Dental Coverage Developments: Medicaid, CHIP, and Medicare

Many individuals in the United States lack affordable oral health insurance coverage, including many Medicaid and Medicare beneficiaries. This White Paper will consider the current state of dental coverage for beneficiaries of these federal health care programs. Much of this White Paper grew out of the Medicare dental services coverage policies addressed in the fiscal year (FY) 2014 OIG Work Plan risk assessment questions included in the Wolters Kluwer Law & Business ComplyTrack Suite™.

The Affordable Care Act addressed part of the problem by labeling pediatric dental care an "essential health benefit," but provides no such coverage for adults. This White Paper will outline the pediatric dental coverage through Medicaid and the Children's Health Insurance Program (CHIP) as well as the difficulties in purchasing pediatric coverage through a Health Insurance Exchange due to what some call a "legal loophole." Ultimately, due to the uncertain future of CHIP and the impact of the legal loophole for coverage under an ACA plan, pediatric dental coverage remains a hot button topic for many.

Under Medicare, dental services are excluded from coverage with only a few exceptions. Many hospitals submit dental claims; the HHS Office of Inspector General (OIG) has found that many of these claims are for noncovered services. This White Paper discusses the Medicare rules governing dental coverage, describes the OIG’s Work Plan initiative, provides examples of OIG claims audits conducted over the last two years, and examines recent court cases that have challenged the Secretary’s interpretation of Medicare’s rules related to dental coverage.

Pediatric Dental Coverage: Obstacles to Accessing Care

Affordable oral health insurance coverage in the United States remains an issue, particularly for pediatric patients. While individuals have numerous ways to gain dental coverage such as through employee health plans, plans purchased through a Health Insurance Exchange, or if qualified, through Medicaid or CHIP coverage, many only have a choice to purchase it on an Exchange as a stand-alone product, which in turn impacts the number of people who purchase or sign up for it. According to a representative from the Pew Center on the States’ Dental Campaign, in 2009 preventable dental conditions accounted for more than 830,000 emergency department visits in the United States. In 2009, 19 million children were uninsured for dental care and dental cavities are the most prevalent chronic disease in children.
Medicaid and CHIP Dental Coverage

Medicaid, the federal health care program administered by the states for certain low-income individuals and their families, has traditionally provided dental services only to individuals under the age of 21. The coverage includes early and periodic screening, as well diagnosis and treatment, which is referred to as an EPSDT program.

In 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) (PL. 111-3) provided mandatory coverage for children enrolled in the CHIP, which is a program available to families with incomes just above the Medicaid threshold, but who do not have sufficient funds to pay for private insurance. CHIP beneficiaries are required to be provided with “dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions” (Soc. Sec. Act sec. 2103(a)). Prior to CHIPRA’s mandate, all states had some level of dental coverage provided through CHIP, but there was no uniformity or federal standard. CMS provided a letter to state health officials to assist in implementing dental coverage through CHIP.

Interplay. If a state's CHIP program is an expansion of Medicaid, the EPSDT services required under the Medicaid program will meet CHIPRA's requirements. If a state has a separate program, it may either define its own dental benefit packages or develop a package equivalent to a benchmark program. State-defined dental benefit packages must include nine benefit categories: (1) diagnostic; (2) preventive; (3) restorative; (4) endodontic; (5) periodontic; (6) prosthodontic; (7) oral and maxillofacial surgery; (8) orthodontics; (9) emergency services.

A state may decide to provide dental benefits comparative to a benchmark program. Under CHIPRA sec. 501(b), the three benchmark programs a state may use are: (1) the plan available to children of federal employees; (2) the plan available to state employees that is most frequently chosen by employees with dependents; or (3) the commercial dental plan that has the largest non-Medicaid enrollment in the state.

The Children’s Dental Health Project reports that 43 million children in the United States have dental coverage through Medicaid and CHIP.

