



American Association of Oral and Maxillofacial Surgeons

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August 18, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted online via www.regulations.gov

Re: File Code CMS-1770-P Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks-LaSure:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States. AAOMS appreciates the opportunity to comment on the proposed 2023 revisions to the Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, published in the July 29, 2022, *Federal Register* (Vol. 87, No. 145, pages 45860-46843).

AAOMS commends CMS on efforts to improve access to high-quality and affordable health care, notably on the proposals aimed at ensuring Medicare beneficiaries have access to medically necessary and essential dental services. However, AAOMS also has concerns that certain aspects of the proposed rule exacerbate the uncertainty faced by Medicare providers under the current payment system.

CY 2023 Physician Fee Schedule (PFS) rate setting and Medicare conversion factor

Medicare providers stand to face another round of significant payment cuts beginning January 1, 2023. In the proposed rule, CMS estimates that the CY 2023 PFS conversion factor (CF) - the basic starting point for calculating Medicare payments - will be \$33.08, representing a nearly 4.5 percent decrease from the \$34.61 CF for 2022.

The Medicare payment system has been devalued through recurring and drastic payment cuts year after year. The ongoing public health emergency continues to require physicians across all specialties to take unprecedented steps to manage patient care, mitigate workforce shortages, navigate limited availability of critical supplies and rapidly respond to changes in patient needs and

clinical protocols. CMS' proposal fails to account for the economic factors that have dramatically increased practice costs in the past year. The CY 2023 PFS proposed rule jeopardizes the already-strained financial stability of many physician practices, especially small independent practices.

The proposed payment cuts, combined with the pending threat of the 4 percent PAYGO reduction and recent termination of the 2 percent sequestration moratorium have created a financial environment for Medicare providers that is simply untenable, putting timely access to essential healthcare services at risk. For these reasons, **AAOMS urges CMS and HHS not to finalize the proposed payment cuts and to work with Congress to fundamentally reform the PFS to ensure reimbursement stability for Medicare providers moving forward.**

Proposals and request for information on Medicare Parts A and B payment for dental services

Oral and maxillofacial surgery is the surgical specialty of dentistry and one of the few dental specialties whose members perform Medicare-covered procedures that range from the removing cancerous tumors in the mouth/jaw area and the extraction of infected teeth to preparing a patient's jaw for radiation cancer treatment to repairing tissue or bones in the facial area following trauma. As such, our members have extensive experience with the Medicare program.

Currently, Medicare Benefit Manual provisions outline coverage for a limited number of dental services and procedures, including those mentioned above, involving certain medically compromised patients. Codifying existing manual provisions would bring regulatory language in line with CMS manual provisions, affirming a Medicare beneficiary's right to access these critical oral and maxillofacial procedures. **AAOMS supports CMS' proposal to codify the existing dental coverage policy and expand coverage for these services to inpatient or outpatient settings.**

As CMS knows, section 1862(a)(12) of 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 (i.e., "dental services"). As stated in the proposed rule, CMS' current interpretation of section 1862(a)(12) has been called into question as being "unnecessarily restrictive."

For example, Medicare currently covers an oral exam for a patient prior to undergoing a Medicare-covered kidney transplant, but not any necessary dental treatment prior to the transplant to ensure the success of the medical procedure. Further, an oral exam and treatment of diagnosed dental infections are not covered for any other transplant procedures or for certain other medically-covered procedures such as head and neck cancer, that rely on a healthy mouth for a successful outcome. AAOMS appreciates CMS' consideration to broaden the definition of medically necessary dental services to better address the oral health needs of the Medicare population.

AAOMS supports efforts to expand Medicare coverage for certain oral and maxillofacial surgery services¹ that the association considers to be "medically necessary" or "essential" because they are integral to a patient's overall health. Such services include the evaluation and definitive treatment of infections of the head and neck and the extraction of teeth prior to transplant surgery, valve replacement and cardiac surgery. AAOMS considers "definitive treatment" to include the extraction of source teeth and incision and drainage procedures for treatment of severe dental infections. If

¹ Essentials of Oral and Maxillofacial Surgery Services.

https://www.aaoms.org/docs/govt_affairs/advocacy_white_papers/essentials_oms.pdf. Accessed August 9, 2022.

left untreated, severe oral and dental infections could lead to sepsis, deterioration of the jaw, heart complications or death. As such, **AAOMS supports CMS' proposal to expand Medicare coverage and payment for necessary dental examinations and treatment for oral infections, prior to organ transplant surgery, cardiac valve replacement or valvuloplasty procedures.**

