CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13029	**Date: December 31, 2024**
	Change Request 13911

SUBJECT: Medicare Benefit Policy Manual, Chapter 15 Update for Dental Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Internet Only Manual (IOM), Publication 100-02 Medicare Benefit Policy Manual, for dental services as finalized in the CY 2024 and CY 2025 Physician Fee Schedule (PFS) final rules.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/150/Dental Services

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 13029	Date: December 31, 2024	Change Request: 13911

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II. GENERAL INFORMATION

A. Background:

Section 1862(a)(12) of the Social Security Act (the 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.

Section 1862(a)(12) of the Act also 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. Our regulation at § 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.

Fee for service (FFS) Medicare Parts A and B also make payment for certain dental services in circumstances where the services are not considered to be in connection with dental services within the meaning of section 1862(a)(12) of the Act. In the CY 2023 PFS final rule (87 FR 69663 through 69688), we clarified and codified at § 411.15(i)(3) that Medicare payment under Parts A and B could be made when dental services are furnished in either the inpatient or outpatient setting when the dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered services. We also added several examples of clinical scenarios that are considered to meet the standard under § 411.15(i)(3)(i) and amended that regulation to add more examples in the CY 2024 PFS final rule (88 FR 79022 through 79029) and in the CY 2025 PFS final rule (89 FR 97932 through 97959).

B. Policy:

Pub. 100-02, Chapter 15 has been revised to reflect examples of clinical scenarios in which Medicare payment for dental services is not excluded. These examples do not provide an exhaustive list of scenarios.

For CY 2024 we added the following clinical scenarios under § 411.15(i)(3)(i):

- Dental or oral examination performed as part of a comprehensive workup prior to Medicare-covered chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer; and, medically necessary

diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer.

- Dental or oral examination performed as part of a comprehensive workup prior to Medicare-covered treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these; medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with, Medicare-covered treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these; and medically necessary diagnostic and treatment services to address dental or oral complications after treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these.

For CY 2025 we added the following clinical scenarios under § 411.15(i)(3)(i):

- Dental or oral examination performed as part of a comprehensive workup prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of end-stage renal disease, and 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 end-stage renal disease.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13911.1	Contractors shall be aware of the updates listed in this CR for Chapter 15 of Pub. 100-02.	X	X							

IV. PROVIDER EDUCATION

CR as Provider Education: MACs shall use the content in the CR to develop relevant education material. Provide a link to the entire instruction in the education content. You can also supplement with local information that would help your provider community bill and administer the Medicare Program correctly. You don't need to separately track and report on this education.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

150 - Dental Services

(Rev.13029 ; Issued:12-31-2024 ; Effective:01-01-2025 ; Implementation:04-01-2025)

As indicated under the general exclusions from coverage in 42 CFR 411.15(i), and subject to exceptions, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. “Structures directly supporting the teeth” means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. Two statutory exceptions to this policy allow for Medicare payment for inpatient hospital services in connection with the provision of dental services if the individual, because of the individual’s 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.

There are some other instances where medical services necessary to diagnose and treat the individual’s underlying medical condition may require the performance of certain dental services and the dental exclusion may not apply. Dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain *other* covered medical services are not excluded. Such non-excluded dental services could include dental and oral examinations as well as medically necessary diagnostic and treatment services to eliminate an oral or dental infection. We note that the necessary treatment to eradicate an infection may not include the totality of recommended dental services for a given patient. For example, if an infected tooth is identified in a patient requiring an organ transplant, cardiac valve replacement, or valvuloplasty procedure, the necessary treatment would be to eradicate the infection, which could result in the tooth being extracted. Additional dental services, such as a dental implant or crown, may not be considered immediately necessary to eliminate or eradicate the infection or its source prior to surgery. Therefore, such additional services would not be inextricably linked to, and substantially related and integral to the clinical success of, the organ transplant, cardiac valve replacement, or valvuloplasty services. As such, no Medicare payment would be made for the additional services that are not immediately necessary prior to surgery to eliminate or eradicate the infection.

Payment may be made under Medicare Parts A and B for dental services furnished in the inpatient or outpatient setting. Scenarios in which Medicare payment for dental services is not excluded include, but are not limited to, the examples below.

