Statement on Third Party Payer Reimbursement for Costs Associated with Increased Standards for Personal Protective Equipment (PPE)

The safety of patients, dentists and dental team members has been and always will be the American Dental Association's (ADA) utmost concern. The ADA has issued interim recommendations aligning with those from the Centers for Disease Control (CDC) for use of personal protective equipment (PPE). Given these interim recommendations, the ADA anticipates that the cost for each patient visit will substantially increase for procedures performed in the dental office.

Third party benefit programs should either (1) adjust the maximum allowable fees for all procedures or (2) allow a standard fee per date of service per patient to accommodate the rising costs of PPE. Not doing so is deemed an automatic reduction in reimbursement rates.

Prior to such adjustments taking effect, dental offices may wish to use CDT code "**D1999** - unspecified preventive procedure, by report" to document and report the use and cost of additional PPE. Dentists can use this code once per patient visit/claim to attempt to cover the cost of PPE.

Dentists should develop a standard office policy to document the additional PPE that will be used across all patients. This documentation methodology will justify a standard fee across all patients. Alternatively, dentists may wish to add a note in the patient's record to document the details of PPE uniquely necessary for the visit when charging different fees based on the level of PPE used.

When adjudicating such claims, the ADA believes that it is inappropriate for any third party benefit program to unfairly place the cost burden on dentists by disallowing or bundling charges for PPE on the pretext that the payment for additional required PPE is included in the payment for any other procedure billed for the visit. Denied claims are typically billable to the patient. For Medicaid patients, please check with your state Medicaid agency.