

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

01120	76	Prophylaxis—Child	14.00	13.00
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NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

y2105	76	Additional Scaling	16.00	15.00
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(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	24.00	22.00
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(Including Prophylaxis)—Child

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
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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
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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
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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
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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
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(d) Space Maintenance (passive appliances):

01510		Space Maintainer—Fixed—Unilateral	85.00	80.00
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NOTE: Utilizing band(s) or stainless steel crowning.

01515		Space Maintainer—Fixed—Bilateral	123.00	115.00
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NOTE: Lingual or palatal arch utilizing bands or stainless steel crowning.

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

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:—

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.

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.

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.

02540	Onlay—Metallic—Per Tooth (In Addition to Inlay)	23.00	20.00
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(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 Weight %	High Noble Alloy Au., Pd. and/or Pt. > 60% (with at least 40% Au)	Noble Alloy Au., Pd. and/or Pt. > 25%	Predominantly Base Alloy Au., Pd. and/or Pt. < 25%
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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.

# 02710	Crown—Resin (Laboratory)	98.00	85.00
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(f) Other restorative services:

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
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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		
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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.

#	Code	Description	49.00	45.00
02950	Crown Buildup Including Any Pins			

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
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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
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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
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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
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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 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 (e)3, substituted "beneficiary" for "recipient".

10:56-3.5 03000-03999 ENDODONTICS

(a) Therapeutic pulpotomy:

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

(b) Pulpotomy:

Y2310	Pulpotomy (Excluding Final Restoration)		17.00	15.00
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(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
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NOTE: Code to be used for incisors and cuspids (permanent).

#	03320	Two Canals (Excluding Final Restoration)	190.00	173.00
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NOTE: Code to be used for premolars and all primary teeth without permanent successors.

#	03330	Three Canals (Excluding Final Restoration)	247.00	225.00
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NOTE: Code to be used for molars (permanent).

03350	Apexification (Per Treatment Visit)		31.00	27.00
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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 Family-Care 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	Apicoectomy (Per Tooth)—First Root		79.00	72.00
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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
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NOTE 1: Reimbursable only in addition to apicoectomy.

NOTE 2: Maximum per tooth—three roots.

	03440		Apical Curettage	49.00	42.00
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NOTE: Per tooth.

	03450		Root Amputation—Per Root	55.00	48.00
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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
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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
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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
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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	Codes	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	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
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NOTE: Per Quadrant.

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

*	04271		Free Soft Tissue Graft Procedure (Including Donor Site)	49.00		42.00
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NOTE: Per site.

*	04272		Apically Repositioning Flap Procedure	36.00		31.50
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NOTE: Per quadrant.

(b) Adjunctive periodontal services:

	04320		Provisional Splinting—Intracoronaral	18.00		16.00
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NOTE: Per tooth.

	04321		Provisional Splinting—Extracoronaral	11.00		10.00
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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
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*	04999		Unspecified Periodontal Service, By Report	BR		BR
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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 Periodontal Scaling and Root Planing—Per Quadrant.

NOTE: Maxillary.

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

* 05120 Complete Lower 342.00 311.00

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

NOTE: Mandibular.

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

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