

CHAPTER 56

MANUAL FOR DENTAL SERVICES

Authority

N.J.S.A. 30:4D-6b(17); 30:4D-7, 7a, b, and c;
30:4D-12; 42 C.F.R. 440.50 and 100.

Source and Effective Date

R.1996 d.428, effective August 14, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Executive Order No. 66(1978) Expiration Date

Chapter 56, Manual for Dental Services, expires on August 14, 2001.

Chapter Historical Note

All provisions of Chapter 56, Dental Services Manual, became effective May 12, 1971 as R.1971 d.70. See: 3 N.J.R. 58(c), 3 N.J.R. 110(b). Chapter 56, Manual for Dental Services, became effective March 1, 1978 as R.1978 d.2. See: 9 N.J.R. 431(c), 10 N.J.R. 66(c).

Subchapter 3, Procedure Codes and Descriptions, was readopted effective March 24, 1986 pursuant to Executive Order No. 66(1978) as R.1986 d.128. See: 18 N.J.R. 154(a), 18 N.J.R. 847(b). Pursuant to Executive Order No. 66(1978), Chapter 56 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Subchapter 3, Procedure Codes and Descriptions, was repealed and replaced with a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), as R.1987 d.166 effective April 6, 1987. See: 19 N.J.R. 15(b), 19 N.J.R. 519(a).

Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was extensively revised by R.1987 d.408, effective October 8, 1987. See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

Pursuant to Executive Order No. 66(1978), Chapter 56 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 was readopted as R.1996 d.428, effective August 14, 1996. See: Source and Effective Date. 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of R.1996 d.428, Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was repealed and a new Subchapter 2, Provisions for Services, was adopted. See, also, section annotations.

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SUBCHAPTER 1. DENTAL SERVICES; GENERAL PROVISIONS

10:56-1.1 Purpose and scope

(a) This chapter (N.J.A.C. 10:56) describes the policies and procedures of the New Jersey Medicaid program 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.

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 recipient. 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 recipient 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 recipient, 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 recipient 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 recipient 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 recipient 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 recipient 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. 10:56-1.2, “Dental treatment plan”, recodified to 10:56-2.1.

10:56-1.3 Provisions for provider participation

(a) A Doctor of Dental Medicine (DMD) or a Doctor of Dental Surgery (DDS), pursuant to N.J.A.C. 13:35 (incorporated herein by reference), who is authorized to provide dental and surgical services by the State of New Jersey, who is an approved Medicaid participating provider in accordance with (b) below, who complies with all of the rules of the New Jersey Medicaid program, shall be eligible to provide dental and surgical dental services to Medicaid recipients.

1. Any out-of-State dentist may provide dental and surgical services under this Program if he or she meets the documentation and licensing requirements in the State which he or she is practicing, and is a New Jersey Medicaid participating provider.

2. An applicant shall provide the Division with a photocopy of the current license at the time he or she applies for enrollment.

(b) In order to participate in the Medicaid program as a dentist, a dental practitioner shall apply to, and be approved by the New Jersey Medicaid program. An applicant shall complete and submit the "Medicaid Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62). The FD-20 and FD-62 can be found as Forms #8 and #9 in the Appendix at the end of the Administration Chapter (N.J.A.C. 10:49), and may be obtained from and submitted to:

Unisys Corporation
 Provider Enrollment
 P.O. Box 4804
 Trenton, NJ 08640-4804

(c) Upon signing and returning the Medicaid Provider Application, the Provider Agreement and other enrollment documents to the fiscal agent for the New Jersey Medicaid program, the dentist will receive written notification of approval or disapproval. If approved, the dentist will be assigned a Medicaid Provider Billing Number, a Medicaid Provider Service Number, and will be provided with an initial supply of pre-printed claim forms.

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. 10:56-1.3, "Prior authorization", recodified to 10:56-1.4.

10:56-1.4 Prior authorization

(a) All Dental Service Prior Authorization Forms (MC-10A) should be submitted to:

Division of Medical Assistance and Health Services
 Dental Claims Review Unit
 CN713
 Trenton, New Jersey 08625-0713
 Telephone: (609) 588-7136 or 1-800-782-0181

1. Generally, claims for items under \$500.00 do not require prior authorization, unless otherwise specified in N.J.A.C. 10:56-1.4 or N.J.A.C. 10:56-3, except that:

i. Oral hygiene devices require prior authorization, regardless of cost.

