CHAPTER 56

MANUAL FOR DENTAL SERVICES

Authority

N.J.S.A. 30:4D–1 et seq., 30:4D–6b(4) and 30:4D–7.

Source and Effective Date

R.2001 d.268, effective July 10, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Chapter Expiration Date

Chapter 56, Manual for Dental Services, expires on July 10, 2006.

Chapter Historical Note

Chapter 56, Dental Services Manual, was adopted as R.1971 d.70, effective May 12, 1971. See: 3 N.J.R. 58(c), 3 N.J.R. 110(b).

Chapter 56, Manual for Dental Services, was adopted as R.1978 d.2, effective March 1, 1978. See: 9 N.J.R. 431(c), 10 N.J.R. 66(e).

Pursuant to Executive Order No. 66(1978), Subchapter 3, Procedure Codes and Descriptions, was readopted as R.1986 d.128, effective March 24, 1986. See: 18 N.J.R. 154(a), 18 N.J.R. 847(b).

Pursuant to Executive Order No. 66(1978), Chapter 56, Manual for Dental Services, was readopted as R.1986 d.385, effective August 26, 1986. See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

Subchapter 3, Procedure Codes and Descriptions, was repealed and a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1987 d.166, effective April 6, 1987. See: 19 N.J.R. 15(b), 19 N.J.R. 519(a).

Pursuant to Executive Order No. 66(1978), Chapter 56, Manual for Dental Services, was readopted as R.1991 d.473, effective August 21, 1991. See: 23 N.J.R. 1992(a), 23 N.J.R. 2862(a).

Pursuant to Executive Order No. 66(1978), Chapter 56, Manual for Dental Services, was readopted as R.1996 d.428, effective August 14, 1996. As part of R.1996 d.428, Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was repealed and a new Subchapter 2, Provisions for Services, was adopted, effective September 16, 1996. See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Chapter 56, Manual for Dental Services, was readopted as R.2001 d.268, effective July 10, 2001. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. DENTAL SERVICES; GENERAL PROVISIONS

10:56–1.1 Purpose and scope

This chapter (N.J.A.C. 10:56) describes the policies and procedures of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs pertaining to the provision of, and reimbursement for, medically-necessary dental services to eligible individuals. In addition to the private office, dental services may be provided in the home, hospital, approved independent clinic, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), residential treatment center, or elsewhere.

New Rule, R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former N.J.A.C. 10:56–1.1, "Definitions", recodified to 10:56–1.2.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
Inserted "/NJ FamilyCare fee-for-service" preceding "programs".

New Jersey State Library

10:56-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Attending dentist" means one who assumes the primary and continuing dental care of the beneficiary. The services of only one attending dentist will be recognized at a given time.

"Clinical laboratory services" means professional and technical laboratory services ordered by a dentist within the scope of practice as defined by the laws of the state in which the dentist practices and, which are provided by a laboratory.

"Concurrent care" means that type of service rendered to a beneficiary by practitioners where the dictates of dental necessity require the services of dentists of different specialties in addition to the attending dentist so that needed care can be provided.

"Consultation" means that service rendered by a qualified dentist upon request of another practitioner in order to evaluate through personal examination of the beneficiary, history, physical findings and other ancillary means, the nature and progress of a dental or related disease, illness, or condition and/or to establish or confirm a diagnosis, and/or to determine the prognosis, and/or to suggest treatment. A consultation should not be confused with "referral for treatment" when one practitioner refers a beneficiary to another practitioner for treatment, either specific or general, for example, "Endodontic treatment on teeth No.'s 3 and 5"; or "Extract teeth No.'s 7, 8, 9, and 10"; or "Extract tooth or teeth causing pain."

"Dental Services" means any diagnostic, preventive, or corrective procedures administered by or under the direct personal supervision of a dentist in the practice of the practitioner's profession. Such services include treatment of the teeth, associated structures of the oral cavity and contiguous tissues, and the treatment of disease, injury, or impairment which may affect the oral or general health of the individual. Such services shall maintain a high standard for quality and shall be within the reasonable limits of those services which are customarily available, accepted by, and provided to most persons in the community within the limitations, and exclusions hereinafter specified.

"Direct personal supervision" means the actual physical presence of the dentist on the premises.

"Division" means the Division of Medical Assistance and Health Services.

"Emergency" means a specific condition of the oral cavity and/or contiguous tissues which causes severe and/or intractable pain and/or could compromise the life, health, or safety of the beneficiary unless treated immediately. For example:

1. Pain or acute infection from a restorable or a non-restorable tooth;

2. Pain resulting from injuries to the oral cavity and related structures;

3. Extensive, abnormal bleeding;

4. Fractures of the maxilla or mandible or related structures or dislocation of the mandible.

"Non-routine dental service" means any dental service that requires prior authorization by a Medicaid dental consultant in order to be reimbursed by the New Jersey Medicaid program.

"Nursing facility" means a long-term care facility or an intermediate care facility for the mentally retarded (ICF/MR).

"Participating dentist" means any dentist licensed to and currently registered to practice dentistry by the licensing agency of the State where the dental services are rendered, who accepts the promulgated requirements of the New Jersey Division of Medical Assistance and Health Services, and signs a provider agreement with the Division.

"Program" means the New Jersey Medicaid program.

"Prior authorization" means approval by a dental consultant to the New Jersey Medicaid program before a service is rendered.

"Referral" means the directing of the beneficiary from one practitioner to another for diagnosis and/or treatment.

"Routine dental service" means any dental service that is reimbursable by the New Jersey Medicaid program without authorization by a Medicaid dental consultant.

"Specialist" means one who is licensed to practice dentistry in the state where treatment is rendered, who limits his or her practice solely to his or her specialty, which is recognized by the American Dental Association and is registered as such with the licensing agency in the state where the treatment is rendered.

"Transfer" means the relinquishing of responsibility for the continuing care of the beneficiary by one dentist and the assumption of such responsibility by another dentist.

Amended by R.1984 d.270, effective July 2, 1984.
See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).
Section substantially amended.
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Specialist amended.
Amended by R.1992 d.98, effective March 2, 1992.
See: 23 N.J.R. 281(a), 24 N.J.R. 845(a).
Added definition of "bundled drug service."
Recodified from 10:56-1.1 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former N.J.A.C. 10:56–1.7, "Utilization review, quality control and peer review", recodified to 10:56–1.9.
Recodified from N.J.A.C. 10:56–1.7 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).
Former N.J.A.C. 10:56–1.8, Recordkeeping requirements, recodified to N.J.A.C. 10:56–1.9.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

10:56–1.9 Recordkeeping requirements

(a) Dentists are required to maintain individual records which fully disclose the type and extent of services provided to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs beneficiary, including detailing all services rendered for each encounter date. These records shall also fulfill the requirements of the New Jersey State Board of Dentistry as outlined in N.J.A.C. 13:30–8.7. The Medicaid/NJ FamilyCare Dental Services Claim Form (MC–10) shall not be an acceptable substitute. Such beneficiary records shall be maintained in the provider's office regardless of the actual place of service (dental office, long-term care facility, or hospital). These records shall be available for a minimum of seven years following the last date of service. The dentist shall also document services in facility records as required in (b) and (c) below. Such information shall be readily available to representatives of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs or their agents as required.

1. The record shall include, but not be limited to, the following:

i. The name, address, and telephone number of the beneficiary, the beneficiary's date of birth and HSP (health services program) number, and, if a minor, name of parent(s) or guardian.

ii. Pertinent dental/medical history; and

iii. Detailed clinical examination data to include where applicable:

(1) Beneficiary's chief complaint;

(2) Diagnosis;

(3) Cavities;

(4) Missing teeth; and

(5) Abnormalities;

iv. Preoperative, progress, and postoperative radiographs retained for a minimum of seven years following the last date of service. Professional liability insurance companies should be contacted for possible retention for longer periods. The number and type of radiographs should be entered on the beneficiary's record. Postoperative radiographs should be taken only when dentally necessary and must have diagnostic value.

v. Treatment plan with description of treatment rendered to include:

(1) Tooth number;

(2) Surfaces involved;

(3) Site and size of treatment area (lesion, laceration, fracture, and so forth);

(4) Materials used;

(5) Date(s) of service(s);

(6) Description of treatment or services rendered at each visit to include the name of the dentist or hygienist rendering it.

(7) All medications;

(8) Diagnostic laboratory and/or radiographic procedure(s) ordered, including the result(s);

(9) Copy of the dental prosthetic work authorization(s) (prescription(s)), and dental prosthetic laboratory receipt(s);

(10) Explanation for any duplication of services within one year (prosthetic services within seven and one-half years);

(11) Reasons for discontinuation of services (including attempts to complete treatment); and

(12) Referral and consultation reports.

(b) A complete description of treatment, as noted above, shall also be entered into a hospital's clinical records for any beneficiary treated at that facility. These entries must also satisfy that specific hospital's regulations.

(c) A dentist who provides services for a nursing facility beneficiary (regardless of the place of service) shall in addition to maintaining his or her own office records, provide the nursing facility with an entry for the beneficiary's clinical record that includes the following:

1. The results of an examination which will establish an admission record of the beneficiary's dental status.

i. If a current examination is required within six months of a previous examination performed by the same provider and billed to Medicaid, the results of the original examination shall be entered into the clinical record as the current dental status.

2. A time frame, established on an individual basis, for the next periodic examination of the beneficiary. The time frame shall be documented either at the time of examination, or at the completion of treatment. For example, it may be entered on the clinical record for six months, one year, two years, three years, or any other time period that the attending dentist has established per his or her knowledge of the beneficiary and the beneficiary's dental status.

3. A record of dental treatment provided at each encounter.

i. A photocopy of the completed and signed Medicaid/NJ FamilyCare Dental Services Claim Form (MC–10) for examination and treatment will be accepted in lieu of a separate entry only if treatments (visits and description thereof) that preceded or followed the "dates of service" entered on the Medicaid/NJ FamilyCare Dental Services Claim Form MC–10 are listed separately on the beneficiary's clinical record in addition to the recordkeeping requirements described in this section.

As amended, R.1981 d.219, eff. July 9, 1981 (to become operative August 1, 1981).
See: 12 N.J.R. 700(a), 13 N.J.R. 430(b).
(a): New text substituted for old; (a)1: "include but not be limited to" was "consist of."
(b) and (c) added.
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Prosthetic service changed from five to seven and one-half years.
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Recodified from N.J.A.C. 10:56–1.8 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Former N.J.A.C. 10:56–1.9, Utilization review, quality control, peer review and TAMI review, recodified to N.J.A.C. 10:56–1.10.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
Rewrote the section.

10:56–1.10 Utilization review, quality control, peer review, and TAMI review

(a) For the purposes of the New Jersey Medicaid/NJ FamilyCare fee-for-service program, utilization review, quality control and peer review are considered to be ongoing components in regard to the dental services provided to eligible beneficiaries.

(b) Utilization refers to that service, procedure or item provided to a beneficiary by a qualified provider, in a setting, at a time, and in an amount which is appropriate and acceptable to the standards of the profession, at a cost described at N.J.A.C. 10:56–3.

(c) Utilization review is the retrospective analysis of the performance of a dental provider with respect to the efficient provision for the use of services noted in (b) above, from the viewpoint of fiscal accountability.

(d) Quality is that standard of dental care or degree of excellence generally prevailing throughout the profession by those who provide similar service which is not related to any geographical area or population group as judged by competent practitioners who are qualified to perform those procedures.

(e) Dental review is the current ongoing review of the degree of quality in the delivery of continuing dental services and health care which is constantly monitored and maintained by the provision of direction, coordination and regulation through the cooperative efforts between representatives of the New Jersey Medicaid Program and a qualified body of peers.

(f) Peer review is the evaluation by practicing dentists as to the quality and efficiency of services ordered and/or performed by other practicing dentists and is considered to be the all-inclusive term for dental review efforts including dental practice analysis, inpatient hospital and extended care utilization review and dental claims audit and review. In the accomplishment of the above, any or all reviews will include but not be limited to the following:

1. A clinical examination made on a sampling of cases. Such examination may be made prior to, during, or upon completion of treatment.

2. Additional diagnostic aids and data which may be requested to evaluate the case.

3. Adequate records which must be maintained by the dentist providing treatment and shall be available for inspection.

4. In the event a provider fails to respond to a request of the Division of Medical Assistance and Health Services for office records, radiographs, and/or other materials and correspondence within 30 days, the Division may recover any reimbursement related to the services involved, or if in reference to services not yet paid, reimbursement may be denied.

(g) TAMI review is that review done by the fiscal agent whereby, during the course of processing for payment, a claim is subjected to the Tooth Allocation Map Inquiry (TAMI). This system selects for further review and investigation any claim which shows a duplication of services or services presented in an illogical or impossible sequence. Claims and pertinent material are forwarded to the Bureau of Dental Services by the Fiscal Agent and the provider is informed of the problem and is likewise asked to forward specific and related material.

Recodified from 10:56–1.7 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Recodified from N.J.A.C. 10:56–1.9 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (a), inserted "/NJ FamilyCare fee-for-service" preceding "program" and substituted "beneficiaries" for "recipients"; in (b), substituted "beneficiary" for "recipient".

SUBCHAPTER 2. PROVISIONS FOR SERVICES

10:56–2.1 Dental treatment plan

(a) In accordance with good dental practice, a plan of treatment shall be developed and described for each Medicaid patient on the Dental Services Claim Form (MC–10) following a comprehensive examination. If no treatment is necessary, this fact must be entered on the Dental Services Claim Form (MC–10) under Remarks (Item 20). (No Other Treatment Necessary or NOTN).

(b) Any dental treatment plan, including those not requiring prior authorization, may be reviewed by dental consultants of the New Jersey Medicaid program.

(c) In those instances where prior authorization is necessary, a Medicaid/NJ FamilyCare dental consultant may modify the provider's treatment plan in accordance with the guidelines of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs specified in this chapter. Such modifications are designed to provide dental treatment to the beneficiary that is adequate for the correction of the problem, that can be expected to last for the longest period of time, and represents, in the opinion of the dental consultant(s), the most judicious application of Medicaid/NJ FamilyCare fee-for-service reimbursement. If in the professional judgment of the provider such modification is not appropriate, the dentist may request another review by the dental consultant. A further review in the office of the Chief, Bureau of Dental Services may be requested through the dental consultant.

(d) In any dental treatment plan, the dentist must discuss the proposed treatment plan and receive approval from the beneficiary and/or family member/guardian before submission for authorization and again after authorization is received and prior to initiation of treatment. It is suggested that the provider have the beneficiary sign the office records or a separate statement that the treatment plan meets with their approval since no alteration of the treatment plan will be reimbursed based on the subsequent rejection of all or part of that treatment plan by the beneficiary or family member/guardian.

(e) Consideration for development of a dental treatment plan shall be based upon the least costly treatment fulfilling the requirements of the specific situation. On the basis of post-utilization review, any dental treatment plan, including those not requiring prior authorization, may be reviewed by dental consultants of the New Jersey Medicaid program to determine appropriateness of treatment. If the treatment is not appropriate, the payment shall be recovered.

(f) Authorization for a dental treatment plan does not guarantee eligibility for payment under the New Jersey Medicaid/NJ FamilyCare fee-for-service programs. The monthly Medicaid/NJ FamilyCare eligibility identification card should be examined carefully on each visit to be certain the beneficiary is eligible during the current month of treatment. (See N.J.A.C. 10:49–2.) It is recommended that, on the first visit of each month, a photocopy of the card be placed and retained in the beneficiary's record.