Affordable Care Act and Final Rules

The Patient Protection and Affordable Care Act (ACA) (PL. 111-148) required that beginning in 2014, health insurance for eligible group markets and individual markets sold through Health Insurance Exchanges must be “qualified health plans.” Qualified health plans must: (1) be certified as eligible; (2) be offered by a duly licensed health insurance issuer that has agreed to offer plans that meet certain cost sharing requirements; and (3) provide specific package of health benefits at certain coverage levels. The health benefits are referred to as an “essential health benefits package” (ACA sec. 1301(a)(1)). The tenth and final item on the list of minimal items and services to be covered is “pediatric services (including oral and vision care)” (ACA sec. 1301(b)(1)). The ACA further provided that if a stand-alone pediatric dental plan is offered through an Exchange, other health plans offered through that Exchange do not need to provide pediatric dental care that is otherwise required (ACA sec. 1301(b)(4)). Adult dental coverage is not an essential benefit under the ACA, and, therefore, is not subject to essential benefit provisions.

Final rule. HHS published the standards for Health Insurance Exchanges and essential health benefits in February of 2013 (Final rule, 78 FR 12833, February 25, 2013). The ACA allows for a separate “reasonable” out of pocket maximum for stand-alone dental plans, or those dental services not packaged into a medical coverage policy. The Final rule determined that it will be up to the Exchange to determine what constitutes a reasonable out of pocket maximum. In states using the federal Exchange, the out of pocket limit for stand-alone dental plans is $700 for one child or $1400 for multiple children. Seven states have set the limit at $1000 per child and $2000 for multiple children.

The Final rule also states that individuals (both with and without children) purchasing benefits through the Exchange are not required to purchase a stand-alone dental plan. HealthCare.gov informs consumers that “Under the health care law, most people must have health coverage or pay a penalty. But this isn’t true for dental coverage. You don’t need to have dental coverage, even for children, to avoid the penalty.”

Premium tax credit. The Internal Revenue Service (IRS) Final rule on health insurance premium tax credits (Final regulations, 77 FR 30377, May 23, 2012) stated that under sec. 36B(b)(3)(E) of the Internal Revenue Code, if an individual enrolls in both a qualified health plan and a stand-alone dental plan, “the portion of the premium for the stand-alone dental plan that is properly allocable to pediatric dental benefits that are essential benefits required to be provided by a qualified health plan is treated as a premium payable for the individuals qualified health
plan.” In other words, regulations require pediatric dental premiums for stand-alone dental plans to be treated as part of the qualified health plan premium for calculations of the tax credit.

The ACA and the IRS have defined premium assistance as the lesser of: (1) the premium paid for coverage purchased through an Exchange, or (2) the excess of the state’s benchmark plan’s (second lowest silver plan) premium over the maximum percentage of the consumer’s household income to be paid in premium. Premium tax credit regulations begin at 26 CFR sec. 1.36B and are sometimes referred to as “section 36B credits.”

Opposition to IRS’ Stated Policy on Premium Assistance for Dental Plans

Despite the IRS Final rule that indicated premium tax credits could be used for stand-alone dental plans, documents emerged that indicated the IRS would not take such a clear-cut approach. As explained by the National Association of Dental Plans, very few individuals will be able to utilize premium assistance for dental plans because premium assistance is only applicable to the first option, i.e., the premium paid for coverage purchased through an Exchange. Because most Exchanges’ second lowest cost silver plan will be a medical policy without dental coverage, consumers will not receive premium assistance for pediatric dental benefits. If the Exchange’s second lowest silver plan includes pediatric dental, all consumers will receive premium assistance for pediatric dental benefits. If the Exchange’s second lowest silver plan includes pediatric dental, all consumers will receive premium assistance for dental coverage, whether or not they purchase it. The Children’s Dental Health Project notes “IRS policy suggests that a family’s tax credit may not cover the cost of dental benefits if they are only offered separately in a marketplace.” This “legal loophole” has become the target of severe criticism.

