurance and not under the patient's dental insurance (if any).
    - The use of HCPCS Code G0330 is not limited to Medicare and may be adopted by state Medicaid programs and other governmental and private payers, based on their own coverage and coding criteria.
    - Medicaid payment rules for dental facility services performed in ASCs vary by state.

Appendix 1- Hospital HOPD and ASC Case Examples

[note: SI is status indicator for HOPDs; PI is payment indicator for ASCs]

Case 1: A pediatric dentist performs pulpotomies, stainless steel crown placements, and resin restorations on multiple teeth on a three-year old child with early childhood caries.

CDT Codes Reported by Pediatric Dentist (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
		HOPD	**ASC**
N/A	**G0330** facility svs. dental rehab	**Does not report G0330**	**$1318.93 (G0330)** *Subject to multiple procedure payment reduction (MPPR); first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)
D0220 intraoral- periapical first radiographic image	D0220	**$86.67** *Conditionally packaged, payment may be bundled with other covered services* (SI:Q1)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D9222 deep sedation/general anesthesia first 15 minutes (X1)	-----	Not paid under the OPPS	Not paid under the ASC system
D9223 deep sedation/general anesthesia- each subsequent 15 minute increment (X5)	-----	Not paid under the OPPS	Not paid under the ASC system
D3220 therapeutic pulpotomy (excluding final restoration)- removal of pulp coronal to the dentinocemental junction and application of medicament (#B)	D3220	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2930 prefabricated stainless steel crown- primary tooth (#B)	D2930	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)

CDT Codes Reported by Pediatric Dentist (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
D2934 prefabricated esthetic coated stainless steel crown- primary tooth (#D)	D2934	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D3230 pulpal therapy (resorbable filling)- anterior primary tooth (excluding final restoration) (#E)	D3230	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2934 prefabricated esthetic coated stainless steel crown- primary tooth (#E)	D2934	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D3230 pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration) (#F)	D3230	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2934 prefabricated esthetic coated stainless steel crown- primary tooth (#F)	D2934	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D3230 pulpal therapy (resorbable filling)- anterior primary tooth (excluding final restoration) (#G)	D3230	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2934 prefabricated esthetic coated stainless steel crown- primary tooth (#F)	D2934	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2930 prefabricated stainless steel crown- primary tooth (#I)	D2930	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)

CDT Codes Reported by Pediatric Dentist (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
D2930 prefabricated stainless steel crown-primary tooth (#L)	D2930	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2930 prefabricated stainless steel crown-primary tooth (#S)	D2930	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2391 resin-based composite – one surface, posterior (#K-O)	D2931	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2391 resin-based composite – one surface, posterior (#T-O)	D2931	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D1206 topical application of fluoride varnish	-----	Not paid under the OPPS	Not paid under the ASC system

Case 2: A general dentist performs multiple restorations and extractions on a disabled adult patient with multiple decayed surfaces.

CDT Codes Reported by Pediatric Dentist (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
		HOPD	**ASC**
N/A	**G0330** facility svs. dental rehab	**Does not report G0330**	**$1318.93 (G0330)** *Subject to multiple procedure payment reduction (MPPR); first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)

CDT Codes Reported by Pediatric Dentist (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
D0120 periodic evaluation - established patient	D0120	**$126.08** *Conditionally packaged, payment may be bundled with other covered services* (SI:Q1)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D9222 deep sedation/general anesthesia first 15 minutes (X1)	-----	Not paid under the OPPS	Not paid under the ASC system
D0210 intraoral-comprehensive series of radiographic images	D0210	**$233.71** *Conditionally packaged, payment may be bundled with other covered services* (SI:Q1)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D1110 prophylaxis-adult	D1110	Not paid under the OPPS	Not paid under the ASC system
D9215 local anesthesia in conjunction with operative or surgical procedures	D9215	Not paid under the OPPS	Not paid under the ASC system
D2391resin-based composite- one surface, posterior (#20)	D2391	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2391resin-based composite- one surface, posterior (#28)	D2391	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2330 resin-based composite-one surface, anterior (#21)	D2330	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)

CDT Codes Reported by Pediatric Dentist (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
D2330 resin-based composite-one surface, anterior (#27)	D2330	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D7140 extraction, erupted tooth or exposed root (elevation and/or forceps removal) (#2)	D7140	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$456.74** *Subject to multiple procedure payment reduction (MPPR); first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)
D7230 removal of impacted tooth-partially bony (#15)	D7230	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$456.74** *Subject to multiple procedure payment reduction (MPPR); first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)
D2160 amalgam-three surfaces, primary or permanent (#19)	D2160	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D2150 amalgam-two surfaces, primary or permanent (#30)	D2150	**$839.78** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D1206 topical application of fluoride varnish	-----	Not paid under the OPPS	Not paid under ASC system

