

**OPEN WIDE—I MEANT YOUR  
POCKETBOOK: REPERCUSSIONS  
OF THE DENTAL EXCLUSION TO  
THE MEDICARE ACT**

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*For many Americans, dental coverage is merely a matter of cosmetics, a pretty smile. But for the elderly, a dental condition can affect nutrition, health, and financial well-being. In her note, Amanda Schwob explores the dental exclusion to Medicare, a provision of great concern to the elderly. Ms. Schwob seeks to define the scope of the dental exclusion by means of the plain language of the Medicare statute, case law, and legislative history. This analysis reveals startling uncertainty in this area of law. Next, Ms. Schwob considers several proposals before Congress as well as state reimbursement policies. The note concludes with concrete suggestions to remedy the ambiguity surrounding Medicare's dental exclusion.*

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## I. Introduction

Suppose you are a sixty-seven-year-old man who has suffered from various life-threatening illnesses, including cancer, and the treatments you have received have destroyed your ability to hold a conventional denture. Consequently, in your already frail state, you lose sixteen pounds because of your inability to chew or swallow a normal diet. Two Doctors of Dental Surgery recommend five dental implants and a prosthetic device which locks everything in place as a remedy. The procedure is done at one of the DDS' office. The procedure is complex and requires two sessions, four months apart to allow for healing. You then file for reimbursement under Medicare Part B. Everyone involved believes this will be covered by Medicare. But is it?<sup>1</sup>

Under the current system, it is hard to say whether or not the patient, Theodore Yeager, would receive reimbursement. Case law shows that the interpretation of the Medicare statute varies. Proposals to Congress illustrate the demand for change under the current reimbursement system. The above case should be allowed reimbursement under the current system. To ensure coverage in such situations, and expand dental coverage under the current reimbursement scheme, a change via Congress is recommended.

The scope of the dental exclusion to the Medicare Act is unclear. The dental exclusion is found in Medicare Part B, where a patient pays a monthly premium for certain outpatient services.<sup>2</sup> These services by and large do not include dental, although some HMOs include dental coverage as an incentive for the elderly to sign up.<sup>3</sup> The result is that most elderly go without any dental coverage at all,<sup>4</sup> and when they have dental work done, it is not always clear from the Medicare Act what is covered and what is not.

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1. This scenario is based upon a Medicare recipient named Theodore Yeager who was denied coverage for dental services received. Subsequently, the author represented the recipient in front of an administrative law judge at a hearing held in Chicago, Illinois, on August 20, 1999. The administrative law judge denied the request for reimbursement on October 17, 1999. The case is currently under review by the Appeals Council.

2. See LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 61, 74 (2d ed. 1999).

3. See *Boneheaded Medicare Formula*, DES MOINES REG., Dec. 17, 1996, at 14.

4. See *Millions Cannot Afford Dental Help, Study Says*, N.Y. TIMES, Nov. 30, 1993, § C, at 14.

This note will address the exclusion of dental services from Medicare Part B. Part II provides background information about the Medicare Act. Part III explores a statutory interpretation of the exclusion through plain language, case law, and legislative history. It also addresses congressional response to the demand for greater inclusion of dental coverage as a part of Medicare. Finally, Part III of this note looks at reimbursement practices among the states, and how those discrepancies potentially affect the dental coverage offered Medicare recipients. This note concludes with the suggestion of implementing more generous and better defined guidelines.

## II. Background

The Medicare Act (the Act) was passed in 1965 as a part of the Social Security Act.<sup>5</sup> The Act “pays for acute care for persons aged 65 years and older without regard to their health status or financial resources.”<sup>6</sup> Medicare is an entitlement for those eligible to participate and who register.<sup>7</sup> The overall purpose of the bill is to “provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act . . . .”<sup>8</sup>

Medicare is divided into two parts, A and B. Part A covers hospitalization charges (inpatient care) and Part B covers physician fees (outpatient care).<sup>9</sup>

Eligibility under Part A includes reaching the age of sixty-five and being eligible for Social Security benefits.<sup>10</sup> Medicare Part A is available for all eligible without charge.<sup>11</sup> A 2.9 percent payroll tax on all wages—one-half collected from the employee and one-half from

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5. See 42 U.S.C. § 1395 (1994).

6. FROLIK & KAPLAN, *supra* note 2, at 56.

7. See *id.* at 57–58.

8. S. REP. NO. 89-404, at 1943 (1965). Congress sought to achieve this coordinated approach by establishing three programs: “(1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians’ and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.” *Id.*

9. See FROLIK & KAPLAN, *supra* note 2, at 56.

10. See *id.* at 57. “[A] person need not actually be collecting Social Security benefits to ‘enroll’ in Medicare. Thus, even if a person has not yet retired or has otherwise chosen to defer receipt of Social Security benefits, mere eligibility for such benefits confers Medicare Part A entitlement.” *Id.* at 58.

11. See *id.* at 57.

the employer—and self-employment income finances the Part A program.<sup>12</sup>

Eligibility under Part B includes the same requirements as those set forth under Part A.<sup>13</sup> Part B differs from Part A in that “enrollees pay a monthly premium that is adjusted annually.”<sup>14</sup> This premium covers twenty-five percent of the program’s costs, and the Federal government covers the remaining seventy-five percent of the costs through general tax revenues.<sup>15</sup>

As stated above, coverage under Part A includes inpatient hospital care.<sup>16</sup> Also included in the coverage is medical care received as an inpatient in a skilled nursing facility, at home, and via a hospice agency.<sup>17</sup>

Coverage under Part B includes, but is not limited to, doctors’ charges, whether it be a hospital or office visit; diagnostic tests; drugs that cannot be self-administered; ambulance services; and some home health services not covered under Part A.<sup>18</sup>

Excluded under Parts A and B are those services that do not meet the “reasonable and necessary” standard.<sup>19</sup> Other general exclusions include the following services: those not provided in the United States, those required as a result of war, those constituting personal comfort items, routine physical checkups, eyeglasses or eye examinations, orthopedic shoes or other supportive devices for the feet, custodial care, cosmetic surgery, charges incurred by immediate relatives, dental, treatment for the feet, and assistants at surgery.<sup>20</sup> All of these exclusions involve exceptions.<sup>21</sup> The dental exclusion will be the focus of the remainder of the note.

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12. *See id.* at 57–58.

13. *See id.* at 60. A person may also be entitled to benefits if they are under age sixty-five and have end stage renal disease. *See also* 42 U.S.C. § 1395c (1994).

14. FROLIK & KAPLAN, *supra* note 2, at 61. In 1998, the premium was \$43.80 per month. *See id.*

15. *See id.*; *see also* 42 U.S.C. § 1395r(a)(1), (3)(1994).

16. *See* FROLIK & KAPLAN, *supra* note 2, at 56.

17. *See id.* at 64.

18. *See id.* at 75; *see also* 42 U.S.C. § 1395k(a).

