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September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: **CMS-1807-P**
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Brooks-LaSure,

As America's leading advocate for oral health, the American Dental Association (ADA) is writing to provide comments on the dental and oral health services included in the Centers for Medicare & Medicaid Services (CMS) proposed rule, "Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies" (CMS-1807-P), published in the Federal Register on July 31, 2024.

The ADA has been a dedicated advocate for oral health, recognizing the vital role that dental services play in the overall health and well-being of Medicare beneficiaries. We welcome the opportunity to provide our expertise on the proposed changes for CY 2025.

Covered Conditions and Clarification for ESRD-Related Dental Services

The ADA supports CMS's proposed rule change that allows payment for dental services as part of the oral health examination and treatment plan workup before dialysis for individuals with end-stage renal disease (ESRD) and those provided to treat oral infections that could compromise dialysis success. The inclusion of these services underscores the critical role that oral health plays in the overall management of ESRD and in the prevention of systemic infections that could jeopardize treatment outcomes.

Request for Information on Diabetes-Related Dental Services

The ADA acknowledges the bi-directional relationship between diabetes and oral health. Evidence exists to show that periodontal treatment improves glycemic control in people with both periodontitis and diabetes by a clinically significant amount. However, in this context we note the interpretation provided by CMS regarding coverage for diabetes-related dental services:

> *"Under § 411.15(i)(3), we have specified that payment can be made for certain dental services that are inextricably linked to other services when the specific covered services with which the dental services are inextricably linked are identified. The studies that have been provided to CMS through submissions have not identified any specific covered*

services for the treatment of diabetes to which dental services are inextricably linked. Rather, the studies indicate that the primary treatment of periodontal disease in patients with diabetes generally leads to better outcomes in the management of the patients' diabetes. While the research makes the case that the dental services are medically necessary for patients with diabetes, medical necessity alone does not permit payment for dental services given the broad statutory prohibition under section 1862(a)(12) on payment for services "in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth." In the case of patients with diabetes, the research does not appear to show that certain dental services are inextricably linked with certain other covered services for the treatment of diabetes, in accordance with our regulation at § 411.15(i)(3) such that the statutory prohibition under section 1862(a)(12) does not apply."

We recognize that CMS is limited in its ability to cover dental services to only those that are inextricably linked to covered medical services. Diabetes is a chronic life-long condition. There are no specific medical services that we could identify associated with diagnosis and management of diabetes whose outcomes can be inextricably linked to provision of dental care. Thus, we believe there are no specific medical services that can be used to qualify payment for dental procedures under the "inextricably linked to other covered medical services" framework. It appears that this framework cannot be used to leverage the role dental care can play in improving health outcomes among Medicare beneficiaries with chronic medical conditions.

Furthermore, given the limitations posed by issues related to budget neutrality under Part B of Medicare, the ADA does not believe that CMS can establish a broader dental program that is adequately funded. For these reasons, the ADA believes that an act of Congress is required to further expand coverage to manage life-long chronic conditions.

Engagement with Future Reviews

The ADA commends CMS for its continued efforts to engage stakeholders in evaluating the inclusion of dental services that are intrinsically linked to medical procedures. The rigorous review process for determining which dental procedures qualify for the limited medically necessary dental benefit is essential to ensuring that Medicare beneficiaries receive comprehensive care that addresses both their medical and dental needs.

Given our longstanding expertise and history of collaboration with federal agencies, the ADA is uniquely positioned to contribute valuable scientific and clinical insights into this review process. As the leading authority in dental science and practice, the ADA brings unparalleled knowledge and experience that can greatly enhance the evaluation of dental services. **We request that the ADA be included in future reviews of scientific evidence related to the limited medically necessary dental benefit**. Such a partnership would enable CMS to leverage the ADA's extensive knowledge and resources, ensuring that decisions are both evidence-based, fiscally responsible, and in the best interest of the patient. This collaboration would not only enhance quality patient care but also streamline the review process, ensuring that Medicare policies are informed by the latest and most reliable scientific data.

High-Dose Bone Modifying Agents and Post-Treatment Dental Services

The ADA acknowledges and appreciates the progress made in the CY 2024 final rule concerning the inclusion of dental services linked to certain medical treatments. However, ambiguity remains regarding the specific timeframe during which dental services may be

reimbursed following treatments such as CAR-T therapy, the administration of high-dose bone-modifying agents for cancer, and radiation/chemotherapy for head and neck cancers. These treatments are known to have profound implications on oral health, necessitating clear and standardized guidelines for dental care post-treatment.

After receiving a query from a Medicare Administrative Contractor (MAC) on this issue, the ADA's Council on Scientific Affairs conducted a review of the available scientific evidence. This review focused on determining the appropriate duration for reimbursable dental services following the completion of cancer treatments, particularly those involving high-dose bone-modifying agents and radiation/chemotherapy for head and neck cancer. The findings and recommendations from this review have been submitted to the MAC in question (Appendix 1).