The loophole was highlighted in a letter written to Jack Lew, Secretary of the Department of Treasury, by the American Dental Association, the Children’s Dental Health Project, Delta Dental and the National Association of Dental Plans (together, organizations) stating: Our organizations and other parties with an interest in pediatric dental issues were not aware of how the Treasury Department envisioned that the section 36B credit would be calculated until after the publication of final regulations on May 23, 2012. In the preamble to the proposed regulations, the Treasury Department stated that premiums for pediatric dental coverage would be added to the premium for the benchmark plan in computing the premium. Despite this statement, in meetings with your department, we have learned that IRS plans to make premium tax credits available to support the purchase of stand-alone pediatric dental plans only in those very limited circumstances when the actual premiums for purchased coverage are lower than the premium assistance amount based on the benchmark plan in a state. The letter goes on to describe the calculation with reference to the price of a benchmark or second lowest cost silver level plan and notes that with this method of calculation, the issue of calculation is critical. The organizations argued that, as they understand it, the current policy interpretation would require some families to pay more than their applicable percentage of income to purchase coverage for all essential health benefits which is “not what Congress intended.”

Congressional frustration. A similar letter was sent to Secretary Lew by 14 Senators including Sherrod Brown, Al Franken, Mark Udall, Barbara Boxer and Dianne Feinstein stating that the primary goal of the ACA was to ensure families could afford the care they need, including pediatric dental care. The Senators asked Secretary Lew “to use [his] rulemaking authority going forward to clarify that the premium tax credit is calculated with reference to plans that reflect the full range of essential health benefits including pediatric dental benefits provided through a stand-alone plan where an individual enrolls in both a qualified health plan and a stand-alone dental plan.” The Senators suggested that this could be accomplished by “calculating the credits in a manner that takes into account the pediatric portion of the premium for the second-lowest cost 70 percent actuarial value.
stand-alone dental plan in states in which the benchmark silver plan does not include pediatric dental benefits.”

States Respond

In relation to pediatric dental benefits, the American Dental Association found that among the 36 states participating in the Federally Facilitated Marketplace (permanently or temporarily), seven states offer no medical plans with embedded pediatric dental benefits, while two states offer embedded pediatric dental benefits with every medical plan (Vermont and West Virginia).

California’s response. After realizing the loophole in premium tax credit calculation would negatively impact California residents, the state planned to include “embedded” dental plans in their Health Insurance Exchange options. A coalition of children’s health advocates urged the state to include embedded plans in 2014. The state, which offered five stand-alone plans in 2014 and one bundled plan with a paired medical plan and stand-alone dental plan, however, ultimately delayed soliciting bids for medical plans with embedded pediatric dental benefits until 2015 due to lack of time. Covered California™, the state’s Health Insurance Exchange, commissioned a report to assess all reasonable options to ensure its children had access to dental coverage. In January of 2014, the California Health Benefit Exchange Board voted to offer embedded pediatric dental benefits beginning in 2015.

Washington’s policy. Similarly, the state of Washington is proposing a policy that would allow health plans on the state’s Washington Health Benefit Exchange to sell plans with embedded dental benefits. Currently only stand-alone pediatric dental plans may be sold on the Exchange. Conversely, state policy requires medical plans sold outside the Exchange to include embedded pediatric dental coverage. Dental insurers have stated, however, that they have concerns with the new proposal as deductibles for embedded plans can be much higher than for stand-alone plans.

Impact on Patients and Providers

Pediatric dental benefits have been deemed as “essential” by the federal government. To that, four avenues exist to provide children with dental coverage: (1) private or employer based coverage, (2) Medicaid, (3) CHIP, and (4) coverage purchased under the ACA. Two of these four avenues—ACA purchased coverage and CHIP—are either in jeopardy or do not currently work as originally intended and, thus, it can be theorized, could negatively impact the ability for children to receive dental benefits.

Loophole. The legal loophole that will prevent some families from being able to purchase dental benefits with premium tax credit assistance could negatively impact the number of children with access to dental coverage. Numerous policy advocates are putting pressure on the federal government to close the loophole to ensure parents are able to afford pediatric dental insurance and to treat dental benefits in the same manner as the remaining essential health benefits.

