September 11, 2023

VIA ELECTRONIC SUBMISSION

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1786-P
P.O. Box 8010
Baltimore, MD 21244-1810

Re: Comments on CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule ("HOPPS/ASC Proposed Rule" or "Proposed Rule")

Dear Administrator Brooks-LaSure:

On behalf of the members of the American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and the American Association of Oral and Maxillofacial Surgeons (AAOMS), we are writing to you to provide our comments on the 2024 HOPPS/ASC Proposed Rule.

We very much appreciate CMS' responsiveness to our concerns about access to hospital and ASC Operating Rooms (ORs) for those of our patients whose dental procedures must be provided under monitored anesthesia. Last year's decision by CMS to adopt a new HCPCS code for dental rehabilitation (G0330) and to increase the Ambulatory Payment Classification (APC) rate for these procedures has begun to significantly help us to address the lack of OR access for dental cases. In this context, we thank CMS for following up on last year's action by including in the Proposed Rule a provision that would include dental rehabilitation (HCPCS G0330) on the ASC Covered Procedures List (CPL). Finalizing this proposal has the potential to make ASC ORs available not only for our Medicare patients but also for Medicaid and other patients whose third-party payers utilize the CPL to determine which procedures are eligible for ASC coverage.

At the same time, we believe that the inadequacy of the proposed payment rates for dental rehabilitation in both the hospital and the ASC settings is likely to stymie use of the dental rehabilitation code to increase OR access for our patients. We also believe that CMS' approach to coverage and payment for other dental services under HOPPS and under the ASC payment system is confusing and is likely to increase administrative burden unless changes are made to reconcile the two payment systems.

Summarizing, our recommendations are as follows:

> ***Recommendations (Dental Rehabilitation****): We recommend that CMS reclassify dental rehabilitation (G0330) into the Level 4 ENT comprehensive APC (APC 5164); establish Medicare payment for dental rehabilitation performed in ASCs using the payment weight and conversion factor applicable to Category 4 ENT Procedures (APC 5164);* and either clarify or refrain from finalizing the proposal to require that dental rehabilitation be billed with a non-payable ancillary service in order for the dental rehabilitation to be covered.
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> ***Recommendations (Other Dental Procedures****): We recommend that CMS reconcile the HOPPS and APC payment systems by including on the ASC CPL all dental services that are classified into APCs under HOPPS, with the exception of imaging and evaluation and management dental services, which should be included on the ASC Ancillary Services List.*

I. Preliminary Observations and Requests

Preliminarily, we wish to request clarification of a principal issue posed by the Proposed Rule. Last year, in addition to adding a specific new HCPCS code (G0330) and providing increased payment for dental rehabilitation, CMS expanded Medicare coverage to include dental services that are inextricably linked to, and substantially related and integral to the clinical success of, particular Medicare-covered services. The 2024 Physician Fee Schedule (PFS) Proposed Rule proposes to expand Medicare coverage for dental services further, and CMS is continuing to solicit recommendations for additional dental coverage expansion.

We appreciate CMS' recognition that some newly covered dental services may be performed in hospital and ASC settings and to include in the HOPPS/ASC Proposed Rule an extensive proposal to add new dental codes (CDT) to HOPPS and to the ASC payment system. However, it is unclear to us whether, and under what circumstances, dental rehabilitation (G0330) can or should be billed with individual dental procedures ("D" codes) proposed for HOPPS/ASC payment. It is unclear to us whether a hospital or ASC that makes its OR available for the performance of dental procedures under monitored anesthesia:

- May opt to bill for its facility services either using G0330 (dental rehabilitation) **or** using individual "D" codes payable under the HOPPS or ASC facility payment system;
- Must bill only for the individual "D" codes if one or more of the procedures performed is payable under HOPPS or under the ASC payment system;
- Must bill only for dental rehabilitation (G0330) if multiple procedures are performed; or
- May bill for any "D" codes that are performed and that are separately billable and, in addition, may bill for dental rehabilitation (G0330) for procedures that are not separately payable.

We are concerned that, in the absence of clarification in the 2024 HOPPS Final Rule, hospitals and ASCs may be extremely confused regarding whether and under what circumstances they should report dental rehabilitation (G0330), CDT codes, or both for payment.

> ***Recommendation****: We strongly recommend that the 2024 HOPPS Final Rule clarify whether and under what circumstances dental rehabilitation (G0330) should be reported in addition to or in lieu of CDT codes, under HOPPS and under the ASC payment system*.