19. 42 U.S.C. § 1395y(a)(1)(A)(1994). The services under this standard must be reasonable and necessary “for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” *Id.* Other reasonable and necessary services are excluded under the Act and are set forth in subsequent sections (B), (C), (D), and (E). *See* FROLIK & KAPLAN, *supra* note 2, at 81. The reasonable and necessary standard is described as “[t]he most pervasive, and in many ways the most nebulous, exclusion.” *Id.*

20. *See* 42 U.S.C. § 1395y (a)(4)–(15).

21. *See id.*

### III. Analysis

#### A. Interpreting the Statute

Two phrases in the plain language of the statute under which a Medicare beneficiary will receive coverage for dental work are: 1) that inpatient hospital services must be “in connection with” the dental services being provided, and 2) that hospitalization can be because of “his underlying medical condition and clinical status.”<sup>22</sup> These are studied for an understanding of their scope and harmony. Consulting the Medicare Carrier’s Manual also provides an interpretation of these difficult and somewhat conflicting phrases.<sup>23</sup> Case law also reveals how districts have interpreted the Medicare statute differently, leaving patients and attorneys without a clear understanding of what to expect from Medicare coverage with respect to dental care. Finally, legislative history from the United States Senate and House Reports explains exactly what the exclusions were meant to include.

#### 1. PLAIN LANGUAGE

The dental exclusion to the Medicare Act provides:

[N]o payment may be made under part A or part B of this subchapter for any expenses incurred for items or services— . . . (12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A of this subchapter in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.<sup>24</sup>

The plain language of the text does not allow payment for a broad range of dental services.<sup>25</sup> At first glance, this appears to be true for Part A (inpatient) as well as Part B (outpatient) services.<sup>26</sup> The exception to this nearly blanket exclusion, however, is that Medicare might provide payment if the individual is hospitalized (included in

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22. *Id.* § 1395y(a)(12).

23. *See* U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH CARE FIN. ADMIN., MEDICARE CARRIER’S MANUAL § 2136 (1984) [hereinafter MEDICARE CARRIER’S MANUAL].

24. 42 U.S.C. § 1395y(a).

25. *See id.*

26. *See id.*

Part A).<sup>27</sup> Unfortunately, the language of the statute is unclear as to when a patient receives reimbursement for dental procedures performed in a hospital setting, and when the patient does not.<sup>28</sup>

First, the plain language seems to say that there must be inpatient hospital services “in connection with” the dental services being provided.<sup>29</sup> Second, however, the statute appears to condition the reimbursement upon whether “the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.”<sup>30</sup> Do both situations need to exist? If they do, it renders the statute redundant. Why should reimbursement hinge upon hospitalizing the patient due to an underlying medical condition or the severity of the procedure if the criteria already require that the patient must be in the hospital receiving “inpatient hospital services in connection with the provision of such dental services?”<sup>31</sup>

If both situations do not need to exist, under the second clause alone, a patient might receive dental work in a hospital and have it covered under Medicare Part A without receiving any nondental inpatient hospital services at all.<sup>32</sup> It would then follow that if a patient’s doctor or dentist is willing to recommend that a procedure needs to be performed in a hospital setting (either because of the patient’s underlying medical condition or the severity of the procedure), the patient could receive payment for the dental procedure. Such a scenario raises the question of the efficient use of resources. Interpreted in this manner, the statute gives an impetus to have work done in a hospital setting when it could be done on an outpatient basis in a dentist’s office.

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27. *See id.*

28. *See id.*

29. *See id.*

30. *Id.* According to this, some discretion as to whether or not to hospitalize a patient for a dental procedure must be placed in the hands of the presiding dentist or oral surgeon. This leads back to the question of whether dental work performed by a dental or oral surgeon in the hospital might be covered. *See infra* notes 31–34 and accompanying text.

31. 42 U.S.C. §1395y(a)(12) (1994).

32. *See id.*

## 2. THE MEDICARE CARRIER'S MANUAL

The Medicare Carrier's Manual (MCM) sheds some light on the situation.<sup>33</sup> The MCM states that “[i]f an otherwise noncovered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by him/her, the total service performed by the dentist on such an occasion is covered.”<sup>34</sup> Any of the regularly covered services, then, if performed by the dentist, will encompass those traditionally excluded services performed by the dentist if done as an integral part or incident to the covered procedure.<sup>35</sup> One example given is that when a reduction of a jaw fracture is done (a covered procedure), the wiring of teeth (a non-covered procedure) would be paid for if done *in connection with* the covered service.<sup>36</sup>

The MCM offers a second example. The reconstruction of a ridge may or may not be a covered procedure.<sup>37</sup> If the reconstruction is done to prepare the mouth for dentures, the procedure is not covered.<sup>38</sup> However, if a tumor is removed “for other than dental purposes” and the ridge is reconstructed, the entire work will be covered.<sup>39</sup> Even though the tumor is not removed for dental purposes, the resulting work needing to be done on the ridge must withstand the “in connection with” test—that the inpatient hospital services are in connection with the provision of such dental services.<sup>40</sup> As a result, two patients can be in the hospital both having ridge reconstruction done, and the reason behind that surgery will allow one of the patients to be reimbursed while the other receives no reimbursement. Both the MCM's explanation of the statute and the examples given seem to suggest that the patient has to undergo some type of actual inpatient hospital service to be eligible for reimbursement.<sup>41</sup>

While the MCM offers some clarity in interpreting the statute, no mention is made that a reimbursement will be given to a dental procedure alone if the person is hospitalized “because of his underlying

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33. See MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2136.

34. *Id.* The noncovered procedure or service performed has to be performed “as incident to and as an integral part of” the covered procedure or service. *Id.*

35. *See id.*

36. *See id.*

37. *See id.*

38. *See id.*

39. *Id.*

40. See 42 U.S.C. §1395y(a)(12) (1994).

41. See MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2136.

medical condition and clinical status or because of the severity of the dental procedure.”<sup>42</sup> What if someone is hospitalized “because of his underlying medical condition?”<sup>43</sup> Does the underlying medical condition have to be “in connection with” the dental procedure that is being done? If so, how attenuated can that connection be? The MCM does not help in this interpretation. Both examples presented conditions that required surgery.<sup>44</sup> The surgery then led to some type of dental work that normally would not have been covered had it been done outside the hospital without the inpatient hospital services.<sup>45</sup> What if the patient has an underlying medical condition that does not require surgery, but leads to a serious dental problem? Would the correction of that resulting dental problem be covered by Medicare if the treatment for that underlying medical condition normally would be covered by Medicare? And must that work be done in a hospital setting?<sup>46</sup> The courts have differed in their interpretation of these difficult questions.