(g) If, in the opinion of a dentist, the beneficiary requires the services of a specialist, the dentist shall note the name of the practitioner to whom the beneficiary is being referred on the Dental Services Claim Form (MC–10) under remarks (Item 20). The specialist shall note the name and Medicaid/NJ FamilyCare Provider Service Number of the referring dentist on the Dental Services Claim Form (MC–10) in section 14, which is designated as Referring Practitioner.

As amended, R.1984 d.270, eff. July 2, 1984.
See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).
Section substantially amended.
Recodified from 10:56–1.2 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former section, "General billing procedures", repealed.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (c) and (f), inserted references to NJ FamilyCare and NJ FamilyCare fee-for-service; in (g), inserted a reference to NJ FamilyCare; in (c), (f) and (g), substituted references to beneficiaries for references to recipients.

10:56–2.2 Standards of service

(a) The dental treatment plan provided shall be in accordance with the ethical and professional standards of the dental profession and meet the same high standard of quality normally provided to the community at large.

(b) All materials used and all therapeutic agents used or prescribed shall meet the specifications established by the American Dental Association.

(c) Experimental procedures, not approved by the New Jersey Board of Dental Examiners (N.J.A.C. 13:30), are not reimbursable by the New Jersey Medicaid program.

(d) When an emergency arises and consultation with the attending practitioner is impossible, due consideration shall be given to the preservation of those teeth that could be involved in the overall treatment plan of the attending practitioner

Recodified from 10:56–1.5 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former section, "Timeliness of claim submission and claim inquiry", repealed.

10:56–2.3 Special dental services

Dental services for which no specific provisions are made, or which are limited or prohibited in these policies and procedures, may be considered on an individual basis. Such a request should be forwarded to the Dental Claims Review Unit, PO Box 713, Trenton, New Jersey 08625–0713. The request shall be accompanied by all supporting documentation.

Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Substantially amended.
Recodified from 10:56–1.6 by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former section, "Dental Services Claim form (MC–10)", repealed.
Amended by R.1998 d.353, effective July 20, 1998.
See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).
Updated the address.

10:56–2.4 Place of service

(a) In addition to the private office, dental services may be provided in the home, a hospital, approved independent clinic, nursing facility, residential treatment center and elsewhere.

(b) Services should be provided in any appropriate setting, governed by medical/dental necessity and not by the convenience or desires of the beneficiary or the providers of services.

1. Policies specific for dental services rendered in the outpatient departments of approved licensed hospitals and services rendered in approved independent clinics are described in, N.J.A.C. 10:52 and N.J.A.C. 10:66, respectively.

i. Hospital outpatient dental clinics are subject to the same New Jersey Medicaid program policies, procedures and reimbursement schedule, as outlined in this manual, that apply to the dentist in "private" practice (see N.J.A.C. 10:52–2.3(a).)

2. Dental services performed on an inpatient basis in approved licensed hospitals are reimbursable provided that they require that level of care which shall be documented on the hospital records.

i. Dental services are also reimbursable if the beneficiary is admitted for an eligible non-dental condition and the dental services are rendered as part of the prescribed treatment for such condition, or to alleviate the beneficiary's discomfort during the period of hospitalization.

(1) Admission may be by the dentist or by a physician depending on the by-laws of the individual hospital.

(2) When inpatient services are performed by a dentist(s), who is reimbursed by the hospital under contractual or other arrangements, the services are considered a hospital cost, and must be billed by the hospital and not by the dentist.

(3) Authorization by a dental consultant of the Medicaid program is for services only and does not authorize the place of service; thus such authorization does not guarantee payment.

(4) Whenever all or any portion of the hospital inpatient claim is denied for payment, the attending practitioner's claim for inpatient services rendered during the denial period will also be denied for payment.

(c) Dental services as performed by a licensed dentist in a nursing facility, or elsewhere outside the provider's office setting are reimbursable provided that:

1. The policies and procedures as detailed in this manual are followed.

2. In a nursing facility, the dentist rendering the dental services is not an owner, administrator, stockholder of the company or corporation or otherwise has a direct financial interest in the facility.

3. Reimbursement of a supplemental fee for an out-of-office visit in addition to a fee for service is limited to once per trip per facility, regardless of the number of recipients examined or treated during the visit.

4. The dentist who examines a nursing facility beneficiary shall provide the treatment necessary unless the examination indicates that a specialist is needed.

As amended, R.1973 d.259, eff. October 1, 1973.
See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).
As amended, R.1981 d.219, eff. July 9, 1981 (to become operative August 1, 1981).
See: 12 N.J.R. 700(a), 13 N.J.R. 430(b).
(c)3 added.
Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Added text in (a) "However, for recipients ... to N.J.A.C. 10:49–1.2)."
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Recodified from 10:56–1.12 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former section, "Patient eligibility", repealed.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
Substituted references to beneficiaries for references to recipients throughout.

10:56–2.5 Visit policies

(a) A provider may be reimbursed for a house call (procedure code 09410) in addition to any other services provided on that day.

(b) The following apply to reimbursement for nursing facility visits (Y3005):

1. Nursing facility visits can be billed in addition to any other services provided on that day; and

2. Nursing facility visits are limited to once per trip to the facility regardless of the number of patients examined or treated.

(c) Reimbursement for hospital calls (09420 52, 09420 22, and 09420) can be billed for an inpatient or outpatient hospital visit in addition to any other services provided on that day, and shall be billed in accordance with the following:

1. Procedure code 09420 52 is not reimbursable if billed in conjunction with a consultation or other hospital calls on the same day.

2. Procedure code 09420 52 is limited to once per trip to the facility regardless of the number of patients examined or treated.

3. For a provider to be reimbursed for an initial hospital call or same day surgery, the hospital record must include, at a minimum:

i. The chief complaint(s);

ii. A complete history of the present illness and related systematic review including recording of pertinent negative findings;

iii. A complete pertinent past medical history;

iv. Pertinent family history;

v. A description of a full examination pertaining to the history of the present condition including the recording of pertinent negative findings, and;

vi. A record of a working diagnosis and treatment plan, and preparation of an "order sheet."

4. If a history and examination required for reimbursement for procedure code 09420 22 is not personally performed by the billing practitioner, the provider should bill for procedure code 09420 52 (hospital call), provided the criteria for that code are met.

5. An initial hospital call or same day surgery call (09420 22) will not be reimbursed for the same beneficiary if the same practitioner, members of a same group, members of a shared health care facility, or practitioner sharing a common record also bill for this procedure code.

6. An initial hospital call or same day surgery call (09420 22) will not be reimbursed in conjunction with a consultation (09310) for same hospital admission and/or stay, if billed by the same practitioner, members of the same group, members of a shared health care facility, or practitioner sharing a common record.

7. In order to bill for a subsequent hospital call (09420), the following may be included in the progress notes:

i. An update of symptoms;

ii. An update of physical findings;

iii. A resume of findings of procedures, if any done;

iv. Laboratory, radiographs, and consultation results, including pertinent positive or negative findings;

v. Changes or confirmations of diagnosis and progress of care;

vi. Any additional planned studies, and reasons why; and/or

vii. Any treatment changes.

New Rule, R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (c)5, substituted "beneficiary" for "recipient".

10:56–2.6 Diagnostic services; general

(a) A complete examination of the oral cavity shall be a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development and recording of a complete treatment plan. It should permit a Dental Consultant (with accompanying radiographs) to determine the appropriateness of the treatment plan.

1. This dental examination is reimbursable only when part of a total treatment plan, unless the examination discloses no need for treatment, in which case this must be indicated by placing the statement "No Other Treatment Necessary (N.O.T.N.)" under Remarks (Item 20) on the Dental Services Claim Form (MC–10).

2. Except as provided in N.J.A.C. 10:78–7.1, for reimbursement purposes, a comprehensive dental examination shall be limited to once every six months for those beneficiaries through age 17 and once every 12 months for those beneficiaries 18 years of age or older except as prior authorized by a Dental Consultant of the Medicaid/NJ Family Care fee-for-service programs.

(b) An emergency oral examination is distinguished from a complete examination of the oral cavity in that it is applicable only for diagnosis and/or observation of a specific complaint in an emergency situation.

(c) The dentist who examines a nursing facility beneficiary shall provide the treatment necessary unless the examination indicates that a specialist is needed.

(d) Handicapping Malocclusion Assessment Examination (refer to N.J.A.C. 10:56–2.15).

1. Since orthodontic treatment will not be authorized for individuals age 21 or older, (see N.J.A.C. 10:56–2.15) the Handicapping Malocclusion Assessment Examination is not reimbursable for individuals age 21 or older.

2. For reimbursement purposes, a Handicapping Malocclusion Assessment Examination is limited to once every 12 months unless authorized. In addition, reimburse-

ment is limited to the provider or provider group who does such an examination with the intention of personally providing any orthodontic treatment necessary.

As amended, R.1982 d.403, effective November 15, 1982. (Operative date: February 1, 1983.)
See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).
Section substantially amended.
As amended, R.1983 d.584, eff. January 1, 1984.
See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Section renumbered and (b)4 new.
Recodified from 10:56–1.14 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (a)2, substituted "Except as provided in N.J.A.C. 10:78–7.1, for" for "For", inserted "/NJ Family Care fee-for-service" preceding "programs", and substituted "beneficiaries" for "recipients"; in (c), substituted "beneficiary" for "recipient".

10:56–2.7 Diagnostic services: radiography

(a) Radiological procedures shall be limited to those normally required to make a diagnosis and must show all areas where treatment is anticipated with the exception of soft tissue lesions.

(b) All radiographs should be examined carefully by the provider to assure quality care and to make certain that all necessary treatment has been diagnosed, planned for and/or completed.

(c) Radiographs may be reviewed by dental consultants of the Medicaid/NJ Family Care fee-for-service programs and/or a dentist in private practice not employed by New Jersey Medicaid/NJ Family Care fee-for-service programs, if appropriate. It is recommended that the two film packet be used or a copy may be made by those dentists who wish to retain a set of radiographs in their office at all times.

(d) The originals of all radiographic films shall be available to authorized representatives of the New Jersey Medicaid/NJ Family Care fee-for-service programs. Radiographs shall be forwarded to the Division of Medical Assistance and Health Services in the following situations:

1. When prior authorization is requested; or

2. Upon request by the Medicaid/NJ Family Care fee-for-service programs for utilization review or adjudication purposes.

(e) All radiographic films shall be suitable for interpretation and when submitted to the New Jersey Medicaid/NJ Family Care fee-for-service programs or their agents shall be properly mounted, marked "Right" and "Left" and identified with the beneficiary's name, the date, and the name of the dentist. Films that are technically unacceptable for proper interpretation will be returned to the provider for replacement at no additional cost to the Medicaid/NJ Family Care fee-for-service programs. No reimbursement shall be made for the new set of radiographs that the dentist is required to provide. When already reimbursed, recoupment will be made, unless a replacement set of radiographs is sent to the Division for review.

(f) Reimbursement for dental radiographs shall be limited according to the following standards:

1. A complete series radiographic study is defined and limited by age. It represents the maximum number of diagnostic radiographs reimbursable as a single radiographic study every three years without prior authorization as follows:

i. Up to and including age six: eight films (six periapical plus two bitewing films);

ii. Age seven, up to and including age 14: 12 films (10 periapical films, plus two bitewing films) or a panorex and two posterior bite wing films;

iii. For those beneficiaries 15 years of age or older: 16 radiographs (at least 14 periapical plus two posterior bitewing films) or a panorex plus four posterior bite wing films;

iv. A complete series radiographic study may include two bitewing or more radiographs. Any additional films over and above that number, as limited by age, are considered to be part of that complete series and no additional reimbursement can be made. If, however, extenuating circumstances exist, the need for additional films in (f)1i through iii above must be substantiated and a specific authorization obtained from the Medicaid dental consultant.

v. The three year limitation in (b)4i(1), (2), and (4) above will continue to apply even though an age change transfers the beneficiary from one age category to another. For example, a beneficiary who has eight radiographs at age six is not eligible for the 12 film series until he or she has reached age nine and three years have passed;

vi. The maximum amount reimbursable for radiographs billed individually or in groups in conjunction with an initial examination, and/or one treatment plan and/or within a six month period is that amount paid for a complete series as outlined in (b)4 above. During any 12 month period subsequent to a complete radiography series study within the three year period, the maximum number of radiographs permitted shall be as follows:

(1) Up to and including age six—four films;

(2) Age seven and up to and including age 14—four films;

(3) Age 15 years of age or older—six films.

vii. If the provider requires additional films, he or she shall first secure prior authorization by the Medicaid/NJ Family Care fee-for-service dental consultant.

(g) In an emergency situation, in order to establish a diagnosis which must be recorded under Remarks (Item 20) of the Dental Services Claim Form (MC–10) a radiograph may be taken at any time, as dentally necessary.

(h) Postoperative radiographs normally taken at the conclusion of dental treatment by a dental provider shall be maintained as part of the beneficiary's dental records (for example, final radiographs at completion of endodontic treatment, or certain surgical procedures).

(i) Radiological services other than those ordinarily provided by a practitioner in his or her own office may be referred to a dental specialist who will provide radiological services limited to his or her own special field. Radiological services may also be requested from a physician who is a specialist in radiology or a qualified hospital facility.

1. Services provided by another dentist, physician, or hospital facility shall be billed directly to the Medicaid/NJ Family Care fee-for-service programs by that provider and not by the referring dentist.

New Rule, R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (e), substituted "their" for "its"; in (f)1, rewrote ii and iii; inserted references to NJ Family Care fee-for-service and substituted references to beneficiaries for references to recipients throughout.

10:56–2.8 Diagnostic services: Clinical laboratory services

(a) "Clinical laboratory services" includes services provided by:

1. Independent clinical laboratories, including physician/dentist operated, out of hospital laboratories which perform primarily diagnostic work referred by other practitioners; and

2. Hospital laboratories and laboratories of educational institutions which provide laboratory services to ambulatory beneficiaries as requested by a licensed practitioner.

(b) Services provided by any of the above laboratories must be billed directly to the Medicaid program by the laboratory, and not by the dentist.

(c) All facilities or entities that perform clinical laboratory testing shall have certification for the services they are performing (see N.J.A.C 10:61). Reimbursement for laboratory testing performed shall not be made to any facility without such CLIA certification. It shall be the initiating entity's responsibility to refer tests to laboratories which are New Jersey Medicaid/NJ Family Care fee-for-service providers and have a valid CLIA identification number.

As amended, R.1982 d.403, effective November 15, 1982. (Operative date: February 1, 1983.)
See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).
Section substantially amended.
As amended, R.1983 d.584, eff. January 1, 1984.
See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Section renumbered and (b)4 new.
Recodified from 10:56–1.14 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (a)2, substituted "beneficiaries" for "recipients"; in (c), inserted "/NJ Family Care fee-for-service" preceding "providers".