Coverage of services in inpatient and outpatient settings, including ASCs

AAOMS believes that access to procedures described above is often critical to successful outcomes for patients with certain conditions. As OMSs routinely evaluate and safely treat patients ranging in complexity across a variety of care settings, AAOMS supports CMS' proposal for coverage of these services in either the inpatient or outpatient setting. AAOMS also requests CMS extend coverage of such services when rendered in ambulatory surgery centers (ASCs) as well as in oral and maxillofacial surgery practices. Lack of and/or limited hospital-based OR access is further magnified by medical staffing shortages, industry-wide inflation and the residual backlog of cases spurred by the COVID-19 pandemic. Other challenges exist for patients unable to access hospital facilities because of geographic or transportation limitations. AAOMS believes that ASCs and oral and maxillofacial surgery practices have the potential to mitigate many of these external pressures. Indeed, industry research indicates the health care system as a whole benefits when procedures migrate to the office or ASC from more costly care settings.

Request for clarification on the proposal on the administration of anesthesia as a covered service ancillary to covered dental procedures

CMS has further proposed that payment could also be made, under the applicable payment system, for the services considered ancillary to those dental services that would be deemed medically necessary and thus not be subject to the preclusion for payment under the Act, if finalized. CMS has proposed such ancillary services may include x-rays, the administration of anesthesia and facility costs including the use of the operating room. **AAOMS supports CMS' proposal to allow Medicare payment for services that are ancillary to or provided in conjunction with dental services that are inextricably linked to, and substantially related and integral to the clinical success of, covered medical services such as X-rays, administration of anesthesia, use of the operating room and other facility services as such services represent necessary diagnostic, clinical and procedural considerations that must be determined by the surgeon on a case-by-case basis.**

OMS anesthesia delivery includes the administration of deep sedation or general anesthesia for procedures performed on pediatric, adult and geriatric patients in the office and ASC settings. OMSs undergo extensive clinical training emphasizing perioperative evaluation of all patients, risk assessment, anesthesia and sedation techniques, monitoring and the diagnosis and management of complications. AAOMS has supported the administration of moderate sedation and general anesthesia, provided by OMSs, when done in conjunction with a separate procedure as medically necessary and essential for the control of pain and anxiety, when clinically appropriate.

Currently, Medicare bundles payment for general anesthesia with payment for the surgical service when both are rendered by the operating surgeon, including an OMS. Although, neither CPT nor CDT coding guidelines mention moderate sedation, deep sedation or general anesthesia as being inclusive to a procedure. In fact, coding guidelines specifically state that only the administration of a local anesthetic is inherent to the procedure. It is the position of the AAOMS that an oral and maxillofacial surgeon who performs both surgery and administers moderate sedation, deep

sedation or general anesthesia with his or her anesthesia team, should be reimbursed for both if he or she has the requisite education, training and required state license and/or permits to perform these services. Under current Medicare policy, a separate provider is required to administer the deep sedation/general anesthesia for separate payment to be allowed. Given this, **AAOMS seeks clarification from CMS on the consideration of the administration of deep sedation/general anesthesia as a covered service ancillary to or provided with covered dental services that are inextricably linked to, and substantially related and integral to the clinical success of, the other covered medical services, specifically whether CMS interprets this to include the administration of anesthesia by the operating surgeon in an office-based setting and an ASC for coverage under this proposal.**

Other clinical scenarios for dental services integral to other covered medical services

In addition to those scenarios outlined above, AAOMS agrees with CMS that there are likely other clinical scenarios in which certain dental services, such as examinations and/or medically necessary diagnostic and treatment services would be inextricably linked to, and medically necessary for, the clinical success of other covered medical services.

AAOMS has supported legislation to expand coverage to dental services that are medically necessary as a direct result of or will have a direct impact on treatments for all head and neck cancers, such as radiation therapy with or without chemotherapy, as well as for joint replacement therapy. Additionally, AAOMS has supported the expansion of coverage to include the extraction of problematic teeth or incision and drainage of severe abscesses when a delay in surgical treatment could result in the impairment of the patient's condition or a delay in pending treatment that should be performed in a timely manner. AAOMS, for example, has supported the Medicare Medically Necessary Dental Care Act (HR 5110) that would allow for coverage of dental services that are furnished in conjunction with treatment relating to a prosthetic heart valve replacement, cancer of the head or neck, lymphoma, leukemia, or organ transplantation. **AAOMS encourages CMS to consider allowing payment under Medicare for dental services such as dental examinations and the treatment of severe dental infections that are medically necessary as a direct result of, or will have a direct impact on treatments for all head and neck cancers, such as radiation therapy with or without chemotherapy; as well as joint replacement therapy.**