Given the ADA's role as a leading authority on dental health, we strongly believe that our evidence-based reviews will provide critical guidance for the consistent and effective administration of dental care in conjunction with the cancer treatments. **The ADA respectfully requests that CMS provide these recommendations as official guidance to all MACs**. Clear, evidence-based guidelines are essential to ensure consistent practices nationwide, thereby improving patient outcomes and significantly reducing the risk of complications associated with delayed or inadequate dental care.

Claim Modifiers

We appreciate the Centers for Medicare & Medicaid Services' efforts to implement electronic transactions for dental claims through 837D. ADA is supportive of this change. The ADA recognizes the necessity of including administrative claim modifiers, such as KX and GY, in the 837D and paper claim forms to facilitate efficient processing by MACs. These modifiers play a critical role in ensuring that claims are accurately categorized and processed, ultimately benefiting both providers and CMS.

However, there are significant concerns regarding the readiness of healthcare IT infrastructure to handle these new modifiers. There has been minimal testing among software developers, electronic dental record companies, and claims clearinghouses to verify that CDT codes with these modifiers can be processed accurately. This lack of testing raises the risk of widespread claim rejections, delayed payments, and increased administrative burdens for providers. Moreover, the ADA 2024 Paper Claim Form cannot accommodate modifiers at the procedure level.

Furthermore, there remains questions specifically about the GY modifier and its use by providers or their billing entities with dual eligible patients who utilize Medicare and Medicaid. CMS has repeatedly stated that Medicare in most instances will be the "first payor;" however, the use of the GY modifier and claims submission may confuse Medicaid dental providers. **ADA is seeking clarification as to whether a dental claim must be submitted with this modifier to coordinate dental benefits with a State's Medicaid Program, even in cases in which the Medicaid provider knows a dual-eligible patient will be ineligible for dental benefits under the medically necessary payment rules.** We request CMS to provide further clarity around the specific instances when a claim must be submitted with the GY modifier.

Considering these issues, the ADA requests that the requirement for KX and GY modifiers in dental claims be waived until January 1, 2026. This delay would provide sufficient time for comprehensive testing and demonstration among a broad range of providers, vendors, and payors. **During this period, the ADA recommends that CMS allow MACs to**

adjudicate claims without modifiers, with an approved claim report advising providers that modifiers will be required starting January 1, 2026. This approach would minimize disruption to quality patient care and ensure a smooth transition to the new coding requirements.

ICD-10 Implementation and Referrals

The ADA appreciates CMS's recognition of the challenges associated with including ICD-10 codes in Medicare dental claim submissions. The inclusion of these codes is intended to improve the accuracy and coordination of care between medical and dental providers, particularly for services that are intrinsically linked to medical procedures. However, the transition to ICD-10 coding presents significant challenges for the entire dental community, which has not historically been required to use these codes in claim submissions.

Furthermore, the ADA has received feedback from a MAC indicating that dental claims submitted by paper or electronically should include both medical ICD-10 codes for diagnosis and the name of the physician providing the Medicare-covered medical service. This requirement is intended to verify that an exchange of information or care coordination has occurred between the physician and the dentist.

However, there is currently no standard or example provided to define what qualifies as an exchange of information or care coordination. This lack of clarity creates significant challenges in coordinating care, particularly given that physicians and dentists often provide services in separate settings. To resolve this ambiguity and prevent inconsistencies in the claims process the ADA requests that CMS provide clear guidance to MACs on this issue. **Specifically, the ADA proposes the adoption of the "ADA Medicare Referral Form" (Appendix 2) as a standard template for verifying care coordination and reducing administrative burden**. This form, which has been approved by the ADA Council on Scientific Affairs, outlines the clinical information that should be communicated between referring physicians and dentists to ensure that dental services are appropriately linked to the underlying medical conditions and their Medicare-covered procedures. Implementing this form would not only streamline compliance with Medicare's requirements but also enhance the coordination of care between dental and medical providers.

Given that dental providers will need support transitioning to reporting ICD codes on a claim form for Medicare covered beneficiaries, t**he ADA supports CMS's consideration of delaying the requirement for ICD-10 codes in Medicare dental claim submissions until January 1, 2026**. While there has not been widespread adoption of ICD-10 coding in the dental field, the urgency of ensuring a smooth transition cannot be overstated. The ADA strongly urges CMS to implement this delay to provide the necessary time for dental providers to adjust to these new requirements, including updating their practice management systems and training staff on the correct use of ICD-10 codes. This transition period is crucial to avoid significant disruptions in care and to ensure that dental practices are fully equipped to comply with these new coding requirements.