(1) Consideration for prior authorization shall be based on the least costly appliance fulfilling the requirements of the specific situation or the extenuating circumstances.

2. Those services which require prior authorization and are defined as "non-routine services" are specified at N.J.A.C. 10:56-3 and are designated by one of the following indicators:

- i. A single asterisk (*); or
- ii. A double asterisk (**); and/or
- iii. A crosshatch (#).

(1) The crosshatch denotes that a special authorization requirement(s) exists. The requirements are listed adjacent to the procedure codes involved.

3. Those services which do not require prior authorization have no asterisk or crosshatch indicators and are those basic services defined by Medicaid as "Routine Services."

4. Prior authorization requests cannot be transferred from one dentist to another.

(b) Procedures which do not require prior authorization (Routine services) include:

- 1. Diagnostic examination with required radiography, necessary to develop a treatment plan, limited to a maximum of \$35.00;
- 2. Emergency treatment with required radiography;
- 3. Adjustments to, or repair of, dentures when the Medicaid reimbursement does not exceed \$115.00, specialist fee, or \$100.00, nonspecialist fee effective for repairs made on or before September 16, 1996.
- 4. The dental services designated below may be performed to the extent that they are dentally necessary but within the limitations listed in this subchapter and N.J.A.C. 10:56-3.
 - i. Oral prophylaxis;
 - ii. Topical fluoride application for persons 20 years of age and under;
 - iii. Restoration of carious permanent and primary teeth with silver amalgam, composite, or other plastic materials;
 - iv. Impactions, fractures, and most surgical procedures;
 - v. Pulpotomy for permanent and primary teeth;

vi. All extractions of non-restorable teeth;

(1) Exception: Extractions of restorable teeth or teeth with no carious lesions require prior authorization;

(2) Exception: Extractions in conjunction with orthodontic treatment not being reimbursed by the Medicaid program require prior authorization.

(c) Supplemental or amended prior authorization requirements include:

1. Additional and/or amended services found necessary after the original dental treatment plan has been prior authorized may be requested by recording such need on the Dental Services Prior Authorization Form (MC-10A). This should then be submitted for supplemental authorization together with the original treatment plan or a photocopy thereof. Payment will not be made for such treatment without prior authorization.

(d) Prior authorized ("Non-routine") services shall be completed within one year of the date of authorization by the Medicaid dental consultant.

1. If providers are unable to complete the services within the prior authorized period, providers may contact the Medicaid dental consultant and request a change in the prior authorization request, in accordance with (c)1 above.

2. All requirements of N.J.A.C. 10:49-7.2, regarding timeliness of claim submission and inquiry requirements shall apply to all prior authorized services.

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.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 10:56-1.3 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. 10:56-1.4, "Non-covered services", recodified to 10:56-1.7.

10:56-1.5 Basis for reimbursement

(a) Reimbursement for covered services furnished under the New Jersey Medicaid Program shall be the customary and usual fee of the provider when it does not exceed Federal regulatory maximums and reasonable rates as determined by the Commissioner of Human Services. In no instance shall the charge to the program exceed the usual and customary fee of the provider for identical services to other governmental agencies or other groups or individuals in the community.

1. If a recipient receives care from more than one member of a partnership or corporation in the same discipline for the same service, the total maximum payment allowance would be the same as that of a single attending dentist. The allowance fee for a given service shall constitute full payment. No additional charge shall be made by the dentist, or on behalf of, the covered Medicaid recipient.

2. The procedure codes which are used when submitting claims are listed in N.J.A.C. 10:56-3—Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). The Fiscal Agent Billing Supplement that follows N.J.A.C. 10:56-3 in Appendix A provides information about the claim form and billing instructions. The provider, when submitting claims for services rendered, shall comply with the provisions of N.J.A.C. 10:56, Appendix A, which is incorporated herein by reference.