AAOMS also acknowledges that significant policy changes, including the expansion of regulatory language to include other clinical scenarios for coverage under the Medicare program, require a calculated and stepped approach. To prioritize dental treatment of greatest need for Medicare beneficiaries, **AAOMS supports the expansion of dental coverage under the Medicare program for the clinical scenarios addressed thus far and summarized as follows:**

- ***Dental examinations and necessary dental treatment for severe dental infections furnished as part of a comprehensive workup prior to any organ transplant surgery or prior to cardiac valve replacement or valvuloplasty procedures, in either the inpatient or outpatient setting.***
- ***Dental examinations and treatments of severe dental infections that are medically necessary as a direct result of or will have a direct impact on treatments for all head and neck cancers, such as radiation therapy with or without chemotherapy, as well as for joint replacement therapy.***

- *The extraction of problematic teeth and incision and drainage when a delay in surgical treatment could result in the impairment of the patient's condition or a delay in pending treatment that should be performed in a timely manner.*
- *Services that are ancillary or provided in conjunction with dental services that are inextricably linked to, and substantially related and integral to the clinical success of, covered medical services such as X-rays, administration of anesthesia, use of the operating room and other facility services.*
- *The administration of moderate sedation and general anesthesia, provided by the surgeon, when rendered in conjunction with a separate procedure as medically necessary and essential for the control of pain and anxiety, when clinically appropriate.*

AAOMS further supports CMS' proposal to retain carrier pricing methodology for the dental services for which payment is currently made under the PFS as well as for those dental services that can be paid under the CMS proposals for CY 2023.

AAOMS recommends that CMS delay expanding additional dental benefits – outside of those mentioned above – to allow stakeholders and interested parties more time to determine the standard of care that is clinically advisable to eliminate the source of dental infection prior to proceeding with treatment, as well as to determine other clinical scenarios in which dental treatment may be integral to or inextricably linked with, clinical success. Examples of such may include the management of immunocompromised patients or those with a diagnosed systemic disease such as diabetes.

Such a policy shift is indicative of the increasing focus on whole person care, requiring intimate collaboration across varying disciplines, including our cohorts outside of dentistry. Additional time would help to ensure CMS has the best clinical data and medical evidence available, including patient outcome measures, to facilitate CMS' consideration of additional dental benefits in other clinically relevant scenarios.

AAOMS also requests additional time for stakeholders and interested parties to consider the following CMS requests for comment, as each requires considerable strategic development:

- *The potential establishment of a process to facilitate recommendations within an annual rulemaking cycle including: (1) relevant medical literature; (2) clinical guidelines or generally accepted standards of care; (3) other supporting documentation to support CMS review and consideration of other clinical scenarios involving dental services.*
- *The establishment of payment models and concerns related to coordinating benefits with Medicaid and other supplemental insurance coverage.*
- *Whether existing care management codes adequately describe and account for time spent coordinating with dentists and their clinical staff?*
- *Whether the current policies for care management services make clear that time spent by physicians or non-physician practitioners coordinating care with dentists regarding the performance and outcomes of services as proposed in this proposed rule, may be counted for purposes of applicable care management codes?*

- *The impact of changes in how healthcare is delivered, specifically whether an increased integration and coordination of care among healthcare providers should also be taken into account in considering dental services that may be inextricably linked to, and substantially related and integral to the clinical success of, a primary medical service.*
- *Whether, and to what extent, the proposed policies in this proposed rule would address any inequitable distribution of dental services for Medicare beneficiaries?*

AAOMS also wishes to reiterate our association's continued support of the expansion of dental benefits under Medicare Advantage as well as through state Medicaid programs. More specifically, AAOMS has advocated in support of the Medicaid Dental Benefit Act (HR 4439/S 3166), which would require state Medicaid programs to cover dental and oral health services for adults. Medicaid as well as the Medicare Advantage programs provide access to oral healthcare for patients who would otherwise not have access to oral healthcare under traditional Medicare. Patients with Medicaid and Medicare Advantage dental benefits have access to networks of qualified dental providers as well as cost savings from network rates and annual out-of-pocket limits. AAOMS believes this, in combination with the proposals outlined here, will work to ensure the most vulnerable of our nation's population have access to high-quality, affordable and appropriate dental and oral health care through all available avenues.

AAOMS looks forward to working with CMS to facilitate access to high-quality, medically necessary and essential dental and oral health services for Medicare beneficiaries.

Global surgical package valuation

The OMS scope of practice encompasses a broad range of services, from diagnostic and therapeutic to complex surgical intervention. AAOMS acknowledges that several factors have contributed to an overall change in how healthcare services are delivered, not the least being advancements in medical technology, an increasing focus on care coordination and the rapidly evolving healthcare landscape.

