

BY ELECTRONIC MAIL:

MedicarePhysicianFeeSchedule@cms.hhs.gov

February 10, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Attention: CMS-1770-F
7500 Security Boulevard
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Dental Recommendations for CY 2025 Review

Dear Administrator Brooks-LaSure:

The American Society of Nephrology (ASN) and The National Kidney Foundation (NKF) commends CMS for clarifying the Medicare payment policy for medically necessary oral and dental care. We are particularly grateful the policy applies to organ transplant candidates. The previous absence of such coverage presented a serious impediment for many individuals with End Stage Renal Disease (ESRD) to proceed with transplantation, the best therapy for most eligible people with ESRD. Tragically, it was an insurmountable barrier for some. Accordingly, the clinical and humanitarian impact of the policy is profound.

We are additionally grateful for the Administration's creation of the annual nominations process enabling stakeholders "to identify for consideration and review submissions of additional dental therapies that are inextricably linked and substantially related and integral to the clinical success of other covered medical services."

Acting on that opportunity, we urge CMS to use its existing authority or its broad waiver authority to allow Medicare payment for diagnostic and therapeutic dental services for Medicare ESRD beneficiaries receiving dialysis when, because of immunosuppression, poorly controlled diabetes, heart disease, malnutrition, and/or other relevant comorbidities, dental treatment can be integral and substantially related to the clinical success of such covered nephrology-related medical services as:

- CPT codes 36901-36906: Dialysis circuit procedures
- CPT codes 90935, 90937, 90940: Hemodialysis procedures
- CPT code 90961: Physician or other qualified healthcare professional visits for ESRD
- CPT codes 90989-90999: Other dialysis procedures
- CPT codes 99212-99215: Evaluation and Management (E/M) Services
- DRG code 872: Hospitalization for septicemia or severe sepsis

Identifying and resolving dental infections can be similarly integral and related to the clinical success of other covered medical services for co-morbidities frequently associated with ESRD.

The lack of medically necessary oral/dental care in such circumstances heightens the risk of costly medical complications, increasing the financial burden on Medicare, beneficiaries, and taxpayers.

Clinical Validation

Treatment of dental infections risking/causing blood stream infections (BSI), poor glycemic control, and other complications can be integral and substantially related to the clinical success of medical therapies to manage ESRD.

Kidney failure patients have higher rates of decayed, missing, and filled teeth, dental plaque, loss of attachment, xerostomia, gingivitis, periodontitis, as well as mouth and jaw-bone lesions, than the general population. The consequences of poor oral health are worse for kidney failure patients due to advanced age, diabetes, polypharmacy, and impaired immune function.

“Oral diseases represent a potential and preventable cause of poor health outcomes in people with ESRD due to their relation to infection, inflammation, and malnutrition....oral health represents a potential determinant of health outcomes in patients with end-stage renal diseases (ESRD).”¹

Many studies have recognized oral health plays a critical role in the outcome of individuals living with kidney failure. Their oral health not only affects transplant access, but also morbidity, such as negative cardiovascular outcomes, systemic infections and peritoneal dialysis associated peritonitis,² and overall mortality.³

“Adults with ESRD have more severe oral diseases than the general population, and dental conditions such as caries, periodontitis, and poor oral hygiene are associated with increased mortality... [additionally,] oral pathologies are associated with inflammation and malnutrition, which may accelerate cardiovascular events in ESRD.”¹

And a study examining people on peritoneal dialysis showed that the group of patients with better dental care had lower rates of hospital admissions due to congestive heart failure, acute coronary syndrome, pneumonia, and peritonitis than the group of patients with worse dental care. They also had lower mortality rates due to congestive heart failure, acute coronary syndrome, pneumonia, and sepsis.⁴

Diabetes

Chronic dental infections can exacerbate management of diabetes, which is the most common cause of kidney failure. Poor dental health can compromise the ability of ESRD patients to achieve good medical

^{1,4}Costantinides F, Castronovo G, Vettori E, Frattini C, Artero ML, Bevilacqua L, Berton F, Nicolin V, Di Lenarda R. Dental Care for Patients with End-Stage Renal Disease and Undergoing Hemodialysis. *Int J Dent*. 2018 Nov 13;2018:9610892. doi: 10.1155/2018/9610892. PMID: 30538746; PMCID: PMC6258100.

