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## *Treatment of Certain Dental Claims as a Result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*

**Note:** This article was updated on April 9, 2013, to reflect current Web addresses. All other information remains unchanged.

### Provider Types Affected

Dentists

### Provider Action Needed



#### **STOP – Impact to You**

As of February 8, 2004, for **outpatient** dental services that are not covered by Medicare, you do not need to submit a claim to Medicare and receive a denial for if the beneficiary has group secondary or supplemental coverage. Group health plans are prohibited from requiring such determinations as of February 8 for such services.



#### **CAUTION – What You Need to Know**

A group health plan may continue to require such determinations in cases involving or appearing to involve inpatient dental hospital services, or other dental services covered by Medicare.



#### **GO – What You Need to Do**

Please amend your procedures regarding dental service claims for Medicare patients as reflected by the new legislation. See the Additional Information section for further illumination.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

## Background

Under present law, the Medicare benefit does not include coverage of most dental services. Some insurers have required dentists to receive a claim denial from Medicare before they will process a claim from the dentist for a Medicare beneficiary holding coverage from that group health insurer. Under section 950 of the Medicare Prescription Drug, Improvement, and Modernization act of 2003, a group health plan providing supplemental or secondary coverage to Medicare beneficiaries cannot require dentists to obtain a claim denial from Medicare for dental services that are not covered by Medicare before paying the claim.

However, a claims determination, i.e., a submission of a claim to Medicare, **may be required** for inpatient dental hospital services or dental services **specifically covered** by Medicare. (Payment may be made under part A for these services).

This section of the new legislation is to be effective 60 days after enactment of the legislation, which was enacted on December 8, 2003. Thus, this provision is effective as of February 8, 2004.

## Additional Information

For your convenience, the actual text of Section 950 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reads as follows:

### “Sec. 950. Treatment of Certain Dental Claims

(a) In General—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 948 (a), the following new subsection:

(k) (1) Subject to paragraph (2), a group health plan (as defined in subsection (a) (1) (A) (v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a Medicare claims determination under this title for dental benefits specifically excluded under subsection (a) (12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.”

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