Case 3: **An OMS performs a comprehensive oral exam; panoramic x-ray; surgical extraction of teeth numbers 22, 23, 24; alveoloplasty and intraoral I&D.**

CDT Codes Reported by OMS (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
		HOPD	**ASC**
N/A	-----	**Does not report G0330**	**Does not report G0330**
D0150 comprehensive oral evaluation - new or established patient	D0150	**$126.08** *Conditionally packaged, payment may be bundled with other covered services* (SI:Q1)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D0330 panoramic radiographic image	D0330	**$233.71** *Conditionally packaged, payment may be bundled with other covered services* (SI:Q1)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)
D7210 extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated (three units)	D7210 (three units)	**$1454.56** *Comprehensive service paid under the OPPS* (SI:J1)	**$666.85** *Subject to multiple procedure payment reduction (MPPR); first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)
D7311 alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	**$1454.56** *Comprehensive service paid under the OPPS* (SI:J1)	**$666.85** *Subject to MPPR; first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)
D7510 incision and drainage of abscess - intraoral soft tissue	D7510	**$671.05** *Subject to MPPR or may be bundled with comprehensive/primary service* (SI:T)	**$364.98** *Subject to MPPR; first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)

Case 4: **An OMS performs five extractions with elevation and forceps and places intra-socket dressings in two of the sites to aid in clot formation**

CDT Codes Reported by OMS (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status Indicators (SI) (2024)	
		HOPD	**ASC**
N/A	-----	**Do not report G0330**	**Do not report G0330**
D7140 extraction, erupted tooth or exposed root (elevation and/or forceps removal) (five units)	D7140 (five units)	**$839.78** *Paid separately under OPPS but MPPR applies when billed with other T services* (SI:T)	**$456.74** *Subject to MPPR; first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI: D2)
D7922 placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site (two units)	D7922 (two units)	**$839.78** *Paid separately under OPPS but MPPR applies when billed with other T services* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI: D1)

Case 5: **An OMS performs a vestibuloplasty and full mouth debridement. Due to the patient's underlying medical condition, the procedure required monitored anesthesia in a facility setting.**

CDT Codes Reported by OMS (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status/Payment Indicators (2024)	
		HOPD	**ASC**
D7340 vestibuloplasty - ridge extension (secondary epithelialization)	D7340 *(HOPD)* ***G0330 (ASC)****	**$5585.51** *Comprehensive service paid under the OPPS* (SI:J1)	**$1318.93 (G0330)** *Subject to multiple procedure payment reduction (MPPR); first service paid at 100% of allowed amount, second and subsequent services paid at 50%* (PI:D2)
D4355 full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	D4355	**$839.78** *Subject to MPPR or may be bundled with primary/comprehensive service* (SI:T)	**$0** *Ancillary dental service, separate payment may not be made* (PI:D1)

Case 6: **An OMS performs a surgical implant removal #'s 12 and 13, in conjunction with bone grafting and placement of a resorbable collagen membrane in site #'s 12 and 13.**

CDT Codes Reported by OMS (Professional Services)	CDT Codes and G0330 Reported by Facility (Facility Fees)	Average Facility Payment Rate and Status Indicators (SI) (2024)	
		HOPD	ASC
D6100 surgical removal of implant body (2 units)	----	Not paid under the OPPS	Not paid under ASC payment system
D7953 bone replacement graft for ridge preservation - per site (2 units)	----	Not paid under the OPPS	Not paid under ASC payment system
D7956 guided tissue regeneration, edentulous area - resorbable barrier, per site (2 units)	----	Not paid under the OPPS	Not paid under ASC payment system

The expansion of Medicare dental coverage in 2023 and 2024 includes only services necessary to identify, diagnose and treat oral/dental infections in patients with certain acute conditions. Under the OPPS, D6100, D7953 and D7956 are not recognized for payment when submitted on a claim for outpatient services. Services not considered medically necessary to identify, diagnose and treat an oral/dental infection in relation to certain Medicare-covered medical services would not be payable by Medicare. Therefore, a hospital outpatient department would likely not be paid by Medicare for the facility costs associated with furnishing these services.

Similarly, Medicare has not recognized these services as payable in the ASC setting, either as covered dental surgical procedures or covered ancillary services.

Appendix 2: State Medicaid Agencies (SMAs) changes to date in facility fee billing for dental cases

Access this AAPD website page, which is regularly updated and coordinated with ADA and AAOMS:

https://www.aapd.org/research/policy-center/rpc-publications/dental-rehabilitation-in-operating-rooms/