In general, AAOMS supports improving the accuracy of physician payment as well as a more stable and predictable payment methodology under the PFS. However, given the incredibly diverse nature of the over 4,000 physicians' services paid as global packages under the PFS, it seems unlikely that a sweeping revaluation of global services would stabilize the Medicare payment system but rather exacerbate existing sustainability concerns.

Currently, a mechanism exists that allows CMS, specialty societies and other interested parties to identify potentially misvalued services. The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) Relativity Assessment Workgroup process continues to be an objective and evidence-based approach for the detection and review of potentially misvalued services. The process utilizes survey data from the practitioners furnishing these services to verify the number, level and relative costs of postoperative visits included in the global packages. **AAOMS does not support cross-the-board revaluation of services with global periods nor the broad reduction in RVUs that would likely result. AAOMS encourages CMS to continue to rely on the Relativity Assessment Workgroup process for the identification of potentially misvalued services with global periods.**

In previous rulemaking, CMS had proposed to transition all 010-day and 090-day global services to 000-day global services, effectively eliminating the concept of the surgical package under the PFS. AAOMS would like to take this opportunity to reiterate the association's concerns with this approach, should CMS seek to reconsider it.

AAOMS notes the newly established CPT codes for the removal of sutures and/or staples not requiring anesthesia effective for CY 2023; however, if postoperative care is unbundled, several other services remain that inclusive to the global surgical package would need to be separately reported:

- Dressing changes
- Local incision care
- Removal of operative pack
- Removal of lines, wires, tubes, drains, casts, and splints
- Insertion, irrigation and removal of urinary catheters
- Routine peripheral intravenous lines
- Insertion, management, and removal of nasogastric and rectal tubes
- Changes and removal of tracheostomy tubes

It is imperative for CMS to ensure physicians are accurately paid for these vital patient care services, necessitating the creation of new CPT/HCPCS codes, or significant revision to existing codes, as well as establishing distinct valuation for the physician work, practice expense and malpractice risk for these services.

Unbundling postoperative services would significantly increase the administrative burden placed on Medicare providers, especially those in small, independent practices, as well as for Medicare Administrative Contractors and CMS, given the separate submission, processing and payment for postoperative services and supplies. Aside from the complexity such a change in policy may create should it fail to be adopted industry-wide, it is not unreasonable to expect that this would shift incentives back towards volume-based care, something CMS has notably worked to eradicate in the Medicare program.

Importantly, the unbundling of postoperative services may also place increased financial strain on patients, requiring them to make co-payments for not only their surgery, but also for each subsequent postoperative office visit or service. This will disproportionately impact patients with economic insecurities, perhaps working to provide a financial incentive to decline necessary postoperative care. As such, **AAOMS does not support the elimination of global periods under the PFS.**

Evaluation and management (E/M) visits

AAOMS is appreciative of CMS' acceptance of the RUC's work RVU recommendations for the hospital inpatient or observation codes, nursing facility codes, home or residence visit codes, emergency department visits and prolonged services codes.

However, AAOMS is disappointed that CMS continues not to recognize the increased value of postoperative E/M services included within the global period of surgical procedures, although the Agency has historically done so. The failure to increase the E/M portion of global services will

foreseeably disrupt the congressionally-mandated relativity within the fee schedule and work to create specialty differentials that contradict Medicare statute. **AAOMS echoes AMA and RUC comments and recommends that CMS apply the office visit increases uniformly across all services and specialties by increasing the relative values of surgical procedures accordingly for all post-operative E/M services within a surgical global period to retain relativity within the RBRVS.**

If CMS is concerned about the accuracy of the number of postoperative visits included in global surgical packages, CMS is encouraged to work with the RUC and affected specialty societies to confirm and/or make new recommendations as specialty societies are most suitable for collecting the actual resources, work and time associated with rendering surgical procedures.

Prolonged services

AAOMS appreciates the collaborative efforts of CMS and AMA that have resulted in the unified adoption of a cohesive set of guidelines for reporting office and outpatient E/M services, implemented in 2021. Effective January 1, 2023, the CPT Editorial Panel has redefined the “other” E/M services to align with the revised office and outpatient E/M services, bringing the full family of E/M services under the guidelines that currently govern office and outpatient visit codes. As proposed for 2023, CMS’ general acceptance and adoption of the revised framework and guidance for other E/M services seeks to further align coding conventions with current clinical practice and streamline reporting for these critical and highly utilized services.

