Medicare Medical Policy

Administrative Guideline for Dental Services

MEDICARE MEDICAL POLICY NUMBER: 162

Effective Date: 6/1/2024

Last Review Date: 5/2024

Next Annual Review: 5/2025

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
IMPORTANT NOTE: The CMS references below are intended to provide instruction on how Medicare might determine a procedure to be either medical or dental in nature, as well as CMS coverage (or non-coverage) position statements regarding dental services in general. According to Medicare, "[i]tems and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered."[1,2] Note that Medicare states, "[c]overage is not determined by the value or the necessity of the dental care but by the type of service provided and the anatomical structure on which the procedure is performed."[3] Therefore, dental services or services rendered in connection to non-covered dental procedure are statutorily excluded under Original Medicare. However, for Medicare Advantage members, for services determined to be dental in nature, benefit eligibility should be considered to determine if benefits may exist for the service under the dental benefit plan.	
Dental services, general	• Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5 – Definitions, §70.2 - Dentists • Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §150 - Dental Services • Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §140 - Dental Services Exclusion • Noridian, Jurisdiction F – Medicare Part B, Dental Services **NOTE:** • Effective January 2023, CMS finalized a ruling to expand their dental position to instances where dental services are so integral and inextricably linked to the clinical success of an otherwise covered medical service, therefore, making the dental procedure substantially related and integral to that primary medical service, and potentially eligible for coverage. • This updated dental coverage extends to dental services needed to identify, diagnose, treat an oral/dental infection in a patient requiring

	an organ transplant, cardiac valve replacement, or valvuloplasty procedure. • This coverage is limited to the extent of dealing with the infection and the necessary treatment to eradicate the infection (e.g., tooth extraction); however, this potential coverage does **not** extend to dental procedures beyond that, such as the provision of implants, crowns or dentures – these remain non-covered as "dental in nature." • Once Medicare references and manuals are updated to incorporate the details of this final ruling, these notes will be removed from this policy.
Treatment of Temporomandibular Joint (TMJ) Syndrome	• Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §150.1 - Treatment of Temporomandibular Joint (TMJ) Syndrome • *The references above may also be applicable*
Inpatient Dental Services	• Medicare Benefit Policy Manual, Chapter 1: Inpatient Hospital Services Covered Under Part A, §70 - Inpatient Services in Connection With Dental Services • *The references above may also be applicable*
Dental Examination Prior to Kidney Transplant	• National Coverage Determination (NCD) for Dental Examination Prior to Kidney Transplantation (260.6) • *The references above may also be applicable*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

- Dental Anesthesia Services, MP328
- Orthognathic Surgery, MP160
- Oral and Sleep Position Appliances for Sleep Disorder Treatment, MP45

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

BACKGROUND

Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his 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."

Medicare also states, “Coverage is not determined by the value or the necessity of the dental care but by the type of service provided and the anatomical structure on which the procedure is performed.” However, effective January 2023, in a Federal Register, CMS finalized a ruling to expand their dental position to recognize that there are instances where dental services are so integral to other medically necessary services that such dental services are inextricably linked to the clinical success of an otherwise covered medical service, and therefore, are substantially related and integral to that primary medical service, making certain dental procedures in select clinical situations also eligible for coverage.

CMS states this updated dental coverage extends to dental services needed to identify, diagnose, treat an oral/dental infection in a patient requiring an organ transplant, cardiac valve replacement, or valvuloplasty procedure. This coverage is also limited to the extent of dealing with the infection and the necessary treatment to eradicate the infection, such as tooth extractions; however, this potential coverage would not extend to dental procedures beyond that, such as the provision of implants, crowns or dentures – these would remain non-covered as “dental in nature.”

CMS also states that while they considered dental services prior to the initiation of other therapies and procedures, as well as dental services for individuals with certain medical conditions (e.g., diabetes and certain lung and cardiac diseases), this expansion in coverage does **not** extend to dental services prior to immunosuppressant therapy, joint replacement surgeries, or other surgical procedures, nor was it extended to other medical conditions at this time, but they will continue to evaluate.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

CODES*		
CPT	None	
HCPCS	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.

- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §150 - Dental Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf. Accessed 10/25/2022.
2. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §140 - Dental Services Exclusion. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf. Accessed 10/25/2022.
3. Medicare Dental Coverage Web page. https://www.cms.gov/medicare/coverage/medicaredentalcoverage?redirect=/medicaredentalcoverage/. Accessed 10/25/2022.
4. Retired Noridian Local Coverage Article (LCA) for *Routine Dental Services* (A52977); Retired 1/1/2023; Available at: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52977

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
12/2022	Interim update (converted to new format 2/2023)
4/2023	Interim update; moved retired LCA A52977 from criteria to "References"
6/2023	Annual update, no changes
6/2024	Annual update, no change to criteria, update title