(b) A fee will be paid only for services rendered. If an eligible recipient does not return for completion of the treatment plan, only those services provided shall be billed.

(c) If circumstances involving an eligible recipient, over which the provider has no control, preclude completion of a service and/or authorized appliance, the New Jersey Medicaid program will reimburse the provider of services an amount consistent with the stage of completion of the authorized service and/or appliance.

1. The stage of completion of the service shall be detailed on the Dental Services Claim Form (MC-10), or in the case of an appliance, denture or crown, the case (to the point of completion) shall be forwarded to a dental consultant for proration as determined by the Chief, Bureau of Dental Services. The case will be returned to the provider and shall be retained for at least one year pending possible return of the recipient.

(d) Partial reimbursement for an appliance completed but not delivered to the recipient because of circumstances beyond the control of the provider will be authorized by the New Jersey Medicaid program. An amount equivalent to the professional component for inserting and adjusting the appliance will be deducted from the total reimbursement for such appliance. In the event the recipient returns and the service is completed, the provider may request reimbursement for the deducted amount. Procedures as outlined in (c) above will apply.

(e) Reimbursement is not made for, and recipients may not be asked to pay for, broken appointments.

(f) Reimbursement for dental treatment can only be made during the period of recipient eligibility.

1. Exception: The treatment listed below, authorized and actually in the process of being rendered during such period may be completed and payment allowed, provided the services are completed within 60 calendar days following the termination of eligibility unless indicated below.

i. Prostheses (to include, for example, dentures, crowns, space maintainers, and appliances) actually in process of fabrication;

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;

Former section, "General billing procedures", repealed.

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, CN 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.

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 recipient or the providers of services.

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 recipient and performing the diagnostic workup:

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 recipient has all permanent teeth unless prior authorized by a dental consultant of the Bureau of Dental Services.

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

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

vi. The practitioner should be aware of the following:

- (1) The Medicaid Eligibility Identification card should be examined on the first visit of each month. Make certain that the recipient being treated is listed as eligible and that the Medicaid number has not changed. If possible, a photocopy should be retained as part of the recipient'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 workup 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
CN 4811
Trenton, New Jersey 08650

(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 recipient, 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 workup 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:

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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 workup, submit the following to the Division of Medical Assistance and Health Services, Bureau of Dental Services, CN 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 recipient which demonstrate the malocclusion and/or extenuating circumstance(s). The maximum number of photographs or slides is reimbursable—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 Service. 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 recipient eligibility continues through completion of treatment, final records similar to diagnostic aids described in (e)iv above, shall be taken at termination of treatment and must be submitted upon request, to:

Division of Medical Assistance and Health Services
Bureau of Dental Services
CN 713
Trenton, New Jersey 08625-0713

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

(h) 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.

(i) 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.

(j) 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 recipient 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).

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 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 \$18.00 for a specialist and \$14.00 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).

10:56-2.17 Adjunctive general services: anesthesia

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

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

ii. 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.

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 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).

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 recipient-prescriber-provider relationship, and to insure the recipient 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.

1. The New Jersey Medicaid program will reimburse pharmaceutical providers for prescriptions prescribed by a dentist within the scope of their practice as defined by the State of New Jersey or the state in which they are practicing.

	07260	Antro-oral Fistula Closure NOTE: Code may also be used for antral root recovery.	72.00	63.00
	07270	Tooth Re-implantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth and/or Alveolus	61.00	53.00
	07270	22 Tooth Re-implantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus NOTE: Includes single stage nerve extirpation and canal filling.	86.00	75.00
	07280	Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reason (Including Orthodontic Attachments)	54.00	47.00
	07281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	30.00	26.00
d	07285	Biopsy of Oral Tissue—Hard NOTE: Independent procedure (laboratory must bill separately).	30.00	26.00
d	07286	Biopsy of Oral Tissue—Soft NOTE: Independent procedure (laboratory must bill separately).	18.00	16.00

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

1. Reimbursement will be based upon quadrants.

	07310	Alveoloplasty in Conjunction with Extraction—Per Quadrant 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.	43.50	37.50
	07320	Alveoloplasty Not In Conjunction With Extraction—Per Quadrant	43.50	37.50