CHIP. Even before the ACA was passed, the future of CHIP was uncertain. Prior to the ACA’s passage, only the Senate version of health care reform preserved federal funding for CHIP. When the ACA was signed into law, it extended eligibility standards through 2019 and extended funding for the program through October 1, 2015. Some states will have leftover funds to continue financing CHIP for an unknown amount of time. Currently, nearly 8 million children receive CHIP benefits including dental coverage. If funding is not renewed, whether these families would then qualify for Medicaid or premium assistance to purchase coverage through the ACA is uncertain due to state-by-state approaches to Medicaid expansion. This funding uncertainty puts dental coverage for those 8 million children at risk.

Rayne DeVivo, an associate at Hunt Henderson in LeRoy, Illinois, notes in an interview with Wolters Kluwer that, in Illinois, within the dental directory for the state Medicaid and CHIP program known as Illinois All Kids, searches indicate that the few dentists who provide care for the Medicaid program are often traveling dentists working out of both a private office and county health departments. She also noted that the state reimburses dentists at about half the rate of private insurers. Combined with a crisis in state funding she stated that “There’s no money and no political pressure or will to raise reimbursement rates to encourage more dentists to see Medicaid patients.”

Fifteen percent of the country’s population lives in a dental health professional shortage area, and children in rural areas must travel further to see a provider. In this vein, some have worried that increasing the number of patients with Medicaid coverage might put further pressure on providers, but a recent study showed that when adults were given dental benefits through Medicaid, dentists were able to accommodate the demand while increasing their incomes through innovations such as making greater use of hygienists.
Medicare Claims for Dental Services: Provider Audits, Denial Challenges

Although under long standing Medicare rules dental services are excluded from coverage with only a few exceptions, over the past few years, the Office of Inspector General (OIG) has audited hospitals and found that hospitals have submitted dental claims for noncovered services, which resulted in significant overpayments. In addition, beneficiaries have challenged the HHS Secretary’s interpretations of the rules governing dental coverage when their claims for payment for dental services have been denied.

Laws, Regulations, and Guidances Governing Dental Services

Medicare does not pay for dental services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except for inpatient hospital services in connection with dental procedures when the individual’s underlying medical condition and clinical status or the severity of the dental procedures requires hospitalization in connection with the provision of such services (Social Security Act Sec. 1862(a)(12); 42 C.F.R. Sec. 411.15(i)). Payment for the services of dentists is limited to those procedures that are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth.

Covered dental services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry, such as dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections, and interpretations of diagnostic X-ray examinations in connection with covered services. If an otherwise noncovered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by the dentist, the total service performed by the dentist on such an occasion is covered (Medicare Benefits Policy Manual, Pub. 100-02, Ch. 15, sec. 150; Ch. 16, sec. 140). An oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery is a covered service because the examination is for the identification, prior to a complex surgical procedure, of existing medical problems where the increased possibility of infection would not only reduce the chances for successful surgery but also would expose the patient to additional risks in undergoing such surgery. The examination would be covered under Part A of the program if performed by a dentist on the hospital’s staff or under Part B if performed by a physician (National Coverage Determination Manual, Pub. 100-03, Ch. 1, sec. 260.6).

Medicare makes payment for a covered dental procedure no matter where the service is performed. The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure (Pub. 100-02, Ch. 15, sec. 150; Ch. 16, sec. 140).

Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. For example, an X-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. In addition, payment may be made for services and supplies furnished incident to covered dental services. For example, the services of a dental technician or nurse who is under the direct supervision of the dentist or physician are covered if the services are included in the dentist’s or physician's bill (Pub. 100-02, Ch. 15, sec. 150; Ch. 16, sec. 140).
**Excluded services.** When an excluded service is the primary procedure involved, the service is not covered, regardless of its complexity or difficulty. Medicare does not pay for an alveoplasty (the surgical improvement of the shape and condition of the alveolar process), frenectomy, or the removal of a torus palatinus (a bony protuberance of the hard palate) even though they may be a covered service if these procedures are performed in connection with an excluded service such as the preparation of the mouth for dentures (Pub. 100-02, Ch. 15, sec. 150; Ch. 16, sec. 140).