II. Dental Rehabilitation

CMS' decision last year to establish a new HCPCS code for dental rehabilitation (G0330) and to assign this HCPCS code to a higher-paying APC was a significant step forward in making dental care accessible for disabled and other Medicare patients whose dental care may require OR facilities. In addition, CMS' action has had a positive impact on Medicaid plans' payment for the facility services associated with dental procedures requiring monitored anesthesia. As the result of CMS' 2023 HOPPS Final Rule and dentist engagement at the state level, several State Medicaid Agencies (SMAs) have increased payment for dental procedures performed for Medicaid patients in hospital settings or have made facility payments available for dental services for the first time. Our organizations are continuing to collect data on Medicaid payment changes and the impact of these changes on OR access for Medicaid patients in need of dental rehabilitation -- many of whom are children.

We anticipate that CMS' inclusion of dental rehabilitation (G0330) on the ASC CPL has the potential to further increase access to safe operating room settings for Medicare patients enrolled in Medicare Advantage (MA) plans, Medicaid, and commercial insurance as well. The CPL is widely used by non-Medicare payers and MA plans, and we believe that the inclusion of dental rehabilitation on the ASC CPL will encourage state Medicaid agencies to include dental rehabilitation as a covered service in ASC settings.

> ***Recommendation (Non-Medicare Payment):*** *We urge CMS to make clear in the Final Rule preamble that because Medicare's coverage of dental procedures remains limited, the exclusion of a particular procedure from the HOPPS or from the CPL does not suggest that facility payment should be disallowed by other payers.*

A. Dental Rehabilitation (G0330) Should Be Reclassified into the Level 4 ENT APC (APC 5164)

Based on our analysis of the cost statistics made available with the Proposed Rule, we believe that the significant proposed reduction in the APC payment for dental rehabilitation provided in the hospital outpatient setting may result from hospitals' billing a wider range of lower cost CDT codes during the two-year base period for the CY 2024 Proposed APC rate than during the base period for the 2023 rate. As the result of the submission of a broader range of claims for dental procedures, the hospital outpatient claims included in the calculation of the APC rate for APC 5871, which currently includes dental rehabilitation, is extraordinarily broad, ranging from a geometric mean cost of $17.75 to a geometric mean cost of $7,883.25. *See Attachment A*.

The payment reduction resulting from hospitals' submission of more lower cost dental claims is exacerbated by CMS' proposal to apply the multiple procedure reduction to dental rehabilitation (G0330). As indicated in our comments on the 2023 Proposed Rule and in multiple meetings with CMS over the last several years, dental rehabilitation involves extensive, multiple procedures performed for patients that require monitored anesthesia due to the extraordinary amount of dental surgical work that needs to be provided, the patient's youth, disability, or medical condition, or other factors.

> ***Recommendation (Multiple Procedure Reduction**): Since the dental rehabilitation code is used to report the performance of multiple procedures that otherwise would be separately billable, it is entirely inappropriate to apply the multiple surgical procedure discount to hospital dental rehabilitation claims.*

We believe that finalizing the Proposed Rule's precipitous drop in the Medicare payment rate associated with dental rehabilitation in the hospital outpatient setting and the Proposed Rule's establishment of a clearly inadequate ASC payment rate will halt and may potentially reverse the progress that has been made in expanding OR access for dental cases. If finalized without change, the APC rate for these services would drop from **$1,722.43** in 2023 to **$938.69**, a reduction of over 45%. Under the Proposed Rule, the national average ASC payment for these services would be only **$495.52**. This devastating drop in hospital outpatient payment for dental rehabilitation and the establishment of a clearly inadequate ASC rate threatens to dissuade both hospitals and ASCs from making their facilities available to address the continuing unmet need for well-equipped ORs for our patients.

More specifically, we urge CMS to reclassify dental rehabilitation (G0330) into APC 5164. This APC reclassification is consistent with the available cost and charge data for dental procedures likely to be reported as dental rehabilitation using HCPCS G0330. Prior to the adoption of a specific HCPCS code to report dental rehabilitation, these procedures were reported using the CPT code for miscellaneous dental procedures (CPT 41899), whose geometric mean costs for the 2024 HOPPS base period are $2261.99, well within the range of geometric mean costs of other procedures classified into the Level 4 ENT APC. *See Attachment B*. Moreover, our analyses suggest that the APC rate for APC 5164 is consistent with the amounts that would be paid if the individual procedures generally involved in dental rehabilitation were billed separately. Therefore, reassigning HCPCS G0330 to APC 5164 is consistent with the mandate of the governing statute, which requires that procedures in the same APC be comparable in terms of resource use.

