AADOCR
American Association for Dental, Oral, and Craniofacial Research

September 6th, 2022

Emily Forrest,
Acting Chair, Medicare
Centers for Medicare & Medicaid Services,
P.O. Box 8016,
Baltimore, MD, 21244, USA

Re: CMS-1770-P. Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2023.

via website: https://www.regulations.gov/docket/CMS-2022-0113

The American Association for Dental, Oral, and Craniofacial Research (AADOCR) respectfully submits these comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2023, published in the Federal Register on July 29, 2022 (87 Fed. Reg. 45860).

AADOCR represents over 3,100 individual and 107 institutional members working throughout dental, oral, and craniofacial research. Our mission is to drive dental, oral, and craniofacial research to advance health and well-being. We appreciate the opportunity to share our thoughts on the proposal on Medicare Parts A and B payment for dental services. AADOCR recognizes and applauds CMS on this proposed rule that will expand access to dental care, particularly in rural and underserved areas, and ultimately improve the clinical success of other medical services. To respond to this request for comments, AADOCR engaged its Science Information Committee and its Board of Directors.

AADOCR supports the payment for all dental services under Medicare Parts A and B that are inextricably linked to, substantially related, and integral to the clinical success of, certain other covered medical services. As indicated in the Federal Register, there are many clinical scenarios where management of oral disease should be part of the overall healthcare for a patient beyond the four specific circumstances delineated. To reduce the risk of infection after some types of surgery and treatment of cancer, patients are asked to undergo preoperative assessments in various medical domains including dental health. Oral bacteria have been shown to contribute to postoperative infectious complications including postoperative pneumonia and surgical site infection (SSI)[1,2]. Perioperative oral management reduces the risk of inflammation, SSI after colorectal, gastrointestinal, lung, and head and neck cancer surgery and shortens postoperative hospital stays[1,2,3]. The benefits of preoperative dental care on preventing SSI and

T +1.703.548.0066 | F +1.703.548.1883 | 1619 Duke Street, Alexandria, VA 22314-3406, USA | www.aadocr.org

inflammation following surgery extends beyond older age groups into broader types of patients including those younger than 60[3]. Therefore, AADOCR supports payment for a dental assessment, screening and treatment of oral infections, including dental caries (tooth decay) and periodontal (gum) diseases to increase the clinical success of covered surgical treatments and cancer therapy.

AADOCR also supports Medicare and Medicaid payments for preventive dental care and conservative periodontal treatment, specifically for persons with chronic diseases such diabetes, heart disease, dementia, chronic lung disease, and stroke. These diseases have been shown to increase the pathogenicity of the oral microbiome, as shown by increased inflammation, osteoclastogenesis, periodontal bone loss, and increased risk or severity of periodontitis[5]. Studies have discerned a relationship between oral bacteria, dental caries, periodontal diseases, and oral squamous cell carcinoma (OSCC)[4]. The increased prevalence of several types of oral bacteria have also been shown to be positively correlated with the metastasis of malignant tumors[7,8]. Early detection and treatment are appropriate strategies to prevent and control oral cancer[4] and for an improvement in patient outcomes[9]. Therefore, payment for the delivery of preventive dental care, and conservative periodontal treatment are key interventions to decrease the prevalence of malignant oral cancers.

Furthermore, periodontal disease has been shown to increase susceptibility to several systemic diseases due to shared risk factors, subgingival biofilms acting as reservoirs to gram negative bacteria, and through the periodontium acting as a reservoir of inflammatory mediators[6]. The treatment of oral diseases can also impact systemic diseases including cardiovascular disease, infective endocarditis, bacteria pneumonia, diabetes mellitus and others[4,6]. Periodontal treatment that includes systemic antibiotics with mechanical therapy results in an improvement in periodontal status as well as an improvement in diabetes control, measured as a reduction in glycated hemoglobin or reduction in insulin requirements[6]. Additionally, treatment of periodontal disease has been shown to reduce the level of C-reactive protein (CRP) by 65%, resulting in a reduced risk of myocardial infarction and stroke[6]. Therefore, AADOCR supports the payment of routine dental services to reduce susceptibility to systemic diseases and improve outcomes of other covered medical services.