### 3. CASE LAW

Current case law helps to answer these difficult questions. The most recent published decision comes from the United States District Court in New York.<sup>47</sup> Joseph Maggio, the plaintiff in the case, suffered from chronic lymphocytic leukemia and severe thrombocytopenia.<sup>48</sup> During the treatment Mr. Maggio received for this medical condition, he developed “nutritional difficulties due to extreme pain in his gums when he consumed food.”<sup>49</sup> In order to remedy this problem, Mr. Maggio’s treating oncologist recommended dental work.<sup>50</sup>

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42. *Id.*; see also *supra* note 34.

43. MEDICARE CARRIER’S MANUAL, *supra* note 23, § 2136.

44. *See id.*

45. *See id.*

46. If the work were done in a hospital setting, it would then be covered under Medicare Part A. See FROLIK & KAPLAN, *supra* note 2, at 64. However, the MCM states that “payment [can be made] for a covered dental procedure no matter where the service is performed. The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.” MEDICARE CARRIER’S MANUAL, *supra* note 23, § 2136.

47. *See* Maggio v. Shalala, 40 F. Supp. 2d 137 (W.D.N.Y. 1999).

48. *See id.* at 138.

49. *Id.*

50. *See id.*



The dental work Mr. Maggio needed normally would not be covered under Medicare Part B.<sup>51</sup> However, when Mr. Maggio was denied coverage, he fought for reimbursement through the internal administrative process, ending up in front of an administrative law judge (ALJ).<sup>52</sup> The ALJ found for Mr. Maggio, ordering reimbursement for the dental work.<sup>53</sup> The Appeals Council took it upon themselves to review the case, reversing the ALJ's decision.<sup>54</sup> Having exhausted his options in the administrative process, Mr. Maggio filed his case in district court where the ALJ's decision was affirmed.<sup>55</sup> The court stated that the procedures should be covered under Medicare Part B because the dental work was "necessary and directly related to his treatment for leukemia and thrombocytopenia" (treatment that normally would be covered).<sup>56</sup>

How does this decision by the district court coincide with the plain language of the statute or the interpretation given that language in the MCM? The plain language of the statute, as discussed above, is unclear.<sup>57</sup> The statute's condition, stating that reimbursement could be sought under Part A if the dental work is done in a hospital "because of his underlying medical condition" seems to be met.<sup>58</sup> Mr. Maggio was recommended to have the dental procedures done in a

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51. See *id.* at 139; see also 42 U.S.C. § 1395(y)(a)(12)(1994); 42 C.F.R. § 411.15(i) (1999); MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2020.3. Joseph Maggio received two crowns that were inserted to stabilize a maxillary prosthesis, the prosthesis was made, inserted, and adjusted, and the plaintiff "was instructed on placement and removal." *Maggio*, 40 F. Supp. 2d at 139 (citing AR at 53-58, 78-81 (the administrative record, filed by Defendant as part of the answer to the Complaint)).

52. See *Maggio*, 40 F. Supp. 2d at 139.

53. See *id.*

54. See *id.*

55. Maggio had been granted coverage for the procedures by the administrative law judge. However, the Medicare Appeals Council had "decided on its own motion to review the ALJ's decision," and subsequently reversed the ALJ's determination on the grounds that the "services were rendered on an outpatient basis to address a dental problem and were not provided as incidental to or an integral part of a covered service." See *id.* (citing AR at 6-10, 71).

56. *Id.* at 141. The "directly related" language used in *Maggio* refers to the Medicare Carrier's Manual's language elaboration on the dental exclusion. The MCM states, "[i]f an otherwise noncovered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by him/her, the total service performed by the dentist on such occasion is covered." MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2136. This language is parallel to the "in connection with" language expressed in 42 U.S.C. § 1395y(a)(12). See *supra* notes 24-36 and accompanying text.

57. See *supra* notes 24-32 and accompanying text.

58. 42 U.S.C. § 1395y(a)(12).

hospital because of complications due to his leukemia and thrombocytopenia.<sup>59</sup> The record states that during the treatment Mr. Maggio received for those ailments, he developed several complications, including nutritional difficulties, because of the extreme pain in his gums when consuming food, suggesting that the treatments caused the complications.<sup>60</sup> There is no evidence from the record, however, that Mr. Maggio's extreme pain in his gums was caused by his leukemia or thrombocytopenia or by the treatment he received to address those conditions,<sup>61</sup> so this does not appear to be a criterion for reimbursement.

Nonetheless, the language of the statute that addresses the requirement for inpatient hospital services is not met.<sup>62</sup> Nor is the language in the MCM that a noncovered procedure needs to be performed as an integral part of or incident to a covered procedure met.<sup>63</sup> Mr. Maggio was not entering the hospital to receive an inpatient hospital service that normally would be covered by Medicare, and then to receive the dental work in connection with that covered procedure.<sup>64</sup> Also, Mr. Maggio was not in the hospital receiving treatment for his underlying medical condition at the time of the dental work.<sup>65</sup> The dental work was done over a period of three months and addressed solely as a dental problem.<sup>66</sup>

How does Mr. Maggio's predicament compare to those examples given in the MCM?<sup>67</sup> The language and examples in the MCM certainly interpret the statute to mean that some sort of inpatient hospital service or procedure needs to be performed in connection with the dental services provided.<sup>68</sup> Mr. Maggio's dental work was not the result of any surgery he underwent, be it related to a dental problem (the reduction of a fractured jaw in example number one) or not (the removal of the tumor in example number two). The dental procedure

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59. See *Maggio v. Shalala*, 40 F. Supp. 2d 137, 138 (W.D.N.Y. 1999).

60. See *id.*

61. See *id.* at 141.

62. See 42 U.S.C. §1395y(a); see also FROLIK & KAPLAN, *supra* note 2, at 64–67.

63. See MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2136; *supra* note 34 and accompanying text.

64. See *Maggio*, 40 F. Supp. 2d at 138.

65. See *id.*

66. See *id.* at 138–39.

67. See MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2136; see also *supra* notes 33–41 and accompanying text.

68. See MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2136.

was performed independently of any other procedure<sup>69</sup> and was performed to accommodate Mr. Maggio's need for nutrition to tolerate the treatment.<sup>70</sup> Therefore, Mr. Maggio's dental work did not in any way parallel those examples given in the MCM.

What makes this decision remarkable is the fact that Mr. Maggio did not enter a hospital at all for the dental work, but had it done on an outpatient basis at a clinic (though in close proximity to the hospital), and the court granted the reimbursement under Part B.<sup>71</sup> The court found that having the work done in the clinic as compared to the hospital did not matter, quoting the MCM that the "hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure."<sup>72</sup> This directly departs from the statute's plain language that an exception to the dental exclusion might be found only under Part A.<sup>73</sup> The court praised the decision not to admit Mr. Maggio to the hospital, but to do the procedure on an outpatient basis, "saving the Medicare system funds."<sup>74</sup>

The *Maggio* case redefines the requirement that in order to qualify for an exception to the dental exclusion, inpatient hospital services must be done in connection with the provision of dental services. The case does this by consulting the MCM's language used in interpreting the statute "as incident to and as an integral part of," and broadening that language to include purely dental problems that arise out of (or at least are effecting the treatment of) medical conditions covered by Medicare.<sup>75</sup> According to the court, a patient: (1) does not have to be in the hospital, and thus can file a claim under Part B; (2) the correlation between the dental procedure performed and the underlying medical condition is open to broad interpretation and can be very attenuated; (3) it is not necessary that a specific procedure be performed addressing the underlying medical condition at the time the dental work is performed; and (4) it is not necessary that the dentist who performs the traditionally noncovered dental work also be responsible for the covered procedures<sup>76</sup> (Mr. Maggio's oncologist is responsible

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69. See *Maggio v. Shalala*, 40 F. Supp. 2d 137, 138–39 (W.D.N.Y. 1999).