10:56–2.9 Preventive dental care

(a) In addition to a dental examination every six months for those beneficiaries through age 17 and once every 12 months for those beneficiaries 18 years of age or older, preventive dental care encompasses the following recommended services:

1. Prophylaxis, as follows:

i. Dental prophylaxis means the complete removal of calculus and stains from the exposed and unexposed areas of the teeth by scaling and polishing.

ii. For reimbursement purposes, dental prophylaxis shall be limited to once every six months for those beneficiaries through age 17 and once every 12 months for those beneficiaries 18 years of age or older, except as otherwise prior authorized by a dental consultant of the Medicaid/NJ Family Care fee-for-service programs, except as provided in (a)1ii(1) below.

(1) Beneficiaries with developmental disabilities, neurological impairments, etc. regardless of age, shall be eligible for examination, radiographs as appropriate, prophylaxis, extra-scaling and topical application of fluoride including prophylaxis, as often as every three months. Claims may be submitted directly to the fiscal agent for payment, without prior authorization. The nature of the beneficiary's disability must be recorded under Remarks (Item 20) on the Dental Services Claim Form. Special procedure codes with the modifier "76" must be submitted for reimbursement, for example, 00110 76 (examination), 01110 76 (prophylaxis-adult), 01120 76 (prophylaxis-child), Y2105 76 (additional scaling) and 01201 76 and 01202 76 (fluoride including prophylaxis). See N.J.A.C. 10:56–3.2(a) and 3.3(a). In the event any of these services is required more often than every three months, prior authorization by the Medicaid/NJ Family Care fee-for-service dental consultant is required.

2. Fluoride Treatment, as follows:

i. Topical fluoride treatment should be administered in accordance with appropriate standards. This consists of topical application of stannous fluoride or acid fluoride phosphate as a liquid or gel.

ii. A complete prophylaxis shall be performed prior to and in conjunction with the topical fluoride treatment.

iii. Reimbursement for topical fluoride treatment shall be limited to once every six months without need for prior authorization for those beneficiaries through

age 17 and once every 12 months for those beneficiaries 18 years of age up to and including 20 years of age.

iv. This is not a covered service for persons 21 years of age and over.

v. Oral fluoride medication may be prescribed (see: N.J.A.C. 10:56–2.17).

vi. Use of a prophylaxis paste containing fluoride shall not be billed as "topical fluoride treatment." For reimbursement purposes, this is considered to be only a prophylaxis.

3. To encourage the maintenance of dental health, the same type of recall procedure as used in dental practice in the community shall be extended to eligible Medicaid/NJ Family Care fee-for-service beneficiaries.

4. Beneficiary education for Medicaid/NJ Family Care fee-for-service beneficiaries should consist of dental health orientation identical to that given all patients.

5. Sealants shall be a covered service of the Medicaid/NJ Family Care fee-for-service programs, subject to the following limitations:

i. Application of sealants shall be limited to a one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars.

ii. Application of sealants shall be limited to beneficiaries up to and including 16 years of age.

iii. Sealants applied, other than as outlined above, are not reimbursable unless authorized by a Medicaid/NJ Family Care dental consultant. A complete explanation of the request must be attached to the prior authorization request.

iv. Since sealants may be reimbursed only once for each tooth, the provider should make certain that sealants have not been applied previously.

As amended, R.1982 d.403, eff. November 16, 1982. (Operative date: February 1, 1983.)
See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).
Section substantially amended.
Amended, R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Old (a)1i deleted and new text substituted.
Recodified from 10:56–1.15 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
Rewrote the section.

10:56–2.10 Restorative services

(a) Restorative treatment shall be limited to those services necessary to adequately restore and maintain the integrity and contours of the natural tooth, as follows:

1. Filling restorations shall be reimbursed as follows:

i. Reimbursement for restorations in primary teeth shall be limited to primary cuspids and molars of children up to and including age nine, or in primary incisors up to and including age five, but not where exfoliation is imminent, except when prior authorization by a Medicaid/NJ Family Care dental consultant has been obtained by the provider.

ii. Silver amalgam and composite restorations may be provided on anterior and posterior teeth (numbers 1 through 16 and 17 through 32). The provider should select the restorative material most appropriate for the beneficiary's dental needs.

iii. Reimbursement for a restoration will include treatment of pulp exposure, lining or base, restoration, polishing of restoration, and local anesthesia.

iv. Plastic, acrylic, or unfilled resin restorative material shall be reimbursable only when utilized for the six anterior teeth in each arch.

v. Silicate restorations shall not be covered by the New Jersey Medicaid/NJ Family Care fee-for-service programs.

vi. A procedure code shall be selected on the basis of the number of surfaces restored per individual tooth (not on the basis of individual restorations); therefore, the fee for any surface shall include one or more restorations on that surface.

vii. Only one code is reimbursable per tooth except when amalgam and composite resin restorations are placed on the same tooth.

viii. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal or lingual surface(s) of the tooth.

ix. Extension of interproximal restorations into self cleansing areas will not be considered as additional surfaces. An additional surface will be reimbursable only when the buccal (facial) or lingual margin extends beyond the proximal one-third of the buccal (facial) and/or lingual surface(s).

2. Crown restorations shall be reimbursed as follows:

i. Prior authorization for crowns shall be granted only when there is substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue justify this treatment. Radiographic studies shall be submitted with the prior authorization request. Prior authorization is not necessary for beneficiaries up to and including age 20. Prior authorization is necessary for beneficiaries age 21 and older.

ii. Generally, temporary (quick cure) acrylic or plastic (prefabricated) crowns shall be reimbursable only for badly broken down anterior teeth up to and including age 15. Likewise, preformed stainless steel crowns shall be reimbursable only for primary teeth and permanent posterior teeth up to and including age 17.

8. Payment for dentures will be denied unless all dental procedures are completed in both arches before impressions are taken.

9. Dentures shall not be prior authorized when:

i. Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remedial because of physiological or psychological reasons; or

ii. Dental history reveals that a denture was provided through any New Jersey State, county, or municipal agency in the seven and one-half year period prior to the date of the current request; or

iii. Repair, relining, or rebasing (jumping) of the beneficiary's present denture will make it serviceable.

(b) Fixed bridges will not normally be prior authorized. If extenuating circumstances exist, any request must be submitted to the Medicaid/NJ Family Care dental consultant accompanied by all supporting documentation. Two examples of extenuating circumstances include:

1. Existing defective fixed bridge; and

2. A patient who is mentally or physically compromised to the extent that a removable prosthesis cannot be tolerated.

(c) Repairs to complete or partial dentures includes adjustments for three months. Prior authorization shall be required when the repair exceeds $165.00 for a specialist or $150.00 for a non-specialist.

(d) Denture relining, rebasing (jumping) or repairing (other than as noted in this section) are reimbursable.

1. Rebasing is the process of refitting a denture by the complete replacement of the denture base material without changing the occlusal relationship of the teeth.

2. Relining is the process of resurfacing the tissue side of a denture with new base material to make it fit more accurately.

3. The fee shall include all necessary adjustments for a six month period following insertion for relining and rebasing and three months for repairs.

4. Adjustments prior to and in conjunction with denture relining, rebasing (jumping) and repair shall not be reimbursable. Adjustments, repairs, relining, and rebasing shall not be reimbursable when new or replacement dentures have been prior authorized.

5. Rebases and relines shall not be reimbursable within 12 months of initial insertion of a denture without prior authorization, and shall thereafter be limited to once every 12 months without prior authorization.

6. The beneficiary's name (first and last names or where space is a factor, first initial and last name) must be processed into all dentures during the original fabrication or where possible during any subsequent processing (repair, reline, rebase, and so forth). The social security number shall also be included if space permits. This requirement is consistent with the "Denture I.D. Law" (N.J.S.A. 45:6–19.1 et seq.).

As amended, R.1984 d.270, eff. July 2, 1984.
See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).
Section substantially amended.
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
(b)9 "Denture" substituted for "Dental".
Recodified from 10:56–1.19 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
In (c), increased the dollar amount of fees for repair of complete or partial dentures.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
Substituted references to beneficiaries for references to recipients throughout; in (b), inserted a reference to NJ Family Care.

10:56–2.14 Exodontia and oral surgery

(a) Exodontia rules are as follows:

1. Extraction of teeth other than those classified as non-restorable shall require prior authorization.

i. Where any extraction is being considered which will necessitate the insertion of a dental prosthesis, prior authorization is required. Reimbursement for such an extraction(s) rendered without prior authorization will be denied, or if already paid, reimbursement will be recovered. Due to the rule limiting the authorization of denture(s) (refer to N.J.A.C. 10:56–2.13) it may be impossible to replace a denture(s) following such extraction(s). Therefore, careful consideration should be given to the condition of teeth prior to a request for dentures initially; and prior to any extraction which would jeopardize an existing denture.

ii. When any extraction is to be performed in conjunction with or during orthodontic treatment, the dentist shall determine:

(1) That such orthodontic treatment has met the Salzmann Handicapping Malocclusion Guidelines established by the New Jersey Medicaid Program or has been prior authorized through the Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services.

(2) That such extraction(s) has the express consent of the practitioner to whom orthodontic treatment has been authorized. Reimbursement will be denied (or if already paid, reimbursement will be recovered) for any extraction(s) performed:

(A) In conjunction with orthodontic care if such orthodontic treatment has not met the New Jersey Medicaid guidelines or has not been prior authorized by the Chief, Bureau of Dental Services; or

(B) On a prior authorized orthodontic case without the consent of the practitioner to whom orthodontic treatment has been authorized, or without the approval of the Chief, Bureau of Dental Services.

2. Reimbursement for dental extraction(s) includes local anesthesia, indicated alveoloplasty and routine postoperative care. Alveoloplasty is reimbursable in conjunction with the extraction of at least three teeth or the roots of at least three teeth in the same quadrant during the same operative session.

3. Alveoloplasty, not related to current dental extraction(s), is reimbursable based on demonstrated dental necessity. Prior authorization shall not be required.

(b) Prior authorization shall not be required for the extraction of impacted teeth for beneficiaries age 18 and older. Extraction of impacted teeth should be undertaken only when conditions arising from such impactions warrant their removal. The extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be accepted for reimbursement.

1. In order to qualify for surgical removal of a tooth with partial or complete bony impaction, the following shall be required:

i. Incision of overlying soft tissue;

ii. Removal of bone; and/or

iii. Sectioning of the tooth.

2. Extractions in more than one quadrant of the mouth must be justified as an emergency procedure.

(c) Oral surgery rules are as follows:

1. Requests for reimbursement or prior authorization of oral surgical procedures, when such authorization is necessary, must include a detailed description giving dates, diagnosis, site, and size of the operative area (number of lesions, and/or number and size of lacerations,). For prior authorization, preoperative and any radiographs taken postoperatively, radiological, operative, and laboratory reports should be submitted directly to the dental consultant with the Dental Services Claim Form (MC–10). The dentist shall also be responsible for making available all other reports, including hospital radiographs upon request.

2. In the event that the oral surgery service to be performed is of an emergency nature and prior authorization is normally required but not feasible, then the Dental Services Claim Form (MC–10A) with all necessary information as mentioned in the above paragraph should be forwarded to the dental consultant for authorization prior to submission for payment.

3. The dentist performing a biopsy will receive reimbursement for the surgical portion only.

i. The laboratory performing the diagnostic service (and not the dentist) shall bill the program directly for their diagnostic services.

ii. There will be reimbursement to the dentist when the biopsy is performed as an independent procedure separate and apart, and on a different date from the excision of the total lesion.

(d) Extractions to be performed for orthodontic purposes only shall be submitted to the Division for prior authorization. Referrals for prior authorization shall be noted in section 14 of the Medicaid/NJ Family Care Dental Services Claim form MC–10.

Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Substantially amended.
Recodified from 10:56–1.20 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (b), substituted "beneficiaries" for "recipients"; added (d).

10:56–2.15 Orthodontic treatment

(a) The procedures in this section shall be followed for orthodontic referral, evaluation, and treatment.

(b) Orthodontic treatment shall be selective and limited to handicapping malocclusions. Cases with 24 or more points on the New Jersey Handicapping Malocclusion Assessment System shall be considered as having a handicapping malocclusion and prior authorization shall not be required.

1. Orthodontic treatment shall not be reimbursed for the following:

i. For cosmetic purposes only;

ii. For individuals age 21 or older; and

iii. Except as specified at (d) below, for individuals with less than 24 points on the New Jersey Handicapping Malocclusion Assessment System (see (c) below).

2. The following factors shall be considered by a dentist before making any referral and also by the practitioner who may render orthodontic treatment before assessing the beneficiary and performing the diagnostic work-up:

i. The assessment system is a modification of the work of Dr. J. A. Salzmann who has consented to allow the New Jersey Medicaid program to modify and utilize it.

ii. The difference from Dr. Salzmann's original work is that the New Jersey Medicaid program does not allow the eight additional points to denote aesthetic handicap for the anterior segment.

iii. Referrals for orthodontics and initiation of orthodontic treatment should be delayed until the beneficiary has all permanent teeth unless prior authorized by a dental consultant of the Bureau of Dental Services.

iv. The beneficiary, together with the parent or guardian, should have the desire and ability to complete an extended treatment plan.

v. The rehabilitative potential of the beneficiary should be considered.

vi. The practitioner should be aware of the following:

(1) The Medicaid/NJ FamilyCare Eligibility Identification card should be examined on the first visit of each month. Make certain that the beneficiary being treated is listed as eligible and that the Medicaid/NJ FamilyCare number has not changed. If possible, a photocopy should be retained as part of the beneficiary's records on a monthly basis.

(c) The New Jersey Medicaid Program Handicapping Malocclusion Assessment System shall be utilized to determine if the case fulfills the requirements for a diagnostic workshop and subsequent orthodontic treatment.

1. A reprint from the American Journal for Orthodontics (10/68) entitled "Handicapping Malocclusion Assessment to Establish Treatment Priority" provides comprehensive instructions for completion of the Handicapping Malocclusion Assessment Record Form (FD–10). A copy of the reprint can be ordered from the Medicaid fiscal agent:

UNISYS
PO Box 4811
Trenton, New Jersey 08650–4811

(d) Procedures to be followed by the practitioner are:

1. The practitioner, considering the factors in this section, shall perform a visual/oral examination of the beneficiary, and complete the Handicapping Malocclusion Assessment Record Form (FD–10) to determine if the severity of the malocclusion will qualify (24 points or more) for diagnostic work-up and initiation of treatment.

2. If the malocclusion does not meet the minimum number of assessment points (24), the practitioner should not proceed with the diagnostic workup since the case does not qualify and reimbursement will be denied.

i. Exception: If the malocclusion does not meet the minimum number of Assessment points (24), but there are other extenuating circumstances that should be considered, the practitioner should proceed with the diagnostic workup; however, the extenuating factors shall be recorded and substantiated and submitted with the diagnostic workup and treatment plan to the Bureau of Dental Services for prior authorization. Examples of possible extenuating circumstances are:

(1) Facial or oral clefts;

(2) Extreme antero-posterior relationships;

(3) Extreme mandibular prognathism;

(4) A deep overbite where incisor teeth contact palatal tissue;

(5) Extreme bi-maxillary protrusion.

ii. For reimbursement of the Handicapping Malocclusion Assessment Examination only, the practitioner shall submit the Dental Services Claim Form (MC–10) directly to the Medicaid fiscal agent:

UNISYS
PO Box 4811
Trenton, New Jersey 08650–4811

identifying, by procedure code Y2975, the service that has been rendered. A copy of the Handicapping Malocclusion Assessment Record Form (FD–10) shall accompany this submission (Limitation—see N.J.A.C. 10:56–2.6).

iii. Submission of requests for treatment with assessments below the minimum number of points required without sufficient justification (see (d)2 above), or due to incorrect calculation, will necessitate denial of reimbursement for the diagnostic materials submitted, or recovery, if payment has already been made.