(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) NOTE: Including management of hypertrophied and hyperplastic tissue, Per Quadrant.	45.00	39.00
	07350	Vestibuloplasty—Ridge Extension (Including Soft Tissue Grafts, Muscle Re-attachments, Revision of Soft Tissue Attachment, and Management of Hypertrophied and Hyperplastic Tissue) NOTE: Per quadrant.	118.00	102.00

(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. NOTE: Up to and including 3 cm.	42.00	37.00

	07420	22 Radical Excision—Lesion Diameter Over 3 cm.	100.00	86.00
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(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 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. NOTE: Up to and including 3 cm.	42.00	37.00
	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. NOTE: Up to and including 3 cm.	274.00	256.00
	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. NOTE: Up to and including 3 cm.	100.00	87.00
	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. NOTE: Up to and including 3 cm.	100.00	87.00
	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	43.50	37.50
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Reimbursement will be based upon quadrants.

	07470	22 NOTE: Per quadrant. Removal of Exostosis NOTE: Torus palatinus.	90.00	79.00
	07480	Partial Osteotomy (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	18.00	16.00
	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

07550	22	NOTE: Intraoral. Sequestrectomy for Osteomyelitis	90.00	75.00
07560		NOTE: Extraoral. Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign body	242.00	210.00
		NOTE: Sinusotomy, maxillary (antrotomy, Caldwell-Luc, unilateral).		

07720	52	NOTE: Teeth immobilized if present. Maxilla—Closed Reduction	30.00	26.00
07730		NOTE: No manipulation or fixation. Mandible—Open Reduction	242.00	210.00
07730	22	NOTE: Teeth immobilized if present Mandible—Open Reduction	303.00	263.00
		NOTE: Complicated-multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.		
07740		Mandible—Closed Reduction	121.00	105.00
07740	52	NOTE: Teeth immobilized if present. Mandible—Closed Reduction	30.00	26.00
07750		NOTE: No manipulation or fixation. Malar and/or Zygomatic Arch—Open Reduction	121.00	105.00
07760		Malar and/or Zygomatic Arch—Closed Reduction	42.00	37.00
		NOTE: Including towel clip technique.		
07760	52	Malar and/or Zygomatic Arch—Closed Reduction	30.00	26.00
		NOTE: No manipulation or fixation.		
07770	YU	Alveolus—Stabilization of Teeth, Open Reduction Splinting	92.00	80.00
		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	92.00	80.00
		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	242.00	210.00
		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.		

(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)	182.00	158.00
07620		Maxilla—Closed Reduction (Teeth Immobilized if Present)	121.00	105.00
07620	52	Maxilla—Closed Reduction	30.00	26.00
		NOTE: No manipulation or fixation.		
07630		Mandible—Open Reduction (Teeth Immobilized if Present)	242.00	210.00
07630	22	Mandible—Open Reduction (Teeth Immobilized if Present)	303.00	263.00
		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)	121.00	105.00
07640	52	Mandible—Closed Reduction	30.00	26.00
		NOTE: No manipulation or fixation.		
07650		Malar and/or Zygomatic Arch—Open Reduction	121.00	105.00
07660		Malar and/or Zygomatic Arch—Closed Reduction	42.00	37.00
		NOTE: Including towel clip technique.		
07660	52	Malar and/or Zygomatic Arch—Closed Reduction	30.00	26.00
		NOTE: No manipulation or fixation.		
07670	YU	Alveolus—Stabilization of Teeth, Open Reduction Splinting	92.00	80.00
		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	92.00	80.00
		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	242.00	210.00
		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	182.00	158.00
07820		Closed Reduction of Dislocation	18.00	16.00
07830	d	Manipulation under Anesthesia	18.00	16.00
		NOTE: Anesthesia additional.		
07840		Condylctomy	362.00	315.00
07850		Meniscctomy	362.00	315.00
07860		Arthrotomy	362.00	315.00
07870	d	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.

