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The mission of ADEA is to lead and support the health professions community in preparing future-ready oral health professionals.

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September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

The American Dental Education Association (ADEA) thanks you for the opportunity to offer its comments on the **Medicare Program; Payment Policies Under the Physician Fee Schedule; Coverage of Specified Dental Services (CMS-1770-P; RIN 0938-AU81)**.

ADEA is The Voice of Dental Education. Our mission is to lead and support the health professions community in preparing future-ready oral health professionals. Our members include all 69 U.S. dental schools; all 10 Canadian dental schools; and more than 800 allied and advanced dental education programs, 50 corporations and 18,000 individuals. Our activities encompass a wide range of research, advocacy, leadership development, collaboration and publications, including the esteemed *Journal of Dental Education*® and the dental school application services ADEA AADSAS®, ADEA PASS®, ADEA DHCAS® and ADEA CAAPID®.

Oral health is an essential component to overall health and well-being and incorporating it into the Medicare delivery model should be explored as an opportunity to improve patient outcomes and control high-cost chronic conditions. Nearly 24 million Medicare beneficiaries lack critical oral health coverage, and 76.5 million adult Americans lack dental coverage overall. Many older adults did not receive regular dental services when they were younger and, as a result, experience more dental disease and need more extensive treatment to maintain their oral and overall health. Among all Medicare and Medicare Advantage recipients, at least 75% of total dental costs were paid out of pocket, adding strain to household budgets for people on fixed incomes.[1]

ADEA applauds the Centers for Medicare & Medicaid Services (CMS) efforts to acknowledge the importance of whole-person care in producing successful and cost-effective outcomes. A major limiting factor in making improvement in patient outcomes is the lack of integration between health professionals generally and the historic separation of dental medicine from

[1] The Glaring Scope of Racial Disparities in Oral Health, Care Quest Institute for Oral Health.

the practice of medicine more broadly. The mouth is a part of the body, and many diseases have manifestations in their early stages in the oral cavity.

A study of medical screenings in a dental office for diabetes and cardiovascular disease conditions (high blood pressure) showed potential health care cost savings ranging from $42.4M ($13.51 per person screened) to $102.6M ($32.72 per person screened) over a one-year period.[2] Providing better access to dental care using a whole-person, integrative approach is imperative. It not only improves the quality of the beneficiaries' lives, but also lowers overall health care costs.

ADEA also commends CMS's continued efforts to advance health equity. In the article "Integrating Oral and Systemic Health: Innovations in Transdisciplinary Science, Health Care and Policy," the authors note that the perception that oral and dental medicine are less important to overall health and well-being, and therefore are not prioritized in funding or access to care, has led to underserved communities having significant and consequential disparities in oral health compared to those seen in other areas of health.[3]

According to the Centers for Disease Control and Prevention, twice as many non-Hispanic Black or Mexican American adults have untreated cavities as non-Hispanic White adults, and among working-age U.S. adults, over 40% of low-income and non-Hispanic Black adults have untreated tooth decay.[4] The impact of untreated oral disease continues to accrue as these populations age. More than nine in ten older adults have had cavities, and one in six have untreated cavities. Older non-Hispanic Black or Mexican American adults have two to three times the rate of untreated cavities as older non-Hispanic White adults.[5] Untreated and active dental disease inequitably affects the general health outcomes of chronic diseases, leading to increased morbidity and costs. We are pleased that CMS acknowledges this in its proposed rule.

ADEA will focus its comments on the coding of medically necessary services dental services and payment of medically necessary dental services.

I. Coding of Medically Necessary Dental Services

To facilitate coverage, we also urge CMS to maintain the ADA's CDT codes (D codes) for billing and payment purposes. More specifically, for D codes describing a Medicare-covered procedure, ADEA has identified the D codes that should be assigned a status code of "R." As noted above, many of the codes already have an "R" status indicator, but CMS should update relevant D codes that have a status indicator of I or N to R where appropriate. Further, in cases where a CPT and D code both describe the relevant procedure, CMS should permit dentists to submit claims using the D code.