3. If the malocclusion meets or exceeds the minimum number of assessment points (24), the practitioner may proceed with the diagnostic workup and subsequent orthodontic treatment.

(e) Certain procedures set forth in (d) above require prior authorization. The rules concerning prior authorization for special orthodontic cases are:

1. Upon completion of the diagnostic work-up, submit the following to the Division of Medical Assistance and Health Services, Bureau of Dental Services, PO Box 713, Trenton, New Jersey 08625.

i. The Dental Services Claim Form (MC–10) utilizing the proper code number(s) with requested fees for:

(1) Assessment examination;

(2) Diagnostic aids utilized;

(3) Treatment necessary to carry the case to completion.

ii. A brief description of the proposed plan of treatment on provider's personal letterhead;

iii. A copy of the Handicapping Malocclusion Assessment Record Form (FD–10);

iv. Diagnostic aids shall include and reimbursement will be limited to:

(1) Photographs or slides of the diagnostic models with the correct inter-arch relationship indicated and/or photographs of the beneficiary which demonstrate the malocclusion and/or extenuating circumstance(s). The maximum number of photographs or slides which is reimbursable is eight;

(A) The actual diagnostic models should only be submitted if it is impossible to demonstrate the orthodontic problem and extenuating circumstances by photographs, or if requested;

(2) A cephalometric radiograph with a detailed tracing;

(3) A series of intra-oral radiographs consistent with N.J.A.C. 10:56–2.7 (or a diagnostic panoramic radiograph);

(4) Extra-oral lateral plate radiographs (but not if diagnostic panoramic radiograph has been submitted);

(5) Photographs (minimum size two inches by two inches) or slides—maximum reimbursable—eight.

(6) All the diagnostic aids will be returned to the practitioner, but shall continue to be available upon request of the Division of Medical Assistance and Health Services. It is suggested that models, radiographs, and photographs be duplicated before submission to enable the practitioner to retain a set in the office should there be breakage or loss in mailing.

2. A consultant of the New Jersey Medicaid program will review the plan of requested treatment utilizing the diagnostic aids submitted and render a decision.

3. The practitioner will be notified by the Medicaid program of the action taken on the treatment request following review by the Medicaid dental consultants.

(f) Periodically, the Division of Medical Assistance and Health Services, Bureau of Dental Services, may request a progress report from the provider, and, as necessary, progress photographs and other appropriate records to determine whether authorization should be continued. Failure to respond to this request in writing, personally signed by the provider, may result in suspension of authorization and reimbursement to the provider.

1. Reimbursement for the monthly fee for comprehensive orthodontic treatment shall be based on one or more visits during any calendar month. Reimbursement shall not be requested for any month in which there is no visit.

(g) If the beneficiary's eligibility continues through completion of treatment, final records similar to diagnostic aids described in (e)1iv above, shall be taken at termination of treatment and shall be submitted upon request, to:

Division of Medical Assistance and Health Services
Bureau of Dental Services
PO Box 713
Trenton, New Jersey 08625–0713

(h) An itemized Dental Services Claim Form (MC–10) should be sent to the Medicaid/NJ FamilyCare fee-for-service fiscal agent for reimbursement of the final records immediately upon completion.

(i) Reimbursement for comprehensive orthodontic examinations and/or orthodontic assessment examinations rules shall be as follows:

1. Reimbursement shall be limited to the provider or provider group who does such an examination with the intention of personally providing any orthodontic treatment necessary.

2. Reimbursement shall be limited to once every 12 months, unless prior authorized.

3. Orthodontic examinations shall not be reimbursable for individuals age 21 or older.

(j) All orthodontic cases are subject to Post-Utilization Review by the Division. Therefore, it shall be necessary for all providers to maintain all pre and post-treatment records for at least seven years following completion.

(k) The following orthodontic cases require prior authorization and/or post service, prepayment review by the Division before reimbursement will be remitted to the provider:

1. Orthodontic cases below 24 points on the Salzmann Assessment;

2. All limited orthodontic treatment cases;

3. All transfer orthodontic cases; and

4. All orthodontic cases in which the beneficiary has discontinued treatment for a period of six months or more and then returns for treatment.

As amended, R.1983 d.584, eff. January 1, 1984.
See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).
Deletion of references to orthodontists and replacement by references to general practitioners.
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Note recodified to (e)1iv(6).
Recodified from 10:56–1.21 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.1998 d.353, effective July 20, 1998.
See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).
Updated addresses throughout the section.
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (b)2vi(1), inserted references to NJ FamilyCare; in (e)1iv(1), rewrote the last sentence; rewrote (g) as (g) and (h); recodified former (h) through (j) as (i) through (k); and substituted "beneficiary" for "recipient" and "beneficiary's" for "recipient's", throughout.

10:56–2.16 Pedodontia: pediatric dentistry

(a) In recognition of the unique needs of providing dental care for children, and in conformance with the Federally mandated Early and Periodic Screening, Diagnosis and Treatment program for providing services for children, a special HCPCS code has been defined, "00110 WT," to be used by dental providers when billing for comprehensive clinical oral examinations of children.

(b) On or after January 15, 1995, a dental provider may bill using the HCPCS code for a comprehensive clinical oral examination provided to a child.

1. This may be an initial or periodic examination.

2. For determining when this HCPCS code may be used, a child is defined as a person under the age of 21 years.

(c) The HCPCS code 00110 WT is reimbursed at an enhanced rate of $25.00 for a specialist and $21.00 for a non-specialist. Reimbursement for a comprehensive clinical oral examination of a child, through age 20 years, is limited to once every six months, except as authorized by a Dental Consultant of the New Jersey Medicaid program. As a minimum, the examination must include:

1. Thorough observation of all conditions present in the oral cavity and contiguous structures including an oral cancer screening;

2. Assessment of dental development;

3. Charting of all abnormalities;

4. Development of a complete treatment plan to be recorded in its entirety, including provisions for further treatment and follow-up, by referral if necessary;

5. Anticipatory guidance concerning dental health to the patient or parent/guardian;

6. Assessment of the caries index and nutritional needs relating to oral health and oral hygiene practices; and

7. Assessment of systemic or topical fluoride needs.

New Rule, R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
In (c), increased the dollar amounts for specialist and nonspecialist reimbursement.

10:56–2.17 Adjunctive general services: anesthesia

(a) Anesthesia, intravenous sedation and analgesia rules are as follows:

1. The administration of local anesthesia is considered part of the operative or surgical procedure and no additional fee will be paid.

2. In any setting exclusive of a hospital, when general anesthesia is provided by the dentist, such may be reimbursed subject to the following:

i. Necessity for same is demonstrated.

ii. Reimbursement can only be made to a dentist who satisfies all the established rules and regulations and has such written certification (permit) as may be required by the State of New Jersey or the state in which the service is being rendered.

(1) A valid copy of the general anesthesia permit issued by the New Jersey State Board of Dentistry must be on file with Unisys, the Division's fiscal agent, in order for the Medicaid/NJ KidCare/NJ FamilyCare fee-for-service programs to reimburse a dentist for administering anesthesia. Providers of dental services have 30 days after receiving the original renewal permit issued by the New Jersey State Board of Dentistry, to forward a copy by certified mail—return receipt requested to the following address:

Provider Enrollment Unit
Unisys
PO Box 4804
Trenton, New Jersey 08650–4804

iii. When the dentist performing the dental service (attending dentist) also administers the general anesthesia, then procedure code 09220 only is used and reimbursement will be limited to one general anesthesia charge per visit.

iv. When general anesthesia is administered by a dentist whose sole function is to administer general anesthesia, such service is reimbursable provided:

(1) Anesthetic management is necessary to perform restorative dentistry alone or restorative dentistry in conjunction with other dental services.

(2) Special general anesthesia codes are utilized (see N.J.A.C. 10:56–3).

(3) An anesthesia record is maintained and submitted with the Dental Claim Form (MC–10) for anesthesia and treatment.

(A) The anesthesia record submitted shall show elapsed anesthesia time, pinpoint the time and amounts of drugs administered, pulse rate and character, blood pressure, and respiration.

(B) Elapsed anesthesia time means the time from induction of the general anesthesia to the point in time when the anesthetist is no longer in personal attendance.

3. Reimbursement for the administration of intravenous sedation shall be subject to the following conditions:

i. Such sedation is administered continuously during the operative or surgical procedure.

ii. No reimbursement will be made for injections given as preoperative medication.

iii. The practitioner shall record the need for this service.

iv. The person administering the intravenous sedation is a dentist satisfying all rules and regulations as established and has such written certification (permit) as is required by the State of New Jersey or may be required in the state in which the procedure is being performed.

v. There shall be only one charge for intravenous sedation per visit.

4. An inhalation anesthetic for the purposes of analgesia shall be reimbursable as part of an operative or surgical procedure, subject to the following conditions:

i. Analgesia is administered, as needed, continuously during the operative or surgical procedure.

ii. No reimbursement shall be made for an injection given as pre-operative medication.

iii. The practitioner shall state the need for this service.

iv. The practitioner administering the analgesia is a dentist satisfying all the rules and regulations as established and, when required, has such written certification (permit) as may be required by the State of New Jersey or by the state in which the procedure is being performed.

v. There can be only one charge for analgesia per visit.

(b) Within the scope of accepted dental practice, intradermal, subcutaneous, intramuscular, and intravenous injections shall be reimbursable in the office or home as follows:

1. Reimbursement for the above injections shall be on a flat fee basis and are all inclusive for the cost of the service and the drug.

2. A visit for the sole purpose of an injection shall be reimbursable for the injection only. If other dental procedures are performed that are reimbursable, an injection may, if medically indicated, be reimbursed in addition to the other procedures. The drug administered shall be consistent with the diagnosis and shall conform to accepted medical and pharmacological principles in respect to dosage, frequency, and route of administration.

3. Intravenous injections shall be reimbursable only when performed by the dentist.

4. No reimbursement shall be made for vitamins, liver or iron injections or combinations thereof except in laboratory proven deficiency states requiring parenteral therapy.

5. No reimbursement shall be made for placebos or any injections containing amphetamines or derivatives thereof.

6. No reimbursement shall be made for an injection given as a preoperative medication in conjunction with general anesthesia or as a local anesthetic which is part of an operative or surgical procedure.

7. The appropriate procedure code, name of the drug injected, dosage and route of administration, along with the complete diagnosis for which the injection was given shall be inserted on the Dental Services Claim Form (MC–10) under remarks (Item 20).

(c) Drugs, biologicals, or supplies used, administered or provided by the dentist shall be considered part of the professional service and no additional fee will be authorized.

As amended, R.1972 d.35, eff. February 23, 1972.
See: 3 N.J.R. 154(a), 4 N.J.R. 49(a).
As amended, R.1972 d.164, eff. August 21, 1972.
See: 4 N.J.R. 125(b), 4 N.J.R. 219(a).
As amended, R.1973 d.163, eff. June 20, 1973.
See: 5 N.J.R. 144(d), 5 N.J.R. 228(c).
As amended, R.1973 d.259, eff. October 1, 1973.
See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).
As amended, R.1974 d.53, eff. March 15, 1974.
See: 6 N.J.R. 13(a), 6 N.J.R. 150(b).
As amended, R.1974 d.114, eff. May 15, 1974.
See: 6 N.J.R. 141(b), 6 N.J.R. 246(a).
As amended, R.1975 d.262, eff. September 1, 1975.
See: 7 N.J.R. 318(a), 7 N.J.R. 466(a).
As amended, R.1975 d.339, eff. November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
As amended, R.1976 d.215, eff. July 12, 1976.
See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).
As amended, R.1977 d.302, eff. October 1, 1977.
See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
(a) substantially amended.
Recodified from 10:56–1.22 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Amended by R.2001 d.10, effective January 2, 2001.
See: 32 N.J.R. 3377(a), 33 N.J.R. 65(a).
In (a), added 2ii(1).

10:56–2.18 Adjunctive general services: prescriptions

(a) This section is intended to describe the practitioner's responsibility in the writing of prescriptions in order to maintain the traditional beneficiary-prescriber-provider relationship, and to insure the beneficiary free choice of provider. Practitioners are urged to familiarize themselves with all aspects of this section in order to effect economies consistent with good medical/dental practices and to facilitate prompt payment to the provider.

10:56–2.20 Consultations

(a) Consultations shall be subject to the following conditions:

1. A written report which includes diagnosis and recommendations for future management shall be provided to the referring practitioner. A copy shall be retained with the beneficiary's records and must be available, upon request, to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs or any of their authorized representatives.

i. When the practitioner rendering the consultation services assumes the continuing care of the beneficiary, any subsequent services rendered by him or her will no longer be considered as consultation.

ii. When consultation services are requested, the referring practitioner must include on the clinical records the name of the consulting practitioner to whom the beneficiary is being referred. The consulting practitioner must note the diagnosis under Remarks (Item 20) the name and the Medicaid/NJ FamilyCare Provider Services number of the referring practitioner on the clinical records and on the Dental Services Claim Form (MC–10) under Referring Practitioner (Item 14).

iii. A consultation will be disallowed if either or both diagnosis or referring practitioner is missing. However, an examination may be billed alone or in conjunction with other treatment if the beneficiary makes an appointment on his or her own.

iv. A consultation will be disallowed if performed on the same beneficiary by the same practitioner, members of the same group, members of a shared health care facility, or practitioners sharing a common record within a 12 month span of a prior claim for the same or related disease, illness or condition.

v. A consultation will be declined in any setting, if the consultation occurs between members of the same group, shared health care facility, or practitioners sharing common records.

vi. If a consultation is billed in an inpatient setting and the beneficiary is then transferred to the service of the consultant, the consultation may not bill for a Hospital Day Initial; however, Hospital Day Subsequent—may be billed for visits on ensuing days.

vii. If a consultation is billed in an Emergency Room setting and the beneficiary is then admitted to the consultant's service as a hospital inpatient, the consultant may not bill for a Hospital Day Initial, HCPCS procedure code 09420–22, but future visits of the consultant may be billed as a Hospital Day Subsequent. If the beneficiary is admitted to another practitioner's service, that practitioner may bill for Hospital Day Initial. Future visits of the consultant for that inpatient hospitalization may be billed as a Hospital Day Subsequent—and be considered as concurrent care if concurrent care can be justified as being dentally/medically necessary.

R.1984 d.270, eff. July 2, 1984.
See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).
Recodified from 10:56–1.23 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (a)1, inserted references to NJ FamilyCare and to NJ FamilyCare fee-for-service, neutralized gender references, and substituted references to beneficiaries for references to recipients throughout.