> ***Recommendation (Reclassification of Dental Rehabilitation into APC 5164**): CMS should reclassify dental rehabilitation (G0330) into APC 5164 based on available cost data and payment amounts for comparable procedures.*

B. CMS Should Not Finalize the Proposed Special Billing Requirements for Dental Rehabilitation Performed in an ASC Setting

We very much appreciate and support CMS' proposal to add dental rehabilitation to the ASC CPL. Dental rehabilitation meets the criteria for inclusion on the CPL[1], since dental rehabilitation procedures are procedures that:

- Are separately paid under the OPPS;
- Would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC; and
- For which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

[1] 42 CFR §416.166(b).

Surgical procedures that meet these requirements and that are not explicitly excluded from coverage are eligible of inclusion on the ASC CPL. Dental rehabilitation does not meet any of the exclusion criteria: These procedures do not pose a risk of significant blood loss, do not involve major or prolonged invasion of body cavities, do not directly involve major blood vessels, are not generally emergent of life threatening in nature, do not require systemic thrombolytic therapy, and are not designated as requiring inpatient care, all of which are grounds for exclusion of a procedure from the ASC CPL.[2]

Since it is clear that dental rehabilitation meets the regulatory criteria for inclusion on the CPL, we are puzzled by CMS' proposed requirement that, to be covered by Medicare, dental rehabilitation (G0330) be billed along with a covered but non-payable dental ancillary service. We simply do not understand what purpose is served by this requirement. We are hopeful that clarity regarding circumstances under which dental rehabilitation (G0330) should be reported in addition to or in lieu of CDT codes, under HOPPS and under the ASC payment system would help us better under the purpose of requiring a covered ancillary service to be billed for dental rehabilitation to be covered.

To the extent that CMS is proposing to impose this requirement to ensure patient safety, we believe that the proposal is misguided. As indicated in our prior discussions with and submissions to CMS, dental rehabilitation involves dental procedures that ordinarily would be performed in a dentist's office, but for the need to administer monitored anesthesia to address the patient's particular age, clinical, psychological, or other needs. In fact, since dental rehabilitation is comprised entirely of procedures performed in dentists' offices for most patients, it is difficult for us to understand what safety considerations would limit the performance of these services in a much more highly regulated ASC setting that is required to meet extensive Medicare and state licensure requirements. According to the Ambulatory Surgery Center Association (ASCA), dental procedures (previously reported using HCPCS 41899) were performed 71,686 times on non-Medicare patients in 492 CMS-certified ASCs that perform dental surgery, apparently without significant incident. Moreover, if there were special safety concerns applicable to dental rehabilitation procedures (which there are not), it is difficult to see how the contemporaneous provision of a non-payable ancillary service would address those concerns.

> **Recommendation (Special Billing Requirement for Dental Rehabilitation)**: *We recommend that CMS clarify why a covered ancillary service must be billed with dental rehabilitation for dental rehabilitation to be covered or, alternatively, refrain from finalizing this requirement in the 2024 PFS Final Rule.*

III. Alignment between HOPPS and ASC Dental Procedures

A. CMS Should Conform Medicare Payment for Dental Procedures Performed in ASCs to Payment for Dental Procedures Performed in Hospital Outpatient Settings

CMS proposes to classify 229 dental procedures into APCs for HOPPS payment, but to include only 26 dental procedures on the ASC CPL. The criteria for determining which procedures are proposed for inclusion on the ASC CPL are not described in the Proposed Rule.

[2] 42 CFR §416.166(c).

We can think of only two rationales for excluding a dental procedure that is payable under HOPPS from the ASC CPL. First, a dental procedure might be excluded from the ASC CPL if it were unsafe to provide in an ASC setting. However, all dental procedures meet the regulatory criteria for inclusion on the ASC list and dental procedures have been and continue to be performed in ASC settings without raising safety concerns. In fact, all of the 229 dental procedures eligible for HOPPS payment are routinely provided in dentists' offices, which are less regulated environments that are subject to neither state licensure nor Medicare certification requirements. The primary safety issues involved relate to unavoidable anesthesia risks, which ASCs are well equipped to handle.