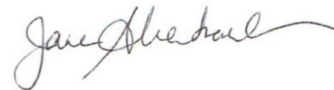
Healthy People 2030 identified oral health as one of the 10 leading health indicators, along with other indicators such as access to health and nutrition[10]. Good oral health enables speaking, smiling, smelling, eating and is important for communication, human relationships, and financial prosperity[10]. In the United States, people are more likely to have poor oral health if they are low-income, uninsured, and/or members of racial/ethnic minority, immigrant, or rural populations who have suboptimal access to quality oral health care[11,12]. The payment of preventative routine dental care by Medicare and Medicaid will help reduce barriers to oral health care and may bolster efforts to integrate

oral health and primary health care, incorporate interventions at multiple levels to improve access to and quality of services, and create health care teams that provide patient-centered care in both safety net clinics and community settings across the life course[13]. Additionally, the payment of services for the treatment of oral diseases by Medicare and Medicaid also serves to improve oral-health-related quality of life (OHRQoL) across the life spectrum[14] for persons within this socio-economic demographic.

AADOCR appreciates the opportunity to provide this input on the request for comments on the proposal on Medicare Parts A and B payment for dental services. AADOCR supports the revision and clarification of the definition of medically necessary dental coverage and stands ready to work with CMS to bolster this effort with scientific evidence.

If you have any further questions, please contact Dr. Makyba Charles-Ayinde, Director of Science Policy, at mcayinde@iadr.org.

Sincerely,



Christopher H. Fox, DMD, DMSc
Chief Executive Officer

Jane A. Weintraub, DDS, MPH
President

[1]Nobuhara H, Yanamoto S, Funahara M, Matsugu Y, Hayashida S, Soutome S, Kawakita A, Ikeda S, Itamoto T, Umeda M. (2018). Effect of Perioperative Oral Management on the Prevention of Surgical Site Infection After Colorectal Cancer Surgery: A Multicenter Retrospective Analysis of 698 Patients Via Analysis Of Covariance Using Propensity Score. 97(40):e12545.
[2]Aoyama T. and Tamagawa A. (2019). Clinical Impact of Perioperative Oral/Dental Care on Cancer Surgery Outcomes. Anticancer Research. 39:2711 – 2714.
[3]Suenaga H, Aida J, Kumasaka A, Shibamoto A, Sato S, Shinohara Y, Hatakeyama T, Yamaguchi H, Sasaki K, Takahashi T, Koseki T, Peck C, Iikubo M, (2022). Impact of Dental Referral Prior to Elective Surgery on Postoperative Outcomes. Journal of the American Medical Directors Association. 23(4): 638-645.e2.
[4]Peng X., Cheng L., You Y., Tang C., Ren B., Li Y., Xu X., and Zhou X. (2022). Oral Microbiota in Human Systematic Diseases. *Int J Oral Sci.* 14. Doi: 10.1038/s41368-022-00163-7.
[5]Graves DT, Corrêa JD, Silva TA. (2019). The Oral Microbiota Is Modified by Systemic Diseases. J Dent Res. 98(2):148-156.
[6]Li X., Kolltveit KM., Tronstad L, and Olsen I. (2000). Systemic Diseases Caused by Oral Infection. Clinical Microbiology Reviews. 13(4): 547-558.
[7]Torralba MG, Aleti G, Li W, Moncera KJ, Lin YH, Yu Y, Masternak MM, Golusinski W, Golusinski P, Lamperska K, Edlund A, Freire M, Nelson KE. (2021). Oral Microbial Species and Virulence Factors Associated with Oral Squamous Cell Carcinoma. *Microb. Ecol.* 82:1030–1046.
[8]Li Q, Hu Y, Zhou X, Liu S, Han Q, Cheng L. (2020). Role of Oral Bacteria in The Development of Oral Squamous Cell Carcinoma. *Cancers.* 12:2797.
[9]Awan Kh. (2014). Oral Cancer: Early Detection is Crucial. J Int Oral Health. 6(5):i-ii.

[10]Office of Disease Prevention and Health Promotion. (2022). Leading Health Indicators. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions. [Accessed on 08/30/2022].
[11]Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. *Annu Rev Public Health*. 2011;32:381– doi:10.1146/annurev-publhealth-031210-101218.
[12]Centers for Disease Control and Prevention. (2022). Basics of Oral Health: Disparities in Oral Health. Retrieved from: https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm. [Accessed on: 08/30/2022].
[13]Northridge ME, Kumar A, and Kaur R. (2020). Disparities in Access to Oral Health Care. Annu Rev Public Health. 2;41:513-535.
[14]Song J-S, Hyun H-K, Shin TJ, and Kim Y-J. (2018). Effects of Dental Treatment and Systemic Disease on Oral Health-Related Quality of Life in Korean Pediatric Patients. BMC Oral Health. 18:92.