CDT codes are the national standard for dental billing and payment purposes, regardless of payer type. A limited number of dental offices are familiar with or able to bill CPT codes.[6] To

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[2] Nasseh K, Greenberg B, Vujicic M, Glick M. The effect of chairside chronic disease screenings by oral health professionals on health care costs. Am J Public Health 2014;04(4), 744-50.
[3] Somerman M, Mouradian WE.Integrating oral and systemic health: innovations in transdisciplinary science, health care and policy. Front Dent Med 2020; 1:599214. doi: 10.3389/fdmed.2020.599214.
[4] Centers for Disease Control and Prevention. Disparities in Oral Health.
[5] Id.
[6] The American Dental Association (ADA) codes on dental procedures and nomenclature, known as CDT codes and here referred to as D codes.

avoid creating an additional burden on dentists that would negatively impact access to care, improved patient care and outcomes for medical services that CMS seeks through this proposed rule, ADEA believes these D codes are, and will continue to be, the best available codes for CMS to use for covered medically necessary Medicare dental treatments.

Because D codes would be payable only in medically necessary situations, ADEA believes CMS should continue to use the "R" status indicator for covered D codes. As CMS knows, the R status indicator denotes restricted coverage and contractor pricing.[7] We urge CMS to review the D codes and assign, as appropriate, the R status indicator to ensure the appropriate codes are billable to Medicare in medically necessary situations. In addition to the 84 codes that currently have an R status indicator, we urge CMS to modify the status indicator of the D codes, attached hereto as Appendix A, that will qualify for coverage under the Final Rule from an I or N to an R status indicator, so that appropriate payment can be made subject to Medicare Administrative Contractor (MAC) determinations and contractor pricing.

We appreciate CMS's attention to this detail and urge that the relevant code status indicators be updated in the Final Rule.

II. Payment of Medically Necessary Dental Services

a. Payment Rates

In the Proposed Rule, CMS solicited comments on potential future payment models for dental and oral health care services (see 87 Fed. Reg. at 46,040). Medically necessary dental care should increase access to needed oral health care and allow the patient to keep their own dentist. As this Proposed Rule focuses solely on medically necessary dental services, many procedures considered part of the dental standard of care or essential for maintaining oral health will continue to be excluded from Medicare coverage. Patients should be able to easily access any Medicare-covered medically necessary dental services from the same provider where they receive their non-Medicare-covered dental services. To limit barriers that will result in increased time and cost to the patient, ADEA strongly urges CMS to create a payment mechanism that limits additional burden on a patient in accessing covered dental services and increases access to needed oral health care.

Currently, MACs make a claim-by-claim determination as to whether a patient's circumstances do or do not fit within the coverage standard as set forth by regulation and CMS policy (see 87 Fed. Reg. at 46,033). We support that continued use of contractor payment discretion on a claim-by-claim basis, *provided that* CMS issues national guidelines for MACs to follow for payment of the relevant dental services. More specifically, while at present MACs do not have specific guidance for establishing prices for covered dental services, such pricing benchmarks do exist and could readily be used by CMS to set payment guidelines. ADEA specifically recommends that CMS use existing data collected by FAIR Health, a non-profit organization aimed at being a trusted and transparent source of health care cost and utilization data for consumers and practitioners,[8] which in our view represents an accurate guidepost for MACs to follow when setting prices. FAIR Health provides cost estimates for CDT procedures in a given geographic area by using both commercial and Medicare data to create the out-of-network and

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[7] Related, ADEA appreciates that CMS and the MACs will need to ensure that D codes billed to Part B were actually part of a designated medical treatment. The use of appropriate ICD Codes on the claim will allow the MACs to reach that determination so the agency is appropriately paying for medically necessary treatment and dental treatments.
[8] FAIR Health Consumer, *Mission*, available at www.fairhealthconsumer.org/#about.

uninsured prices, as well as generate fee estimates for practitioners.[9] We further urge CMS to require MACs to price covered dental services at or around 80% of average charges set forth in the most recent and currently available FAIR Health Dental Benchmarks. We recommend benchmarking against billed charges as they represent a reasonably accurate estimate of the cost of dental services and as dental charges have been relatively stagnant, and insurance reimbursement has been stagnant or declining in the past decade.

