CHAPTER 56

MANUAL FOR DENTAL SERVICES

Authority

N.J.S.A. 30:4D–6b(4), 6g, 7, 7a, b and c; 30:4D–12; 42 C.F.R. 440.100.

Source and Effective Date

R.1991 d.473, effective August 21, 1991.
See: 23 N.J.R. 1992(a), 23 N.J.R. 2862(a).

Executive Order No. 66(1978) Expiration Date

Chapter 56, Manual For Dental Services, expires on August 21, 1996.

Chapter Historical Note

All provisions of Chapter 56 became effective May 12, 1971 as R.1971 d.70. See: 3 N.J.R. 58(c), 3 N.J.R. 110(b).

1972 Revisions: Amendments became effective February 23, 1972 as R.1972 d.35. See: 3 N.J.R. 154(a), 4 N.J.R. 49(a). Further amendments became effective August 21, 1972 as R.1972 d.164. See: 4 N.J.R. 125(b), 4 N.J.R. 219(a).

1973 Revisions: Revisions became effective June 20, 1973 as R.1973 d.163. See: 5 N.J.R. 144(d), 5 N.J.R. 228(c). Further revisions became effective October 1, 1973 as R.1973 d.259. See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).

1974 Revisions: Amendments became effective March 15, 1974 as R.1974 d.53. See: 6 N.J.R. 13(a), 67 N.J.R. 150(b). Further amendments became effective May 15, 1974 as R.1974 d.114. See: 6 N.J.R. 141(b), 6 N.J.R. 246(a). Further amendments became effective August 15, 1974 as R.1974 d.203. See: 6 N.J.R. 242(a), 6 N.J.R. 313(c).

1975 Revisions: Amendments became effective September 1, 1975 as R.1975 d.262. See: 7 N.J.R. 318(a), 7 N.J.R. 466(a). Further amendments became effective November 10, 1975 as R.1975 d.339. See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).

1976 Revisions: Amendments became effective July 12, 1976 as R.1976 d.215. See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).

1977 Revisions: Amendments became effective October 1, 1977 as R.1977 d.302. See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).

1978 Revisions: Revisions were filed on January 3, 1978, to become effective March 1, 1978 as R.1978 d.2. See: 9 N.J.R. 431(c), 10 N.J.R. 66(e).

1981 Revisions: Amendments became effective May 7, 1981 as R.1981 d.113. See: 13 N.J.R. 134(b), 13 N.J.R. 299(b). Further amendments became effective July 9, 1981 (to become operative August 1, 1981) as R.1981 d.219. See: 12 N.J.R. 700(a), 13 N.J.R. 430(b). Further amendments became effective September 10, 1981 as R.1981 d.333. See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).

1982 Revisions: Amendments became effective November 15, 1982 (operative February 1, 1983) as R.1982 d.403. See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).

1984 Revisions: Amendments became effective January 1, 1984 as R.1983 d.584. See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a). Further amendments became effective July 2, 1984 as R.1984 d.270. See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).

1985 Revisions: Amendments became effective February 4, 1985 as R.1985 d.7. See: 16 N.J.R. 1933(a), 17 N.J.R. 309(a).

1986 Revisions: Subchapter 3 was readopted effective March 24, 1986 pursuant to Executive Order 66(1978) as R.1986 d.128. See: 18 N.J.R. 154(a), 18 N.J.R. 847(b). Further amendments became effective June 16, 1986 (operative July 1, 1986) as R.1986 d.236. See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a). This chapter was readopted pursuant to Executive Order 66(1978) effective August 26, 1986 with amendments to Subchapter 11 effective September 22, 1986 as R.1986 d.385. See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

1987 Revisions: 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). See section level for further amendments.

1991 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 56 was readopted by R.1991 d.473, effective August 21, 1991. See: Source and Effective Date.

See subchapters and sections for specific rulemaking activity.

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SUBCHAPTER 1. DENTAL SERVICES; GENERAL PROVISIONS

10:56–1.1 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 patient. The services of only one attending dentist will be recognized at a given time.

"Bundled drug service" means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

"Concurrent care" means that type of service rendered to a patient by practitioners where the dictates of dental necessity requires the services of dentists of different specialties in addition to the attending dentist so that appropriate and 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 patient, history, appropriate 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 appropriate therapy. A consultation should not be confused with "referral for treatment" when one practitioner refers a patient to another practitioner for treatment, either specific or general, that is, 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; etc. For additional procedures on consultation, please refer to N.J.A.C. 10:56–1.23.