**Exceptions.** Although the reconstruction of a ridge performed primarily to prepare the mouth for dentures is a noncovered procedure, if the reconstruction of a ridge is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes), the totality of surgical procedures is a covered service. Medicare also will pay for the wiring of teeth when done in connection with the reduction of a jaw fracture. Dental splints used to treat a dental condition generally are excluded from coverage but will be covered if the treatment is determined to be a covered medical condition such as dislocated upper/lower jaw joints. In addition, the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease also is covered. Ordinarily, the dentist extracts the patient’s teeth, but another physician, e.g., a radiologist, administers the radiation treatments (Pub. 100-02, Ch. 15, sec. 150; Ch. 16, sec. 140).

**OIG Work Plans and Audits**

In its Work Plans for FYs 2012, 2013, and 2014, the OIG set out new and continuing review activities related to Medicare hospital outpatient payments for dental services to determine whether such payments were made in accordance with Medicare requirements. OIG noted that based on current audits, providers received Medicare reimbursement for noncovered dental services that resulted in significant overpayments (see OIG Work Plan 2012, W-00-12-35603, October 5, 2011; OIG Work Plan for FY 2013, W-00-13-35603, page 6, October 3, 2012; OIG Work Plan for FY 2014, W-00-14-35432, page 4, January 31, 2014.) OIG began this initiative in 2012. Although it was expected to be issued in 2012, the initiative was included again in the Work Plans for 2013 and 2014. The OIG expects to issue details regarding this initiative in FY 2014.

**Audits.** The OIG audited hospital claims that were at risk for noncompliance with Medicare billing requirements that were submitted, for the most part, in calendar years (CYs) 2010 and 2011. The OIG found that errors occurred primarily because the hospitals did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas. Examples of the OIG’s audits of hospitals that submitted outpatient dental claims that did not comply with Medicare billing rules and the reasons for the errors, as well as the corrective actions the hospitals have taken, are discussed below.

- **Good Samaritan Medical Center.** Eight of the 37 selected claims that the hospital billed for the treatment or removal of teeth resulted in $52,470 in overpayments. The dental claims subject to the audit were elective procedures where the patient required full anesthesia, and no coding valuation occurred. The hospital expanded its billing edits software to identify any dental procedures performed in the hospital and has provided coders with education to ensure that covered dental procedures are properly charged, including correct modifiers (OIG Report, No. A-01-13-00501, March 12, 2014).

- **Ben Taub Hospital.** The OIG review covered 344 Medicare claim lines for hospital outpatient dental services with a diagnosis not related to cancer or physical trauma. A review of a random sample of 30 claim lines confirmed that the 344 claim lines identified were ineligible for Medicare payment. The OIG determined that the hospital’s billing system edits related to dental services were not ensuring that all dental services were eligible for Medicare payment. In addition, the hospital did not have written policies and procedures in place related to billing for dental services. The hospital determined that while editing systems were in place to identify dental claims that should not be billed to Medicare, the editing systems were only effective for the general dental service areas and not for the Oral and Maxillofacial department. The hospital expanded the edits related to Medicare claims for dental services to all hospital departments that provide dental services, effective June 1, 2013. In addition, the hospital provided training to employees who enter dental charges and billing for dental services (OIG Report, No. A-06-13-00004, February 18, 2014).

- **Morton Hospital.** For two of the 27 selected claims, the hospital incorrectly billed Medicare for the treatment or removal of teeth, resulting in $3,260 in overpayments. The dental claims subject to the audit were elective procedures where the patient required full anesthesia. The hospital explained that the errors occurred because the billing software did not contain an edit to identify noncovered dental services and the hospital did not review these services prior to...
billing. The hospital expanded its billing edits software to identify any dental procedures performed in the hospital and has provided coders with education to ensure that covered dental procedures are properly charged, including correct modifiers (OIG Report, No. A-01-13-00500, January 6, 2014).

