

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12702	Date: June 27, 2024
	Change Request 13649

SUBJECT: Utilization of KX Modifier Medicare Physician Fee Schedule Payment for Dental Services Inextricably Linked to Covered Medical Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instruction to the A/B Medicare Administrative Contractors (MACs) regarding the usage of the KX modifier for the submission of Medicare claims for dental services inextricably linked to covered medical services under the Medicare Physician Fee Schedule.

EFFECTIVE DATE: July 1, 2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: July 1, 2024

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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: The purpose of this CR is to provide instruction to the A/B Medicare Administrative Contractors (MACs) regarding the usage of the KX modifier for the submission of Medicare claims for dental services inextricably linked to covered medical services under the Medicare Physician Fee Schedule.

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. That section of the statute 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 42 Code of Federal Regulation 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.

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 or our regulation at § 411.15(i). CMS makes payment when a physician, including a doctor of dental medicine or dental surgery, furnishes dental services (within their applicable scope of practice) that are an integral part of the covered primary procedure or service furnished by another physician treating the primary medical illness. On November 1, 2022, CMS issued regulation number CMS-1770-F, Medicare and Medicaid Programs; CY 2023 Payment Policies Under the PFS and Other Changes to Part B Payment Policies (the CY 2023 PFS Final Rule), in which CMS clarified and codified that Medicare payment under Parts A and B could be made when dental services are furnished in either the inpatient or outpatient setting under particular kinds of circumstances. (See Medicare Benefit Policy Manual (Internet Only Manual (IOM) Publication (Pub 100-02, Chapter 15, Section 150); and Medicare National Coverage Determinations Manual Chapter 1, Part 4 (IOM Pub 100-03, Chapter 1, Part 4, Section 260.6)).

B. Policy: On November 1, 2022, CMS issued regulation number CMS-1770-F, Medicare and Medicaid Programs; CY 2023 Payment Policies Under the PFS and Other Changes to Part B Payment Policies (the CY 2023 PFS Final Rule) with additional updates codified in the CY 2024 PFS Final Rule. This CR intends to provide instruction to the A/B MACs regarding the usage of the KX modifier for the submission of claims for Medicare payment for dental services as described in Section II.L of the CY 2023 PFS final rule (87 FR 69663-69688) as well as the CY 2024 PFS final rule (88 FR 79013 through 79040).

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 PFS final rules, we 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. MACs should not deny payment for dental services just because the medical service is not provided in the list of examples under § 411.15(i).

Additionally, consistent with existing statutory authority, MACs should 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 Act).

Determining Inextricable Linkage

In the CY 2023 and CY 2024 PFS final rules, we provided examples where dental and medical services are inextricably linked and therefore payment may be made under Medicare Parts A and B for services furnished in the inpatient or outpatient setting.

We recognize 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 non-physician 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.

Existing Policy and Uses for the KX Modifier

In general, the KX modifier is submitted on a Medicare Part B claim to indicate that the service or item is medically necessary, and that the provider has included appropriate documentation in the medical record to support or justify the medical necessity of the service or item. For example, for *Therapy Caps for Physical Therapy, Speech-Language Pathology, and Occupational Therapy*, the Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORE/OPT Services, Section 10.3.1 - Exceptions to Therapy Caps – General, states that “the KX modifier is added to claim lines to indicate that the clinician attests that services at and above the therapy caps are medically necessary and justification is documented in the medical record.” <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf>

Furthermore, CR 6638 *Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict* (<https://www.cms.gov/Regulations-and-guidance/Guidance/Transmittals/downloads/R1877CP.pdf>) states that “The definition of the KX modifier is: Requirements specified in the medical policy have been met.”

Usage of the KX Modifier for Dental Services Inextricably Linked to Covered Medical Services for Medicare Payment

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, providers may include the KX on the claim in order to expedite determination of inextricable linkage determinations by the MACs.

Providers are encouraged (but not currently required) to include the KX modifier on the claim to indicate that they believe that the dental service is medically necessary, that the provider has included appropriate documentation in the medical record to support or justify the medical necessity of the service or item and demonstrates the inextricable linkage to covered medical services, and that coordination of care between the medical and dental practitioners has occurred for services with dates of service in CY2024.

Moreover, beginning July 1, 2024, MACs may establish adjudication guidelines related to claims submitted with dental services inextricably linked to covered medical services related to the inclusion or absence of the KX modifier.