"Dental Services" means any diagnostic, preventive, or corrective procedures administered by or under the direct personal supervision of a dentist in the practice of his profession. Such services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may effect 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 and provided to most persons in the community within the limitations and exclusions hereinafter specified.

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

"Emergency" means a specific condition of the oral cavity and/or contiguous tissues which cause severe and/or intractable pain or could compromise the life, health, or safety of the patient 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.

NOTE: When a case of an emergency nature arises and consultation with the attending practitioner is impossible, due consideration must be given to the preservation of those teeth that could be involved in the overall treatment plan of the attending practitioner.

"Participating dentist" means any dentist licensed to practice dentistry by the appropriate agency of the State where the dental services are rendered, who accepts the policies, regulations and procedures as promulgated by the New Jersey Division of Medical Assistance and Health Services, and signs a provider agreement.

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

NOTE: If in the opinion of a dentist, the patient requires the services of a specialist, he must note the name of the practitioner to whom the patient is being referred on the Dental Services Claim Form (MC–10) (remarks). The specialist must note the name and individual Medicaid practitioner number (IMP number) of the referring dentist on the Dental Services Claim Form (MC–10) (referring practitioner).

"Specialist" means one who is licensed to practice dentistry in the state where treatment is rendered, who limits his practice solely to his specialty, which is recognized by the American Dental Association.

NOTE: Further conditions regarding the qualifications for a dental specialist for the New Jersey Medicaid Program may be found at N.J.A.C. 10:56–1.13.

"Transfer" means the relinquishing of responsibility for the continuing care of the patient by one dentist and the assumption of such responsibility by another dentist. Such transfers will require a new authorization where prior authorization is required.

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."

10:56–1.2 Dental treatment plan

(a) In accordance with good dental practice, a plan of treatment, as appropriate, shall be developed and described for all patients on the Dental Services Claim Form (MC–10) following an examination. If no treatment is necessary, this fact must be entered on the dental form (diagnosis).

(b) The dental treatment plan not requiring prior authorization may be reviewed by dental consultants of the New Jersey Medicaid Program to determine its appropriateness.

(c) In those instances where prior authorization is necessary, a dental consultant may modify the provider's treatment plan in accordance with the guidelines of the dental aspects of the New Jersey Medicaid Program. If in the professional judgment of the provider such modification is not appropriate, he may request another review by the dental consultant. A further review in the office of the Chief, Bureau of Dental Services may be requested through the dental consultant.

(d) In any dental treatment plan, the dentist must discuss the proposed treatment with the patient or responsible person.

(e) Consideration for development of a dental treatment plan shall be based upon the least costly treatment fulfilling the requirements of the specific situation.

(f) Authorization for a dental treatment plan does not guarantee eligibility for payment under the New Jersey Medicaid Program. The validation form should be examined carefully on each visit to be certain the patient is currently eligible.

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.

10:56–1.3 Prior authorization

(a) Prior authorization means approval by a dental consultant of the New Jersey Medicaid Program before a service is rendered. All dental service claim forms to request prior authorization should be submitted to:

Division of Medical Assistance and Health Services
Dental Claims Review Unit
CN–713
Trenton, New Jersey 08625
Telephone: (609) 633–7787

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

1. Diagnostic examination with required radiography (limited to a maximum of $25.00) necessary to develop a treatment plan;

2. Emergency treatment with required radiography;

3. Adjustments to, or repair of dentures when the Medicaid reimbursement does not exceed $53.00, specialist fee or $48.00, nonspecialist fee.

4. Routine dental services, as limited to those designated below, may be performed to the extent that they are dentally necessary:

i. Oral prophylaxis;

ii. Topical fluoride application for persons 20 years of age and under;

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

iii. Restoration of carious permanent and deciduous teeth with silver amalgam, composite, or other plastic materials;

iv. Pulp capping for permanent and deciduous teeth;

v. Pulpotomy for permanent and deciduous teeth. More than one pulpotomy requires prior authorization;

vi. Uncomplicated extractions of non-restorable teeth;

(1) Exception: Extractions necessitating a dental prosthesis require prior authorization.

vii. All dental services other than those listed as not requiring prior authorization in this subsection are defined as non-routine dental services and must be authorized.

viii. No reimbursement will be made for any dental service performed beyond one year (365 days) from the date of the initial examination on that treatment plan.