We recommend that the average charge be adjusted for differences in market prices across geographic markets, either by analyzing the FAIR Health data at a regional level or by adjusting the national average for geographic differences in practice costs. For 2023, we recommend CMS could use the Physician Fee Schedule's Geographic Practice Cost Index (GPCI) for practice expense, although we recommend that CMS develop a dental-specific GPCI for use in later years to better reflect the costs of dental practice. Given that the Medicare pricing could influence future years' cost reporting, we suggest (1) that the most recent and currently available FAIR Health data serve as the benchmark pricing year, and (2) that CMS updates dental services prices using the Medicare Economic Index (MEI), its methodology of estimating annual changes in physicians' operating costs and earning levels, but adapted to represent the relative importance of dental practice operating cost components.[10]

We also acknowledge that in the future, CMS may seek to provide coverage for additional D codes that are shown to be integral and inextricably linked to the clinical success of other covered services. ADEA thus recommends that when new D codes become eligible for coverage and are provided with an R letter indicator, that CMS continue using 2022 FAIR Health data to set initial pricing that can then be adjusted by analyzing factors set forth in the MEI methodology. Finally, as noted above, to the extent there are D codes that describe the same services as CPT codes, we urge CMS to allow dentists to bill the relevant D codes for consistency, coding accuracy and simplicity.

b. Location of Treatment

CMS sought comments regarding its proposal to provide medically necessary dental services, regardless of whether the services are furnished in an inpatient or outpatient setting. ADEA strongly agrees with this proposal and recommends that CMS finalize its policy of allowing for dental treatment to be appropriately provided by dentists and their teams in outpatient or inpatient facilities as necessary. Currently, the vast majority of dental services are provided by dentists and their teams in a dental office that is not connected to a hospital or inpatient setting. Furthermore, dentistry today is still primarily small private practices of fewer than 10 dental team members, and half of private practice dentists are the sole dentist in their dental office.[11] Treatments may also be provided in assisted living and private residences as needed and appropriate, usually by dentists who bring mobile dental equipment to the patient, setting up and taking down the surgical equipment for each location and patient. Dental offices are equipped more like surgical suites than a primary care physician's office, with significant surgical equipment, water lines, suction, sterilization and infection control such as personal protective

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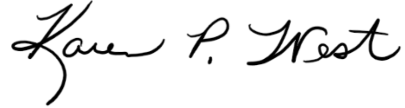
[9] FAIR Health Consumer, Dental Services. At: www.fairhealthconsumer.org.
[10] Medicare Economic Index Technical Advisory Panel, Charter, (Accessed Aug. 8, 2022). As with the GPCI, we urge CMS to develop a dental-specific MEI for future use to better reflect dental cost changes.
[11] American Dental Association. Health Policy Institute. The Dentist Workforce – Key Facts. At: ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0221_1.pdf?rev=1829a4f788c14974a1ac89ff1e288c0f&hash=A27C6AD199EB6FCAB15DB069BAF0CC85.

equipment. Dentists directly employ members of the dental team, including hygienists, dental assistants, billing and scheduling staff. Thus, dental rates must be set in a way that acknowledges the full cost of dental care and services.

Sincerely,



Karen P. West, D.M.D., M.P.H.
President and CEO

Attachment: Appendix A: ADEA Medicare D Code Reference Table

Appendix A: ADEA Medicare D Code Reference Table

ADEA has identified CDT codes (D codes) that describe the recommended medically necessary dental services. ADEA urges CMS to review the D codes and assign, as appropriate, the R status indicator to ensure that the appropriate codes are billable to Medicare in medically necessary situations. Many of the codes already have an R status indicator and we urge CMS to modify the status indicator of the additional D codes that will qualify for coverage under the Final Rule from an I or N to an R status indicator, so appropriate payment can be made subject to MAC determinations and contractor pricing.