- **Parkland Health and Hospital System.** For calendar years 2010 and 2011, the hospital received the most reimbursement of any hospital in Texas for certain Medicare outpatient dental services that may have been unallowable. Of 100 claim lines in the random sample, the hospital properly claimed Medicare payment for one claim line. The OIG estimated that the hospital received $743,582 in payments for outpatient dental services that did not comply with Medicare requirements. The majority of the claim lines billed were for tooth extractions performed as a result of tooth decay and for partial or full mouth X-rays of the teeth that were performed during a general dental examination and evaluation. Other charges were for repair of a tooth socket in preparation for dentures. The OIG concluded that the errors occurred because the hospital did not have written policies and procedures related to billing for dental services during the audit period. In addition, the hospital did not have system billing edits in place to ensure that it billed only for services that met Medicare requirements (OIG Report, No. A-06-13-00003, November 18, 2013).

- **UPMC Presbyterian Shadyside.** For six of the 83 selected claims, the hospital incorrectly billed Medicare for the treatment or removal of teeth. OIG reported that the hospital officials attributed this to human error in reviewing dental claims for noncovered services. As a result of these errors, Presbyterian Shadyside received overpayments of $10,574 (OIG Report, No. A-03-12-06105), October 15, 2013).

- **Somerset Hospital.** For all 40 sampled claims, the hospital incorrectly billed Medicare for the treatment or removal of teeth. The hospital stated that the errors occurred because billing staff incorrectly used bill type 131, instead of bill type 130 with condition code 21, for dental claims. In addition, when the hospital took corrective action in November 2010 as the result of a prior OIG audit, it did not correct claims paid prior to that date and did not include four dental HCPCS codes in the edit. As a result of these errors, the hospital received overpayments totaling $197,577. In response to these findings, the hospital educated and re-educated its billing staff regarding the correct bill type and condition code to be reported for outpatient surgery cases involving noncovered dental services. It also initiated a pre-billing review of all dental surgery cases to confirm the accuracy of the bill type and condition code reported on future claim submissions to Medicare (OEI Report, No. A-03-12-06107, April 17, 2013).

**OIG’s recommendations.** Generally, the OIG recommended that the hospitals strengthen their internal structures. Among the steps that the hospitals took to strengthen internal structures were: (1) develop and implement policies and procedures prohibiting billing for noncovered dental services, (2) develop and implement policies and procedures providing guidelines for exceptions for dental services, (3) audit claims for dental services to ensure they are billed properly, (4) train staff on proper billing and coding for dental services when covered, (5) develop and implement system billing edits, and (6) initiation of pre-billing review of dental surgery cases.

**Cases**

Beneficiaries who suffered with covered medical conditions that caused significant dental problems have challenged the denial of their Medicare claims for coverage of the dental procedures. The beneficiaries contended that the Secretary’s decisions violate HHS policy or the CMS.
Manual misinterprets the dental exclusion provisions. The courts affirmed the Secretary's decisions to deny coverage. **Fournier v Sebelius**, (No. 12-15478, May 31, 2013). Three Medicare beneficiaries who suffered medical issues that caused significant dental problems received dental services to correct the problems, but their Medicare claims for those services were denied. The beneficiaries challenged the Secretary's underlying policy decision to exclude dental procedures that are not performed at the same time and by the same dentist as a covered procedure. The denial of coverage in each case was upheld by the Medicare Appeals Council (MAC). The beneficiaries challenged the MAC decisions, which represent the HHS Secretary's final decisions regarding Medicare coverage, and sought declaratory and injunctive relief, stating that the Secretary's decision to deny coverage for their "extraordinary, medically related dental services" violated HHS policy, the Medicare Act, and their right to equal protection. The district court held that (1) substantial evidence supported the Secretary's decisions denying coverage; (2) the Secretary's statutory interpretation excluding coverage was reasonable; and (3) the Secretary's policy does not violate the equal protection guarantee in the Fifth Amendment's due process clause. The Ninth Circuit Court of Appeals affirmed the district court's opinion finding that the statute does not compel the Secretary to cover dental work that is related to complex procedures under Part B. The court concluded that the Secretary's interpretation of the statute was reasonable and, therefore, permissible. On March 4, 2014, the Supreme Court denied the petition of certiorari of a class action suit involving the beneficiaries who contended that the **Medicare Benefit Policy Manual** misinterprets the Medicare dental exclusion provisions. **Bour v Sebelius**, (No. 13-859).