(c) Procedures which require prior authorization include:

1. Treatment plans involving a combination of routine and non-routine dental services;

2. All treatment plans involving non-routine dental services;

3. Supplemental authorization:

i. Additional and/or amended services found necessary after the dental treatment plan has been authorized may be requested by recording such need on the Dental Services Claim Form (MC–10). This should then be submitted for supplemental authorization together with the original treatment plan. Payment will not be made for such treatment without authorization (see subsection (a)).

ii. No reimbursement will be made for any dental services performed beyond one year (365 days) from the date of the initial examination on that treatment plan.

(1) Exception: Orthodontic treatment.

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.

10:56–1.4 Noncovered services

(a) A noncovered service is that procedure which is primarily for cosmetic purposes or for which dental necessity cannot be demonstrated.

(b) Any bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid Program.

1. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

2. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

i. Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug in someone who has been receiving bundled drug would result in deprivation of life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

ii. Those instances where use of the bundled drug has show marked improvement in the recipients clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

3. In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultation, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625–0712.

4. If the Commissioner determines that a bundled drug is eligible for reimbursement under this section, New Jersey Medicaid recipients shall be eligible for the bundled drug service if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to establish that it is medically necessary to continue the bundled drug services and mailing the completed form and documentation to:

Medical Director
Division of Medical Assistance and Health Services
CN 712
Trenton, NJ 08625–0712

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.

10:56–1.5 Standards of service

(a) The dental treatment plan provided shall be in accordance with the ethical and professional standards of the dental profession.

(b) All materials used must meet the specifications established by the American Dental Association.

10:56–1.6 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. The request must 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.

10:56–1.7 Utilization review, quality control and peer review

(a) For the purposes of the New Jersey Medicaid program utilization review, quality control and peer review are considered to be ongoing components in regard to the dental services provided to eligible recipients.

(b) Utilization refers to that service, procedure or item provided to a patient by a qualified provider in a setting at a time and in an amount which is appropriate and acceptable to the standards of the profession at an appropriate cost.

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

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

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

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

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

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

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

10:56–1.8 Patient records

(a) Dentists are required to maintain individual patient records which fully disclose the type and extent of services provided to the New Jersey Medicaid Program recipient detailing all services rendered for each encounter date. Such records must be maintained in the provider's office regardless of the actual place of service (such as dental office, long-term care facility, hospital) for a minimum of seven years following the last date of service rendered. The dentist must also document services in appropriate facility records as required in (b) and (c) below. Such information must be readily available to representatives of the New Jersey Medicaid Program or its agents as required.

1. The record shall consist of the following:

i. Pertinent dental/medical history;

ii. Detailed clinical examination data to include where applicable:

(1) Patient's chief complaint;

(2) Diagnosis;

(3) Cavities;

(4) Missing teeth;

(5) Abnormalities.

iii. Preoperative, progress, and postoperative radiographs (retained for a minimum of seven years; check with your professional liability insurance company for a possible retention for longer periods). The number and type of radiographs should be entered on patient's record.

iv. Treatment plan with description of treatment rendered to include where appropriate:

(1) Tooth number;

(2) Surfaces involved;

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

(4) Materials used;

(5) Date(s) of service(s).

v. Medications:

(1) Ordered by prescription or OTC;

(2) Used in office treatment.

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

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

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

ix. Reasons for discontinuation of services (including attempts to complete treatment).

x. Referral and consultation reports.

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

(c) A dentist who provides services for a long-term care facility patient (regardless of the place of service) must in addition to maintaining his own office records, provide the long-term care facility with an entry for the patient's clinical record that includes the following:

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

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

2. A time frame, established on an individual basis, for the next periodic examination of the recipient. It is

mandatory that this be documented either at the time of examination, or at the completion of treatment. It may be entered on the clinical record for six months, one year, two years, three years, or any other time period that the attending dentist has established per his knowledge of the patient and the patient's dental status.

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

i. A photocopy of the completed and signed Medicaid Dental Services Form (MC–10) for examination and treatment will be accepted in lieu of a separate entry only if treatments (visits and description thereof) that preceded or followed the "dates of service" entered on the Form MC–10 are listed separately on the patient's clinical record.

As amended, R.1981 d.219, eff. July 9, 1981 (to become operative August 1, 1981).
See: 12 N.J.R. 700(a), 13 N.J.R. 430(b).
(a): New text substituted for old; (a)1: "include but not be limited to" was "consist of."
(b) and (c) added.
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Prosthetic service changed from five to seven and one-half years.