AAOMS is disappointed however that CMS has proposed not to accept the CPT coding and guideline changes related to prolonged services. Our association has concerns that a bifurcated system for reporting this subset of services will create administrative burden and undue confusion on the part of healthcare providers and coders. **To ensure consistency and alleviate unnecessary claims denials and reimbursement discrepancy for prolonged services, AAOMS encourages CMS to work with the CPT/RUC E/M workgroup to align CMS and CPT prolonged services policies.**

Virtual direct supervision

Under Medicare Part B, certain types of services (e.g., many diagnostic tests, services incident to physicians’ or practitioners’ professional services) must be furnished under the direct supervision of a physician or practitioner. This requirement was temporarily changed with certain Public Health Emergency (PHE) waivers to allow the supervising professional to be remote and use real-time, interactive audio-video technology. As many AAOMS members are educators who practice in academic environments, our association does see the potential long-term benefits of the PHE waivers for virtual direct supervision.

AAOMS understands and appreciates CMS’ continued commitment to patient safety and agrees that a broad expansion of direct supervision via interactive audio-video communication technology may not be warranted for all services. However, given the ongoing need to mitigate workforce shortages and ensure the availability of physicians and healthcare providers, **AAOMS does support the permanent expansion of virtual direct supervision for those services demonstrated during the PHE as safe and effective in the delivery of high-quality, appropriate care under the virtual direct supervision of a physician working within their scope of practice.**

Updates to practice expense data collection and the Medicare Economic Index

The Medicare Economic Index (MEI) serves as a proxy for the economic environment within the healthcare space, aiming to represent the true cost of doing business across the industry. CMS has proposed a rebasing of the Medicare Economic Index (MEI) for CY 2023, utilizing aggregate data sources, including the 2017 data from the United States Census Bureau's Service Annual Survey (SAS), to update the MEI weights. Although not proposed for implementation in 2023, the rebased MEI would also be used to calculate updates to practice expense data.

AAOMS appreciates CMS' intent to reflect current cost inputs more accurately for physician practices and healthcare organizations, however the association has concerns over the proposed MEI weights based on the new methodology and data sources. The aggregate data sources proposed by CMS do not appear to capture data from physician practice owners, only from those practitioners considered employed physicians, requiring additional data manipulation on the part of CMS to understand practice owner costs. Therefore, the proposed values of physician work, practice expense and professional liability insurance (47.3 percent, 51.3 percent and 1.4 percent, respectively) may not be representative of the true cost of physician work and PLI relative to practice expense.

Current MEI weights are based on 2006 data obtained from the AMA's Physician Practice Information (PPI) Survey, last conducted in 2007/2008. CMS has a long-standing history of collaborating with the AMA and utilizing the data generated from AMA-led physician surveys for both direct and indirect practice cost inputs. There has been acknowledgment on both sides that the data currently in use is outdated, with the AMA currently engaging in robust data collection for 2022 inputs. Given CMS' historical use of the PPI and the AMA's current efforts, **AAOMS encourages CMS to continue to collaborate with the AMA in the data collection process and to delay applying updates to the MEI weights under the proposed methodology until the new AMA survey data are available.**

Changing the terminology of skin substitutes

CMS is proposing to replace the term "skin substitutes" with the term "wound management" or "wound management products" which, CMS asserts in the proposed rule, more accurately describe the suite of products that are currently referred to as "skin substitutes." CMS is of the belief the term is misleading as skin substitute products are not a substitute for a skin graft because they do not actually function like human skin that is grafted onto a wound but rather, these products are applied to wounds to aid wound healing.

Under the CPT code set, the description of the family of codes that describe skin substitute grafts accurately captures the procedures related to skin replacement surgery as well as tissue repairs. Further, the description established by the CPT Editorial Panel clarifies the instances that are, and are not appropriate to report as the application of skin substitutes. From this definition, as well as individual code descriptors, it is clear that skin substitutes are very specific and separately reportable from wound dressings. AAOMS believes a change in terminology to "wound management" would differ from CPT nomenclature and cause confusion and inconsistent reporting.

AAOMS would like to echo the concerns of the AMA RUC regarding the proposed change in terminology and would encourage CMS to delay the implementation of such changes until the matter may be considered by the CPT Editorial Panel.

Thank you for your consideration of these comments. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality & Reimbursement, with any questions at 800-822-6637, ext. 4394 or pserpico@aaoms.org.

Sincerely,

A handwritten signature in black ink that reads "J. David Johnson Jr., DDS". The signature is written in a cursive style with a large initial "J" and a distinct "Jr." at the end.

J. David Johnson Jr., DDS
AAOMS President