Issue Brief – Medicare Coverage of Dental Services

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The Problem

Mr. Jones tripped and fell on his driveway, fracturing his cheek and jaw, tearing the musculature, and crushing several teeth. He was stabilized in the emergency room on the day of the accident, but in the days that followed he required assessments and procedures to repair damage and restore function to his face and mouth. Medicare covered nearly all of his treatment, but denied coverage of the extractions and a crown for his shattered teeth on the basis that payment for dental care is excluded by the Medicare statute.

Similar coverage denials are encountered by Medicare beneficiaries who need dental services to medically manage or treat an underlying and immediate injury, illness, or disease.

Background

When Congress established the Medicare program in 1965, it excluded payment for certain items and services that are not commonly associated with illness, but are needed in the normal process of aging. Excluded items and services include routine check-ups, hearing and eye examinations, hearing aids, eyeglasses, orthopedic shoes, and dental treatment. However, the legislative history made clear that Congress did not intend for these exclusions to apply when the item or service was medically necessary to diagnose a specific complaint or treat a serious ailment.

Despite the strong clarification that the payment exclusions should apply only in routine situations, the Center for Medicare & Medicaid Services (CMS), which administers the Medicare program, has interpreted the statutory exclusion broadly with respect to dental services since the inception of the program. Thus, beneficiaries like Mr. Jones may be denied payment for medically-related dental services that Congress likely intended for Medicare to cover.

Medicare Policy on Dental Services

Traditional Medicare does not cover preventive dental services like exams, cleanings, and x-rays. Nor does it cover basic or major restorative services and items like fillings, extractions, root canals and dentures. When such dental work must be performed in a hospital setting due to the severity of the procedure or the patient's underlying medical condition or clinical status, Medicare will cover the costs of hospitalization (including room and board, anesthesia, and x-rays), but not the procedure itself or fees for the dentist and other physicians.

Under CMS' policy, Medicare will cover extractions needed to prepare the jaw for cancer radiation therapy, and inpatient oral examinations (but not treatment) prior to kidney transplants and, in certain settings, heart valve replacements. The Medicare Benefits Policy Manual (Policy Manual) also recognizes that payment must be made for a non-covered dental procedure when it is "incident to and an integral part of a covered service performed by the dentist." However, the policy requires that the dental procedure be carried out *at the same time and by the same dentist* who performs the primary covered service. Coverage is granted only in rare circumstances under this exacting test. An example given in the Policy Manual is that Medicare will pay for reconstruction of a ridge when performed as a result of and at the same time as the surgical removal of a tumor (a covered procedure), but not to prepare the mouth for dentures or other dental purpose.

In the above case of Mr. Jones, depending on the facts, there may be an argument that the dental services he required are entitled to coverage because they were "incident to and an integral part of" the reduction of his fractured jaw or cheek bone.

Judicial Interpretation of Medicare Dental Policy

The "same time/same dentist rule" is viewed by some as being unduly restrictive, as well as flawed from a clinical perspective. The rule hinges Medicare coverage on the timing of the dental procedure, who administers it, and the anatomical location of the primary covered procedure, rather than taking into account clinical standards and protocols and whether the procedure is, medically-speaking, incident to and an integral part of a covered medical procedure or course of treatment

Recently, in *Lodge v. Burwell,* 227 F.Supp.3d 198 (D. Conn. 2016), a federal district court cautioned against "a too-literal application" of the incident-and-integral coverage rule to require that services be performed by the same doctor and on the same occasion. The decision states that rigid adherence to the same-time/same-dentist rule "is not compelled by the language of the Act and could under certain circumstances lead to results at odds with the purpose of the Act[.]" It further suggests that the strict requirements of the rule "stand in tension" with the remedial ends of the Act, which would "permit payment for dental services whose primary purpose is not merely the care or treatment of teeth."