10:56–1.9 through 10:56–1.10 (Reserved)

10:56–1.11 Basis of payment

(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. If a patient receives care from more than one member of a partnership or corporation in the same discipline for the same service, the maximum payment allowance would be the same as that of a single attending dentist. The allowable fee for a given service shall constitute full payment. No private agreement, transaction or additional charge may be made by the dentist with, or on behalf of the covered person.

(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 should 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 should be detailed on the dental form (MC–10), or in the case of an appliance, denture or crown, and so forth, the case to the point of completion should be forwarded to the regional dental consultant for proration as determined by the Chief, Bureau of Dental Services. The case will be returned to the provider and should be retained for at least one year.

(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 patient 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 patient 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.

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

ii. Extractions 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.

2. Exception: 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 a specific arch is extracted during the period of eligibility.

i. A denture, complete or partial, may be furnished in the opposing arch, if appropriate within the guidelines of the program, and 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.

iii. Notwithstanding anything in these regulations to the contrary, payment may be made for an immediate complete denture (and the extractions of teeth incident to the insertion of that denture) initiated after termination of eligibility. However, prior authorization must have been obtained during an eligible period and all preliminary extractions (other than those extractions done in conjunction with procedure code 5135) completed during the period of eligibility.

iv. A denture, complete or partial, may be furnished in the opposing arch, if appropriate within the guidelines of the program, and authorized in conjunction with the above denture.

v. 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. Authorization procedures set forth in these regulations are applicable.

(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 10:49–1.7 Utilization of Insurance Benefits for further information. Supplementation may be made by the Medicaid program up to the provider's customary and usual fee, but the combined total shall 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. No coinsurance will be payable by the New Jersey Medicaid Program in combination Medicare/Medicaid cases, however, payment toward the deductible will be made.

3. No payments will be made by the program for any automobile accidents occurring on or after January 1, 1973, which are covered by "no fault" insurance polices (New Jersey Automobile Reparation Reform Act, P.L. 1972, c.70). For more detailed information, please refer to this subchapter.

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).

10:56–1.12 Place of service

(a) In addition to the private office, dental services may be provided in the home, a hospital, approved independent clinic, long term care facility, 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 patient or the providers of services.

1. Policies specific for dental services rendered in the outpatient departments of approved licensed hospitals and services rendered in approved independent clinics are described in their respective manuals.

i. Hospital outpatient dental clinics are subject to the same New Jersey Medicaid Program policies, procedures and reimbursement schedule as outlined in this manual that apply to the dentist in "private" practice (reference is made to N.J.A.C. 10:52–2.8A).

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

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

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

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

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

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

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

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

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

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

4. The dentist who examines a long term care facility patient must provide the treatment necessary unless the examination indicates that a specialist is needed.

As amended, R.1973 d.259, eff. October 1, 1973.
See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).
As amended, R.1981 d.219, eff. July 9, 1981 (to become operative August 1, 1981).
See: 12 N.J.R. 700(a), 13 N.J.R. 430(b).
(c)3 added.
Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Added text in (a) "However, for recipients ... to N.J.A.C. 10:49–1.2)."
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

10:56–1.13 Requirements for specialists

(a) The following conditions shall apply to specialists as defined in N.J.A.C. 10:56–1.1:

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

2. In those states not requiring specialty certification:

i. Is a diplomate of the appropriate American Dental Association recognized board; 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 written documentation to the Prudential Insurance Company Medicaid Claims Division II, Provider Enrollment Section, P.O. Box 5007, Millville, New Jersey 08332. This documentation must be as follows:

1. In New Jersey, and where required in other states, a copy of the specialty certificate/permit issued by the appropriate agency of the state where dental services are to be rendered; or

2. In those states not requiring specialty certification and when the practitioner is not listed in the Directory of the American Dental Association under "Character of Practice–Specialist."

i. From his specialty board indicating his specialist status as a diplomate; or

ii. From the American Dental Association stipulating that he meets the minimum requirements for his specialty.

(c) Specialist reimbursement where appropriate will be limited to the following specialties.