70. See *id.* at 138.

71. See *id.* at 141.

72. *Id.* at 140.

73. See *supra* notes 24–32 and accompanying text.

74. *Maggio*, 40 F. Supp. 2d at 142.

75. *Id.* at 141–42.

76. See MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2020.3.

for the treatments he receives to address his leukemia and thrombocytopenia, a dentist performed the necessary work now in question<sup>77</sup>). While the Medicare Appeals Council that denied Mr. Maggio reimbursement treated this as strictly a dental problem, the court did not, relating the problem directly to Mr. Maggio's other medical conditions.<sup>78</sup>

A similar case involved Marion Chipman, a plaintiff who suffered from atrophy of the upper and lower jaws, resulting in chronic pain and an inability to wear dentures.<sup>79</sup> Mr. Chipman also suffered from a history of ulcers, making it especially important that he be able to properly digest his food.<sup>80</sup> Mr. Chipman had endosteal bone augmentation surgery followed by implanting porcelain veneer crowns.<sup>81</sup>

Upon considering Mr. Chipman's request for reimbursement, the ALJ found that the bone augmentation was a covered procedure under Part B.<sup>82</sup> The ALJ came to this decision not because of Mr. Chipman's inability to eat properly, resulting in the aggravated ulcer condition,<sup>83</sup> but rather because of the exposure of the peroneal nerve, the potential of jaw fractures, and likelihood that the "tissue between the mouth and sinus cavity will perforate," leading to infections of the sinus or mouth.<sup>84</sup>

The ALJ also decided that the porcelain veneer crowns were dental services and not covered.<sup>85</sup> The Appeals Council denied a request for review, so the plaintiff filed suit in district court.<sup>86</sup>

The court affirmed the ALJ's decision that the crowns were not a covered procedure.<sup>87</sup> The court found that the procedure to implant the crowns was not "incident to and as an integral part of a covered

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77. See *Maggio v. Shalala*, 40 F. Supp. 2d 137, 138 (W.D.N.Y. 1999).

78. See *id.* at 141.

79. See *Chipman v. Shalala*, 894 F. Supp. 392, 393 (Kan. 1995).

80. See *id.* After the dental implants, Chipman's "ulcer condition 'began to calm down,'" and he stopped taking ulcer medication less than a year later. *Id.* at 393-94.

81. See *id.* at 393; see also *supra* note 51 for a comparison of Joseph Maggio's treatments.

82. See *Chipman*, 894 F. Supp. at 394.

83. See *id.*

84. See *id.* Dr. Smith, a board-certified oral and maxillofacial surgeon, testified on behalf of the Department of Health and Human Services at the hearing in front of the administrative law judge. Dr. Smith testified that the surgery would add strength to the jaw so that the peroneal nerve would not be exposed, addressing plaintiff's chronic pain. See *id.*

85. See *id.*

86. See *id.* at 394-95.

87. See *id.* at 396.

procedure or service.”<sup>88</sup> The bone augmentation was a covered procedure but, according to the court, the crowns were not.<sup>89</sup>

The court’s analysis of this case uses both the language in the statute,<sup>90</sup> and the interpretation of that language found in the MCM.<sup>91</sup> The court only addressed the ulcer problem in its analysis of the procedures under 42 U.S.C. § 1395y(a)(12).<sup>92</sup> The court dismissed the plaintiff’s argument that the implants should be covered due to the fact that they were “required because of his underlying medical condition, his ulcers” because that claim could only be addressed when the patient was hospitalized and has filed under Part A.<sup>93</sup> Mr. Chipman filed for reimbursement under Part B and was denied because the work was categorized as a dental procedure.<sup>94</sup> The *Chipman* court, unlike the court in *Maggio*, did not accept the argument that the “hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.”<sup>95</sup>

The court’s analysis under the MCM confronts the language that the procedure should be covered when it is “incident to and as an integral part of a covered procedure or service.”<sup>96</sup> Mr. Chipman argued that implanting the crowns was incident to and an integral part of the bone augmentation procedure.<sup>97</sup> The court did not agree, stating that the “medical evidence does not support such a conclusion.”<sup>98</sup>

The fault in the logic of the court lies in its misplaced attention as to why the bone augmentation was done in the first place.<sup>99</sup> The ALJ brought in an expert during the administrative hearing, Dr. Smith, who recited his reasons for bone augmentation surgery.<sup>100</sup> According to Dr. Smith’s testimony, Mr. Chipman was experiencing chronic pain

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88. MEDICARE CARRIER’S MANUAL, *supra* note 23, § 2136. This is the language that parallels the “in connection with” language found in 42 U.S.C. § 1395y(a)(12) (1994).

89. *See Chipman v. Shalala*, 894 F. Supp. 392, 396 (Kan. 1995).

90. *See supra* note 24 and accompanying text.

91. *See Chipman*, 894 F. Supp. at 394–97.

92. *See id.* at 396.

93. *Id.*

94. *See id.* at 396–97.

95. *Id.*; *see also Maggio*, 40 F. Supp. 2d at 137. The court also refused to address whether the implants would have been covered under Part A had Marion been hospitalized. *See Chipman v. Shalala*, 894 F. Supp. 392, 396–97 (Kan. 1995).

96. *See Chipman*, 894 F. Supp. at 395.

97. *Id.* at 396.

98. *See id.*

99. *See id.* at 393–94.