(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	182.00	158.00
		NOTE: Teeth immobilized if present.		
07720		Maxilla—Closed Reduction	121.00	105.00

07910	52	Suture of Recent Small Wounds	18.00	16.00
		NOTE: Up to 2.5 cm.		
07910		Suture of Recent Small Wounds up to 5 cm.	24.00	21.00

07910 22 NOTE: 2.5 cm. up to 5 cm.
Suture of Recent Small Wounds 30.00 26.00
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 32.00 28.00
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).

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	Codes	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	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.

Y	Procedure Description	S	NS
Y2910	Appliances	178.00	155.00
Y2920	1st Through 12th Month of Treatment (To Start On Day Insertion of Appliances Is Completed), Per Month	40.00	35.00
Y2930	13th Through 24th Month of Treatment, Per Month	40.00	35.00
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).

Y	Procedure Description	S	NS
Y2965	Orthodontic Examination (Comprehensive) and (Complete Orthodontic) Treatment Plan	6.00	5.00
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).

10:56-3.12 09000-09999 ADJUNCTIVE GENERAL SERVICES

(a) Unclassified treatment:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	09110		Palliative (Emergency) Treatment of Dental Pain—Minor Procedures	7.00		6.00
			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 treat-			

Ind	HCPCS Codes	Mod	Procedure Description ment is required. Per tooth or per site.	Maximum Fee Allowance		09420	NOTE: Code to be used for Hospital Day—Initial—Inpatient or Same Day Surgery. Hospital Call 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. Office Visit for Observation (During Regularly Scheduled Hours)—No Other Services Performed NOTE: Code may also be used when post-operative services are necessary following a major surgical procedure (e.g., bony impactions, fractures, etc.)	9.00	7.00
				\$	\$				
(b) Anesthesia:									
	09210		Local Anesthesia Not in Conjunction with Operative or Surgical Procedures 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.	13.00	11.00	09430		9.00	7.00
	09220		General Anesthesia 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.	25.00	25.00				
(c) Special general anesthesia:									
1. Basic units—(See American College of Anesthesiologists Relative Value Guide—1967).									
	09220	22	Maximum 4 units	22.00	22.00	d* 09630	Therapeutic Drug Injection	2.50	2.50
	09220	52	Time units: Each additional 15 minute period or major portion thereof. (Limited to "table" or "chair" time only). Maximum reimbursable two hours. 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.	5.50	5.50		Therapeutic Drug Injection NOTE: Injection of one or more muscles of mastication in conjunction with treatment of T.M.J. dysfunction. Other Drugs and/or Medicaments, By Report	13.00	11.00
	09230		Analgesia	10.00	9.00				
	09240		Intravenous Sedation NOTE: Parenteral Conscious Sedation	10.00	9.00				
(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	09930	Treatment of Complications (Post Surgical)—Unusual Circumstances, By Report 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.	6.00	5.00
(e) Professional visits:									
	09410		House Call	10.50	9.00				
	Y3005		Long Term Care Facility Visits	10.50	9.00				
	09420	52	Hospital Call NOTE: Code 09420 52 will not be reimbursable in conjunction with Code 09310 or Codes 09420 22 or 09420.	9.00	7.00	# 09920	Behavior Management NOTE 1: Code to be used for those recipients with developmental and other disabilities whose disorders necessitate an excessive amount of time to accomplish treatment. (e.g., mental retardation, neurological disorders, etc.) NOTE 2: Payment will be based on 15 minute time units or a major portion thereof. Maximum reimbursement 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 when four or more time units are requested on one date of service. NOTE 5: Code to be used in addition to other procedures performed.	15.00	13.00
	09420	22	Hospital Call	22.00	17.00				

09940		Occlusal Guards NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards). NOTE 2: Office procedure.	35.00	30.00
09940	22	Occlusal Guards NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards). NOTE 2: Laboratory procedure.	50.00	43.00
09951		Occlusal Adjustment—Limited NOTE: 1 to 3 Teeth.	6.00	5.00
09951	22	Occlusal Adjustment NOTE: Per quadrant (minimum six teeth).	17.00	15.00
d** 09999		Unspecified Adjunctive Procedure, By Report 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.	BR	BR

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).

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
CN 4801
Trenton, New Jersey 08650

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN 049
Trenton, New Jersey 08625

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