Dental Services
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☐ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☐ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☐ Community Care (Commercial/Exchange)

Policy

Supplemental dental benefits
While Original Medicare doesn't cover expenses incurred for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth (i.e., "dental services"), some Fallon Health Medicare Advantage plans offer supplemental dental benefits. A Dental Addendum, part of the Evidence of Coverage, outlines the specific terms and conditions of the dental coverage, including a list of covered services, any limitations and cost-sharing requirements. Some dental services require prior authorization (approval in advance). Dental services must be provided by plan dentists. For a list of plan dentists, see the online Provider Directory at https://fallonhealth.org/find-insurance/medicare, or call Customer Service at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31).

Fallon Health's NaviCare HMO SNP and SCO plans include coverage for dental services. Some dental services are covered under the MassHealth (Medicaid) benefit and some are supplemental dental benefits. The Evidence of Coverage outlines the specific terms and conditions of coverage, including a list of covered dental services and limitations that apply. Some dental services require prior authorization (approval in advance). Dental services must be provided by plan dentists. For a list of plan dentists, see the online Provider Directory at https://fallonhealth.org/find-insurance/navicare, or call Customer Service at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31).

Effective January 1, 2024, DentaQuest is Fallon Health's dental vendor.

- Requests for prior authorization must be sent directly by the treating dentist to DentaQuest for review.
- Claims for dental services must be submitted by the treating dentist to DentaQuest.

Dentists can contact DentaQuest directly for information on enrollment, authorizations and claims submission: https://www.dentaquest.com/en/providers/massachusetts.

Original Medicare coverage of dental services
Section 1862(a)(12) of the Social Security Act generally precludes payment under Medicare Parts A or B for any expenses incurred for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.

The following two categories of services are excluded from Medicare coverage:

- A primary service provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth, e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw.

Note that the structures directly supporting the teeth are the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and the alveolar bone (i.e., alveolar process and tooth sockets).

When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered.

- A secondary service that is related to the teeth or structures directly supporting the teeth unless it is incident to an integral part of a covered primary service that is necessary to treat a non-dental condition (e.g., tumor removal) and it is performed at the same time as the covered primary service and by the same physician/dentist. In those cases in which these requirements are met and the secondary services are covered, Medicare does not make payment for the cost of dental appliances, such as dentures, even though the covered service resulted in the need for teeth to be replaced, the cost for preparing the mouth for dentures, or the cost of directly repairing teeth or structures directly supporting teeth (e.g., alveolar process).

Inpatient hospital services in connection with the provision of noncovered dental services

Section 1862(a)(12) of the Social Security Act includes an exception to allow payment to be made for inpatient hospital services in connection with the provision of such dental services if the individual, because of their 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. 42 CFR 411.15(i) similarly excludes payment for dental services except for inpatient hospital services in connection with dental services when hospitalization is required because of: (1) the individual's underlying medical condition and clinical status; or (2) the severity of the dental procedure.

Consistent with existing statutory authority, the Plan will make payment for inpatient hospital services connected to dental services when the patient requires hospitalization because the patient's underlying medical condition and clinical status, or the severity of the dental procedure, requires hospitalization in compliance with section 1862(a)(12) of the Social Security Act.

Dental services inextricably linked to, and substantially related and integral to, the clinical success of other covered medical services

There are instances where dental services are so integral to other medically necessary services that they are inextricably linked to the clinical success of that medical service(s), and, as such, they are not in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth within the meaning of section 1862(a)(12) of the Act. Rather, these dental services are inextricably linked to the clinical success of an otherwise covered medical service and are payable under Medicare Parts A and B.

In the CY 2023 and CY 2024 Physician Fee Schedule final rules, CMS provided examples where dental and medical services are inextricably linked and codified such examples provided under subsection (§) 411.15(i)(3). These are examples of circumstances where CMS believes there is a clear inextricable link between the dental and medical services, but it is not an exhaustive list of instances where dental and medical services are inextricably linked.

Examples of dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain Medicare-covered services could include, but aren't limited to:

- Dental or oral exams as part of a comprehensive workup prior to the Medicare-covered services listed below. And, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with these Medicare-covered services:
  - Organ transplant, including hematopoietic stem cell and bone marrow transplant
  - Cardiac valve replacement
  - Valvuloplasty procedures
  - Chemotherapy, chimeric antigen receptor (CAR) T-cell therapy, and the administration of high-dose bone-modifying agents (antiresorptive therapy) when used to treat cancer

- Dental or oral exams as part of a comprehensive workup prior to, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with, and medically necessary diagnostic and treatment services to address dental or oral complications after, Medicare-covered treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these.
- Dental ridge reconstruction done as a result of and at the same time as surgery to remove a tumor.
- Services to stabilize or immobilize teeth related to reducing a jaw fracture.
- Dental splints, only when used as part of covered treatment of a covered medical condition such as dislocated jaw joints.
- Dental or oral examination performed as part of a comprehensive workup prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of ESRD.
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of ESRD.

Medicare payment can also be made under Part A and Part B for ancillary services and supplies incident to the covered dental services, such as:

- Administering anesthesia
- Diagnostic x-rays
- Operating room use
- Other related procedures

For additional information, including scenarios in which payment for dental services is not excluded refer to the Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services Section 150 - Dental Services.

The Plan will not deny payment for dental services just because the medical service is not provided in the list of examples under § 411.15(i). See <u>Determining inextricable linkage</u> below.