100. *See id.* at 394.

probably related to the peroneal nerve exposure.<sup>101</sup> Mr. Chipman apparently had also suffered from sinus and mouth infections that would be avoided with the surgery.<sup>102</sup> Were Mr. Chipman and his doctors concerned about jaw fractures (the other reason Dr. Smith gave for performing the surgery)?<sup>103</sup> The record does not reflect that they were concerned with jaw fractures.<sup>104</sup> While Dr. Smith's reasons for performing bone augmentation surgery were valid and may also have addressed some of Mr. Chipman's concerns, Mr. Chipman and his doctors wanted the bone augmentation performed so that he could chew a proper diet and cure his ulcer problem; he wanted dentures that would work properly.<sup>105</sup>

The court stated that "[n]othing in the medical records would indicate that the dental implant procedure was a necessary part of the bone augmentation surgery, or that the bone augmentation would be beneficial only if plaintiff would later receive dental implants."<sup>106</sup> If Mr. Chipman could not chew a proper diet, and had a history of ulcers due to this problem, and then received the surgery (bone augmentation followed by implanting the crowns) to correct this problem,<sup>107</sup> how could the dental implants *not* be a necessary part of the surgery? If what Dr. Smith has testified to as the benefits of bone augmentation surgery are true, then of course Mr. Chipman will receive benefits from the surgery.<sup>108</sup> But should a doctor who is not treating the patient be able to testify that those are the benefits received and conclude that Mr. Chipman's ulcer condition alone does not justify the procedures chosen for him by his attending physicians?<sup>109</sup> The fact that the patient will receive some other benefits from the procedure, testified to by a doctor that is not even treating the patient, should not be a reason to preclude reimbursement. The crowns were implanted in connection with the bone augmentation surgery to relieve an underlying medical condition of ulcers.<sup>110</sup> The

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101. *See id.*

102. *See id.*

103. *See id.* at 393-94.

104. *See id.*

105. *See id.*

106. *Id.* at 396.

107. *See id.* at 393.

108. *See supra* note 84 and accompanying text.

109. *See Chipman v. Shalala*, 894 F. Supp. 392, 394 (Kan. 1995).

110. *See id.* at 393.

bone augmentation surgery is a covered procedure,<sup>111</sup> and implanting the crowns should be covered as incident to that procedure.

The court does not address whether or not implanting the crowns would have been covered had the entire procedure been done in the hospital.<sup>112</sup> The court in this instance is not as persuaded as the court in *Maggio* to promote the efficient use of resources by granting a reimbursement regardless of whether or not the patient is hospitalized.<sup>113</sup>

The *Maggio* case distinguishes its facts from those in the *Chipman* case.<sup>114</sup> The *Maggio* court states that Joseph Maggio “has produced substantial evidence in the form of medical opinions and billing records to show that the dental services at issue were rendered as an integral part of his treatment . . . for leukemia and thrombocytopenia.”<sup>115</sup> As stated above, the dental services Joseph Maggio received were not rendered at the same time as the treatment for his underlying medical conditions, nor was it in the record that the need for the dental services was because of the treatments received for his underlying medical conditions.<sup>116</sup> Joseph Maggio needed the dental services in order to correct nutritional difficulties.<sup>117</sup> The same could be said for Marion Chipman, whose doctor said it was medically necessary that Mr. Chipman “have a dental implant procedure due to his history of peptic ulcer disease which required proper nutrition and properly chewed food.”<sup>118</sup>

The two cases taken together prove how differently the courts can work under the same guidelines. Both Plaintiff's had underlying medical conditions that needed, at least partially, dental solutions.<sup>119</sup> Which court comes closer to what the legislature intended when enacting the dental exclusion to the Medicare Act?

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111. *See id.* at 397.

112. *See id.*

113. *See id.* at 396; *see also supra* note 74 and accompanying text. The *Maggio* court recognized that certain procedures can be done as efficiently and safely on an outpatient basis, without wasting the resources of the hospital. *See supra* note 74 and accompanying text.

114. *See Maggio v. Shalala*, 40 F. Supp. 2d 137, 141–42 (W.D.N.Y. 1999).

115. *See id.* at 142.

116. *See supra* notes 60–66 and accompanying text.

117. *See Maggio*, 40 F. Supp. 2d at 138.

118. *See Chipman v. Shalala*, 894 F. Supp. 392, 393 (Kan. 1995).

119. *See Maggio*, 40 F. Supp. 2d at 138; *Chipman*, 894 F. Supp. at 393.

#### 4. LEGISLATIVE HISTORY

The Senate Report specifies the purpose for the dental exclusion in Medicare.<sup>120</sup> The report states:

The committee bill provides a specific exclusion of routine dental care to make clear that the services of dental surgeons covered under the bill are restricted to complex surgical procedures. Thus, payment would be made under the supplementary plan for the physician's services connected with the diagnosis of a specific complaint and the treatment of the ailment, but a routine annual or semiannual checkup would not be covered.<sup>121</sup>

Two items in the above report are persuasive to the interpretation that more dental work should be covered under Medicare than is currently being provided. First addressed is the use of the word "routine."<sup>122</sup> Second, the services rendered by a physician would be covered when "connected with the diagnosis of a specific complaint and the treatment of the ailment."<sup>123</sup>

The use of the word "routine" occurs twice.<sup>124</sup> This emphasizes the fact that Congress did not want Medicare to be responsible for check-ups or care that was not a complex surgical procedure.<sup>125</sup> This interpretation fits together nicely with other exclusions found in Medicare, such as the exclusion of "routine" examinations by physicians and podiatrists.<sup>126</sup>

Second, Congress specifies that payment would be made "connected with the diagnosis of a specific complaint and the treatment of the ailment."<sup>127</sup> This language seems to suggest that when a patient expresses a complaint and a diagnosis is given, and dental work is needed to treat the ailment, that work would be covered.<sup>128</sup> The complaint needs to be specific,<sup>129</sup> but does it need be dental in nature? Because Congress is addressing the dental exclusion at that point, it might seem obvious that the complaint should be dental in nature.<sup>130</sup> However, due to the language found in the dental exclusion to the Medicare Act addressing an "underlying medical condition," Con-

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120. See S. REP. NO. 89-404, at 1943 (1965).

121. See *id.* at 1989-90.

122. See *id.*

123. *Id.*

124. See *id.*

125. See *id.*

126. See FROLIK & KAPLAN, *supra* note 2, at 76.

127. S. REP. NO. 89-404, at 1989-90 (1965).

128. See *id.*

129. See *id.*

130. See *id.*



gress may have meant any medical complaint that had dental repercussions.<sup>131</sup> Therefore, patients receiving dental care that is a solution to a specific ailment should be covered.

This approach is easily reconciled with the language of the statute.<sup>132</sup> A patient has a medical problem that is normally covered under Medicare Parts A or B, and the fact that the treatment needed to help solve this problem happens to be dental should not preclude reimbursement. This still protects the integrity of the statute by denying reimbursement for such things as routine dental care or the fitting of dentures.<sup>133</sup> Under the guidelines given in the legislative history, it becomes clear that the outcome in the *Maggio* case better reflects what the legislature intended than the result in the *Chipman* case.<sup>134</sup>

How would Theodore Yeager's request for reimbursement come out under the statutory interpretation discussed above? The plain language seems to say that there must be inpatient hospital services "in connection with" the dental services being provided.<sup>135</sup> In Mr. Yeager's case, no inpatient hospital services were provided during the time he received dental services.<sup>136</sup> So, the services would be excluded under this interpretation. But, the second phrase, "if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services[.]" addresses the underlying condition of the patient.<sup>137</sup> Mr. Yeager certainly has underlying conditions that led to his need for dental services (in connection with), but unless his dentist or doctor requires hospitalization, which they did not, coverage would probably be denied.<sup>138</sup>

The MCM's two examples do not really apply to the situation presented in Mr. Yeager's case.<sup>139</sup> Both of the examples pertain to dental work being performed in the hospital at the same time an actual

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131. 42 U.S.C. § 1395y(a)(12) (1994).