**Logan v Sebelius**, (No. 1:12cv00118-CL, April 3, 2013). The determination of the MAC that surgery to restore a patient's jaw was not a covered benefit was supported by substantial evidence. The patient suffered from progressive atrophy of the mandible because she had not had teeth for ten years. She could not wear dentures or support dental implants because of resorption of the bone. As a result, she had trouble taking in adequate nutrition. CareSource, her Medicare Advantage plan denied preauthorization for surgical reconstruction of her jaw and a bone graft, which were necessary for her to support a dental prosthetic. Because of the severity of the procedures, the patient required inpatient hospitalization. When preauthorization was denied, she underwent the surgery and filed a claim, which also was denied. The court was required to defer to the MAC's findings of fact and its interpretation of the regulations and manuals; it was not required to defer to the favorable decision of the administrative law judge (ALJ) because it was not the final decision of the agency. The magistrate judge recommended that the district court affirm the MAC's decision.

**McBroom v Sebelius**, (No. 2:11-cv-772, November 28, 2012). A Medicare beneficiary who had osteopenia maintained that a bone graft procedure was necessary to address her digestion and dental implants were necessary to improve chewing. The beneficiary argued that the bone deterioration in her jaw was the result of osteopenia and treatment for osteopenia is covered. The procedure the beneficiary sought, however, would not treat the medical condition of osteopenia, but would be in preparation for dental implants. The osteopenia would continue to exist after the bone graft procedure because the bone graft procedure would not address the primary medical condition. As a result, the bone graft procedure was not being performed incidental to or as an integral part of another treatment. Substantial evidence in the record supported the Secretary's decision that the denial of the procedure was appropriate. Therefore, the Secretary's denial of the beneficiary's appeal seeking coverage for a bone graft surgery of her jaw in preparation for dental implants was affirmed and her motion to dismiss was granted.

**Conclusion**

With the number of emergency room visits due to preventable dental issues, it is clear that access to dental care remains an issue in the country. Whether the IRS, Congress or the White House address this issue going forward remains to be seen, but with the pressure from consumer advocates, dental associations and lawmakers, it is sure to be a continuing topic being discussed.
in Washington D.C. In the meantime, it wouldn’t be unusual to see more states attempting to patch the ACA’s premium tax credit loophole by embedding dental plans in the state’s benchmark plan, or by requiring all plans to contain embedded dental benefits.

OIG’s scrutiny of hospital billing practices related to Medicare’s long-standing exclusion of coverage for dental services revealed that hospitals continue to submit claims for dental services that are not covered. The main reason for the submission of such claims is the lack of sufficient controls. Hospitals should ensure that they have policies and procedures in place that address proper billing and coding for dental services, provide training for staff on the dental coverage exclusion as well as the exceptions, ensure that system billing edits are in place, review dental claims prior to submission, and routinely audit dental claims.

Though the courts deferred to the Secretary’s interpretation of the rules governing dental services and affirmed the decisions denying the dental claims, perhaps it is time to consider expanding coverage of dental services. In the cases discussed in this White Paper, the beneficiaries were suffering from covered medical conditions such as osteopenia, atrophy of the mandible, and an autoimmune disease that destroyed their salivary glands, teeth, and gums and has led to life threatening infections and required such procedures as bone grafts and jaw reconstruction. It is well accepted that oral health has a connection with overall health and dental examinations often lead to the discovery of medical conditions such cancer and other diseases. In addition to expanding pediatric dental coverage, the ACA required the HHS Secretary to establish a 5-year national public education campaign that focuses on oral health care prevention and education. While the ACA did not address expanding Medicare dental coverage, is it time to reconsider such coverage?