MEDICARE COVERAGE OF DENTAL SERVICES

— THE PROBLEM —

Mr. Jones was diagnosed 4 years ago with cancer of the mouth, which was treated conventionally with surgery followed by chemotherapy and radiation treatments. Mr. Jones’ doctors advised him at the outset of treatment that the chemotherapy and radiation could be expected to cause damage to his teeth and, as predicted he has experienced mucositis, an inflammation and ulceration of the lining of the mouth, together with xerostomia (dry mouth) that increases susceptibility to infection. As a result of these conditions, Mr. Jones has already lost approximately half of his teeth, and his dentist has performed extensive dental procedures to save his remaining teeth. The Medicare contractor refuses to pay for this dental work on the basis that routine dental care is excluded by the Medicare statute.

Similar denials of coverage are encountered by Medicare beneficiaries who need extraordinary dental services as a result of other conditions, such as Sjogrens Syndrome, although their needs are related to serious medical conditions rather than the routine dental needs or the aging process.

BACKGROUND

When Congress established the Medicare program in 1965 it excluded coverage of certain items and services it believed were routinely needed and low in cost. Such excluded items included physical examinations, drugs, hearing aids, dental services, and eyeglasses, with limited exceptions for certain eyewear and eye examinations, orthopedic shoes, and certain dental procedures. The legislative history indicates that Congress intended the exclusions of coverage for the various services listed in this section of the Medicare statute to apply only to routine services. Other than prescription drugs, and limited physical examinations, the Medicare statute still excludes payment for these services.

Despite the strong statement that the coverage exclusions in the statute should apply only to items and services that are routine in nature, the Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, has applied the exclusions broadly since the inception of the program. Thus, beneficiaries like Mr. Jones may be denied coverage for dental services that are not routine in nature and should, in fact, be coverable under Medicare. In this paper, current CMS policy with respect to these services will be examined, together with arguments and case law supporting a return to the more liberal interpretation of the exclusion intended by Congress.

MEDICARE POLICY ON DENTAL SERVICES

The statutory exclusion of Medicare coverage of dental services is applied to a number of specific situations in the CMS policy manuals. The policy manuals control the initial decisions
on coverage that are made by the Medicare claims processing contractors when claims are submitted by beneficiaries.

The Medicare Benefits Policy Manual (Policy Manual) allows for some, rather arbitrary, exceptions to the usual exclusion of dental services. It specifies that a service should be covered if it is “incident to and an integral part of a covered service performed by the dentist.” An application of this “incident to and an integral part of” rule that is provided in the manual is reconstruction of a ridge that can be used to prepare the mouth for dentures if it is done at the same time as surgical removal of a tumor, but not if it occurs afterwards.

The Policy Manual also allows Medicare coverage of certain other dental services that are related to cancer treatment. For example, Medicare will cover the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease. However, the Policy Manual warns that coverage of such extractions is an exception to the usual rule that the dental service must be “incident to and an integral part of a covered procedure or service performed by the dentist.” Coverage of such an extraction is considered an exception because the extraction does not occur simultaneously with the radiation treatment. Thus, CMS admits that the “incident to and an integral part of” requirement is not applied consistently to all situations as a restriction on coverage.

JUDICIAL INTERPRETATION OF THE EXCLUSIONS

Medicare beneficiaries have the right to appeal denials of coverage through a number of levels of administrative review, and finally to judicial review in federal district courts. In appeals by beneficiaries seeking coverage for items and services that are excluded from coverage as “routine,” some courts have held that CMS’ strict exclusionary policies do not comply with the Medicare statute. Even below the judicial review level of appeal, the Medicare Appeals Council (MAC) has held that the statutory exclusions are limited to situations that are truly routine.

A series of decisions by a federal district court in Maine overturned the denial of a video monitor (VM) or personal reader used by a Medicare beneficiary with macular degeneration. The VM uses a camera and a video monitor to greatly magnify the size of print, and is used by the beneficiary to read prescriptions, therapy instructions, financial documents, and to engage in activities of daily living. Under Medicare policy, this complex equipment used to assist individuals with extremely limited vision is denied under the exclusion of coverage for eyeglasses in the Medicare statute.

In its first decision in this case, the district court rejected the CMS argument that the VM could be categorized as eyeglasses within the statutory exclusion. The judge held that the provision in the Medicare statute applies only to routine eyeglasses, but not to more specialized equipment like the VM. He cited two other court cases coming to the same conclusion regarding coverage of low vision technology: Although these latter decisions are not officially reported, they provide support for the position that the eyeglass exclusion in the statute should be given a limited scope.\(^1\) When the same case on appeal a second time, the court held that the VM must be covered by Medicare under the category of durable medical equipment.