Fee Guidance for Dental Services

Regarding the *Implementation of Payment for Dental Services Inextricably Linked to Other Specific Covered Services* section, the proposed rule states:

"In the CY 2023 PFS final rule, we stated that we believed that MACs are appropriately situated to establish contractor prices for dental services inextricably linked to covered services until we have additional pricing data that could enable national pricing (87 FR 69680). Therefore, dental services inextricably linked to covered services are currently contractor priced. However, we have received feedback from the MACs regarding pricing information for dental services inextricably linked to covered services, and the MACs have requested information that would support their efforts to assign payment amounts for such dental services. The MACs retain broad flexibility with respect to assigning payment amounts to claims for dental services inextricably linked to covered services; however, we seek to facilitate the sharing of available pricing information with the MACs for these purposes. Thus, we seek comment from the public on potential sources of payment information for the pricing of dental services inextricably linked to covered services. We note, for example, that publicly available data (such as Fair Health cost data) are available for purchase; however, we understand that this information may not directly inform payment amounts in a manner useful for the payment of Medicare claims for dental services. According to Fair Health's website, cost estimate information is based on claims for medical and dental services paid for by private insurance plans, including the country's largest insurers.234 We are also aware of other fee schedules, such as those used by state governments for state employees, or discount fee schedules, such as discount dental programs (for example, https://www.dentalbenefitprogram.com/groupfees.php?id=NEV). We aim to support the ongoing efforts by the MACs to price these services and seek any information from the public that may serve to support and inform the MAC development of payment amounts for dental services inextricably linked to covered services."

We also note that the Physician Payment System (Sec. 1848. [42 U.S.C. 1395w–4]) states that "*The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services."*

As the ADA, an organization representing dentists who are recognized as physicians, we appreciate CMS's proposal to solicit fee guidance specifically for dental services that are intrinsically linked to medical procedures. We maintain that the current mechanisms for determining fee reimbursement for medical services under the Medicare physician fee-for-service schedule, such as the resource-based relative value unit system (RBRVS) as used with the CPT coding system is not applicable to dentistry. This request from CMS represents a significant step forward to begin to address payment for dental services reported using CDT codes.

Currently, a widely accepted 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 700+ CDT Codes to develop a viable fee schedule using the RBRVS methodology. In addition, other features of the medical 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 for the CDT coding system.

Further, a dental practice typically has high 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). The weighting of practice expenses, physician work and malpractice insurance used in the development of the relative value units for the physician fee schedule are unfavorable to the practices that are equipment heavy.

For these reasons, until CMS has adequate claims experience to establish a national fee schedule to guide payment for dental services, intrinsically linked to covered medical services, **the ADA requests that the fee guidance reflective of current market data be adopted to support and inform interim contractor pricing for dental claim reimbursement**. This will ensure reimbursement to dental providers is adequate compared to medical physicians, and that geographic variation in payment of dental services across different regions and providers is considered.

The ADA is responding to this solicitation by offering guidance on fees for dental services that are necessary to support provision of dental services in an outpatient setting. We are able to provide such guidance searchable by CDT code for each MAC locality. A sampling of the fee guidance for a few CDT codes for a couple of MAC localities is available below as an example.

Table 1: Sample of ADA's Fee Guidance for Various CDT Codes in 4 MAC Carriers/Localities

Carrier	Locality	CDT	Fee Guidance
10112	00	D0120	$58
01182	18	D0703	$100
12202	01	D0170	$133
06302	00	D0350	$97

The proposed fee guidance is based on rates charged by dentists for dental services in 2023 and are inclusive of multiple practice settings and dental specialties, ensuring that they reflect the costs associated with providing these services in today's healthcare environment. The ADA has acquired market data to build this look-up tool expressly for the purpose of responding to this solicitation for comment from CMS. The look-up tool includes guidance across all covered CDT codes for all MAC localities. We look forward to providing access to this tool to CMS, if the agency or the Medicare Administrative Contractors express interest.

Coding for Sleep Apnea Devices

The ADA supports the recognition of Current Dental Terminology (CDT) codes for the billing of oral sleep apnea appliances under the Medicare Physician Fee Schedule (PFS). We believe that allowing dental providers to utilize CDT codes, specifically D9947 through D9957, for these services will significantly reduce the administrative burden and streamline the billing process. As dental practitioners are often the primary providers of these appliances, aligning the billing codes with their existing practice frameworks is critical. We encourage CMS to consider this recommendation as part of its ongoing efforts to refine payment policies for diagnosis and management of sleep apnea.

While the ADA is appreciative of CMS taking the necessary steps to align more with the industry's coding framework, ADA is also supportive of use of DME coding for sleep apnea devices for those healthcare professionals who feel that DME coding works best for their patients and practice.

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The ADA appreciates the opportunity to provide comments on the CY 2025 Payment Policies under the Physician Fee Schedule and related changes. We commend CMS for its ongoing efforts to integrate dental and medical care under Medicare, recognizing the critical role that oral health plays in overall health and well-being.

We look forward to continuing our collaboration with CMS to ensure that Medicare beneficiaries receive the highest standard of care, with fair and adequate reimbursement for the services provided to help construct the conditions for an optimal patient quality outcome. Together, we can continue to enhance patient overall health opportunities and ensure that oral health is fully integrated into the broader healthcare landscape.

On behalf of the 159,000 members of the American Dental Association, thank you for considering our request. Please contact Jim Schulz, Senior Vice President of Government Affairs, for more information at schulzJ@ada.org.

Sincerely,

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