²Sirirat Purisinsith, Patnarin Kanjanabuch, Jeerath Phannajit, Bruce Robinson, Kriang Tungsanga, et al. “Oral Health-Related Quality of Life, A Proxy of Poor Outcomes in Patients on Peritoneal Dialysis.” doi:<https://doi.org/10.1016/j.ekir.2022.07.008> (August 5, 2022).

³See, e.g., Palmer S. C., Ruospo M., Wong G., et al. Oral-D study investigators. Dental health and mortality in people with end-stage kidney disease treated with hemodialysis: a multinational cohort study. *American Journal of Kidney Diseases*. 2015;66:666–676.

⁴Hiramatsu, T., Okumura, S., Iguchi, D. et al. Higher dental care is positively associated with key prognosis factors in peritoneal dialysis patients: findings from a retrospective study.

outcomes due to its impact on serum albumin levels and glucose control. Periodontitis can worsen blood glucose control in diabetics by increasing the levels of inflammatory mediators, such as cytokines and C-reactive protein. This enhanced systemic inflammation can interfere with insulin, increase insulin resistance, resulting in clinical complications of diabetes, including CKD.

Heart disease

As noted, periodontitis contributes to systemic inflammation, thereby functioning as an exacerbating factor for heart and other inflammatory-linked diseases. Access to dental services not only is important for dialysis patients as part of their ability to access kidney transplants, but also to access cardiovascular procedures given that many dialysis patients also live with serious, chronic cardiovascular conditions.

Infection

Beneficiaries who are immunocompromised by end stage renal disease (ESRD), advanced chronic kidney disease (CKD), and other renal diseases, as well as kidney transplant candidates and recipients maintained on immunosuppressive medications are all at increased risk of systemic infections developing from an oral source.

CMS has rightly focused on reducing bloodstream infections (BSI) among those individuals who receive dialysis. Dialysis clinicians report that many of these infections begin with bacteria in the mouth. Regular dental visits could have a positive impact on reducing BSI.

Further, the Society for Vascular Surgery has noted that transient bacteremia from dental infections can seed hemodialysis access grafts. Among strategies to prevent infection of vascular grafts, recommended preoperative measures include identifying and treating remote site infections, including dental sites.⁵⁶

Malnutrition

Poor oral health care also affects nutrition, an area of vulnerability for many people with kidney failure, particularly those who lack the socioeconomic resources to tailor a nutritionally appropriate diet to their oral health limitations. Dialysis patients frequently report that dental infections as well as loose dentures resulting from weight loss are contributive, if not causative, to their declining nutritional status. This nutritional vulnerability, exacerbated by health equity issues, is another gap in care that MedPAC has identified.

Anemia

Individuals with poor oral health often experience periodontal diseases and subsequent inflammation that can make managing anemia more difficult and increase the needed dose of ESAs.

Summarizing, we respectfully submit that in such circumstances, and when supported by clinical evidence, dental care is not for a limited dental purpose but, instead, is integral and substantially related to improved outcomes of Medicare covered procedures to manage ESRD. Accordingly, the dental care is medically necessary and should qualify under the statute.⁷

⁵Surgical Site Infection Toolkit, CDC, [SSI Toolkit Activity C: ELC Prevention Collaboratives \(cdc.gov\)](https://www.cdc.gov/surgical-site-infection/toolkit/)

⁶Pear S, Patient Risk Factors and Best Practices for Surgical Site Infection Prevention, http://www.kchealthcare.com/media/1515/patient_risk_factors_best_practices_si.pdf

⁷See 87 Fed. Reg. at 46040

To discuss this letter, please contact ASN and NKF directly through:

David L. White
Regulatory and Quality Officer
dwhite@asn-online.org

Ivory Harding, MS
Director, Quality and Regulatory Affairs
ivory.harding@kidney.org

Respectfully,

The American Society of Nephrology

The National Kidney Foundation

