

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-02 Medicare Benefit Policy</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 11995</b>	<b>Date: April 21, 2023</b>
	<b>Change Request 13181</b>

**SUBJECT: Medicare Policy Updates for Dental Services as Finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (MPFS) Final Rule**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update Internet Only Manual (IOM) Medicare benefit policy for dental services as finalized in the CY 2023 MPFS final rule.

**EFFECTIVE DATE: January 1, 2023**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: May 12, 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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	15/150/Dental Services

**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:**

**Business Requirements  
Manual Instruction**

# Attachment - Business Requirements

Pub. 100-02	Transmittal: 11995	Date: April 21, 2023	Change Request: 13181
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**EFFECTIVE DATE: January 1, 2023**

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## I. GENERAL INFORMATION

**A. Background:** As indicated under the general exclusions from coverage in 42 Code of Federal Regulations (CFR) 411.15(i), and subject to exceptions, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.

Two statutory exceptions to this policy allow for Medicare payment for inpatient hospital services in connection with the provision of dental services if the individual, because of the individual's 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.

There are some other instances where medical services necessary to diagnose and treat the individual's underlying medical condition may require the performance of certain dental services and the dental exclusion may not apply.

Dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services are not excluded. Such non-excluded dental services could include dental and oral examinations as well as medically necessary diagnostic and treatment services to eliminate an oral or dental infection.

**B. Policy:** This update provides examples of scenarios in which Medicare payment for dental services is not excluded. These examples do not provide an exhaustive list of scenarios.

CMS makes payment for covered dental services furnished by a physician, including a doctor of dental medicine or dental surgery, or a non-physician practitioner in accordance with state law and scope of practice in the state where the service is furnished.

Integration between the health care professionals furnishing dental and other covered services is a key component in assessing whether dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services.

Payment may also be made for covered dental services and supplies furnished incident to the professional services of the billing physician or practitioner by auxiliary personnel. For example, services performed by a dental technician, dental hygienist, dental therapist, or registered nurse who is under the direct supervision of the physician, including a dentist, are covered if the services meet the requirements for "incident to" services as described in 42 CFR Subsection (§) 410.26.

Ancillary services and supplies furnished incident to covered dental services are also not excluded, and Medicare payment may be made under Part A or Part B, as applicable, regardless of 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, otherwise covered procedures.

MACs have the flexibility to determine on a claim-by-claim basis whether a patient’s circumstances do or do not fit within the terms of the statutory preclusion or exceptions specified in section 1862(a)(12) of the Act and our regulation at 42 CFR § 411.15(i). These policies do not prevent a MAC from making a determination that payment can be made for dental services in other circumstances under which the dental services are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services, but are not specifically addressed in final rules, manual provisions, and the finalized amendments to § 411.15(i).

## 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	
13181.1	Contractors shall be aware of the updates listed in this CR for Chapter 15 of Pub. 100-02.	X	X							

## III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13181.2	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 content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X			

## 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: N/A**

**V. CONTACTS**

**Pre-Implementation Contact(s):** Erick Carrera, erick.carrera@cms.hhs.gov , Scott Lawrence, Scott.Lawrence1@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**

## 150 - Dental Services

*(Rev. 11995; Issued: 04-21-23; Effective: 01-01-23; Implementation: 05-12-23)*

As indicated under the general exclusions from coverage *in 42 CFR 411.15(i), and subject to exceptions*, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. “Structures directly supporting the teeth” means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. *Two statutory exceptions to this policy allow for Medicare payment for inpatient hospital services in connection with the provision of dental services if the individual, because of the individual’s 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.*