Second, under the current proposal, a dental procedure for which a facility fee is payable under HOPPS might be excluded from the ASC CPL. However, for the purposes of inclusion on the ASC CPL, our groups advise that all surgical procedures – including most dental procedures involving hard or soft tissue - should be payable in both settings. The AMA defines "surgery" broadly to include procedures "performed for the purpose of structurally altering the human body by the incision or destruction of tissues…" including:

> the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system.[3]

Moreover, while the Medicare regulations no longer include the prior regulatory definition of surgical procedure, it is relevant that Medicare regulations previously defined a surgical procedure as "one that requires a dedicated operating room (or suite), and generally requires a post-operative recovery room or short-term (not overnight) convalescent room."[4] Under this definition, all dental procedures performed in an OR setting that require convalescence should be considered "surgical" for ASC CPL purposes.

We also note that CMS itself appears to recognize that many dental procedures not included on the ASC CPL are surgical procedures. Many procedures not included on the ASC CPL are designated with status indicator "T" for HOPPS payment purposes, indicating that the procedure is subject to the Multiple Procedure Reduction, a payment reduction applicable only to diagnostic and certain surgical procedures.

> ***Recommendation (ASC CPL):*** *We urge CMS to include all dental procedures payable under HOPPS on the ASC CPL, with the exception of imaging and dental evaluation services, which should be included on the ASC "Ancillary Services" List. We also urge CMS to include D1120 (dental prophylaxis – child) on the Ancillary Services List, to accompany D1110 (dental prophylaxis – adult) for services across the lifespan.*

[3] AMA Definition of Surgery. H-475.983; https://policysearch.ama-assn.org/policyfinder/detail/surgery?uri=%2FAMADoc%2FHOD.xml-0-4317.xml.

[4] 42 CFR §416.65((a)(3) (applicable prior to January 1, 2022).

V. Future Challenges

We look forward to continuing to work with CMS to address coding and payment structures to ensure facility payment for dental services under appropriately priced APCs that reflect the facility resources involved for these services, and to authorize the same code set to be paid in both hospital outpatient and ASC settings. The establishment of the new HCPCS code G0330 for dental rehabilitation and the classification of this code into the Level 4 ENT APC provides a useful paradigm for the establishment of appropriate comprehensive APCs for dental cases.

We would further reiterate that the need for a hospital or ASC setting for the performance of dental services often is not dictated by the nature of the procedure itself but rather the unique characteristics of the patient involved.

We appreciate that CMS will continue to assess Medicare coverage and payment policies for dental services under HOPPS and under the ASC payment system in future rulemaking. We anticipate that claims data will be critical in future rate setting. We are concerned that inadequate payment rates and other coverage restrictions reflected in the Proposed Rule flagged in this letter and our individually submitted organization comment letters may not only significantly limit the extent to which hospital and ASC settings are made available to the patients collectively cared for by our members but also severely limit the availability of claims data for CMS' and our future analysis.

We appreciate the opportunity to comment on the Proposed Rule. If you have any questions, please do not hesitate to contact Julie Allen at Julie.Allen@PowersLaw.com.

Sincerely yours,

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Attachment A

HCPCS	Single Frequency	Total Frequency	Median Cost	Geometric Mean Cost
D2910	1	1	$17.75	$17.75
D2920	5	7	$30.14	$41.79
D2932	3	10	$57.10	$57.10
D2954	2	2	$114.40	$94.08
D2950	6	6	$104.60	$98.90
D3220	2	3	$129.41	$129.16
D2331	5	90	$109.17	$130.54
D4342	6	26	$102.59	$231.91
D4910	7	11	$189.00	$248.09
D3320	1	1	$267.08	$267.08
D3310	2	4	$326.43	$309.46
D2330	7	117	$126.98	$313.83
D2940	8	12	$848.54	$337.82
D3221	4	4	$767.78	$437.65
D2740	8	11	$465.91	$462.90
D2332	6	59	$349.64	$490.49
D2751	2	2	$502.46	$502.46
D7473	2	9	$529.28	$529.28
D4341	13	166	$1,604.48	$535.63
D2335	6	60	$691.31	$668.51
D7111	1	1	$676.03	$676.03
D3330	2	2	$686.08	$686.08
D2150	3	72	$1,795.18	$934.53
D2710	4	5	$1,632.54	$1,070.06
D7220	2	10	$1,817.08	$1,800.95
D7250	1	8	$2,362.80	$2,362.80
D2391	13	163	$2,845.88	$2,455.60
D7210	28	233	$2,629.75	$2,498.43
D2392	7	97	$2,659.86	$2,606.62
D7472	3	3	$2,163.98	$2,652.60
D2140	6	64	$2,567.60	$2,671.63
D2160	1	32	$2,692.34	$2,692.34
D7140	36	338	$2,578.45	$2,716.69
D4346	1	4	$3,478.76	$3,478.76