1. Oral surgery;

2. Endodontics;

3. Pedodontics;

4. Orthodontics;

5. Periodontics;

6. Prosthodontics.

New Rule R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

10:56–1.14 Diagnostic Services

(a) Examination rules are:

1. A complete examination of the oral cavity must be a comprehensive and thorough inspection of the oral cavity to include diagnosis, charting, and recording of the recommended treatment. It should permit a Dental Consultant (with accompanying X-rays) to determine the appropriateness of the treatment plan.

i. This dental examination is reimbursable only when part of a total treatment plan, unless the examination discloses no need for treatment, in which case this must be indicated by placing the statement, "No other treatment necessary (N.O.T.N.)" in the Diagnosis box on the Dental Form (MC–10).

ii. For reimbursement purposes, a complete dental examination shall be limited to once every six months for those patients through age 17 and once every 12 months for those patients 18 years of age or older except as authorized by a Dental Consultant of the Medicaid Program.

2. An emergency oral examination is distinguished from a complete examination of the oral cavity in that it is applicable only for diagnosis and/or observation of a specific complaint in an emergency situation. It is not reimbursable as an adjunct when other reimbursable services are performed (except diagnostic X-rays).

3. The dentist who examines a long-term care facility patient must provide the treatment necessary unless the examination indicates that a specialist is needed.

4. Handicapping Malocclusion Assessment Examination (refer to N.J.A.C. 10:56–1.21).

i. Since orthodontic treatment will not be authorized for individuals age 20 or older, (see N.J.A.C. 10:56–1.21(b)1ii) the Handicapping Malocclusion Assessment Examination is not reimbursable for individuals age 20 or older.

ii. For reimbursement purposes, a Handicapping Malocclusion Assessment Examination is limited to once every 12 months unless authorized. In addition, reimbursement is limited to the provider or provider group who does such an examination with the intention of personally providing any orthodontic treatment necessary.

(b) Radiography rules are as follows:

1. Radiological procedures are limited to those normally required to make a diagnosis and as may be dentally appropriate. Radiographs must be taken to show all areas where treatment is anticipated.

i. Exception: Soft tissue lesions.

2. The originals of all X-ray films must be available to authorized representatives of the New Jersey Medicaid Program or other agencies of the State of New Jersey as approved by the New Jersey Medicaid Program. Forward them to the Division of Medical Assistance and Health Services as follows:

i. When procedures requiring prior authorization are requested (forward them to the Medicaid Dental Consultant);

ii. Upon request for post utilization review; and

iii. Upon request for adjudication of claim reimbursement problems;

iv. X-rays may be reviewed by dental consultants of the Medicaid Program and/or dentists representing organized dentistry, if appropriate. It is recommended that the two film packet be used or a copy be made by those dentists who wish to retain a set of X-ray films in their office at all times.

3. Reimbursement for dental X-rays shall be limited according to the following guidelines.

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

(1) Up to and including age six—eight films (six periapical plus two bitewing films);

(2) Age seven, up to and including age 14—12 films (10 periapical films, plus two bitewing films);

(3) The need for additional films in (b)3i(1) and (2) above must be substantiated and the specific authorization obtained from the Dental Consultant.

(4) For those patients 15 years of age or older—16 X-rays (at least 14 periapical plus two posterior bitewing films).

(5) The three year limitation in (b)3i(1), (2), and (4) above will continue to apply even though there should be an age change that would transfer the patient from one age category to another. For example, a patient who has eight X-rays at age six is not eligible for the 12 film series until he or she has reached age nine and three years have passed.

4. In an emergency situation, in order to establish a diagnosis (which must be recorded in Item 16 of Dental Claim Form MC–10) an X-ray may be taken at any time as dentally appropriate.

5. All X-ray films must be suitable for interpretation and when submitted to the New Jersey Medicaid Program or its agents must be properly mounted, marked "Right" and "Left" and identified with the patient's name, the date, and the name of the dentist. Films that are technically unacceptable for proper interpretation will be returned to the provider for replacement at no additional cost to the Medicaid program, or where appropriate, no reimbursement will be made. When already reimbursed, recoupment will be made where indicated.

6. The originals of all X-ray films must be forwarded to the dental consultant when procedures requiring prior authorization are requested. It is recommended that the two film packet be used or a copy made by all dentists who wish to retain a set of X-ray films in their offices at all times.

7. Postoperative X-rays normally taken at the conclusion of dental treatment by a dental provider shall be maintained as part of the patient's dental records (for example—final X-ray(s) at completion of endodontic treatment, certain surgical procedures, and so forth).