132. *See id.*

133. *See id.*

134. *See Maggio v. Shalala*, 40 F. Supp. 2d 137, 141-42 (W.D.N.Y. 1999); *Chipman v. Shalala*, 894 F. Supp. 392, 396 (Kan. 1995). Even though the *Maggio* court says that their outcome need not change the outcome in *Chipman*, because of the flaws in the reasoning of the *Chipman* case, the author contends that the two cases are not reconcilable. *See supra* notes 99-113 and accompanying text.

135. *See* 42 U.S.C. § 1395y(a)(12).

136. *See supra* note 1 and accompanying text.

137. 42 U.S.C. § 1395y(a)(12)(1994).

138. *See id.*

139. *See* MEDICARE CARRIER'S MANUAL, *supra* note 23, § 2136.

surgery is taking place.<sup>140</sup> The MCM does not discuss whether or not a dental procedure caused by an underlying medical condition would be covered.<sup>141</sup> The MCM does, however, make the comment that the “hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.”<sup>142</sup> In Mr. Yeager’s situation, then, the fact that he was never admitted to the hospital would probably have no bearing on whether or not reimbursement would be provided.

If the hospitalization requirement is removed from the equation, then whether or not he would be eligible for reimbursement becomes more difficult to determine. While no nondental surgery was performed at the time of the dental surgery, the argument could be made that Mr. Yeager was having the dental services performed because of his underlying medical condition. The question then becomes whether the dental work being done because of problems that originated due to an underlying medical condition satisfies the “in connection with” language of the statute.<sup>143</sup> The situation presented in Mr. Yeager’s case meets that test, and the outcome of *Maggio v. Shalala* confirms that assertion.<sup>144</sup>

In *Maggio*, Joseph Maggio received reimbursement for dental procedures that were interfering with his treatment of certain underlying medical conditions.<sup>145</sup> This was enough for the court to find that Mr. Maggio’s case was an exception to the dental exclusion found in Medicare.<sup>146</sup> Like Mr. Yeager, Mr. Maggio did not have any surgical procedures done at the time he was having the dental work done.<sup>147</sup> Neither patient was in the hospital.<sup>148</sup> In the *Maggio* case, Mr. Maggio needed the dental work because of the nutritional difficulties he was facing while undergoing treatment for his underlying medical condition.<sup>149</sup> If that scenario satisfies the “in connection with” language,

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140. *See id.*

141. *See id.*

142. *Id.*

143. *See* 42 U.S.C. § 1395y(a)(12) (1994); *see also supra* notes 29–31 and accompanying text.

144. *See Maggio v. Shalala*, 40 F. Supp. 2d 137, 141–42 (W.D.N.Y. 1999).

145. *See id.* at 142.

146. *See* 42 U.S.C. § 1395y(a)(12) (1994).

147. *See Maggio*, 40 F. Supp. 2d at 138–39; *supra* note 1 and accompanying text.

148. *See Maggio*, 40 F. Supp. 2d at 138; *Chipman v. Shalala*, 894 F. Supp. 392, 396 (Kan. 1995).

149. *See Maggio*, 40 F. Supp. 2d at 138.

then Mr. Yeager's scenario would also satisfy that hurdle.<sup>150</sup> In Mr. Yeager's situation, not only did the patient suffer nutritional difficulties (the sixteen pound weight loss), but the patient's dental problems were directly caused by the treatments he received to address his underlying medical conditions.<sup>151</sup> Surely, under the precedent set in *Maggio*, Mr. Yeager would be entitled to reimbursement.<sup>152</sup>

The outcome of whether or not Mr. Yeager should be reimbursed under *Chipman* might be different than that under the *Maggio* court.<sup>153</sup> The *Chipman* case hinged upon whether the implants were an integral part of the bone augmentation surgery.<sup>154</sup> The case did not explore questions involving Marion Chipman's underlying medical condition, but what the bone augmentation might prevent.<sup>155</sup> In fact, the court completely ignored Mr. Chipman's underlying medical condition, his ulcers.<sup>156</sup> If the court in the *Chipman* case had based the dental procedure on his underlying medical condition—the reason Mr. Chipman's doctors gave for ordering the dental procedure,<sup>157</sup> then the implants would have been an integral part of that procedure.<sup>158</sup> The implants that Mr. Yeager received, and the prosthetic device to hold them, were not an integral part of any other surgery.<sup>159</sup> Therefore, under the analysis of the *Chipman* court, the reimbursement for Mr. Yeager might be denied.

Under the legislative history, however, Mr. Yeager should be reimbursed. The implants and the prosthetic device were not routine dental work.<sup>160</sup> The work was done in two sessions over a period of four months.<sup>161</sup> The procedures obviously were not dental check-ups

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150. See *supra* notes 1, 29–31 and accompanying text.

151. See *supra* note 1 and accompanying text.

152. See *Maggio v. Shalala*, 40 F. Supp. 2d 137, 143 (W.D.N.Y. 1999); *supra* note 1 and accompanying text.

153. See *supra* note 1 and accompanying text.

154. See *Chipman v. Shalala*, 894 F. Supp. 392, 396 (Kan. 1995).

155. See *id.* at 394.

156. See *id.* Dr. Smith testified that Mr. Chipman's ulcer condition alone was not enough to justify bone augmentation surgery and implants. See *id.* This seems an odd evaluation when the very reason the surgery was recommended by Dr. Rif-fel was because of Mr. Chipman's inability to wear a conventional denture, causing the inability to properly chew and digest his food, leading to the ulcer. See *id.* at 393.

157. See *id.*

158. See *id.* at 396. The ulcer problem would not have been solved without the implants enabling Mr. Chipman to chew his diet properly. See *id.* at 394.

159. See *supra* note 1 and accompanying text.

160. See *supra* notes 121–26 and accompanying text.

161. See *supra* note 1 and accompanying text.

or a patient receiving implants for no other medical reason than to replace his teeth or dentures.<sup>162</sup>

The legislative history also provides that payment would be made “connected with the diagnosis of a specific complaint and the treatment of the ailment.”<sup>163</sup> Mr. Yeager complained that he could not chew or swallow a proper diet.<sup>164</sup> The diagnosis revealed he was unable to retain a conventional denture and should receive dental implants and a prosthetic device to lock everything in place.<sup>165</sup> Mr. Yeager was unable to hold a conventional denture because of the treatments he received for various underlying medical conditions.<sup>166</sup> Surely this fits the criteria set forth in the legislative history of a specific complaint (the inability to chew or swallow a normal diet), the diagnosis of that complaint (no longer capable of holding a conventional denture due to past medical treatments), and the treatment of that ailment (the dental implants and the prosthetic device).<sup>167</sup>

Thus, under the plain language of the statute, the most recent case law found in *Maggio v. Shalala*, and the legislative history, Mr. Yeager should be entitled to reimbursement under the current system. Yet, that reimbursement has been repeatedly denied.<sup>168</sup> Differing opinions of the nature of the exceptions to the dental exclusion continue to leave patients and dentists in the dark.