10:56–2.21 Pharmaceutical; program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement shall be denied (except for dentist's prescriptions) if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in the Pharmaceutical Services chapter at N.J.A.C. 10:51–1.11 and 1.12, respectively, incorporated herein by reference;

2. Pharmaceutical services requiring prior authorization (see N.J.A.C. 10:51–1.13, incorporated herein by reference);

3. Quantity of medication (see N.J.A.C. 10:51–1.14, incorporated herein by reference);

4. Dosage and directions (see N.J.A.C. 10:51–1.15, incorporated herein by reference);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51–1.16, incorporated herein by reference);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51–1.17, incorporated herein by reference);

7. Prescription refill (see N.J.A.C. 10:51–1.18, incorporated herein by reference);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E–1 et seq.) (see N.J.A.C. 10:51–1.20, incorporated herein by reference);

i. Products listed in the New Jersey Drug Utilization Review Council (DURC) Formulary, N.J.A.C. 8:71, (hereafter referred to as, "the Formulary"); and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51–1.9, incorporated herein by reference).

9. Federal regulations (42 CFR 447.301, 447.331–447.333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see

N.J.A.C. 10:51–1.5, Basis of payment, incorporated herein by reference);

10. Drug Efficacy Study Implementation (DESI): "less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51–1.20 and listing of DESI drugs in Appendix A of N.J.A.C. 10:51, incorporated herein by reference);

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (see N.J.A.C. 10:51–1.21, incorporated herein by reference);

12. Medical exception process (see N.J.A.C. 10:56–2.22); and

13. Diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid. These services require prior authorization from the Medicaid District Office (MDO). (See Medical Supplier Services chapter, N.J.A.C. 10:59.)

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).
See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

10:56–2.22 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed PDUR standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DHSS, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) The medical exception process (MEP) shall be administered by a contractor, referred to as the MEP contractor, under contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the New Jersey DUR Board which has been approved by the Commissioners of DHS and DHSS, in accordance with the rules of those Departments.

(d) The medical exception process (MEP) is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies, or drug therapies which exceed established PDUR standards, to request written justification to determine medical necessity for continued drug utilization.

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of their review and include at a minimum, the beneficiary's name, mailing address, HSP number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims (see N.J.A.C. 10:49–10, Notices, Appeals and Fair Hearings).

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).
See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:56–3.1 Introduction

(a) The New Jersey Medicaid program utilizes the level 3 HCPCS coding system. This system is patterned after the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The dental HCPCS, although a level 3 state-defined HCPCS, are patterned after some of the Medicare level 2 HCPCS. The allowable assigned codes and modifiers which contain both alphabetic and numeric characters follow the HCPCS rules.

(b) The HCPCS codes listed in this subchapter are divided into 11 sections.

Section 3.2—Diagnostic

Section 3.3—Preventive

Section 3.4—Restorative

Section 3.5—Endodontics

Section 3.6—Periodontics

Section 3.7—Prosthodontics, Removable

Section 3.8—Maxillofacial Prosthetics

Section 3.9—Prosthodontics, Fixed

Section 3.10—Oral Surgery

Section 3.11—Orthodontics

Section 3.12—Adjunctive General Services

(c) The basic categories and their assigned code series are as follows:

	Category of Service	HCPCS Codes
I.	Diagnostic	00100–00999 Y2000–Y2099
II.	Preventive	01000–01999 Y2100–Y2199
III.	Restorative	02000–02999 Y2200–Y2299
IV.	Endodontics	03000–03999 Y2300–Y2399
V.	Periodontics	04000–04999 Y2400–Y2499
VI.	Prosthodontics, Removable	05000–05899 Y2500–Y2599
VII.	Maxillofacial Prosthetics	05900–05999 Y2600–Y2699
VIII.	Prosthodontics, Fixed	06000–06999 Y2700–Y2799
IX.	Oral Surgery	07000–07999 Y2800–Y2899
X.	Orthodontics	08000–08999 Y2900–Y2999
XI.	Adjunctive General Services	09000–09999 Y3000–Y3099

(d) Specific elements of the HCPCS which require the attention of the dental provider are as follows:

1. The lists of HCPCS in the 11 separate sections of this subchapter are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODES", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

Column Title

2. IND — (Indicator) Lists symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used. Explanation of indicators used in this column is given below:

i. An asterisk (*) denotes those procedures which normally require prior authorization in order to be eligible for reimbursement under the New Jersey Medicaid program.

ii. A double asterisk (**) denotes those procedures which may be treated in an emergency situation when prior authorization is not feasible. These procedures must receive authorization prior to payment.

iii. The letter (d) denotes those procedures which require that a diagnosis be entered in the appropriate item on the Dental Services Claim form (MC-10) in order to be eligible for reimbursement.

iv. The cross-hatch (#) denotes those procedures for which special prior authorization requirements exist. Those requirements are listed below the procedure codes involved or in N.J.A.C. 10:56-2.

3. HCPCS Codes — Lists the HCPCS procedure code numbers.

4. MOD — (Modifier) Lists alphabetic or numeric characters. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic or numeric characters at the end of the code. The New Jersey Medicaid/NJ FamilyCare fee-for-service programs' recognized modifier codes are listed with appropriate procedure codes in this subchapter 3. The modifiers "22," "52" and "76" are designated for use in the New Jersey Manual for Dental Services as follows:

i. 22— Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure number. A report may also be appropriate.

(1) This modifier may also be applied when a dental laboratory procedure is used in conjunction with specified chairside procedures or where an adjunctive service is rendered in addition to the basic service.

ii. 52— Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier "52", signifying that the service is reduced.

iii. 76— Repeat Procedure by Same Practitioner: The practitioner may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier "76" to the procedure code of the repeated service.

iv. YL Mandibular—Lower.

v. YU Maxillary—Upper.

(1) When it is necessary for the New Jersey Medicaid/NJ FamilyCare fee-for-service programs to distinguish between services rendered in the mandibular arch as opposed to the maxillary arch and the modifiers "YL" and "YU" have been assigned to make this distinction.

vi. The appropriate quadrant codes shall be entered on the Dental Claim Form, MC-10, for the dental procedures listed below. Acceptable quadrant values are as follows:

UL—Upper Left
UR—Upper Right
LL—Lower Left
LR—Lower Right

The codes requiring the quadrant values are:

04210—Gingivectomy or Gingivoplasty
04220—Gingival Curettage
04260—Osseous Surgery
04341—Periodontal Scaling and Root Planing
04272—Apically repositioning Flap Procedure
07310—Alveoloplasty in Conjunction with Extraction
07320—Alveoloplasty not in Conjunction with Extraction

07340—Vestibuloplasty—Ridge Extension—Secondary Epithelialization
07350—Vestibuloplasty—Ridge Extension
09951 22—Occlusal Adjustment
07470—Removal of Exostosis

5.	Description	Lists the code narrative.
6.	Maximum Fee Allowance	Lists the New Jersey Medicaid/NJ FamilyCare fee-for-service programs' maximum reimbursement schedule for Specialist and Non Specialist.

i. S— Denotes Specialist fee.
ii. NS—Denotes Non-Specialist fee.
iii. BR—Denotes By Report (Individual Consideration of Procedure and Fee).
(1) This means that additional information will be required in order to properly evaluate the service and determine an appropriate fee. A copy of this report must be attached to the Dental Services Claim form (MC-10).

(e) Alphabetic and numeric symbols under "IND" & "MOD" and notes under "DESCRIPTION"

1. These symbols and notes when listed under the "IND", "MOD" and "DESCRIPTION" columns are elements of the HCPCS coding system. They assist the dentist in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

2. These symbols and/or letters and/or notes must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the HCPCS code. THE PROVIDER WILL THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.

3. If there is no identifying symbol or note listed, the HCPCS code narrative prevails.

(f) Listed throughout this subchapter are some general and specific policies of the New Jersey Medicaid/NJ FamilyCare programs relevant to HCPCS. For complete and specific policies in addition to those outlined herein, the practitioner must consult N.J.A.C 10:56–1 and/or 2.

1. When requesting prior authorization or filing a claim, the HCPCS codes, including the referenced modifiers, must be used in conjunction with the narratives in this subchapter.

2. The use of a procedure code will be interpreted by the New Jersey Medicaid/NJ FamilyCare programs as evidence that the dentist personally furnished, as a minimum, the service for which it stands.

3. For purposes of reimbursement, a dentist, dental group, shared health care facility or dentists sharing a common record shall be considered a single provider.

4. When billing, the provider shall enter into the procedure code column (Item 15B) of the Dental Services Claim form (MC–10), a HCPCS code as listed in this subchapter. If an appropriate code cannot be found, the provider shall leave the procedure code column blank and shall submit a narrative description of the service for authorization and fee assignment.

5. Date(s) of service(s) must be indicated on the Dental Services Claim form (MC–10).

6. When submitting a claim, the dentist shall always use her or his usual and customary fee. The fee designated for the HCPCS procedure codes represents the New Jersey Medicaid/NJ FamilyCare fee-for-service programs' maximum reimbursement for the given procedure.

(g) This subsection sets forth an index by dental procedure of codes in this subchapter.

Description	HCPCS Procedure Codes (Dental)
Alveoloplasty	07310–07320
Amalgam Restoration	
Permanent Teeth	02140–02161
Primary Teeth	02110–02131
Analgesia	09230
Anesthesia	
General	09220
Intravenous Sedation	09240
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Tooth, Single 07210
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Administrative Correction to (f)1iv.
See: 22 N.J.R. 1375(a).
Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (d): added new (d)1iv.
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
In (g), deleted references to Denture Identification, Identification and Scaling (Additional to Prophy).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
Rewrote (d)4 and (d)6; in (f), rewrote the introductory paragraph, inserted a reference to NJ FamilyCare in 2, and inserted a reference to NJ FamilyCare fee-for-service in 6.

10:56–3.2 00100–00999 DIAGNOSTIC

(a) Clinical Oral Examination:

Maximum Fee

IND	HCPCS Codes	Mod	Procedure Description	Allowance S	S	NS
	00110		Initial Oral Examination	14.00		13.00

NOTE 1: This is the code to be used for a Comprehensive Clinical Oral Examination of Medicaid/NJ FamilyCare fee-for-service beneficiaries.

NOTE 2: All conditions present in the oral cavity and contiguous structures to include oral cancer screening:

a. Charting of all abnormalities;

b. Development of a complete treatment plan to be recorded in its entirety on the Dental Services Claim form (MC-10).

NOTE 3: for reimbursement of the examination:

a. All items on the Dental Services Claim form (MC-10) must be completed;

b. If No Other Treatment is Necessary, this fact must be noted on the Dental Services Claim Form (MC–10) in the diagnosis box. The abbreviation "NOTN" may be used.

	00110	76	Initial Oral Examination	14.00		13.00

NOTE 1: This code is to be used only if a beneficiary is developmentally disabled or neurologically impaired, in which case an examination may be provided as often as every three months and may be submitted directly to the fiscal agent for payment without prior authorization. The nature of the beneficiary's disability must be recorded under "Remarks" on the Dental Services Claim Form (MC–10).

NOTE 2: In the event an examination is required more often than every three months, prior authorization by a Medicaid dental consultant is required.

	00110	WT	Comprehensive oral examination —child	25.00		21.00

NOTE 1: This code is to be used for comprehensive clinical oral examination of a beneficiary through and including the age of 20.

NOTE 2: This code requires a thorough observation of all conditions present in the oral cavity and contiguous structures to include:

a. An oral cancer screening;

b. Assessment of dental development;

c. Charting of all abnormalities;

d. Development of a complete treatment plan to be recorded in its entirety, including provisions for further treatment and follow-up, by referral if necessary;

e. Anticipatory guidance concerning dental health to the patient or parent/guardian;

f. Assessment of the caries index and nutritional needs relating to oral health and oral hygiene practices;

g. Assessment of systemic or topical fluoride needs.

NOTE 3: For reimbursement of the comprehensive oral examination with code 00110-WT:

a. The examination is limited to once every six months except as authorized by a dental consultant of the New Jersey Medicaid Program;

b. All items on the Dental Services Claim form (MC-10(A)) should be completed;

c. If no other treatment is necessary, this fact must be noted on the Dental Services Claim form (MC-10(A)) in the diagnosis box (20). The abbreviation "NOTN" may be used to indicate no other treatment needed.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00120		Periodic Oral Examination	14.00	13.00

NOTE: An examination performed on a patient of record to determine any changes in the patient's oral health status since a previous initial or periodic examination.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
d	00130		Emergency Oral Examination	4.00	3.00

NOTE: Make NOTE of diagnosis and/or observation(s) on the Dental Services Claim form (MC-10).

(b) Radiographs:

1. Intraoral Radiographs: (Periapicals/Bitewing/Occlusal)

i. Indicate number of films in items 13, 17D, and 17H of the Dental Services Claim form (MC–10);

ii. For a complete series of radiographs, limitations pertaining to age are found in the first note below each code, and the maximum number of radiographs reimbursable as a single radiographic study every three years without prior authorization is found in the second note below each code.

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance $	$ NS
	00210	52	Intraoral—Complete Series (including bitewings)	18.00	18.00

NOTE 1: Limited to patients up to and including age 6.

NOTE 2: 8 films.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00210		Intraoral—Complete Series (including bitewings)	22.00	22.00

NOTE 1: Limited to patients age 7 up to and including age 14.

NOTE 2: 12 films.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
		22	Intraoral—Complete Series (including bitewings)	26.00	26.00

NOTE 1: Limited to patients age 15 or older.

NOTE 2: Minimum of 16 films.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00220		Intraoral—Periapical—First Film	3.75	3.75
	00230		Intraoral—Periapical—Each Additional Film	2.75	2.75

NOTE 1: Indicate complete number of films (00220 Plus 00230) in items 12, 17D and 17H.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00240		Intraoral—Occlusal Film	5.00	5.00

NOTE 1: Per film (maximum—two (2 films).

NOTE 2: Indicate number of films in item 17D and 17H.

2. Extraoral Radiographs

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00250	52	Extraoral, First Film	10.00	10.00

NOTE: Code to be used for lateral, anteroposterior, temporomandibular radiographs, etc. (one view).

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00260		Extraoral—Each Additional Film	5.00	5.00

NOTE 1: Indicate number of views in item 17D and 17H of the Dental Services Claim form (MC-10).

NOTE 2: Maximum reimbursable—2 additional views.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00270		Bitewing—One Film	3.00	3.00
	00272		Bitewings—Two Films	5.00	5.00
	00274		Bitewings—Four Films	9.00	9.00
	00310		Sialography	15.00	15.00
	00310	22	Sialography	30.00	30.00

NOTE: Includes injection of contrast material (filling and/or emptying phases).

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00330		Panoramic Film	15.75	15.75
	00340		Cephalometric Film	15.00	15.00
	00340	22	Cephalometric Film	22.50	22.50

NOTE: Includes tracing.

(c) Test and laboratory examinations:

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00470		Diagnostic Casts	11.50	10.00

NOTE: Casts must have bases and be trimmed to permit articulation, per cast.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
	00471		Diagnostic Photographs	1.00	1.00

NOTE: Or slides, per view.

Ind	HCPCS Codes	Mod	Procedure Description	$	$ NS
d	00501		Histopathologic Examination	10.00	

NOTE 1: The gross and microscopic examination of oral tissues, both hard and soft.

NOTE 2: Limited to specialists in oral pathology, and Oral Diagnosis (Pathology) Department of dental schools.

d*	00999		Unspecified Diagnostic Procedure, By Report	BR	BR

NOTE: Complete description of procedure and the reason the procedure was performed.

Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Rewrote (a) and (b).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (a) NOTE 1, substituted "NJ FamilyCare" for "NJ KidCare"; in (a)b NOTE 1, substituted "beneficiary" for "recipient" and "beneficiary's" for "recipient's".

