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American Association of Oral and Maxillofacial Surgeons

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March 28, 2025

The Honorable. Michael Sarge Pollock
Chair
Health Insurance & Long-Term Care Issues
National Council of Insurance Legislators
616 5th Avenue, Suite 106
Belmar, NJ 07719

The Honorable Justin Boyd
Vice Chair
Health Insurance & Long-Term Care Issues
National Council of Insurance Legislators
616 5th Avenue, Suite 106
Belmar, NJ 07719

Dear Representative Pollock and Senator Boyd:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), which represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States, we appreciate the opportunity to submit this letter regarding the proposed *Improving Affordability for Patients Model Act.* While we do not have any specific comments or concerns regarding the model act at this time, we want to bring to the committee's attention an important issue involving facility fees and access to hospital and ambulatory surgical center (ASC) systems for dental providers.

OMSs are surgically and medically trained dental specialists who treat conditions, defects, injuries and esthetic aspects of the mouth, teeth, jaws, neck and face. After earning a dental degree from an accredited four-year dental school, OMSs complete a minimum of four years of hospital-based oral and maxillofacial surgery residency training that includes rotations in such areas as general surgery, anesthesia, and clinical research. Nearly 40 percent also earn a medical degree or complete a fellowship training program.

Hospital and ASC systems have frequently denied or significantly restricted access to hospital operating rooms for dental procedures, including some critical and pediatric cases that require such settings due to patient safety concerns. The reasons for these denials often stem from limited operating room availability and the relatively low facility reimbursements for outpatient dental procedures in comparison to inpatient medical procedures. This financial disincentive leads hospitals and ASCs to prioritize more profitable procedures, thereby reducing access to necessary dental treatments.

To address this issue, the American Dental Association (ADA), AAOMS and the American Academy of Pediatric Dentistry (AAPD) collaborated with the Centers for Medicare & Medicaid Services to increase facility payments for hospitals and ASCs, including by development of the HCPCS G0330 code and assignment of facility fees to individual dental procedure codes. These changes provide financial incentives for hospitals to accommodate critically necessary dental

procedures under Medicare, as well as under Medicaid in states that adopt the CMS provisions. Since private insurers often base their reimbursement policies on Medicare and Medicaid, we hope this will lead to broader adoption of policies that sustain access to dental procedures in hospitals and ASCs going forward.

We urge NCOIL to be mindful of these important changes to the facility landscape as discussions continue regarding the model act. Ensuring access to hospital and ASC settings for dental procedures is crucial for patient safety and public health. We have included two talking points with additional information for your consideration.

Please contact Sandy Guenther, AAOMS Director of State Government Affairs, at 800-822-6637, ext. 4388, or sguenther@aaoms.org for additional information.

Sincerely,

J. David Morrison, DMD
President

CC: Rep. Tom Oliverson, MD, Improving Affordability for Patients Model Act sponsor and immediate past-chair, NCOIL
William Melofchik, CEO, NCOIL
Anne Kennedy, General Counsel, NCOIL
Karin K. Wittich, CAE, Executive Director, AAOMS
Srini Varadarajan, Associate Executive Director, Practice Management, Health Policy and Governmental Affairs, AAOMS

Facility Fees for ASC-Based Dental Procedures

Ambulatory surgical centers (ASCs) may bill facility fees for costs associated with many dental surgical procedures, enabling access to necessary patient care.

Why is facility access to dental surgical care necessary?

Thousands of children, adults with special needs and disabilities, and the frail elderly suffer from significant dental decay and require extensive dental treatment.

The complexity of the dental work – combined with the fragile condition of the patient – may require these services to be conducted in a hospital or ASC.

Medicare recognizes the need for facility access and recently expanded coverage for oral exams and treatment for certain medically compromised patients when treated in outpatient settings.

Many states also mandate medical coverage for anesthesia rendered in conjunction with dental procedures in a facility setting for children and adults who are developmentally disabled or medically compromised.

What has changed to enable ASCs to be reimbursed for dental services?

Effective Jan. 1, 2025, CMS has added 19 additional dental surgical procedures, each with their own facility fees, to the ASC Covered Procedures List (CPL). This means, as of Jan. 1, even more dental services may be payable by Medicare (and possibly some commercial medical plans) when rendered in the ASC. These policy changes establish a standard influencing Medicaid and payer coverage.

The facility fee for G0330 in the ASC setting will be $1,394.45. The facility fee paid to ASCs for each of the other assigned dental procedures will range from $377.60 to $2,917.35. When multiple procedures are performed, ASCs may bill multiple facility fees cumulatively, although multiple procedure reductions may apply.

Ask of ASCs

Utilize G0330 and/or CDT Codes on the ASC-CPL

to enable OMSs and pediatric dentists much-needed access to ASCs for their patients while **securing appropriate facility payments for the ASC**.

- Successful patient outcomes are dependent upon ASC or hospital access for certain patients.
- A coalition of organizations – AAOMS, ADA and the American Academy of Pediatric Dentistry – lobbied CMS for establishment of the G0330 code and addition of CDT codes to the ASC CPL.
- The coalition is working with state Medicaid agencies to support adoption of the facility code and CMS's covered procedures list and assigned dental codes by Medicaid.

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Increase in Facility Fees for Hospitals

Hospitals may collect facility fees of up to $5,915.66 per procedure ($3,243.07 for G0330) for costs associated with necessary hospital-based outpatient dental surgical care.

Why is facility access to dental surgical care necessary?

Thousands of children, adults with special needs and disabilities, and the frail elderly suffer from significant dental decay and require extensive dental treatment.

The complexity of the dental work – combined with the fragile condition of the patient – may require these services to be conducted in a hospital or ambulatory surgical center (ASC).

Medicare recognizes the need for facility access and recently expanded coverage for oral exams and treatment for certain medically compromised patients when treated in outpatient settings.

Many states also mandate medical coverage for anesthesia rendered in conjunction with dental procedures in a facility setting for children and adults who are developmentally disabled or medically compromised.

What has changed to enable hospitals to be reimbursed more for dental services?

In 2024, CMS assigned facility fees to 243 dental procedures, including Healthcare Common Procedure Coding System (HCPCS) code G0330 that took effect in 2023, for hospitals to report dental services that require monitored anesthesia and the use of a hospital's operating room. In 2025, CMS has added three more CDT codes to the list of payable outpatient services. CMS' policies establish a standard influencing Medicaid and payer coverage.

The hospital outpatient facility fee for G0330 will be $3,243.07 (up from $1,722 in 2023). Facility fees for most other dental procedures on average range from $1,481 to $3,244, with a few as high as a $5,915 per service. When multiple procedures are performed, hospitals can bill multiple facility fees cumulatively, while multiple procedure reductions may apply.

Ask of Hospitals

Utilize G0330 and CDT Codes on the Hospital Outpatient List

to enable OMSs and pediatric dentists much-needed access to hospital-outpatient services for their patients while **significantly increasing facility payments for the hospital.**

- Successful patient outcomes are dependent upon hospital access for certain patients.
- A coalition of organizations – AAOMS, the American Dental Association and the American Academy of Pediatric Dentistry – lobbied CMS for establishment of the G0330 code and addition of CDT codes to the hospital outpatient lists.
- The coalition is working with state Medicaid agencies to support adoption of the facility code and CMS's covered procedures list and assigned APCs by Medicaid.

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