

FREQUENTLY ASKED QUESTIONS
Regarding New Hospital Code for Dental Treatment Under General Anesthesia

Prepared by AAPD, ADA and AAOMS
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The final Medicare Calendar Year 2023 Hospital Outpatient Prospective Payment System (OPPS) rule was formally published in the Federal Register on November 23, 2022. The OPPS rule addresses payment policies and coding for dental services provided under general anesthesia in hospitals. **Of special significance, the Centers for Medicare & Medicaid Services (CMS) has established a new Healthcare Common Procedure Coding System G code (G0330) and assigned that code to the Medicare Ambulatory Payment Classification (APC) 5871 (Dental Procedures) with a national average Medicare facility payment rate of \$1722.43.¹ This facility payment rate is much higher and far more appropriate than what was used in the past.**

Changes in Medicare Payment and Coding for HOSPITAL Operating Room and Related Costs (Facility Costs) for Dental Cases

1. I understand that the Medicare program is increasing the amount it pays to hospitals for facility costs incurred in conjunction with dental rehabilitation in hospital OR settings. Does this change the codes I should use or the payment I will receive for my professional services for patients whose procedures are performed in a hospital operating room?

The new HCPCS code G0330 for dental rehabilitation services covers the facility fee and will result in a payment of such fee to the hospital. Payment for dental professional services is billed separately and will be determined based on the type of coverage (and coverage terms) for the patient, whether the patient is covered by public or private insurance, a stand-alone or an embedded dental plan.

2. What code should hospitals report to claim Medicare payment for their facility costs for covered dental rehabilitation cases requiring anesthesia and use of an operating room?

HCPCS code G0330.

3. How will hospitals be aware of this new code?

Hospitals may receive updates from hospital associations and/or CMS. Anyone may sign up for CMS alerts at www.CMS.gov. However, dentists and dental advocates should also be proactive in alerting their department heads and local hospital administrators about the new code.

4. How much will Medicare pay to hospitals for dental rehabilitation facility costs?

¹ For more background on advocacy efforts to obtain this code see:
<https://www.aapd.org/advocacy/legislative-and-regulatory-issues/latest-advocacy-news/aapd-secures-win/>

The published national average rate for HCPCS code G0330 is \$1722.43; however, the actual amount will vary based on the hospital's geographic location and other factors. Also, we believe that CMS may have made an error in calculating the rate, and we are hopeful that it may eventually be higher. The final determination is subject to a comment period to CMS that runs through January 2023. The national average rate will be adjusted by CMS on an annual basis.

5. Are the new code and new rate applicable in all states?

The new code and new rate applies to hospital facility fees for patients covered under the Medicare program (except for patients in the state of Maryland, because that state has its own system for paying for hospital services, including hospital outpatient services). It may also be applicable for patients with Medicaid coverage in states where the Medicaid program utilizes the HCPCS system and bases state Medicaid payment for hospital outpatient services on Medicare rates. See response to question 7 below.

6. Will private payers recognize the new code and payment rate?

Private payers are not required to recognize the new code and payment rate, but they have the option to do so. Historically, private insurers tend to adopt changes made in public programs over time. Dental advocates are strongly encouraged to petition for adoption of the new code. The AAPD, ADA, and AAOMS will be communicating with major insurers to alert them to the new code and make this request.

7. Is the new code and payment rate applicable for my Medicaid patients?

There are additional steps that a state Medicaid agency (SMA) will need to take to adopt the new code. The AAPD, ADA, and AAOMS are developing a guide for state dental advocates, which will include a sample letter that should be sent to the SMA.

While it may be more difficult to persuade those SMAs that do not utilize the HCPCS code or that do not base Medicaid rates on those paid by Medicare, dental advocates still may be able to use CMS's decision to increase facility payment for dental procedures as grounds for beginning a conversation with their SMA.

8. What can I do to get private payers and the state Medicaid program to recognize the new code and to increase the hospital facility payment for dental rehabilitation?