- For those Medicare claims submitted with codes for dental services and also submitted with the KX modifier, the MACs may develop rules such that the claim automatically suspends for further development.
- For those Medicare claims submitted with codes for dental services and submitted without the KX modifier, the MACs may develop and apply local rules such that the claim may be adjudicated without further review, including returning the claim to the provider.

Additionally, MACs shall develop education materials that include information for providers about the procedures for the submission of the KX modifier for Medicare-reimbursable dental services that are inextricably linked to covered medical services. Education and messaging to providers should state that if a provider is certain 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 the policy and that coordination of care between the medical and dental practitioners has occurred and have met the criteria of the payment policy, the providers should include the KX on the 837D or 837P claim.

Existing Policy and Uses for Modifiers for Denial

MACs shall develop education materials that include information for dental providers about the existing claims submission processes when providers need a claim denial from CMS so secondary payers can properly process the claim. MACs should instruct providers to continue to submit claims like they usually do with Healthcare Common Procedure Coding System (HCPCS) modifiers used to show that the provider believes Medicare should not pay the claim. For claims submitted on the 837d transaction, when that becomes available, only the GY modifier is allowable per transaction rules.

MACs may also provide supplemental educational material about billing and coding requirements. These materials could include information on the appropriate billing codes, claim formats, and all other applicable instructions for such professional or institutional or other claim formats.

Use of Enforcement Discretion for Requirement to Submit an ICD10 Diagnosis Code on the ASC X12 837 Dental Claim Transaction (837D)

In order to facilitate submission of dental claims inextricably linked to the provision of covered medical services, CMS is implementing the 837D. Although the diagnosis code field is required for Medicare Fee for Service to process the claim, CMS is exercising enforcement discretion for the first few months the transaction will be received, so that claims submitted on the 837D will not reject for that reason alone. Claims received on and after 01/01/2025 will reject if not submitted with a valid ICD10 diagnosis. 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.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13649.1	Contractors shall develop educational materials to supplement CMS developed		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	national content describing policies related to dental services inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services as specified under § 411.15(i)), with dates of services on or after January 1, 2023.									
13649.2	MACs shall develop educational materials that include information for dental providers about the procedures for the submission of the KX modifier for Medicare-reimbursable dental services that are inextricably linked to covered medical services.		X							
13649.3	MACs should instruct dental providers to utilize existing claims submission procedures, including the use of appropriate HCPCS modifiers, when a Medicare claim denial is sought for submission to third party payers.		X						Dental - MAP	
13649.4	Contractors shall accept modifiers KX and GY in the dental MAP.		X						Dental - MAP	
13649.4.1	Contractors shall process these claims in accordance with the policy outlined above for the KX and with existing policy for the GY.		X						Dental - MAP	
13649.4.2	For claims received on and after 1/1/2025, contractors may deny dental claims not containing the KX modifier as statutorily non-covered. Contractors shall use Group Code PR and CARC 96 (Non-covered Charge(s)) and RARC N425		X						Dental - MAP	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(statutorily excluded service(s)) for these claims. Contractors shall use message Z04, MSN 16.10 (Medicare does not pay for this item or service). These denials may be appealed. Claims submitted with modifier GY shall follow existing rules, and use existing CARC/RARC and MSN combinations.									
13649.5	MACs shall develop educational materials to explain that for a dental and medical service to be inextricably linked, there needs to be a level of integration and coordination between the dental and medical professionals. MACs shall develop educational materials to explain this requirement to providers and instruct them on how it should be documented.		X						Dental - MAP	
13649.6	MACs shall consider developing for inextricable linkage all claims received for dental services with the KX modifier on the claim line.		X							
13649.6.1	For dental claims received prior to 1/1/2025, contractors shall not automatically deny dental claims submitted without the KX modifier on the claim line.		X						Dental - MAP	
13649.7	Contractors shall reject 837D transactions received on and after dates 01/01/2025 with dates of service on and after 7/1/2024 that do not contain a valid ICD10 diagnosis code.		X						Dental - MAP	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13649.7.1	Contractors shall not reject 837D transactions received prior to 1/1/2025 for the sole reason of a missing diagnosis code. Any diagnosis code received must be a valid ICD10 diagnosis code.		X							Dental - MAP

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13649.8	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.		X			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0