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\(^1\) The official CMS policy remains opposed to coverage of such low vision aids, based on the agency's restrictive reading of the statutory eyeglass exclusion. In re CMS LCD Complaint: Low Vision Aids (V2600-V2615), HHS
Another successful court case was brought by a beneficiary who needed crowns and prosthesis to address nutritional deficiencies that affected his treatment for leukemia and thrombocytopenia. The court found that the dental services at issue were "incident to and an integral part of" the covered treatment that the beneficiary was receiving for his leukemia. A key fact was the role of the claimant's primary oncologist, who directed and supervised the dental services. This decision provides an excellent precedent for coverage of dental care resulting from radiation treatments, because the court refused to accept Medicare’s interpretation of the "incident to and an integral part of" language in the MBPM as limiting coverage to dental services provided at the same time and by the same provider as the underlying treatment.

Finally, another fairly recent decision shows that the MAC, a federal district court, and a federal circuit court of appeals believe that dental services should be covered by Medicare when they are needed by a post-cancer beneficiary. The Medicare beneficiary needed dental implant surgery following cancer treatment. Initially, coverage of the implants was denied by Medicare, but on appeal an ALJ determined that the implants were medically necessary and covered by Medicare. From that level through MAC, federal district court, and federal circuit court levels of appeal, the issue concerned simply the amount of reimbursement the dentist should receive; neither the MAC nor the federal courts questioned the determination that these non-routine dental services were covered by Medicare.

**ADVOCACY TIPS**

Advocates should consider the following steps to help obtain Medicare coverage for clients who need dental care as a result of radiation and/or chemotherapy treatments:

1. If at all possible, the attending physician should incorporate follow-up dental care into a radiation/chemotherapy treatment plan established at the outset of treatment. When particular dental services are needed, there should be further notations in the physician’s records that the services are incident to and necessary for the patient’s cancer treatment, and the actual dental services should be prescribed and supervised (indirectly) by the physician. If the dental services are also medically necessary to meet the patient’s nutritional needs or other health requirements for recovery, the physician should document that fact. These steps are important to establish that such dental services are not subject to the exclusion for routine care, and that they are “incident to and an integral part of” the radiation and chemotherapy treatments for cancer.

2. If a claim for Medicare coverage of dental services is denied, the beneficiary should consider appealing the denial through the available processes. In order to obtain a successful decision, it will be necessary to go through a number of lower levels of administrative appeal that will almost certainly be unsuccessful before reaching the ALJ or federal court levels. At these higher levels of appeal, the beneficiary or her advocate may be able to show that her services should be covered under the statute because they were not routine, but were “incident to and an integral part” of her covered treatment for oral, head or neck cancer.

3. Oral or written testimony from the beneficiary’s physicians should be presented to show that the dental services were ordered and supervised by them as part of the claimant’s covered

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oncology treatment. Articles from medical journals should be introduced to establish the predictable connection between cancer treatment and subsequent deterioration of dental structures.

4. Legal arguments should be made that:
   • The controlling Medicare statute, as shown by its legislative history, excludes only coverage of routine dental services;
   • The CMS manual requirement that services be “incident to and an integral part of” covered services was met; or if not met;
   • The interpretations of the statute in the manual are too inconsistent and unreasonable to be given deference.

Finally, litigation should be considered to force CMS to change its policies to extend coverage of extraordinary dental services to beneficiaries who need them because of serious health conditions. There is no guarantee that the current Medicare policy of denying coverage for dental care after radiation and/or chemotherapy can be changed. However, a carefully planned challenge based on the approach described above offers hope for coverage of these services.

CONCLUSION

Congress intended the exclusion of coverage for dental services to apply only in routine situations, as shown by both the statutory language and its legislative history. Administrative law judges, the Medicare Appeals Council, and federal courts have occasionally recognized that the exclusion is so limited. However, CMS policy manuals continue to misinterpret the Medicare statute so as to broadly exclude coverage. Because most claims by beneficiaries are not appealed beyond the initial determination level, it is important that CMS policy be changed to extend coverage of these items and services to individuals who need them because of serious health conditions.

REFERENCES

• 42 U.S.C. §§ 1395x, 1395y
• Medicare Benefits Policy Manual, CMS Pub 100-02, Chapters 15 and 16.
• Medicare Claims Processing Manual, CMS Pub 100-04, Chapter 1.
• National Claims Determination Manual, CMS Pub 100-3
• 42 C.F.R. § 411.15(1)(2)
• Davidson v. Thompson, No. CIV 04-32 LFG, slip op. (D.N.M. 2004)