<u>Determining inextricable linkage</u>
CMS recognizes that there are additional circumstances where dental services are inextricably linked to a covered medical service, beyond the list of examples provided under subsection (§) 411.15(i)(3).
The below information serves as examples of types of evidence that providers may submit to demonstrate that a dental service is inextricably linked to a covered medical service. The evidence submitted should include at least one of the following examples to support the linkage between the dental and covered medical services.

1. Evidence to support that the standard of care would be to not proceed with the covered medical procedure until a dental or oral exam is performed to clear the patient of an oral or dental infection, or, in instances where a known oral or dental infection is present, the standard is such that the medical professional would not proceed with the medical service until the patient received the necessary treatment to immediately eradicate the infection. We note that the dental services necessary to immediately eradicate an infection may or may not be the totality of recommended dental services for a given patient; or
2. Literature to support that the provision of certain dental services leads to improved healing, improved quality of surgery, or the reduced likelihood of readmission and/or surgical revisions, because an infection has interfered with the integration of the implant and interfered with the implant to the skeletal structure; or
3. Evidence that is clinically meaningful and demonstrates that the dental services result in a material difference in terms of the clinical outcomes and success of the medical procedure; or
4. Clinical evidence that is compelling to support that certain dental services would result in clinically significant improvements in quality and safety outcomes, for example, fewer revisions, fewer readmissions, more rapid healing, quicker discharge, and/or quicker rehabilitation for the patient.

Examples of literature could include any of the following: 1) relevant peer-reviewed medical literature and research/studies regarding the medical scenarios requiring medically necessary dental care; 2) evidence of clinical guidelines or generally accepted standards of care for the suggested clinical scenario; and/or (3) other supporting documentation to justify the inclusion of the proposed medical clinical scenario requiring dental services.

Integration and Coordination Between Dental and Medical Professionals
Medicare payment may be made when a dentist furnishes dental services that are an integral part of the covered primary procedure or service furnished by another physician, or non-physician practitioner, treating the primary medical illness. If there is no exchange of information, or integration, between the medical professional (physician or other non-physician practitioner) regarding the primary medical service and the dentist in regard to the dental services, then there would not be an inextricable link between the dental and covered medical service within the meaning of our regulation at § 411.15(i)(3).

Integration between medical and dental professionals can occur when these professionals coordinate care. This level of coordination can occur in various forms such as, but not limited to, a referral or exchange of information between the medical professional (physician or non-physician practitioner) and the dentist. This coordination should occur between a dentist and another medical professional (physician or other nonphysician practitioner) regardless of whether both individuals are affiliated with or employed by the same entity.

Without both integration between the Medicare enrolled medical and dental professionals, and the inextricable link between the dental and covered medical services, dental services fall outside of the Medicare Part B benefit as they would be in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth within the meaning of section 1862(a)(12) of the Act; though they may be covered by types of supplemental health or dental coverage. This is because the medical and dental professionals would not have the necessary information to decide that the dental service is inextricably linked to a covered medical service, and therefore, not subject to a statutory payment exclusion under section 1862(a)(12) of the Act.

Definitions

Medically Necessary or Medical Necessity – in accordance with 130 CMR 450.204, Medically Necessary services are those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Reimbursement

Consistent with existing statutory authority, the Plan will reimburse inpatient hospital services connected to dental services when the patient requires hospitalization because the patient's underlying medical condition and clinical status, or the severity of the dental procedure, requires hospitalization in compliance with section 1862(a)(12) of the Social Security Act.

The Plan will reimburse dental services inextricably linked to, and substantially related and integral to, the clinical success of other covered medical services. Reimbursement may be made for dental services furnished in the inpatient or outpatient setting, as clinically appropriate. Ancillary services and supplies incident to covered dental services may also be reimbursed, whether the service is performed in the inpatient or outpatient setting, including, but not limited to:
- Administering anesthesia,
- Diagnostic x-rays,
- Operating room use, and

- Other related procedures.

Referral/notification/prior authorization requirements

Inpatient hospital services in connection with the provision of noncovered dental services require prior authorization.

Dental services inextricably linked to, and substantially related and integral to, the clinical success of other covered medical services do not require prior authorization. However, some services and supplies related to dental services inextricably linked to, and substantially related and integral to, the clinical success of other covered medical services, may require prior authorization.

Billing/coding guidelines

The Plan requires all professional charges to be submitted on a CMS-1500 claim form (837P) and hospital charges to be submitted on a UB-04 claim form (837I), per industry standard guidelines.

The Plan does not accept 837D forms. "837D" refers to the dental transaction format used for electronic billing and claims submission, based on the ASC X12N standard.

The Plan applies industry standard claims edits.

Usage of the KX modifier for dental services inextricably linked to covered medical services for Medicare payment
For claims received on and after 07/01/2025, if a physician, including a dentist, believes that they possess information to support that the dental services are inextricably linked to a covered medical service that demonstrates adherence to the requirements of this policy and that coordination of care between the medical and dental practitioners has occurred and have met the criteria of the payment policy, the provider should include the KX modifier on each claim line in order to expedite determination of inextricable linkage determinations by the Plan.

For claims received on or after 07/01/2025, with codes for dental services submitted without the KX modifier, the claim will be denied.

Dental claims received on and after 07/01/2025 will reject if not submitted with a valid ICD-10 diagnosis code. NOTE: This diagnosis is not required to be the diagnosis for the covered medical service; it may be a diagnosis reflective of the dental treatment.

Place of service

This policy applies dental services provided in the inpatient or outpatient setting.

Policy history

Origination date: 07/01/2025
Connection date & details: April 2025 – Policy origination.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.