8. The originals of all X-rays must be available to authorized representatives of the New Jersey Medicaid Program or other agencies of the State of New Jersey as approved by the New Jersey Medicaid Program. Such X-rays will be reviewed by dental consultants of the Medicaid program and/or dentists representing organized dentistry, if appropriate.

9. It is most important, also, that all X-rays be examined carefully by the provider to assure quality care and to make certain that all necessary treatment has been diagnosed and completed.

(c) "Clinical laboratory services" means professional and technical laboratory services ordered by a dentist within the scope of his practice as defined by the laws of the state in which he practices and provided by a laboratory that is qualified to participate under the program. Such laboratories include:

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

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

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

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

1. Services provided by another dentist, physician, or hospital facility must be billed directly to the program by that provider and not by the referring dentist.

(e) Prior authorization is required for reimbursement for additional aids such as diagnostic models, photographs, and so forth (exception—see section N.J.A.C. 10:56–1.21 of this subchapter).

As amended, R.1982 d.403, effective November 15, 1982. (Operative date: February 1, 1983.)
See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).
Section substantially amended.
As amended, R.1983 d.584, eff. January 1, 1984.
See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Section renumbered and (b)4 new.

10:56–1.15 Preventive dental care

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

1. Prophylaxis:

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

ii. For reimbursement purposes, dental prophylaxis shall be limited to once every six months for those patients through age 17 and once every 12 months for those patients 18 years of age or older except as authorized by a dental consultant of the Medicaid Program.

2. Fluoride Treatment:

i. Topical fluoride treatment should be administered in accordance with appropriate standards. This consists of topical application of stannous fluoride or acid fluoride phosphate as a liquid or gel. The use of fluoride incorporated in the prophylaxis paste is not reimbursable as topical fluoride treatment.

ii. A complete prophylaxis must be performed prior to the topical fluoride treatment.

iii. Reimbursement for topical fluoride treatment shall be limited to once every six months without authorization for those patients through age 17 and once every 12 months for those patients 18 years of age up to and including 20 years of age.

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

v. Oral fluoride medication may be prescribed (see: N.J.A.C. 10:56–1.22).

3. Recall: Participating dentists are requested to extend the same type of recall procedure to eligible recipients as is used in good dental practice to encourage the maintenance of dental health.

4. Patient education: Eligible recipients should receive dental health orientation identical to that given all patients.

As amended, R.1982 d.403, eff. November 16, 1982. (Operative date: February 1, 1983.)
See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).
Section substantially amended.
Amended, R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Old (a)1i deleted and new text substituted.

10:56–1.16 Restorative services

(a) Restorative treatment is limited to those services necessary to adequately maintain and restore the integrity and contours of the natural tooth.

1. Filling restorations:

i. Reimbursement for restorations in deciduous teeth is limited to deciduous cuspids and molars of children up to and including age nine, or in deciduous incisors up to and including age five, but not where exfoliation is imminent.

(1) Exception: Prior authorization by a dental consultant.

ii. Reimbursement will only be made when silver amalgam is utilized for restoration of posterior teeth and silicate cement, composite, plastic, or acrylic filling material is utilized for the six anterior teeth in each arch.

(1) Exceptions:

(A) Composite restorations may be provided on the mesial, occlusal, and buccal surfaces of the first bicuspids; however, the distal surface may also be provided, but only in conjunction with the mesial and occlusal surfaces; or

(B) Prior authorization by the dental consultant.

iii. Linings or bases will be provided under all fillings as required by good dental practice.

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

2. Crown restorations:

i. Authorization for crowns may be granted only when there is substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue justify this treatment. X-ray studies must be submitted.

ii. Generally, temporary (quick cure) acrylic or plastic (prefabricated) crowns or acid etch type restorations only, may be authorized for badly broken down anterior teeth up to and including age 15. Likewise, preformed stainless steel crowns may only be authorized for deciduous teeth and permanent posterior teeth up to and including age 17.

iii. Acrylic or porcelain veneer on metal may be authorized only when esthetically necessary.

iv. Porcelain jackets will not be authorized.

As amended, R.1975 d.262, eff. September 1, 1975.
See: 7 N.J.R. 318(a), 7 N.J.R. 466(a).

10:56–1.17 Endodontia

(a) When requesting endodontic treatment, consideration should be given to the age and general health of the patient, the status of the tooth in the arch, and the condition of the remaining dentition and supporting structures.