In an earlier case, *Maggio v. Shalala,* 40 F.Supp.2d 137 (W.D.N.Y. 1999), a beneficiary won coverage for dental items and services needed to address nutritional deficiencies that affected his treatment for leukemia and thrombocytopenia. The court in *Maggio* found that the crowns and prosthesis at issue were "incident to and an integral part of" the beneficiary's covered treatment for leukemia. A key fact was that the claimant's primary oncologist ordered and supervised the dentist's work. Importantly, the court refused to accept CMS' interpretation of incident-and-integral services as limiting coverage to dental procedures performed at the same time and by the same provider as the underlying covered medical service.

Advocacy Note

Advocates should consider the following when assisting Medicare beneficiaries who have medically-related dental issues.

1. The Medicare statute excludes from coverage services "in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth," which CMS has interpreted to include the "gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process." If the primary service that the beneficiary requires or receives from a dentist falls within this description, chances are likely that Medicare will not cover it and an appeal would not be successful.
2. If the client requires treatment from a dentist that *is* covered under current Medicare dental policy (e.g., removal of growth or tumor for non-dental purpose, repair of jaw fracture, extractions preceding radiation treatment to the jaw, or a service that is incident and integral to a covered primary covered procedure performed by the dentist), advise the client to seek treatment from a practitioner who participates in Medicare or will accept Medicare assignment. If the client enters into a private contract to receive and pay privately for services from a physician who has formally opted out of Medicare, no claim for Medicare reimbursement may be submitted for covered services and Medicare limitations on actual charges will not apply. A listing of all practitioners that are currently opted out of Medicare is available at: https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z.
3. If the client is enrolled in a private Medicare Advantage plan that includes dental benefits, the plan may require prior authorization before approving coverage of needed dental services. Advise the client to engage the relevant physicians and practitioners to contact the plan directly to advocate for coverage. It may be helpful for the client's physician to request a peer-to-peer review with a plan physician to explain the clinical justification for the prescribed dental treatment.

4. Medicare beneficiaries have the right to appeal claim denials through four levels of administrative review, and finally to judicial review in federal district courts. A beneficiary may have a better chance of getting a coverage denial overturned at the third level of review, which allows an evidentiary hearing before an Administrative Law Judge (ALJ), who is not bound by CMS policy in rendering coverage determinations. ALJs sometimes recognize that the Medicare statute should be liberally construed in favor of coverage for beneficiaries and that the facts in a particular case support coverage. Beneficiaries should be aware, however, that the agency sometimes moves to overturn favorable ALJ decisions on dental claims.

There is strong and growing public interest in expanding Medicare coverage for oral and dental care. Increasingly, older adults value having healthy teeth and gums, and understand the importance of oral health to overall health. Despite this, the large majority of the Medicare population has no dental coverage. Lack of coverage and the high cost of dental care lead many beneficiaries to delay or forgo necessary dental care altogether. There are currently bills introduced in Congress that, if passed and enacted, would remove the statutory dental exclusion and add oral health benefits to the Medicare program. In the meantime, CMS should exercise its authority to expand coverage for oral and dental services that are vital to the medical management or treatment of serious underlying diseases, illnesses, and injuries.

References

- 42 U.S.C. §§ 1395x, 1395y
- S.Rep.No. 89-404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1989-90
- Medicare Benefits Policy Manual, CMS Pub 100-02, Chapter 15, § 150
- Medicare Benefits Policy Manual, CMS Pub 100-02, Chapter16, § 140
- Medicare National Coverage Determination Manual, CMS Pub 100-3, Chapter 1, § 260.6
- 42 C.F.R. § 411.15(i)
- *Lodge v. Burwell,* 227 F.Supp.3d 198 (D. Conn. 2016)
- *Maggio v. Shalala,* 40 F.Supp.2d 137 (W.D.N.Y. 1999)
- *The Medicare Dental Benefit Act* (S.22)
- *Dental, Vision, & Hearing Benefit Act of 2019* (H.R. 1393)
- *Seniors Have Eyes, Ears, & Teeth Act* (H.R. 576)