New York State Dental Association

Clearing Up the Confusion about Medicare and Dentistry

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Most dental practices that treat patients over 65 years of age will be affected by a significant change to the Medicare regulations. Medicare recipients who purchase supplemental Medicare insurance policies (i.e., Part D drug plans) will be eligible for benefits from those plans *only* when the ordering doctor is enrolled in Medicare, i.e., opted in, opted out, or enrolled using the 855O. The Centers for Medicare and Medicaid Services (CMS) has delayed the implementation of this regulation until ***January 1, 2019***.

It is still advisable for dentists to enroll as Medicare providers as soon as possible by opting-in to Part B, submitting a CMS 8550, or submitting an affidavit opting-out of Medicare Part B. Enrollment is not immediate, it is advisable to submit the necessary documentation – or register online. If a dentist takes no action, patients with Part D coverage will not receive benefits when their dentist writes a prescription for them (which can result in a very disgruntled patient). Important things to note are:

1. *Regardless of your decision* (opt in, opt out, or submit an 855O), your patients with Medicare Part D plans will have coverage for any prescriptions covered by their Part D plans.

2. Dentists with participating provider contracts will not be entitled to payment from plans that serve patients who have purchased Medicare advantage Dental Plans if they "opt-out" of Medicare Part B.

3. It is advisable for dentists to inform their patients that Medicare does not cover dental treatment. They may wish to include this information with the information given to patients about their practices and billing policies; e.g.: "Medicare does not cover dentistry. Our practice does not participate in Medicare. Nonetheless, if you have a Part D supplemental drug plan, your plan will cover our prescriptions because we have registered with the Medicare program."

4. Dentists who opt out of Medicare Part B are required to enter into a written agreement with a patient advising that they are not Medicare providers only when and if they are performing a procedure covered by Medicare Part B.

5. ***Again, dentists contracted with a Medicare Advantage Plan cannot "opt out" if they wish to receive reimbursement from these plans for dental treatment services. These dentists should either "opt in" or enroll using the CMS 8550***.

Dentistry is excluded from the Medicare benefit package with very limited exceptions. The drawbacks to enrolling by "opting out" were that:

- The "opt out" only was in effect for a 2-year period and had to be renewed. [1]
- Dentists contracted with Medicare Advantage Plans are not eligible for reimbursement.
- Dentists must notify patients and enter into contracts for covered services with Medicare recipients to be eligible for payment from the patient.

In addition to opting in or out, CMS established a third enrollment option that enables patients with Medicare Part D Supplemental Drug Plans to receive coverage for their dentists' prescriptions. Dentists now may choose to submit the Form 8550 to be placed on the Medicare Ordering and Referring Registry and will be deemed eligible to order and refer patients to Medicare enrolled providers and suppliers and for prescribing. The ability to utilize the 8550 is a desirable alternative for most dentists, given that Medicare does not cover dental treatment. Submitting the 8550 is not a form of "opting in" because it does not allow the practitioner to bill Medicare, but it is also not "opting out" because it does not trigger any other obligations in that regard.

The new regulations do not change anything with respect to the relationship between dental specialists who do perform medical services covered by Medicare Part B and Medicare. Those dentists that bill Medicare can simply continue to do what they have always done with respect to enrolling. That is, if they opt in, they are compelled to accept Medicare reimbursement when they perform a medical service

[1] Until recently, opting out was a less desirable option because doctors who opted out had to resubmit an opt-out affidavit every two years and could not opt-in until two years expired. With what is referred to as the new Medicare "doc fix", valid opt-out affidavits signed *on or after June 16, 2015,* will automatically renew every 2 years. If practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare Administrative Contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed *before June 16, 2015* will expire 2 years after the effective date of the opt out. If practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out.

covered by Medicare Part B. If they opt out, they can bill their patients and collect their usual fees.

Medicare and Dentistry

Again, Medicare does not include coverage for routine dental treatment. Nonetheless, to refer or order services for a Medicare patient (where the service provider expects to be paid by Medicare), practitioners must be on record as known to the Medicare program. Medicare will not pay a second provider if the referring provider is not enrolled as either a Medicare provider or as having opted out. Do not be confused by the terminology – opting out is different than completely ignoring Medicare by doing nothing. Opting out is a status that Medicare recognizes even though it means a doctor will neither be billing nor be reimbursed by Medicare.

Dentists are not required to provide written notification to their patients that they do not participate as Medicare providers, unless they are providing services that are covered by Medicare Part A or B. Because dental care is excluded from Medicare generally, it is exempt from the advance beneficiary notice of non-coverage requirements.

Section 1862 (a)(12) of the Social Security Act states, "where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, *except* that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his 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."

Most of the procedures performed by dentists that do qualify for Medicare reimbursement typically are performed by specialists, e.g., biopsies, including brush biopsies. Medicare Part B excludes the following two categories of services from coverage:

1. A primary service (regardless of cause or complexity) 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.

2. A secondary service that is related to the teeth or structures directly supporting the teeth unless it is incident to and 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 cases where 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 the teeth to be replaced, the cost of preparing the mouth for dentures, or the cost of directly repairing teeth or structures directly supporting teeth (e.g., alveolar process).

Certain dental services always are covered, including the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease and an oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a rural health center/federally qualified health center prior to a heart valve replacement. Dentists should check with Medicare directly with specific questions about whether a service will or will not be covered. A key thing to remember is that Medicare is not really paying for a dental service, but is either paying for a covered medical service that a dentist can perform or is paying for a dental service that is a necessary adjunct to a covered medical service (Medicare would not pay for it otherwise as just a dental service).