10:56–3.3 01000–01999 PREVENTIVE

(a) Dental prophylaxis:

IND	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance S $	NS
	00110		Prophylaxis—Adult	17.00	16.00

NOTE: Patients 16 years of age or older, maxillary and mandibular arches; includes additional scaling.

	00110	52	Prophylaxis—Adult	8.50	8.00

NOTE 1: Patients 16 years of age or older, maxillary or mandibular arch; includes additional scaling.

NOTE 2: Code to be used if patient is edentulous in one arch.

	01120		Prophylaxis—Child	14.00	13.00

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches; includes additional scaling.

1. The following codes should be used when a beneficiary is developmentally disabled or neurologically impaired. (See N.J.A.C. 10:56–2.9(a)1ii.)

	01110	76	Prophylaxis—Adult	17.00	16.00

NOTE: Patients 16 years of age or older, maxillary or mandibular arches.

	01120	76	Prophylaxis—Child	14.00	13.00

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

	y2105	76	Additional Scaling	16.00	15.00

(b) Topical fluoride treatment (office procedure):

1. Topical application of stannous fluoride or acid fluoride phosphate—one treatment following a complete prophylaxis (fee includes both services).

	01201		Topical Application of Fluoride (Including Prophylaxis)—Child	24.00	22.00

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

	01202		Topical Application of Fluoride (Including Prophylaxis)—Adult	27.00	25.00

NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.

	01202	52	Topical Application of Fluoride (Including Prophylaxis)—Adult	13.50	12.50

NOTE: Patients age 16 up to and including 20 years of age, maxillary or mandibular arch Code to be used if patient is edentulous in 1 arch.

2. The following codes should be used when a beneficiary is developmentally disabled or neurologically impaired (see N.J.A.C. 10:56–2.9(a)1ii) when the topical application of fluoride in conjunction with a complete prophylaxis (code includes both services) is necessary.

	01201	76	Topical Application of Fluoride (Including Prophylaxis)—Child	24.00	22.00

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

	01202	76	Topical Application of Fluoride (Including Prophylaxis)—Adult	27.00	25.00

NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.

(c) Other Preventive Services:

	01351		Sealant—Per Tooth	10.00	9.00

(d) Space Maintenance (passive appliances):

	01510		Space Maintainer—Fixed—Unilateral	85.00	80.00

NOTE: Utilizing band(s) or stainless steel crowning.

	01515		Space Maintainer—Fixed—Bilateral	123.00	115.00

NOTE: Lingual or palatal arch utilizing bands or stainless steel crowning.

	01525		Space Maintainer—Removable—Bilateral	69.00	60.00
	01550		Recementation of Space Maintainer	7.00	6.00
*	Y2125		Unspecified Preventive Procedure, By Report	BR	BR

NOTE: The complete description of procedure(s) and the reason(s) the procedure was performed must be included in the report.

Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (a)2: added text regarding recipients up to and including 17 years of age. Deleting text regarding patients 16 years of age or older and

increasing "Additional Scaling" fees. In "01202 52" changed "and" to "or" regarding mandibular arch.
In (c): Revised text in Note 1 and added new Note 2, recodifying Notes 2–3 as 3–4.
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Rewrote the section.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (a)1, substituted "beneficiary" for "recipient" and increased the Maximum Fee Allowances for Adult and Child Prophylaxis; in (b)2, substituted "beneficiary" for "recipient".

10:56–3.4 02000–02999 RESTORATIVE

(a) Amalgam restorations (including polishing):

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance S	$	NS
	02110		Amalgam—One Surface, Primary	32.00		30.00
	02120		Amalgam—Two Surfaces, Primary	38.00		35.50
	02130		Amalgam—Three Surfaces, Primary	44.00		41.00
	02131		Amalgam—Four or more Surfaces, Primary	51.00		46.50
	02140		Amalgam—One Surface, Permanent	32.00		30.00
	02150		Amalgam—Two Surfaces, Permanent	38.00		35.50
	02160		Amalgam—Three Surfaces, Permanent	44.00		41.00
	02161		Amalgam—Four or More Surfaces, Permanent	51.00		46.50

(b) Filled or Unfilled Resin Restorations:

1. Proximal restorations in anterior teeth are normally considered to be single surface restorations. When access to a proximal cavity is gained by involvement of a second surface, reimbursement will be permitted for only one surface. A two or three surface proximal restoration will be reimbursed only when the facial and/or lingual margin(s) of the restoration extends beyond the proximal one-third of the facial and/or lingual surface(s).

2. Reimbursement will include acid etch where appropriate.

Code	Procedure Description	S	NS
02330	Resin—One Surface	35.50	33.00
02331	Resin—Two Surfaces	42.50	39.00
02332	Resin—Three Surfaces	49.50	45.00
02335	Resin—Four or More Surfaces or Involving Incisal Angle	59.50	54.00

For permanent teeth only:—

Code	Procedure Description	S	NS
02385	Resin—one surface, posterior permanent	32.00	30.00
02386	Resin—two surfaces, posterior permanent	38.00	35.50
02387	Resin—three surfaces, posterior permanent	44.00	41.00

NOTE: Code to be used for three or more surfaces.

(c) Gold Foil Restorations:

1. Primarily for use in Dental Colleges.

Code	Procedure Description	S	NS
02410	Gold Foil—One Surface	9.00	8.00
02420	Gold Foil—Two Surfaces	18.00	16.00
02430	Gold Foil—Three Surfaces	27.00	24.00

NOTE: Code to be used for three or more surfaces.

(d) Inlay Restorations:

1. Primarily for use in dental colleges.

Code	Procedure Description	S	NS
02510	Inlay—Metallic—One Surface	31.00	27.00
02520	Inlay—Metallic—Two Surfaces	56.00	49.00
02530	Inlay—Metallic—Three Surfaces	75.00	65.00

NOTE: Code to be used for three or more surfaces.

Code	Procedure Description	S	NS
02540	Onlay—Metallic—Per Tooth (In Addition to Inlay)	23.00	20.00

(e) Crowns—single restoration only:

1. There is only one fee for each type of crown Use the type of alloy most appropriate for the patient's needs.

2. The Noble Metal Classification System has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of noble metal content.

Classification	High Noble Alloy	Noble Alloy	Predominantly Base Alloy
Weight %	Au., Pd. and/or Pt. > 60% (with at least 40% Au)	Au., Pd. and/or Pt. > 25%	Au., Pd. and/or Pt. < 25%

3. Prior authorization is not required for the codes listed below with the crosshatch (#) indicator when the beneficiary is 20 years of age or younger.

Ind	Code	Procedure Description	S	NS
#	02710	Crown—Resin (Laboratory) NOTE: Laboratory processed.	98.00	85.00
#	02720	Crown—Resin with High Noble Metal NOTE: Acrylic veneer.	161.00	140.00
#	02721	Crown—Resin with Predominantly Base Metal NOTE: Acrylic veneer.	161.00	140.00
#	02722	Crown—Resin with Noble Metal NOTE: Acrylic veneer.	161.00	140.00
#	02750	Crown—Porcelain Fused to High Noble Metal	279.00	253.00
#	02751	Crown—Porcelain Fused to Predominantly Base Metal	279.00	253.00
#	02752	Crown—Porcelain Fused to Noble Metal	279.00	253.00
#	02790	Crown—Full Cast High Noble Metal	161.00	140.00
#	02791	Crown—Full Cast Predominantly Base Metal	161.00	140.00
#	02792	Crown—Full Cast Noble Metal	161.00	140.00

(f) Other restorative services:

Code	Procedure Description	S	NS
02910	Recement Inlay	7.00	6.00
02920	Recement Crown	7.00	6.00
02930	Prefabricated Stainless Steel Crown—Primary Tooth	76.00	70.00

NOTE: Reimbursable only for deciduous teeth.

EXCEPTION: Prior authorization by a Division dental consultant.

	02931	Prefabricated Stainless Steel Crown—Permanent Tooth	76.00	70.00

NOTE: Reimbursable only for permanent posterior teeth up to and including 17 years of age.

EXCEPTION: Prior authorized by a Division dental consultant.

	02932	Prefabricated Resin Crown		

NOTE: e.g., Polycarbonate—Reimbursable only for primary and permanent anterior teeth up to and including 15 years of age.

EXCEPTION: Authorization by a Division dental consultant.

#	02950	Crown Buildup Including Any Pins	49.00	45.00

NOTE 1: And/or post.

NOTE 2: Core of composite or amalgam.

	02951	Pin Retention—Per Tooth, In Addition to Restoration	6.00	5.00

NOTE 1: Per pin.

NOTE 2: Maximum reimbursable—three pins.

NOTE 3: Not in conjunction with Procedure Code 03950 and 03950-22.

#	02952	Cast Post and Core In Addition to Crown	75.00	68.00

NOTE 1: Post and core fabricated (cast) and cemented as a separate unit from crown.

NOTE 2: Preparatory to crown restoration only.

NOTE 3: Not in conjunction with Procedure Code 03950 and 03950-22.

#	02954	Prefabricated Post and Core In Addition to Crown	49.00	45.00

NOTE 1: Preparatory to crown restoration only.

NOTE 2: Not in conjunction with Procedure Code 03950 and 03950-22.

	02970	Temporary (Fractured Tooth)	29.00	25.00

NOTE: Temporary crown—not reimbursable in conjunction with any other restorative procedure on same tooth.

*	02980	Crown Repair, By Report	BR	BR
*	02999	Unspecified Restorative Procedure, By Report	BR	BR

Public notice: Pursuant to N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowances increased in (b) and (d)8, effective August 1, 1988.
See: 20 N.J.R. 2101(a).
Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (h): added "02980——Crown Repair".
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Changed Maximum Fee Allowances thoughout.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (e)3, substituted "beneficiary" for "recipient".
Administrative correction.
See: 34 N.J.R. 4204(a).

10:56-3.5 03000-03999 ENDODONTICS

(a) Therapeutic pulpotomy:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance S	S	NS
	03220		Therapeutic Pulpotomy (Excluding Final Restoration)	28.00		26.00

(b) Pulpectomy:

	Y2310		Pulpectomy (Excluding Final Restoration)	17.00		15.00

(c) Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care):

1. For emergency endodontic procedures, use code 03220.

2. Prior authorization is not required for the codes listed below with the crosshatch (#) indicator when the beneficiary is 20 years of age or younger. Check beneficiary's age carefully.

#	03310		One Canal (Excluding Final Restoration)	148.00		135.00

NOTE: Code to be used for incisors and cuspids (permanent).

#	03320		Two Canals (Excluding Final Restoration)	190.00		173.00

NOTE: Code to be used for premolars and all primary teeth without permanent successors.

#	03330		Three Canals (Excluding Final Restoration)	247.00		225.00

NOTE: Code to be used for molars (permanent).

	03350		Apexification (Per Treatment Visit)	31.00		27.00

NOTE 1: Treatment may extend over a period of 6 to 18 months.

NOTE 2: Maximum—two (2) visits.

Exception: Prior authorization by a Medicaid dental consultant.

(d) Periapical Services:

1. When more than one apical curettage and/or apicoectomy and/or other apical surgery is performed through the same operative site, the maximum amount reimbursable by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs shall be the amount specified in this schedule with the greater allowance, plus one-half of the amounts specified for each of the other procedures.

	03410		Apiocctomy (Per Tooth)—First Root	79.00	72.00

NOTE: Maximum—two additional roots

(e) Apicoectomy performed in conjunction with endodontic procedure:

1. Single stage nerve extirpation and canal filling. Services provided at same visit.

d*	03410	22	Apicoectomy/Endodontic Procedure (Per Tooth)—First Root	135.50	122.50
d*	03411	22	Apicoectomy/Endodontic Procedure (Per Tooth)—Each Additional Root	44.00	36.00

NOTE: Maximum—two additional roots. Must be billed in conjunction with Code 03410 22.

	03430		Retrograde Filling—Per Root	9.00	7.50

NOTE 1: Reimbursable only in addition to apicoectomy.

NOTE 2: Maximum per tooth—three roots.

	03440		Apical Curettage	49.00	42.00

NOTE: Per tooth.

	03450		Root Amputation—Per Root	55.00	48.00

NOTE 1: Surgical resection of entire root(s).

NOTE 2: Per tooth.

(f) Other endodontic procedures:

	03920		Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	55.00	48.00
	03950		Canal Preparation and Fitting of Preformed Dowel or Post	16.00	14.00

NOTE: Without cementation.

	03950	22	Canal Preparation and Fitting of Preformed Dowel or Post	23.00	20.00

NOTE 1: Can be used when the final restoration is an amalgam or composite resin.

NOTE 2: With cementation.

	03960		Bleaching Discolored Tooth	11.00	10.00

NOTE 1: Limited to non-vital teeth.

NOTE 2: Per visit.

NOTE 3: Reimbursement limited to two visits without prior authorization.

d*	03999		Unspecified Endodontic Procedure, By Report	BR	BR

Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Changed Maximum Fee Allowances throughout; and in (d), inserted a reference to NJ KidCare fee-for-services programs.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (c)2, substituted references to beneficiaries for references to recipients; in (d)1, substituted "NJ FamilyCare" for "NJ KidCare.

10:56-3.6 04000-04999 PERIODONTICS

(a) Surgical services (including usual post-operative services):

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance $	NS
*	04210		Gingivectomy or Gingivoplasty—Per Quadrant	43.60	37.50
	04211		Gingivectomy or Gingivoplasty—Per Tooth	6.00	5.50

NOTE: Maximum number of teeth reimbursable—Three

*	04220		Gingival Curettage, By Report	22.60	19.50

NOTE: Per Quadrant.

*	04260		Osseous Surgery (Including Flap Entry and Closure) Per Quadrant	75.00	64.50
*	04261		Osscous Graft—Single Site (Including Flap Entry, Closure, and Donor Sites)	BR	BR
*	04262		Osseous Graft—Multiple Sites (Including Flap Entry, Closure, and Donor Sites)	BR	BR
*	04270		Pedicle Soft Tissue Graft Procedure	32.00	28.00

NOTE: Per site.

*	04271		Free Soft Tissue Graft Procedure (Including Donor Site)	49.00	42.00

NOTE: Per site.

*	04272		Apically Repositioning Flap Procedure	36.00	31.50

NOTE: Per quadrant.

(b) Adjunctive periodontal services:

	04320		Provisional Splinting—Intracoronal	18.00	16.00

NOTE: Per tooth.

	04321	Provisional Splinting—Extracoronal	11.00	10.00

NOTE 1: Per tooth.

NOTE 2: This code may also be used for stabilization of traumatized teeth.

*	04341	Periodontal Scaling and Root Planing—Per Quadrant	37.50	34.50
*	04999	Unspecified Periodontal Service, By Report	BR	BR

Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
In (b), changed Maximum Fee Allowances for Peridontal Scaling and Root Planing—Per Quadrant.

10:56–3.7 05000–05899 PROSTHODONTICS (REMOVABLE)

(a) Complete dentures (including routine post delivery care and placement of I D included in fee):

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance S	S	NS
*	05110		Complete Upper	334.00		302.00

NOTE: Maxillary.

*	05120		Complete Lower	342.00		311.00

NOTE: Mandibular.