*There are some other instances where medical services necessary to diagnose and treat the individual’s underlying medical condition may require the performance of certain dental services and the dental exclusion may not apply. Dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services are not excluded. Such non-excluded dental services could include dental and oral examinations as well as medically necessary diagnostic and treatment services to eliminate an oral or dental infection. We note that the necessary treatment to eradicate an infection may not include the totality of recommended dental services for a given patient. For example, if an infected tooth is identified in a patient requiring an organ transplant, cardiac valve replacement, or valvuloplasty procedure, the necessary treatment would be to eradicate the infection, which could result in the tooth being extracted. Additional dental services, such as a dental implant or crown, may not be considered immediately necessary to eliminate or eradicate the infection or its source prior to surgery. Therefore, such additional services would not be inextricably linked to, and substantially related and integral to the clinical success of, the organ transplant, cardiac valve replacement, or valvuloplasty services. As such, no Medicare payment would be made for the additional services that are not immediately necessary prior to surgery to eliminate or eradicate the infection.*

*Payment may be made under Medicare Parts A and B for dental services, prior to or, in certain circumstances, contemporaneously with, certain covered medical services furnished in the inpatient or outpatient setting. Scenarios in which Medicare payment for dental services is not excluded include, but are not limited to, the examples below.*

### **EXAMPLE 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. For purposes of this manual only, hematopoietic stem cell and bone marrow transplants have a similar risk of infection to organ transplants, and an oral examination and subsequent necessary diagnostic and treatment services, performed in either the inpatient or outpatient setting would be payable under this example. (The term “organ transplant” may not be considered to include bone marrow or hematopoietic stem cell transplants in all contexts. These services are not considered organs for purposes of the definition of organs in 42 CFR 486.302 or Medicare payment policies for organ procurement organizations.)*

**EXAMPLE 2:**

*The reconstruction of a ridge performed as a result of and at the same time as the surgical removal of a tumor. The reconstruction of a ridge performed primarily to prepare the mouth for dentures is a noncovered procedure.*

**EXAMPLE 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.*

**EXAMPLE 4:**

*The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.*

*See Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, Definitions for provisions applicable to doctors of dental surgery or dental medicine.*

*CMS makes payment for covered dental services furnished by a physician, including a doctor of dental medicine or dental surgery, or a non-physician practitioner in accordance with state law and scope of practice in the state where the service is furnished.*

*Medicare Part A and Part B payment is made for dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services. Integration between the health care professionals furnishing dental and other covered services is a key component in assessing whether dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services. This integration could take the form of a referral or other exchange of information between the physicians, non-physician practitioners, or other practitioners involved in the delivery of dental and other covered medical services.*

*This coordination should occur between the health care professionals furnishing the dental and other covered services regardless of whether both individuals are affiliated with or employed by the same entity. If there is no exchange of information, or integration, between the health care professionals regarding the dental services, then there would not be an inextricable link between the dental and covered medical services within the meaning of our regulation at § 411.15(i)(3). This is because the professionals would not have the necessary information to decide that the dental service(s) is inextricably linked to a covered medical service, and therefore, not subject to the statutory payment exclusion under section 1862(a)(12) of the Act.*

*Payment may also be made for covered dental services and supplies furnished incident to the professional services of the billing physician or practitioner by auxiliary personnel. For example, services performed by a dental technician, dental hygienist, dental therapist, or registered nurse who is under the direct supervision of the physician, including a dentist, are covered if the services meet the requirements for “incident to” services as described in 42 CFR § 410.26.*

*Ancillary services and supplies furnished incident to covered dental services are also not excluded, and Medicare payment may be made under Part A or Part B, as applicable, regardless of 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, otherwise covered procedures.*

*No payment is made for dental services that may be inextricably linked to, and substantially related and integral to the clinical success of other non-covered services. Such services remain subject to the statutory exclusion at § 1862(a)(12) for items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. More specifically, dental services inextricably linked to a non-covered medical service(s) are not covered or payable. For example, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. Similarly, with rare exception, the removal of a torus palatinus (a bony protuberance of the hard palate) is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, Medicare does not pay for this procedure.*

*MACs have the flexibility to determine on a claim-by-claim basis whether a patient's circumstances do or do not fit within the terms of the statutory preclusion or exceptions specified in section 1862(a)(12) of the Act and our regulation at 42 CFR § 411.15(i). These policies do not prevent a MAC from making a determination that payment can be made for dental services in other circumstances under which the dental services are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services, but are not specifically addressed in final rules, manual provisions, and the finalized amendments to § 411.15(i).*