D4355	2	10	$3,549.99	$3,495.77
D7240	11	38	$2,902.39	$3,502.89
D2393	1	44	$4,181.47	$4,181.47
D7230	2	10	$7,493.39	$7,387.89
D2161	1	6	$7,883.25	$7,883.25

Procedures in red were also performed during the base period for the current APC rates.

Attachment B

41110	Excision of tongue lesion	5164	$ 3,087.88	$ 1,931.74
41112	Excision of tongue lesion	5164	$ 3,087.88	$ 2,062.44
41113	Excision of tongue lesion	5164	$ 3,087.88	$ 2,122.72
41899	Misc Dental	5161	$ 233.00	$ 2,261.99
41114	Excision of tongue lesion	5164	$ 3,087.88	$ 2,338.54
41116	Excision of mouth lesion	5164	$ 3,087.88	$ 2,442.92
41520	Reconstruction tongue fold	5164	$ 3,087.88	$ 2,459.42
41530	Tongue base vol reduction	5164	$ 3,087.88	$ 2,535.50
41820	Excision gum each quadrant	5164	$ 3,087.88	$ 2,535.99
41825	Excision of gum lesion	5164	$ 3,087.88	$ 2,602.28
41826	Excision of gum lesion	5164	$ 3,087.88	$ 2,619.31
41830	Removal of gum tissue	5164	$ 3,087.88	$ 2,655.23
41872	Repair gum	5164	$ 3,087.88	$ 2,680.51
41874	Repair tooth socket	5164	$ 3,087.88	$ 2,748.77
42104	Excision lesion mouth roof	5164	$ 3,087.88	$ 2,812.80
42106	Excision lesion mouth roof	5164	$ 3,087.88	$ 2,829.75
42140	Excision of uvula	5164	$ 3,087.88	$ 2,848.20
42160	Treatment mouth roof lesion	5164	$ 3,087.88	$ 2,935.72
42305	Drainage of salivary gland	5164	$ 3,087.88	$ 3,022.23
42330	Removal of salivary stone	5164	$ 3,087.88	$ 3,023.55
42335	Removal of salivary stone	5164	$ 3,087.88	$ 3,026.20

42340	Removal of salivary stone	5164	$ 3,087.88	$ 3,056.06
42408	Excision of salivary cyst	5164	$ 3,087.88	$ 3,097.92
42409	Drainage of salivary cyst	5164	$ 3,087.88	$ 3,135.42
42510	Parotid duct diversion	5164	$ 3,087.88	$ 3,231.30
42600	Closure of salivary fistula	5164	$ 3,087.88	$ 3,254.46
42665	Ligation of salivary duct	5164	$ 3,087.88	$ 3,361.42
42720	Drainage of throat abscess	5164	$ 3,087.88	$ 3,373.45
42804	Biopsy of upper nose/throat	5164	$ 3,087.88	$ 3,392.82
42806	Biopsy of upper nose/throat	5164	$ 3,087.88	$ 3,415.22
42808	Excise pharynx lesion	5164	$ 3,087.88	$ 3,498.38
42810	Excision of neck cyst	5164	$ 3,087.88	$ 3,543.25
42821	Remove tonsils and adenoids	5164	$ 3,087.88	$ 3,553.89
42826	Removal of tonsils	5164	$ 3,087.88	$ 3,577.91
42830	Removal of adenoids	5164	$ 3,087.88	$ 3,578.78
42831	Removal of adenoids	5164	$ 3,087.88	$ 3,591.48
42836	Removal of adenoids	5164	$ 3,087.88	$ 3,817.06
42860	Excision of tonsil tags	5164	$ 3,087.88	$ 3,917.32
42962	Control throat bleeding	5164	$ 3,087.88	$ 4,087.37
42972	Control nose/throat bleeding	5164	$ 3,087.88	