(b) Immediate complete dentures (including six months post delivery care and placement of I D is included in fee):

1. Reimbursement also includes necessary rebases and/or relines for the six months following insertion.

2. In order to qualify for immediate denture reimbursement, the denture must involve the immediate replacement of anterior teeth which may include first premolars (teeth nos. 5 through 12 and 21 through 28 only). Second premolars and molars must not be included among the qualifying teeth. The date of insertion of a denture and the extractions must carry an identical date of service. List tooth code(s) of teeth involved.

*	05130		Immediate Upper	365.00	332.00

NOTE 1: Maxillary.

NOTE 2: 1 through 4 teeth.

*	05130	22	Immediate Upper	392.00	353.00

NOTE 1: Maxillary.

NOTE 2: 5 through 8 teeth.

*	05140		Immediate Lower	372.00	338.00

NOTE 1: Mandibular.

NOTE 2: 1 through 4 teeth.

*	05140	22	Immediate Lower	400.00	363.00

NOTE 1: Mandibular.

NOTE 2: 5 through 8 teeth.

(c) Partial dentures (including routine post delivery care):

*	05211		Upper Partial—Acrylic Base—(Including Any Conventional Clasps and Rests)	275.00	250.00

NOTE: Includes a minimum of two cast chrome clasps with rests.

*	05211	52	Upper Partial—Acrylic Base—Without Clasps (Flipper)	186.00	173.00
*	05212		Lower Partial—Acrylic Base—(Including Any Conventional Clasps and Rests)	275.00	250.00

NOTE: Includes a minimum of two cast chrome clasps with rests.

*	05212	52	Lower Partial—Acrylic Base—Without Clasps (Flipper)	186.00	173.00
*	05213		Upper Partial—Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests)	361.00	328.00

NOTE: Includes a minimum of two cast chrome clasps with rests.

*	05214		Lower Partial—Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests)	342.00	311.00

NOTE: Includes a minimum of two cast chrome clasps with rests.

(d) Immediate replacement of anterior teeth in conjunction with partial dentures (codes 05211 through 05214 only) in addition to denture, maximum six teeth (Teeth #s 6 through 11 and 22 through 27 only).

1. Immediate partial dentures—Reimbursement also includes necessary rebases and/or relines for the six months following insertion.

*	Y2505		Immediate Replacement of Anterior Teeth—Per Tooth	11.00	10.00

NOTE: List tooth code(s) of tooth being replaced.

(e) Adjustments to dentures—other than dentist providing denture or after the required period of post delivery care

05410		Adjust Complete Denture—Upper	10.00	9.00
05411		Adjust Complete Denture—Lower	10.00	9.00
05421		Adjust Partial Denture—Upper	10.00	9.00
05422		Adjust Partial Denture—Lower	10.00	9.00

(f) Repairs to complete dentures:

1. Repair Broken Complete Denture Base:

i. Includes replacing teeth on denture.

05510	YU	Repair Broken Complete Denture Base	49.50	45.00

NOTE: Maxillary—Upper.

05510	YL	Repair Broken Complete Denture Base	49.50	45.00

NOTE: Mandibular—Lower.

05520		Replace Missing or Broken Teeth—Complete Denture (Each Tooth)	15.00	15.00

NOTE 1: Code may be used in addition to codes 05510YU or YL above.

NOTE 2: List tooth codes of teeth being replaced.

(g) Repairs to partial denture:

05610	YU	Repair Acrylic Saddle or Base	49.50	45.00

NOTE: Maxillary.

05610	YL	Repair Acrylic Saddle or Base	49.50	45.00

NOTE: Mandibular.

05620		Repair Cast Framework	33.00	30.00

NOTE 1: Welding in addition to repair procedure(s), limit two (2) welds per denture.

NOTE 2: May be used in conjunction with other repair procedures or as a separate repair procedure.

05630	YU	Repair or Replace Broken Clasp	76.50	72.00

NOTE 1: Maxillary.

NOTE 2: For additional clasp(s) in same quadrant, use code Y2510.

05630	YL	Repair or Replace Broken Clasp	76.50	72.00

NOTE 1: Mandibular.

NOTE 2: For additional clasp(s) in same quadrant, use code Y2510.

05640		Repair Broken Teeth—Per Tooth	15.00	15.00

NOTE: Code 05640 may be used in addition to partial denture repair procedure(s), 05610 YU or YL above.

05650		Add Tooth to Existing Partial Denture	66.00	60.00

NOTE 1: To replace extracted tooth (List tooth code being replaced).

NOTE 2: For additional replacements beyond the first tooth use code 05640. List tooth (teeth) being replaced.

05660	YU	Add Clasp to Existing Partial Denture	76.50	72.00

NOTE 1: Maxillary—First Clasp.

NOTE 2: List tooth being clasped.

NOTE 3: For additional clasp(s) in same quadrant, use code Y2510.

05660	YL	Add Clasp to Existing Partial Denture	76.50	72.00

NOTE 1: Mandibular—First Clasp.

NOTE 2: List tooth code being clasped.

NOTE 3: For additional clasp(s) in same quadrant, use code Y2510.

Y2510		Each additional Clasp—For Repair	30.00	27.00

NOTE 1: List code of tooth being clasped.

NOTE 2: Code Y2510 may be used in addition to repair procedure(s).

(h) Denture rebase procedures:

05710	Rebase Complete Upper Denture	132.00	120.00
05711	Rebase Complete Lower Denture	132.00	120.00
05720	Rebase Upper Partial Denture	124.00	113.00
05721	Rebase Lower Partial Denture	124.00	113.00

(i) Denture relining procedures:

05730	Reline Upper Complete Denture (Chairside)	29.00	26.00
05731	Reline Lower Complete Denture (Chairside)	29.00	26.00
05740	Reline Upper Partial Denture (Chairside)	29.00	26.00
05741	Reline Lower Partial Denture (Chairside)	29.00	26.00
05750	Reline Upper Complete Denture (Laboratory)	99.00	90.00
05751	Reline Lower Complete Denture (Laboratory)	99.00	90.00
05760	Reline Upper Partial Denture (Laboratory)	91.00	83.00
05761	Reline Lower Partial Denture (Laboratory)	91.00	83.00

(j) Other removable prosthetic services:

*	05899	Unspecified Removable Prosthodontic Procedure, By Report	BR	BR

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowances increased at (i), (j) and (k) effective October 1, 1988, January 1, 1989 and April 1, 1989.
See: 20 N.J.R. 2101(a).
Administrative Correction: In (k) 05212 effective April 1, 1989 corrected 140.00 to 165.00.
As amended by R.1989 d.135.
See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).
(k)1 deleted and NOTE changed to "a minimum of 2 cast chrome casts with rests".
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Changed Maximum Fee Allowances throughout.

10:56-3.8 05900-05999 MAXILLOFACIAL PROSTHETICS

(a) Treatment prostheses:

	05982	Surgical Stent	50.00	43.00
*	05999	Unspecified Maxillofacial Prosthesis By Report	BR	BR

Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

10:56-3.9 06000-06999 PROSTHODONTICS, FIXED

(a) Each abutment and each pontic constitutes a unit in a bridge.

1. The Noble Metal Classification System has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of noble metal content.

Classification	High Noble Alloy	Noble Alloy	Predominantly Base Alloy
Weight %	Au., Pd. and/or Pt. > 60% (with at least 40% Au)	Au., Pd. and/or Pt. > 25%	Au., Pd. and/or Pt. < 25%

2. There is only one fee for each type of pontic or crown. Use the type of alloy most appropriate for the patient's needs.

(b) Bridge pontics:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance S $	NS
*	06210		Pontic—Cast High Noble Metal	76.00	66.00
*	06211		Pontic—Cast Predominantly Base Metal	76.00	66.00
*	06212		Pontic—Cast Noble Metal	76.00	66.00
*	06240		Pontic—Porcelain Fused to High Noble Metal	170.00	165.00
*	06241		Pontic—Porcelain Fused to Predominantly Base Metal	170.00	165.00
*	06242		Pontic—Porcelain Fused to Noble Metal	170.00	165.00
*	06250		Pontic—Resin with High Noble Metal	90.00	80.00
*	06251		Pontic—Resin with Predominantly Base Metal	90.00	80.00
*	06252		Pontic—Resin with Noble Metal	90.00	80.00

(c) Bridge retainers—crowns:

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
*	06720		Crown—Resin with High Noble Metal	161.00	140.00
*	06721		Crown—Resin with Predominantly Base Metal	161.00	140.00
*	06722		Crown—Resin with Noble Metal	161.00	140.00
	06750		Crown—Porcelain Fused to High Noble Metal	279.00	253.00
*	06751		Crown—Porcelain Fused to Predominantly Base Metal	279.00	253.00
*	06752		Crown—Porcelain Fused to Noble Metal	279.00	253.00
*	06790		Crown—Full Cast High Noble Metal	161.00	140.00
*	06791		Crown—Full Cast Predominantly Base Metal	161.00	140.00
*	06792		Crown—Full Cast Noble Metal	161.00	140.00

(d) Other fixed prosthetic services:

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
	06930		Recement Bridge	8.00	7.00

NOTE 1: One abutment.

NOTE 2: Code may be used when recementing facing.

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
	06930	22	Recement Bridge	14.00	12.00

NOTE: Two or more abutments.

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
*	06970		Cast Post and Core in Addition to Bridge Retainer	75.00	68.00

NOTE: Post and core fabricated (cast) and cemented as a separate unit from crown.

Not in conjunction with Procedure Codes 03950 and 03950-22

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
*	06972		Prefabricated Post and Core in Addition to Bridge Retainer	49.00	45.00

Not in conjunction with Procedure Codes 03950 and 03950-22

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
*	06980		Bridge Repair, By Report	BR	BR
*	06999		Unspecified Fixed Prosthodontic Procedure, By Report	BR	BR

Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Changed Maximum Fee Allowances throughout.

10:56-3.10 07000-07999 ORAL SURGERY

(a) Extractions—includes local anesthesia and routine post-operative care:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance S $	NS
	07110		Single Tooth	32.00	30.00
	07130		Root Removal—Exposed Roots	15.00	13.00

NOTE 1: Per tooth.

NOTE 2: Root partially imbedded in bone.

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
	07130	52	Root Removal—Exposed Roots	19.50	18.00

NOTE 1: Per tooth.

NOTE 2: Root completely located in soft tissue.

(b) Surgical extractions—includes local anesthesia and routine post-operative care:

1. Prior authorization for the removal of impacted teeth is necessary for those beneficiaries up to and including 17 years of age as denoted by those codes with the "#" (cross-hatch) indicator.

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
	07210		Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of tooth	33.00	31.00
#	07220		Removal of Impacted Tooth—Soft Tissue	43.00	40.00
#	07230		Removal of Impacted Tooth—Partially Bony	114.00	106.00
#	07240		Removal of Impacted Tooth—Completely Bony	114.00	106.00
#	07250		Surgical Removal of Residual Roots (Cutting Procedure)	43.00	39.00

NOTE: Completely covered by bone.

(c) Other surgical procedures:

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
	07260		Oroantral Fistula Closure	108.00	99.00

NOTE: Code may also be used for antral root recovery.

Ind	HCPCS Codes	Mod	Procedure Description	S	NS
	07270		Tooth Re-implantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth and/or Alveolus	93.00	85.00
	07270	22	Tooth Re-implantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth and/or Alveolus	118.00	107.00

NOTE: Includes single stage nerve extirpation and canal filling.

	07280	Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reason (Including Orthodontic Attachments)	101.00	94.00
	07281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	45.00	41.00
d	07285	Biopsy of Oral Tissue—Hard	30.00	26.00

NOTE: Independent procedure (laboratory must bill separately).

d	07286	Biopsy of Oral Tissue—Soft	18.00	16.00

NOTE: Independent procedure (laboratory must bill separately).

(d) Alveoloplasty—surgical preparation of ridge for dentures:

1. Reimbursement will be based upon quadrants.

07310	Alveoloplasty in Conjunction with Extraction—Per Quadrant	62.50	56.50

NOTE 1: In conjunction with extractions of at least three teeth or the roots of at least three teeth in the same quadrant.

NOTE 2: Specify quadrant.

07320	Alveoloplasty Not in Conjunction with Extraction—Per Quadrant	62.50	56.50

(e) Vestibuloplasty—including revision of soft tissues on ridges, muscle reattachment, tongue, palate, and other oral soft tissues (complete description including size and position must be submitted). Reimbursement will be based upon quadrants.

07340	Vestibuloplasty—Ridge Extension (Secondary Epithelialization)	65.00	59.00

NOTE: Including management of hypertrophied and hyperplastic tissue, Per Quadrant.

07350	Vestibuloplasty—Ridge Extension (Including Soft Tissue Grafts, Muscle Re-attachments, Revision of Soft Tissue Attachment, and Management of Hypertrophied and Hyperplastic Tissue)	169.00	153.00

NOTE: Per Quadrant.

(f) Surgical excision of reactive inflammatory lesions (scar tissue or localized congenital lesions):

NOTE: Biopsy report must be available upon request for review by the Division's dental consultants.

1. Includes lesions of skin, subcutaneous or mucous membranes, pyogenic granulomata and opercula.

07410	Radical Excision—Lesion Diameter Up to 1.25 cm.	30.00	26.00
07420	Radical Excision—Lesion Diameter Over 1.25 cm.	42.00	37.00

NOTE: Up to and including 3 cm.

07420	22	Radical Excision—Lesion Diameter Over 3 cm.	100.00	86.00

(g) Removal of tumors, cysts, and neoplasms:

1. In the excision and management of this type of lesion a biopsy report must be available for review by the Medicaid/NJ FamilyCare dental consultants.

07430	Excision of Benign Tumor—Lesion Diameter Up To 1.25 cm.	30.00	26.00
07431	Excision of Benign Tumor—Lesion Diameter Over 1.25 cm.	42.00	37.00

NOTE: Up to and including 3 cm.

07431	22	Excision of Benign Tumor—Lesion Diameter Over 3 cm.	100.00	86.00
07440		Excision of Malignant Tumor—Lesion Diameter Up To 1.25 cm.	100.00	86.00
07441		Excision of Malignant Tumor—Lesion Diameter Over 1.25 cm.	274.00	256.00

NOTE: Up to and including 3 cm.

07441	22	Excision of Malignant Tumor—Lesion Diameter Over 3 cm.	473.00	413.00
07450		Removal of Odontogenic Cyst or Tumor—Lesion Diameter Up to 1.25 cm.	50.00	43.00
07451		Removal of Odontogenic Cyst or Tumor—Lesion Diameter Over 1.25 cm.	100.00	87.00

NOTE: Up to and including 3 cm.

07451	22	Removal of Odontogenic Cyst or Tumor—Lesion Diameter Over 3 cm.	150.00	130.00
07460		Removal of Non-Odontogenic Cyst or Tumor—Lesion Diameter Up To 1.25 cm.	50.00	43.00
07461		Removal of Non-Odontogenic Cyst or Tumor—Lesion Diameter Over 1.25 cm.	100.00	87.00

NOTE: Up to and including 3 cm.

07461	22	Removal of Non-Odontogenic Cyst or Tumor—Lesion Diameter Over 3 cm.	150.00	130.00
07465		Destruction of Lesion(s) by Physical Methods: Electrosurgery, Chemotherapy, Cryotherapy or Laser	18.00	15.00

(h) Excision of bone tissue:

07470	Removal of Exostosis—Maxilla or Mandible	62.50	56.50

Reimbursement will be based upon quadrants.