EXAMINATION CODES	
D0120	Periodic exam
D0140	Limited/problem focused
D0150	Comprehensive
D0160	Detailed and extensive/problem focused
D0170	Re-evaluation of a limited/problem focused condition that did not receive treatment
D0171	Re-evaluation - post operative visit
D0180	Comprehensive periodontal evaluation (new or established patient)

DIAGNOSTIC CODES	
D0431	Adjunctive, pre-diagnostic test that aids in detection of mucosal abnormalities, including premalignant and malignant lesion (not cytology or biopsy)
D0460	Pulp vitality
D0472	Accession of tissue, gross examination, preparation and transmission of written report
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report
D0480	Accession of exfoliative cytologic smears, microscopic evaluation, written report preparation and transmission
D0486	Lab accession of transepithelial cytologic sample, microscopic examination, report preparation and transmission
D0999	Unspecified diagnostic procedure, by report

IMAGING	
D0210	Full mouth series
D0220	Single periapical film
D0230	Additional periapical films
D0270 - D0274	1-4 bitewing films
D0277	Vertical bitewing films
D0330	Panoramic film
D0364-D0371	Cone Beam CT captures with interpretation
D03 80-D03 84	Cone Beam CT image not associated with interpretation
D0385	Maxillofacial MRI image capture
D0386	Maxillofacial ultrasound image capture
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report

EMERGENCY/EXTRACTIONS/ORAL SURGERY/OTHER	
D9110	Palliative
D3220	Therapeutic pulpotomy
D7140	Extraction, erupted tooth or exposed root
D7210	Extraction, erupted tooth requiring bone removal, sectioning of tooth, including mucoperiosteal flap elevation
D7250	Extraction of residual tooth roots, including soft and hard tissue removal and closure
D7251	Coronectomy
D7220	Extraction, impacted tooth, soft tissue
D7230	Extraction, impacted tooth, partial bony
D7240	Extraction, impacted tooth, complete bony
D7510	Abscess, incision and drain, intraoral soft tissue
D7511	Abscess, incision and drain, intraoral soft tissue complicated (incision through skin)
D7520	Abscess, incision and drain, extraoral soft tissue
D7521	Abscess, incision and drain, intraoral soft tissue complicated (drainage of multiple fascial spaces)

D3310-D3330 and D3921	Endodontic procedures for anterior and posterior teeth followed by decoronation (used when full tooth extraction poses a risk to bone healing/tissue health)
D7950	Mandible/maxillary bone graft
D7953	Bone graft
D4266 and D4267	Resorbable and non-resorbable barriers
D7440 and D744 1	Removal of malignant tumors
D7450, D7451, D7460 and D7461	Removal of benign cysts or tumors
D7610 to D7740	Fracture repair, including wiring/immobilization of teeth
D7880	Occlusal orthotic device (used for TMD)
D4322 and D4323	Intra and extra coronal splints that link teeth together to provide stabilization and strength
D5986	Fluoride gel carrier
D5988	Surgical splint

PERIODONTAL CARE AND DISEASE PREVENTION	
Dl 110	Prophylaxis
D4341 and D4342	Scaling and root planning procedures
D4910	Periodontal maintenance
D4355	Full mouth debridement
D4999	Unspecified periodontal procedure, by report
D1354	Silver diamide fluoride (to prevent dental caries from progressing to oral foci of infection)
Dl 206 and Dl 208	Topical fluoride applications (in office procedure)
D5986	Fluoride gel carrier (for at home fluoride therapy)
D1330	Oral health instruction

FILLINGS	
D2140 to D21 61	Amalgam fillings, 1-4 or more surfaces
D2330 to D2335	Resin based composite fillings, anterior teeth, 1-4 or more surfaces
D2391 to D2394	Resin based composite fillings, posterior teeth, 1-4 or more surfaces