## B. Congressional Response

Do constituents agree that more dental care should be covered under Medicare? From the number of proposals made in Congress over just the past ten years alone, it seems that this is an issue that needs reform.<sup>169</sup> Testimony from two town hall meetings held in California and presented to the National Bipartisan Commission on the Future of Medicare repeatedly asked for the inclusion of dental services.<sup>170</sup>

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162. See *supra* notes 1, 121–26 and accompanying text.

163. *Supra* notes 121, 127–31 and accompanying text.

164. See *supra* note 1 and accompanying text.

165. See *id.*

166. These conditions included, among other things, cancer and Guillain Barre’s disease.

167. See *supra* notes 1, 121, 127–31 and accompanying text.

168. See *supra* note 1.

169. See *infra* notes 173, 177, 180 and accompanying text.

170. See 144 CONG. REC. E1809-04 (daily ed. Sept. 25, 1998) (statement of Hon. Nancy Peles).

What is covered under Medicare in terms of dental care? In an attempt not only to clear up the confusion about what is covered, but to extend greater coverage of dental services, Congress has been bombarded with proposals over the past years.<sup>171</sup> Three proposals before Congress over the past ten years highlight an attempt not only to include more dental services under Medicare, but to create clearer guidelines under which to work. Also discussed briefly are proposals as to how increased coverage for dental services will be funded.

### 1. THE PROPOSALS

A 1992 proposal recommended inclusion of surgical and prosthodontic procedures following oral cancer and jaw reconstruction surgery within Medicare coverage.<sup>172</sup> This proposal would have covered, among other things, the replacement of teeth with dentures when a patient has suffered from cancer.<sup>173</sup> This would eliminate the confusion surrounding whether or not the dental procedure needs to happen as a result of, in connection with, or as an integral part of a nondental procedure.<sup>174</sup> But the proposal is very narrow in scope, affecting only those who had *oral* cancer.<sup>175</sup>

In 1993, a broad proposal amending Part B was made pushing for the inclusion of dental services and dentures.<sup>176</sup> This bill was referred to committee and reintroduced in 1995.<sup>177</sup> This proposal is far more wide-reaching in its scope, and more controversial, for the most part eliminating the dental exclusion from Medicare Part B.<sup>178</sup>

In 1997, Congress proposed the Medically Necessary Dental Care Act.<sup>179</sup> This Act would provide coverage for outpatient dental procedures that are “medically necessary as a direct result of, or will have a direct impact on, an underlying medical condition . . . .”<sup>180</sup>

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171. See *infra* notes 173, 177, 180 and accompanying text.

172. See S. 2615, 102d Cong. (1992).

173. See *id.*

174. See 42 U.S.C. § 1395y(a)(12)(1994); *supra* notes 33–41 and accompanying text.

175. See S. 2615, 102d Cong. (1992).

176. See H.R. 442, 103d Cong. (1993).

177. See H.R. 166, 104th Cong. (1995).

178. See FROLIK & KAPLAN, *supra* note 2, at 74–76.

179. H.R. 1288, 105th Cong. (1997).

180. *Id.* The coverage will only be given if the service is cost-effective. Subsection (j) determines what is cost-effective: “(1) Dental services shall be considered to be cost-effective if furnished in connection with treatment of an individual with any of the following diagnosis: congenital or acquired valvular heart disease, cancer of the head or neck, lymphoma, leukemia, and organ transplantation.” *Id.* § 1.

Under this Act, the confusion over whether hospitalization is a factor in reimbursement would be eliminated.<sup>181</sup> Outpatient care would be provided for those services "in connection with" certain diagnoses.<sup>182</sup>

This act would extend the exception found in 42 U.S.C. § 1395y(a)(12) to include Part B claims, an extension since made in *Maggio*.<sup>183</sup> Although this would clarify claims such as those made by Joseph Maggio, the Act falls short of covering much needed care such as routine dental work and preventative care.<sup>184</sup>

## 2. FUNDING AND HEALTH MAINTENANCE ORGANIZATIONS

Unfortunately, the scope of this note does not provide for an in-depth discussion of funding. However, providing more services will obviously cost more. Some suggestions have included:

- (1) those enrollees who can pay more for the insurance should;<sup>185</sup>
- (2) rewarding hospitals for effective preventative care;<sup>186</sup>
- (3) an optional part C insurance program to provide coverage of certain vision, hearing, and dental services.<sup>187</sup>

Health Maintenance Organizations have provided another option for Medicare beneficiaries to receive dental benefits. HMOs offer services such as dental coverage as an incentive to get enrollees to sign up.<sup>188</sup> Initially, this arrangement seemed to be a viable option for offering more services and controlling costs.<sup>189</sup> However, there have been at least two problems with this arrangement. First, because of

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There is also a clause allowing for reimbursement in connection with a diagnosis not listed in paragraph (1). *See id.* § 2. The coverage must result in reductions in expenditures under the Medicare Act that exceed the expenditures resulting from such coverage. *See id.*

181. *See id.*

182. *See id.*

183. *See Maggio v. Shalala*, 40 F. Supp. 2d 137, 142 (W.D.N.Y. 1999). The *Maggio* court praised the fact that the plaintiff's dental work was done at a clinic rather than in a hospital, thus saving the Medicare system's funds. *See id.*

184. *See Millions Cannot Afford Dental Help, Study Says*, *supra* note 4, § C, at 14.

185. *See Medicare Reform: Bipartisan Commission Goes to Memphis*, AM. HEALTH LINE, *Politics and Policy*, Aug. 19, 1998. United States Representative Bill Thomas of California and Senator Bill Frist of Tennessee attended the National Bipartisan Commission on the Future of Medicare hearings. Both suggested that those who could afford to pay more for the insurance should. *See id.*

186. *See id.*

187. *See H.R. 207*, 101st Cong. (1989).

188. *See Jane Bryant Quinn, Medicare HMOs Need Thought*, TIMES UNION, Mar. 31, 1997, at C8.

189. *See Caution: Medicare Market at Work*, CHI. TRIB., Nov. 13, 1998, at 26 (editorial).

disproportionate reimbursements between the counties within a state, certain states are able to offer more benefits while everyone continues to pay the same premiums.<sup>190</sup> Second, HMOs have begun cutting back the services they once offered as incentives for enrollees to join,<sup>191</sup> or canceling their programs for seniors altogether.<sup>192</sup>

*a. Disproportionate Reimbursements* Through the managed care system, HMOs pay providers a flat fee for caring for their enrollees.<sup>193</sup> "Medicare pays HMOs 90 percent of the *average charges allowed in a geographic area* under standard plans."<sup>194</sup> Based on this system, huge discrepancies arise.<sup>195</sup> States such as New York and California receive disproportionately higher reimbursements because their geographic location allows it no matter what the actual cost of the procedure might be, so their HMOs are able to offer extra perks such as prescription drugs, vision, and dental care.<sup>196</sup> In counties with reimbursement rates below \$300 a month, Medicare HMOs offered dental coverage in one percent of those counties.<sup>197</sup> In counties with reimbursement rates above \$500 a month, Medicare HMOs offered dental coverage in eighty-eight percent of those counties.