1. Reimbursement for root canal therapy for all teeth shall include extirpation, treatment, complete filling of the root canal(s) with permanent material, all necessary X-rays during treatment and postoperatively, and follow-up care.

i. Prior authorization is necessary. When the patient is in pain, the dentist should institute appropriate emergency measures to extirpate the pulp and/or relieve the pain only until authorization is requested and received.

2. Pulpotomy: A pulpotomy will be limited to a deciduous tooth or a permanent tooth with incompletely formed roots. A postoperative X-ray must be available.

3. Pulpectomy: Root canal therapy for deciduous teeth (with permanent successors only) will include extirpation, treatment, and filling of the root canal(s) with resorbable filling material. A postoperative X-ray must be available.

4. Pulp capping (direct) is defined as an obtundent or regenerative dressing over the directly exposed vital pulp. This is differentiated from the routine placement of a medicated base or lining under a filling, which is not reimbursable.

5. Apicoectomy:

i. Apicoectomy will be considered for authorization and reimbursement only if one or more of the following conditions exist:

(1) Overfilled canal (previously treated tooth);

(2) Canal cannot be filled properly because of excessive root curvature or calcification;

(3) Fractured root tip that cannot be reached endodontically;

(4) Broken instrument in canal;

(5) Perforation of the apical third of canal;

(6) Broken root canal filling lying free in periapical tissues and acting as an irritant;

(7) Periapical pathology not resolved by previous endodontic therapy;

(8) Periapical pathology which will not be resolved by endodontic therapy alone;

(9) A post, post and core, or post-crown which cannot be removed.

ii. Apicoectomy should not be performed for convenience. If endodontic treatment is necessary, but none of the above conditions exist, reimbursement for the apicoectomy will not be made.

iii. Retrograde filling(s) will be inserted when necessary in conjunction with appropriate endodontic treatment, but not in lieu of a properly filled canal.

iv. Post-treatment X-rays are required.

Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Note is renumbered to (a)5ii.

10:56–1.18 Periodontal treatment

(a) Periodontal treatment may be authorized on a very selective basis. A detailed description of the condition, including radiographs must be submitted to the dental consultant.

(b) When requesting periodontal treatment, consideration should be given to the age and health of the patient, the amount of bone loss, the condition of the remaining dentition, the desire, ability, and motivation of the patient to follow through with necessary home and follow-up care, and the prognosis, that is, will the requested treatment preserve the remaining teeth for an appreciable length of time.

10:56–1.19 Prosthodontic treatment

(a) Fixed bridges will not be authorized.

(b) Removable denture policies are as follows:

1. Dentures, both partial and complete, may be authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the patient. Prefabricated dentures or dentures that are temporary in nature are not reimbursable.

2. The following factors should also be considered when requesting authorization for dentures (including immediate dentures);

i. Age, school status, employment status and rehabilitative potential of the patient (for example, provision of dentures will enhance vocational placement);

ii. Medical status of patient (nature and severity of disease or impairment) and psychological predisposition;

iii. Condition of the oral cavity, including abnormal soft tissue or osseous conditions;

iv. Condition of present dentures, if applicable.

3. Generally, authorization for partial dentures to replace posterior teeth will not be permitted if there are at least eight posterior teeth periodontally sound in good occlusion and position, or where prosthesis in one arch will produce equivalent dentition.

4. Normally, there must be a three month wait (for healing) between the date of last extraction and initiation of the denture(s) (partial or complete) (except immediate denture(s)).

i. Should the provider initiate the denture treatment (that is, take final impressions) prior to the expiration of the three month healing period, he will be responsible for all subsequent relines, rebases, and/or remaking of the denture(s) if necessary for a six month period following insertion.

ii. When all services are to be performed by the same practitioner, the total treatment plan for the extractions and denture(s) will be authorized in toto. As soon as the extractions are completed the claim should be submitted for payment for the diagnostic and/or extractions service. After the required period of time for healing has taken place and the denture provided, a second claim should be completed (for the dentures only) and submitted to contractor marked "continuation of previously authorized treatment plan".

5. The fee for complete maxillary and/or mandibular dentures will include necessary adjustments for a six month period following insertion.

i. The fee for immediate dentures will include the necessary adjustments and relines for a six month period following insertion.

6. Partial dentures must be described on the Dental Services Claim Form (MC–10), indicating material used, position of clasps and teeth to be replaced. Fee includes necessary adjustments for a six month period following insertion.