As noted above, follow up advocacy will be required for private payers and state Medicaid programs to recognize the code and to increase hospital facility payment rates. It is important to note that if patients have separate medical and dental insurance – as is the most common situation – G0330 would be billed by the hospital under the patient's medical insurance.

9. How does the new code impact the reimbursement for services provided by medical or dental anesthesiologists?

Anesthesia fees are typically separate from facility fees. In most cases, the anesthesia fees and an anesthesiologist's professional service fees will not be impacted by the new code and rate change.

10. Do I have to be a participating provider in Medicare, Medicaid, or a private insurance plan for a dental OR case involving a patient covered by such insurance plan in order for the G0330 code to be utilized by the hospital?

Not necessarily. Hospitals are considered "providers" just as dentists are considered "providers." The new code (G0330) pertains to the hospital facility fee, and nearly all hospitals participate in the Medicare and Medicaid programs and other networks. Therefore, the hospital may submit G0330 on the claim form regardless of the dentists' participation in these networks. However, a dentist who provides services in a hospital OR will be required to provide his or her NPI to the hospital for billing purposes and will be required to meet hospital requirements to obtain staff privileges.

11. Is the new dental code related to CMS' expansion of Medicare coverage for additional dental procedures that are considered necessary to facilitate medically necessary medical treatment?

No. The dental benefits provided under Medicare to patients who require certain procedures (including organ transplants, cardiac valve replacement, and valvuloplasty) were expanded under the Calendar Year 2023 Physician Fee Schedule rule, which is a separate regulation. The new code described in this FAQ for dental surgeries in a hospital operating room is not limited to patients needing an organ transplant, cardiac valve replacement, or valvuloplasty. However, the expansion of the Medicare dental benefit to patients with those conditions is an additional reason why a hospital should recognize this new code, as patients who are newly eligible for dental treatment may need to have their dental care performed in the hospital's operating room.

Impact on Ambulatory Surgical Centers (ASC)

1. Is the new code on the Medicare Ambulatory Surgical Center (ASC) Covered Procedures List (CPL)?

Not at present. However, the AAPD, ADA, AAOMS and other advocacy partners will strongly urge CMS to include the new code on the ASC CPL next year.

2. Even though the new code is not on the Medicare ASC CPL, can other payers choose to recognize the new code for payment in an ASC?

Yes, and dental advocates should strongly encourage them to do so. Dental advocates may wish to inform any payer (including any state Medicaid program) that has historically provided ASC payment for CPT 41899 (Miscellaneous Dental Procedures, i.e. the CPT code that historically has been reported for dental procedures) that dental procedures requiring general anesthesia are to be reported under HCPCS code G0330 beginning January 1, 2023, and that the national average rate associated with these procedures under G0330 has increased substantially.

3. As a result of this change in Medicare coding and payment, are Medicaid programs required to cover the facility costs incurred by ASCs for dental rehabilitation or to pay comparable rates?

No. However, if a state Medicaid program has historically recognized CPT 41899 in the ASC setting, dental advocates should inform the Medicaid agency that G0330 should be used instead beginning on and after January 1, 2023, and that Medicare has increased the hospital average facility rate for these procedures under the new code.

4. If a private payer or our state Medicaid program is willing to cover an ASC's dental rehabilitation facility costs, how much should we ask them to pay?

The national average Medicare rate of \$1722.43 would be a starting point for negotiations; however, please note that dental advocates in Michigan have managed to negotiate rates that exceed Medicare's national average payment rate and included both hospitals and ASCs!

Suggestions for Dentists and Dental Advocates

- Please notify your operating room, hospital administrators and state Medicaid agency of the changes going into effect on January 1, 2023 – the new G0330 code and associated average payment rate of \$1722.43 – regardless of whether dental cases have been reduced in your hospital.
- Appropriate coding and fair payment for these services is crucial for the continued allocation of hospital operating room resources to treat those with the most complex cases in need of comprehensive dental care.
- Additional information is available from CMS at <https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2>; <https://public-inspection.federalregister.gov/2022-23918.pdf>.