What could possibly be wrong with a program that offers the elderly more benefits? The problem is that all Medicare beneficiaries in this country pay the same 2.9 percent tax on wages and the same \$42.50 in monthly premiums for Medicare supplemental insurance, but those living in states that do not reap the benefits of high reimbursements do not have access to all the perks, such as free dental care.<sup>198</sup> Also, those seniors living in rural areas are hit hardest, with lower-quality HMO coverage and less preventative care.<sup>199</sup>

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190. See generally *Boneheaded Medicare Formula*, *supra* note 3, at 14.

191. See *First Option Health Plan: Makes Changes to Medicare HMO*, AM. HEALTH LINE, *Managed Care Monitor*, Dec. 9, 1997.

192. See *id.*; see also Jennifer Maddox, *Seniors Seek Better HMO Coverage*, PRESS J., Sept. 23, 1999, § A, at A15.

193. See *Boneheaded Medicare Formula*, *supra* note 3, at 14.

194. *Id.* (emphasis added).

195. See *id.*

196. See *id.*

197. See *Medicare HMOs: Rural Seniors Get Fewer Benefits*, AM. HEALTH LINE, *Managed Care Monitor*, Nov. 10, 1998.

198. See Bill Salisbury, *Extra Medicare Benefit Payments Called Unfair*, POST & COURIER, Mar. 22, 1996, § A, at 4.

199. See *Medicare HMOs: Rural Seniors Get Fewer Benefits*, *supra* note 197, at A15.

b. *Cut-Backs and Cancellations* The managed care option was created by Congress and is known as Medicare Plus Choice.<sup>200</sup> In Medicare HMOs, doctors get a flat fee each month for every patient, regardless of the treatment they receive.<sup>201</sup> The HMOs claim is that they cannot turn a profit by servicing the senior market on what Medicare reimburses them.<sup>202</sup> After only a year or two of service, some HMOs are pulling out of their programs offered to seniors.<sup>203</sup> This leaves many of the elderly inconvenienced and in a position to have to go out and find a new HMO or return to a traditional Medicare arrangement, losing the services they switched to the HMO for in the first place.<sup>204</sup>

Some HMOs are not pulling out of the programs altogether, but are instead cutting the incentives they offer to entice the elderly to join up in the first place.<sup>205</sup> HMOs blame the two to three percent cap Congress has placed on Medicare payments, claiming they can no longer make a profit.<sup>206</sup> California Blue Cross is both raising premiums and eliminating its coverage of dental care.<sup>207</sup> As mentioned above, the Medicare recipient could try to find a new HMO that will cover dental services.<sup>208</sup> But the real answer lies in Medicare extending its coverage to include dental services such as those suggested in the 1993 and 1997 proposals.<sup>209</sup> The current system leaves too much doubt as to whether or not a dental procedure will be covered by Medicare and too many of the elderly without much needed dental care.<sup>210</sup>

#### IV. Conclusion

The attempt in Part II above to decipher the dental exclusion to the Medicare Act gives the reader an idea of how difficult this task can

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200. See Maddox, *supra* note 192, at A15.

201. See *id.*

202. See *id.*; *First Option Health Plan: Makes Changes to Medicare HMO*, *supra* note 191, at A15.

203. See Maddox, *supra* note 192; *Caution: Medicare Market at Work*, *supra* note 189, at 26.

204. See *Caution: Medicare Market at Work*, *supra* note 189, at 26.

205. See *Medicare HMOs Trim the Extras*, BUS. & HEALTH, Feb. 1, 1998, Vol. 16, § 2, at 11.

206. See *id.*

207. See *id.* The company is also eliminating coverage of drug and vision care.

208. See *Caution: Medicare Market at Work*, *supra* note 189, at 26.

209. See *supra* notes 177, 180.

210. See *Millions Cannot Afford Dental Help, Study Says*, *supra* note 4, § C, at 14.



be. What might appear clear upon a cursory reading becomes hopelessly complicated after a closer look. What most would probably agree with is that reform is needed. The guidelines for what is covered need to be clearer. What is in fact covered needs to be greater.

Some of the proposals in Congress have addressed these issues but have not been enacted.<sup>211</sup> The hope that the managed care system through Medicare Choice Plus would pick up the slack also has not succeeded, but has widened the gulf between those who are lucky enough to receive dental services and those who are not.<sup>212</sup>

A proposed guideline for services under Part A might read something like the following:

Notwithstanding any other provision of this subchapter, no payment may be made under Part A of this subchapter for any expenses incurred for items or services where such expenses are for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under Part A if the above services are needed as a result of an underlying medical condition, also surgical procedures may be covered if necessary in order to receive the above services.<sup>213</sup>

A proposed guideline for services under Part B might read something like the following:

Payment will be provided for the filling, removal, or replacement of teeth or structures directly supporting teeth under Part B if the above services are necessary.<sup>214</sup>

Repealing the dental exclusion to the Medicare Act and establishing new guidelines will§ not be an easy task, but it is a necessary

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211. See *supra* notes 173, 177, 180 and accompanying text.

212. See *supra* note 193.

213. The basic format for this proposed guideline is taken from 42 U.S.C. § 1395y(a)(12) (1994). This proposed guideline would allow patients who suffer from a medical condition that results in a dental need to seek reimbursement for that work, if done in a hospital setting. This would clarify that Marion Chipman would be entitled to reimbursement for the dental implants he received, not just the bone augmentation surgery. The implants would be covered under the proposed guideline because the implants were needed as a result of the underlying condition of his ulcers. See *supra* notes 105–11 and accompanying text. This proposed guideline would also solve the disparity between allowing payment for such surgical procedures as a ridge reconstruction only if done as a result of a nondental surgical procedure. Under the proposed guideline, the ridge reconstruction would be covered regardless of it being performed as a result of a tumor being removed (nondental) or for the preparation of dentures (dental). See *supra* notes 36–40 and accompanying text.

214. This proposal is a considerable departure from 42 U.S.C. § 1395y(a)(12). However, the proposed guideline is not all-inclusive, continuing to prohibit coverage for routine preventative dental care such as treatments, cleanings, and x-rays. The proposed guideline would allow coverage for dentures, implants, and fillings. See *supra* note 23 and accompanying text.

one. With more generous and better defined guidelines, recipients such as Mr. Yeager will not have the surprise that their much needed care is not covered.