EXAMPLE 1:

Dental or oral examination performed as part of a comprehensive workup prior to Medicare-covered organ transplant, cardiac valve replacement, or valvuloplasty procedures; and, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, the organ transplant, cardiac valve replacement, or valvuloplasty procedure. For purposes of this manual only, hematopoietic stem cell and bone marrow transplants have a similar risk of infection to organ transplants, and an oral examination and subsequent necessary diagnostic and treatment services, performed in either the inpatient or outpatient setting *may* be payable under this example. (The term “organ transplant” may not be considered to include bone marrow or hematopoietic stem cell transplants in all contexts. These services are not considered organs for purposes of the definition of organs in 42 CFR 486.302 or Medicare payment policies for organ procurement organizations.)

EXAMPLE 2:

Dental or oral examination performed as part of a comprehensive workup prior to Medicare-covered chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer; and, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer.

EXAMPLE *3*:

The reconstruction of a *dental* ridge performed as a result of and at the same time as the surgical removal of a tumor. The reconstruction of a *dental* ridge performed primarily to prepare the mouth for dentures is a noncovered procedure.

EXAMPLE *4*:

The stabilization or immobilization of teeth in connection with the reduction of a jaw fracture, and dental splints only when used in conjunction with covered treatment of a covered medical condition such as dislocated jaw joints.

EXAMPLE *5*:

The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.

EXAMPLE 6:

Dental or oral examination performed as part of a comprehensive workup prior to Medicare-covered treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these; medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with, Medicare-covered treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these; and medically necessary diagnostic and treatment services to address dental or oral complications after treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these.

EXAMPLE 7:

Dental or oral examination performed as part of a comprehensive workup prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of end-stage renal disease, and 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 end-stage renal disease.

See Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, Definitions for provisions applicable to doctors of dental surgery or dental medicine.

CMS makes payment for covered dental services furnished by a physician, including a doctor of dental medicine or dental surgery, or a non-physician practitioner in accordance with state law and scope of practice in the state where the service is furnished.

Medicare Part A and Part B payment *can be* made for dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services. Integration between the health care professionals furnishing dental and other covered services is a key component in assessing whether dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services. This integration could take the form of a referral or other exchange of information between the physicians, non-physician practitioners, or other practitioners involved in the delivery of dental and other covered medical services.

This coordination should occur between the health care professionals furnishing the dental and other covered services regardless of whether both individuals are affiliated with or employed by the same entity. If there is no exchange of information, or integration, between the health care professionals regarding the dental services, then there would not be an inextricable link between the dental and covered medical services within the meaning of our regulation at § 411.15(i)(3). This is because the professionals would not have the necessary information to decide that the dental service(s) is inextricably linked to a covered

medical service, and therefore, not subject to the statutory payment exclusion under section 1862(a)(12) of the Act.

Payment may also be made for covered dental services and supplies furnished incident to the professional services of the billing physician or practitioner by auxiliary personnel. For example, services performed by a dental technician, dental hygienist, dental therapist, or registered nurse who is under the direct supervision of the physician, including a dentist, are covered if the services meet the requirements for "incident to" services as described in 42 CFR § 410.26.

Ancillary services and supplies furnished incident to covered dental services are also not excluded, and Medicare payment may be made under Part A or Part B, as applicable, regardless of whether the service is performed in the inpatient or outpatient setting, including, but not limited to the administration of anesthesia, diagnostic x-rays, use of operating room, and other related, otherwise covered procedures.

No payment is made for dental services that may be inextricably linked to, and substantially related and integral to the clinical success of other non-covered services. Such services remain subject to the statutory exclusion *under section* 1862(a)(12) *of the Act* for items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. More specifically, dental services inextricably linked to a non-covered medical service(s) are not covered or payable. For example, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. Similarly, with rare exception, the removal of a torus palatinus (a bony protuberance of the hard palate) is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, Medicare does not pay for this procedure.

MACs have the flexibility to determine on a claim-by-claim basis whether a patient's circumstances do or do not fit within the terms of the statutory preclusion or exceptions specified in section 1862(a)(12) of the Act and our regulation at 42 CFR § 411.15(i)*(3)*. These policies do not prevent a MAC from making a determination that payment can be made for dental services in other circumstances under which the dental services are inextricably linked to, and substantially related and integral to the clinical success of, certain *other* covered medical services, but are not specifically addressed in final rules, manual provisions, and the finalized amendments to § 411.15(i)*(3)(i)*.