ii. Extractions and such ancillary services as general anesthesia and radiographs, in conjunction with the insertion of an immediate denture when initial impressions have been taken during the period of eligibility;

iii. Endodontic treatment if pulp has been extirpated and treatment authorized and those services necessary to complete the restoration of that tooth such as filling restoration(s) or, if authorized during a period of eligibility, post and core and crown.

2. Notwithstanding anything in these regulations to the contrary, payment may be made for a denture(s) furnished after termination of eligibility of an individual where the last tooth in any specific arch is extracted during the period of eligibility.

i. A denture, complete or partial, may be furnished in the opposing arch as described at N.J.A.C. 10:56–2.13, Prosthodontic treatment, if it meets the guidelines of the program as specified in this chapter, and is authorized in conjunction with the above denture.

ii. In order to obtain reimbursement for this denture(s), the primary impression(s) must be initiated within 120 days and the denture(s) inserted within 180 days after the extraction of the last tooth. Authorization procedures set forth in these regulations are applicable.

3. For immediate dentures, similar to provisions for dentures inserted subsequent to the healing period, prior authorization must have been obtained during the eligibility period and all preliminary extractions completed during that same period. Authorized complete or partial dentures in conjunction with immediate replacement codes Y2505 and Y2505–52 should be completed within 180 days of termination of eligibility.

i. A denture, complete or partial, may be furnished in the opposing arch as described at N.J.A.C. 10:56–2.13, Prosthodontic treatment, if it meets the guidelines of the program as specified in this chapter, and is authorized in conjunction with the above denture.

ii. In order to receive reimbursement for this denture(s), primary impression(s) must be initiated within 120 days and the denture inserted 180 days after the last preliminary extraction. Prior authorization procedures set forth in these regulations are applicable as described at N.J.A.C. 10:56–1.4.

(g) When other health or liability insurance is available, the Medicaid program requires that such benefits be utilized first and to the fullest extent. See New Jersey Administrative Code 10:49–7.3 Third Party Liability Benefits for further information. Supplemental payment shall be made by the Medicaid program up to the provider's customary and usual fee, if the combined total does not exceed the amount payable under the Medicaid program.

1. When other health insurance is involved, claims should not be filed with the Program unless accompanied by a statement of payment or denial from any other carriers.

2. Medicare coinsurance and deductible shall be payable by the New Jersey Medicaid program in combination Medicare/Medicaid cases.

Amended by R.1985 d.7, effective February 4, 1985.
See: 16 N.J.R. 1933(a), 17 N.J.R. 309(a).
(g) text added: "and to the . . . further information."
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 10:56–1.11 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. 10:56–1.5, "Standards of service", recodified to 10:56–2.2.

10:56–1.6 Reimbursement based on specialist designation

(a) The following conditions shall apply to a specialist:

1. In New Jersey, and where required in other states, a specialist has obtained a specialty certification from the licensing agency of the state where dental services are to be rendered; or

2. In those states not requiring specialty certification:

i. The specialist is a diplomate of a specialty board recognized by the American Dental Association; or

ii. Meets the minimum requirements for that specialty as stipulated by the American Dental Association.

(b) Any provider who meets the qualifications in (a) above and desires specialist reimbursement is required to submit proof of specialist certification as described above to:

UNISYS
Provider Enrollment Unit
PO Box 4801
Trenton, New Jersey 08650–4801

(c) Specialist reimbursement will be limited to the following specialties:

1. Oral and Maxillofacial Surgery;

2. Endodontics;

3. Pedodontics—Pediatric Dentistry;

4. Orthodontics;

5. Periodontics; and/or

6. Prosthodontics.

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. 10:56–1.6, "Special dental services", recodified to 10:56–2.3.

10:56–1.7 Personal contribution to care requirements for NJ KidCare–Plan C

(a) General policies regarding the collection of personal contribution to care for NJ KidCare–Plan C are set forth at N.J.A.C. 10:49–9.

(b) Personal contribution to care for NJ KidCare–Plan C services is $5.00 a visit for dental services, except when the service is provided for preventive dental care.

1. A dental visit is defined as a face-to-face contact with a medical professional, including services provided under the supervision of the dentist, which meets the documentation requirements of this chapter and allows the dentist to request reimbursement for services.

2. Dental visits include dental services provided in the office, patient's home, or any other site, except the hospital, where the child may have been examined by the dentist or the dental staff.

3. Dental services which do not meet the requirements of an office visit, such as surgical services, laboratory or x-ray services, do not require a personal contribution to care.

(c) Dentists shall not charge a personal contribution to care for services provided to newborns, who are covered under fee-for-service for plan C; or for preventive dental services, including screenings, fluoride treatments and routine dental examinations.

New Rule, 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. 10:56–1.7, Non-covered services, recodified to N.J.A.C. 10:56–1.8.

10:56–1.8 Non-covered services

(a) A non-covered service is that procedure which is primarily for cosmetic purposes, for which dental necessity cannot be demonstrated, or which is determined to be beyond the scope of the Program by a Medicaid dental consultant as specified in this chapter.

(b) Medical/dental supplies and equipment and other devices that are essential for the recipient's medical/dental condition are allowable unless otherwise available at no charge from community services (such as the American Cancer Society or other service organizations).

(c) Standard tooth brushes, dental floss, and like items are considered personal hygiene items and are not covered by the Program.

Amended by R.1974 d.53, effective March 15, 1974.
See: 6 N.J.R. 13(a), 6 N.J.R. 150(b).
Amended by R.1992 d.98, effective March 2, 1992.
See: 23 N.J.R. 281(a), 23 N.J.R. 1310(a), 24 N.J.R. 845(a).
Added subsection (b) on bundled drug services.
Recodified from 10:56–1.4 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.

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 Program recipient, 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 Dental Services Claim Form (MC–10) shall not be an acceptable substitute. Such recipient 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 Program or its agents as required.

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

i. The name, address, and telephone number of recipient, the recipient's date of birth and HSP (health services) 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) Recipient'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 (7) 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 recipient'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;