NOTE: Per quadrant.

07470	22	Removal of Exostosis	109.00	98.00

NOTE: Torus palatinus.

07480	Partial Ostectomy (Guttering or Saucerization)	211.00	184.00

d*	07490		Radical Resection of Mandible with Bone Graft	BR	BR

(i) Surgical incision:

07510		Incision and Drainage of Abscess —Intraoral Soft Tissue	28.00	26.00
07520		Incision and Drainage of Abscess—Extraoral Soft Tissue	42.00	37.00
07530		Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue	18.00	16.00
07540		Removal of Reaction—Producing Foreign Bodies, Musculoskeletal System	51.00	45.00
07550		Sequestrectomy for Osteomyelitis	48.00	42.00

NOTE: Intraoral.

07550	22	Sequestrectomy for Osteomyelitis	90.00	75.00

NOTE: Extraoral.

07560		Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign body	242.00	210.00

NOTE: Sinusotomy, maxillary (antrotomy, Caldwell-Luc, unilateral).

(j) Treatment of fractures—simple:

1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.

07610		Maxilla—Open Reduction (Teeth Immobilized if Present)	273.00	249.00
07620		Maxilla—Closed Reduction (Teeth Immobilized if Present)	182.00	166.00
07620	52	Maxilla—Closed Reduction	80.00	76.00

NOTE: No manipulation or fixation.

07630		Mandible—Open Reduction (Teeth Immobilized if Present)	363.00	331.00
07630	22	Mandible—Open Reduction (Teeth Immobilized if Present)	454.00	414.00

NOTE: Complicated-multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.

07640		Mandible—Closed Reduction (Teeth Immobilized if Present)	182.00	166.00
07640	52	Mandible—Closed Reduction	80.00	76.00

NOTE: No manipulation or fixation.

07650		Malar and/or Zygomatic Arch—Open Reduction	182.00	166.00
07660		Malar and/or Zygomatic Arch—Closed Reduction	63.00	58.00

NOTE: Including towel clip technique.

07660	52	Malar and/or Zygomatic Arch—Closed Reduction	56.00	52.00

NOTE: No manipulation or fixation.

07670	YU	Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00

NOTE 1: Maxillary alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07670	YL	Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00

NOTE 1: Mandibular alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07680		Facial Bones—Complicated Reduction with Fixation and Multiple Surgical Approaches	363.00	331.00

NOTE 1: Maxilla, malar and/or zygomatic arch.

NOTE 2: Multiple surgical approaches (three or more), fixation, traction, headframe, multiple internal and/or external fixation, and head cap.

(k) Treatment of fractures—compound:

1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.

07710		Maxilla—Open Reduction	273.00	249.00

NOTE: Teeth immobilized if present.

07720		Maxilla—Closed Reduction	182.00	166.00

NOTE: Teeth immobilized if present.

07720	52	Maxilla—Closed Reduction	80.00	76.00

NOTE: No manipulation or fixation.

07730		Mandible—Open Reduction	363.00	331.00

NOTE: Teeth immobilized if present

07730	22	Mandible—Open Reduction	454.00	414.00

NOTE: Complicated-multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.

07740		Mandible—Closed Reduction	182.00	166.00

NOTE: Teeth immobilized if present.

07740	52	Mandible—Closed Reduction	80.00	76.00

NOTE: No manipulation or fixation.

07750		Malar and/or Zygomatic Arch—Open Reduction	182.00	166.00
07760		Malar and/or Zygomatic Arch—Closed Reduction	63.00	58.00

NOTE: Including towel clip technique.

07760–52		Malar and/or Zygomatic Arch—Closed Reduction	56.00	52.00

NOTE: No manipulation or fixation.

07770	YU	Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00

NOTE 1: Maxillary alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07770	YL	Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00

NOTE 1: Mandibular alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07780		Facial Bones—Complicated Reduction with Fixation and Multiple Surgical Approaches	363.00	331.00

NOTE 1: Maxilla, malar and/or zygomatic arch.

NOTE 2: Multiple surgical approaches (three or more), fixation, traction, headframe, multiple internal and/or external fixation, and head cap.

(*l*) Reduction of dislocation and management of other temporo-mandibular joint dysfunctions:

	07810	Open Reduction of Dislocation	273.00	249.00
	07820	Closed Reduction of Dislocation	27.00	25.00
d	07830	Manipulation under Anesthesia	27.00	25.00

NOTE: Anesthesia additional.

	07840	Condylectomy	362.00	315.00
	07850	Meniscectomy	362.00	315.00
	07860	Arthrotomy	362.00	315.00
d	07870	Arthrocentesis	18.00	16.00

NOTE: Injection or aspiration (Give complete details).

(m) Repair of traumatic wounds:

1. Describe completely, giving size, site, and all pertinent information.

2. Fee includes suture removal.

07910	52	Suture of Recent Small Wounds	26.00	24.00

NOTE: Up to 2.5 cm.

07910		Suture of Recent Small Wounds up to 5 cm.	35.00	32.00

NOTE: 2.5 cm. up to 5 cm.

07910	22	Suture of Recent Small Wounds	43.00	39.00

NOTE: Over 5 cm. up to 7.5 cm.

3. Laceration over 7.5 cm. use code 07999.

(n) Complicated suturing (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure):

1. Also for irregularly shaped lacerations requiring extensive debridement.

**	07911	Suture—Up to 5 cm.	BR	BR
**	07912	Suture—Over 5 cm.	BR	BR

(*o*) Other repair procedures:

*	07940	Osteoplasty—For Orthognathic Deformities	BR	BR
*	07955	Repair of Maxillofacial Soft and Hard Tissue Defects	BR	BR
	07960	Frenulectomy (Frenectomy or Frenotomy)—Separate Procedure	60.00	56.00
	07980	Sialolithotomy	48.00	42.00
	07981	Excision of Salivary Gland	182.00	158.00
	07982	Sialodochoplasty	151.00	131.00
	07983	Closure of Salivary Fistula 1	151.00	131.00
	07990	Emergency Tracheotomy	121.00	105.00
d**	07999	Unspecified Oral Surgery Procedure, By Report	BR	BR

NOTE: Complete description of procedure and the reason the procedure was performed.

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowance increased for (c) single tooth and (d) surgical removal of erupted tooth effective August 1, 1988.
See: 20 N.J.R. 2101(a).
Amended by R.1989 d.135, effective March 20, 1989.
See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).
Qualifier added to 07130, in (c); prior authorization requirement removed from 07210, in (d).
Administrative Corrections to (c), (*l*)1 and (q).
See: 22 N.J.R. 1375(a).
Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (d): revised (d)1 to specify conditions for extraction, by incorporating text from old (d)2. Recodified (d)3 as (d)2 and added new (d)3. Deleted asterisks in List. In (f)1: added new "07310".
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Changed Maximum Fee Allowances throughout.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
In (g)1, inserted a reference to NJ FamilyCare.

10:56-3.11 08000-08999 ORTHODONTICS

(a) Minor treatment for tooth guidance:

1. Includes all necessary adjustments.

2. Code may also be used for Orthodontic Retention Appliances following comprehensive treatment by a previous dentist.

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance $	$	NS
	08110		Removable Appliance Therapy	115.00		100.00
	08120		Fixed Appliance Therapy	115.00		100.00

(b) Minor treatment to control harmful habits:

1. Includes all necessary adjustments.

08210	Removable Appliance Therapy	115.00	100.00
08220	Fixed Appliance Therapy	115.00	100.00

(c) Comprehensive orthodontic treatment—permanent dentition:

1. Treatment of permanent dentition. Indicate anticipated time under treatment—maximum treatment reimbursable including retention—three years. Reimbursement for comprehensive orthodontic treatment will include retention as required at no additional charge.

Y2910	Appliances	493.00	370.00
Y2920	1st Through 12th Month of Treatment to Start on Day Insertion of Appliances is Completed), Per Month	80.00	75.00
Y2930	13th Through 24th Month of Treatment, Per Month	80.00	75.00
Y2940	25th Through 30th Month of Treatment Per Month	14.00	12.00
Y2950	31st Through 36th Month (Maximum Reimbursable Period of Treatment), Per Month	14.00	12.00

(d) Other orthodontic services:

1. When requesting reimbursement for the orthodontic assessment examination, the Definition and Criteria for Assessing Handicapping Malocclusion Permanent Dentition form (FD–10) must accompany the Dental Services Claim form (MC–10).

	Y2965	Orthodontic Examination (Comprehensive) and (Complete Orthodontic) Treatment Plan	11.00	10.00
	Y2975	Orthodontic Assessment Examination, using the Handicapping Malocclusion Assessment System	6.00	5.00
*	08999	Unspecified Orthodontic Procedure, By Report	BR	BR

NOTE: Complete description, diagnosis and treatment plan must be submitted.

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D–2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowance increased at (c), effective August 1, 1988.
See: 20 N.J.R. 2101(a).
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
In (c) and (d), changed Maximum Fee Allowances.

10:56–3.12 09000–09999 Adjunctive General Services

(a) Unclassified treatment:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance S	$	NS
d	09110		Palliative (Emergency) Treatment of Dental Pain—Minor Procedures	10.00		9.00

NOTE: Emergency treatment of dental pain or infection, palliative (flat fee for all services performed, when not covered by separately listed procedure). Diagnosis and description of treatment is required. Per tooth or per site.

(b) Anesthesia:

09210	Local Anesthesia Not in Conjunction with Operative or Surgical Procedures	13.00	11.00

NOTE 1: Infiltration and/or nerve block for diagnostic purposes or purposes other than anesthesia.

NOTE 2: Complete report must be available in patient records.

09220	General Anesthesia	125.00	125.00

NOTE: This code applies when the dentist performing the services (attending dentist) also administers the general anesthesia or in conjunction with oral surgery services only.

(c) Special general anesthesia:

1. (Basic units—See American Society of Anesthesiologists Relative Value Guide—2000).

09220	22	Maximum 4 units	44.00	44.00
09220	52	Time units: Each additional 15 minute period or major portion thereof. (Limited to "table" or "chair" time only). Maximum reimbursable: two hours.	11.00	11.00

NOTE 1: The general anesthesia codes above are limited to use in restorative dentistry alone or restorative dentistry in conjunction with other dental services requiring anesthetic management. These codes are reimbursable only to the dentist whose sole function is to administer general anesthesia.

NOTE 2: An anesthesia record must be available which shows elapsed anesthesia time, and pinpoints time and amounts of drugs administered, pulse rate and character, blood pressure, respiration and so forth.

09230	Analgesia	15.00	14.00
09240	Intravenous Sedation	50.00	49.00

NOTE: Parenteral Conscious Sedation

(d) Professional consultation (diagnostic service provided by a dentist other than practitioner providing treatment):

1. A complete report must be available.

d	09310	Consultation—Per Session	22.00	17.00

(e) Professional visits:

09410		House Call	20.50	19.00
Y3005		Long Term Care Facility Visits	20.50	19.00
09420	52	Hospital call	19.00	17.00

NOTE: Code 09420 52 will not be reimbursable in conjunction with Code 09310 or Codes 09420 22 or 09420.

09420	22	Hospital Call	32.00	27.00

NOTE: Code to be used for Hospital Day—Initial—Inpatient or Same Day Surgery.

09420		Hospital Call	19.00	17.00

NOTE 1: Code to be used for Hospital Day—Subsequent.

NOTE 2: Consisting of care and treatment by the Practitioner subsequent to the date of "Hospital Day—Initial" and including those procedures ordinarily performed during a hospital visit dependent upon the practitioner's discipline.

NOTE 3: Not reimbursable for those services that include follow-up days.

09430		Office Visit for Observation (During Regularly Scheduled Hours)—No Other Services Performed	9.00	7.00

NOTE: Code may also be used when post-operative services are necessary following a major surgical procedure (e.g., bony impactions, fractures, etc.)

(f) Drugs:

09610		Therapeutic Drug Injection	2.50	2.50
09610	22	Therapeutic Drug Injection	13.00	11.00

NOTE: Injection of one or more muscles of mastication in conjunction with treatment of T.M.J. dysfunction.

d* 09630		Other Drugs and/or Medicaments, By Report	BR	BR

(g) Miscellaneous services:

09910		Application of Desensitizing Medicaments	6.00	5.00

NOTE 1: Application to a tooth, i.e., cervical sensitivity, erosions etc.

NOTE 2: Specify tooth code(s).

# 09920		Behavior Management	15.00	13.00

NOTE 1: Code to be used for those beneficiaries with developmental and other disabilities whose disorders necessitate an excessive amount of time to accomplish treatment (e.g., mental retardation, neurological disorders, etc.) For any use of this code, the dentist shall specify the beneficiary's disability which necessitates the use of this code on the MC-10A, Request for Prior Authorization, under Section 20, Remarks.

NOTE 2: Payment will be based on 15-minute time units or a major portion thereof. Maximum reimbursement is eight time units on a single date of service.

NOTE 3: The type of disorder and the number of time units requested must be entered on the Dental Services Claim form (MC-10).

NOTE 4: Prior authorization is required for all occurrences of this code.

NOTE 5: Code to be used in addition to other procedures performed.

09930		Treatment of Complications (Post Surgical)—Unusual Circumstances, By Report	9.00	8.00

NOTE: This code may also be used for post-operative treatment beyond that normally provided as part of the basic procedure or when provided by practitioner other than one who provided the original service or in excess of "follow-up days". (California Relative Value Study—1964), per visit.

09940		Occlusal Guards	50.00	45.00

NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards).

NOTE 2: Office procedure.

09940	22	Occlusal Guards	65.00	58.00

NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards).

NOTE 2: Laboratory procedure.

09951		Occlusal Adjustment—Limited	6.00	5.00

NOTE: 1 to 3 Teeth.

09951	22	Occlusal Adjustment	17.00	15.00

NOTE: Per quadrant (minimum six teeth).

d** 09999		Unspecified Adjunctive Procedure, By Report	BR	BR

NOTE: To be used only where no code number exists or existing code is not precisely applicable. Complete description of condition and proposed treatment must be submitted to the Medicaid dental consultants.

As amended, R.1981 d.331, effective September 10, 1981.
See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).
Delete text of (e)22 and substitute new text therefor.
As amended, R.1983 d.584, effective January 1, 1984.
See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).
Further requirements for reimbursement added.
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Substantially amended.
Public notice: Pursuant to the provisions of N.J.S.A. 30:4D–2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowance increased at (b) Adjunctive general services effective August 1, 1988.
See: 20 N.J.R. 2101(a).
Administrative Correction to (c).

See: 20 N.J.R. 1375(a).
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.1998 d.353, effective July 20, 1998.
See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).
In (g), rewrote NOTE 1 and NOTE 4.
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Changed Maximum Fee Allowances throughout.
Amended by R.2001 d.10, effective January 2, 2001.
See: 32 N.J.R. 3377(a), 33 N.J.R. 65(a).
In (c)1, substituted "Society" for "College" following "American", and substituted "2000" for "1967" following "Guide—".

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the fiscal agent billing supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

UNISYS
PO Box 4801
Trenton, New Jersey 08650–4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625–0049

New Rule, R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.1998 d.353, effective July 20, 1998.
See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).
Updated the addresses.