Understanding Medicare Part B and Supplemental Plan Coverage

There are two key issues to understand with respect to Medicare in deciding which enrollment option is best for an individual dentist. The first issue pertains to the scope of coverage of Medicare Part B. The second is the impact of the regulatory changes to the Part D supplemental plans taking effect this year.

Issue #1: Billing for Medicare Part B Covered Services

A provider who opts out *cannot* be paid any Medicare dollars for Part B Medicare services. If a dentist has not opted out of the Medicare program and that dentist performs Medicare-covered services for patients eligible for Medicare, the dentist has only three options:

1. Enroll as a Medicare provider and submit a claim for the treatment in accordance with the Medicare fee schedule.
2. Refer the patient for services covered by Medicare to a dentist who is a Medicare provider.
3. Not charge the patient for the treatment provided.

Unless the dentist has opted out, the dentist legally could not charge a Medicare recipient for a treatment service covered under the Medicare Part B schedule.

Issue #2: Coverage for Prescription Drugs Under Medicare Part D Supplemental Coverage

As a result of new CMS regulations, in December 2015, patients who purchase Medicare Part D prescription drug coverage will only receive benefits for prescriptions issued by prescribers who have enrolled with Medicare by opting in, opting out, or submitting an 8550 enrollment application. Thus it is beneficial for

dentists to enroll with CMS to assure that their patients will be eligible for benefits when the dentist prescribes a covered drug.

Medicare Dental Advantage Plans

Dentists who choose to opt out cannot receive payment from a Medicare Advantage plan. Their patients also cannot receive payment. Medicare Advantage plans are part of Medicare. They are private insurers contracted to administer Medicare benefits.

It is important for anyone contracted as a Medicare Advantage provider to review whether they are contracted to provide medical services covered by Medicare and consider this in making their enrollment decision. **Dental practices may not be aware that a patient's dental plan is a Medicare Advantage plan.** CMS is requiring all participating providers in Medicare Advantage plans to "opt in" or submit an 855O, rather than "opting out".

Sleep Apnea Devices

There is one other type of service for which dentists are eligible for Medicare reimbursement. Dentists that fabricate sleep apnea/snoring devices for patients over 65 years of age must enroll with CMS as *providers of durable medical equipment* (CMS form 855S). This is unrelated to the dentist's status as a "Medicare provider" for the purpose of billing for medical/dental treatment. It is completely unrelated to the doctor's status as a practitioner. A dentist who enrolls using form 855S would still need to opt in or opt out as a dentist provider.

Treatment for sleep apnea is outside of the scope of practice for dentistry in New York. Because dentists do not treat sleep apnea, they cannot submit claims to Medicare for such treatment. Nevertheless, dentists can fabricate sleep apnea appliances on the order of a physician. Dentists who fabricate such appliances ***must*** be registered with Medicare as a DME (durable medical equipment) provider to bill Medicare or Medicare Advantage for any sleep apnea device. Medicare is billed for the DME service, not for the dental/medical service by the DME provider (in this instance, the DME provider just coincidentally happens to also be a dentist). Dentists who fabricate sleep apnea appliances can enroll as DME providers on the CMS website.

A dentist may enroll as a Medicare DME provider and opt out of Medicare Part B. DME suppliers *cannot* "opt out" of Medicare with respect to payment for durable medical equipment, i.e., sleep apnea devices, but can enroll as "non-participating DME providers". No Medicare dollars can be paid by anyone to a DME supplier who is not registered with Medicare. A dentist who makes sleep apnea devices cannot be paid with Medicare monies if the person is not registered as a DME provider.

How to Enroll or Opt Out

Patients' ability to obtain benefits from the program and supplemental insurers is not affected – as long as the dentist opts in or out (or completes the 8550). In order to opt out, the dentist must notify the contractor handling Medicare claims for New York State that the dentist intends to contract privately with Medicare patients. This is done by filing an affidavit in which the dentist attests to certain specific terms. Affidavits must be filed within 10 days of entering the first private contract, and are valid for two years.

Changes to the requirements associated with opting out of Medicare Part B have eliminated the impediment of having to re-enroll biannually. Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), opting out was a less desirable option because opt-out affidavits were only effective for 2 years.

As a result of these changes, valid opt-out affidavits signed ***on or after June 16, 2015***, will automatically renew every 2 years. Dentists that file affidavits effective on or after June 16, 2015, who do not want their opt-out to automatically renew at the end of a two year opt-out period, may cancel the renewal by notifying all Medicare Administrative Contractors (MACs) with which they filed an affidavit *in writing at least 30 days prior to the start of the next opt-out period.*

Valid opt-out affidavits signed ***before June 16, 2015***, will expire 2 years after the effective date of the opt out. Dentists that filed affidavits effective before June 16, 2015, that want to extend their opt-out must submit a renewal affidavit within 30 days after the current opt-out period expires.

Practitioners can file an opt out affidavit with the contractor for New York State, ***National Government Services, Inc***. An opt out affidavit form is available on the NYSDA website, www.nysdental.org, in the "members only" section. Contact information for National Government Services, Inc.:

National Government Services, Inc.
PO Box 7149
Indianapolis, IN 46207-7149
888-379-3807
http://www.ngsmedicare.com

Information and enrollment forms are available at:
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html

For additional information regarding opting out: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf

For general information, doctors can call the Medicare provider customer service number, 1-866-837-0241.

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