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

8. Dentures will not be authorized when:

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

ii. Dental history reveals that a denture was provided through any New Jersey State, county, or municipal agency in the seven and one-half (7½) year period prior to the date of the current request; or

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

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

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

10. The patient's name (first and last names or where space is a factor, first initial and last name) must be processed into all dentures during the original fabrication or where possible during any subsequent processing procedure (repair, reline, rebase, and so forth). The social security number should also be included if space permits.

As amended, R.1984 d.270, eff. July 2, 1984.
See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).
Section substantially amended.
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
(b)9 "Denture" substituted for "Dental".

10:56–1.20 Exodontia and oral surgery

(a) Exodontia rules are as follows:

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

i. Where any extraction is being considered which will necessitate the insertion of a dental prosthesis, prior authorization is mandatory. Reimbursement for such an extraction(s) rendered without appropriate authorization will be denied, or if already paid, reimbursement will be recovered. Due to the rule limiting the authorization of denture(s) (refer to N.J.A.C. 10:56–1.19) it may be impossible to replace a denture(s) following such extraction(s). Therefore, careful consideration should be given to the condition of teeth:

(1) Prior to a request for dentures initially; and

(2) Prior to any extraction which would jeopardize an existing denture.

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

(1) That such orthodontic treatment has been authorized through the Chief, Bureau of Dental Services, Division of Medical Assistance and Health Services.

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

(A) In conjunction with orthodontic care if such orthodontic treatment has not had authorization from the Chief, Bureau of Dental Services; or

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

2. Reimbursement for dental extraction(s) will include indicated alveoplasty.

3. Alveoplasty, not related to current dental extraction(s), is reimbursable based on demonstrated dental necessity.

4. Reimbursement will not be made for the extraction of impacted teeth which have not been prior authorized. Extraction of impacted teeth will be authorized only when conditions arising from such impactions warrant their removal. Thus, the extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be accepted for reimbursement.

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

(b) Oral surgery rules are as follows:

1. Requests for reimbursement or authorization of oral surgical procedures must include a detailed description giving dates, diagnosis, site, and size of the operative area (number of lesions, number and size of lacerations, and so forth). For authorization, preoperative and postoperative X-rays, radiological, operative, and laboratory reports should be submitted directly to the dental consultant with the dental form (MC–10). The dentist will also be responsible for making available all other reports, including hospital X-rays upon request.

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

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

i. The laboratory performing the diagnostic service (and not the dentist) must bill the program directly.

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

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.

10:56–1.21 Orthodontic treatment

(a) The following procedures are to be followed for orthodontic referral, evaluation, and treatment.

(b) Authorization for orthodontic treatment shall be selective and limited to handicapping malocclusions as determined by the Medicaid Dental Consultant.

1. Orthodontic treatment will not be authorized:

i. For cosmetic purposes only;

ii. For individuals age 20 or older.

2. The following factors must be considered by a dentist before making any referral and also by the practitioner who may render orthodontic treatment before assessing the patient and performing the diagnostic workup:

i. All referrals for orthodontics and requests for orthodontic treatment should be delayed until the patient has all succedaneous teeth.

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

iii. The rehabilitative potential of the patient should be considered.

iv. Reminders:

(1) Many children become ineligible for Medicaid at age 18.

(2) The prospects of the patient remaining in the geographic area where treatment is to be rendered should be considered.

(3) The time period that the patient will remain eligible for Medicaid benefits should be sufficient to complete the treatment.

(4) The New Jersey Medicaid Program will not reimburse a provider for orthodontic treatment rendered during periods of ineligibility.

(c) The New Jersey Medicaid Program Handicapping Malocclusion Assessment System[1] is to be utilized to determine the need for a diagnostic workshop.

1. A reprint from the American Journal of Orthodontics (10/68) entitled "Handicapping Malocclusion Assessment to Establish Treatment Priority" provides comprehensive instructions for completion of the assessment record. A copy of the reprint can be ordered from:

The Prudential Insurance Company
P.O. Box 1900
Millville, New Jersey 08332

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

1. The practitioner, after considering the factors in this section, performs a visual/oral examination of the patient, and completes the Assessment Record Form (FD–10) to determine if the severity of the malocclusion will qualify (24 points) for further diagnostic workup and submission of a proposed treatment plan.

2. If the malocclusion does not meet the minimum number of assessment points (24), do not proceed with

the diagnostic workup since 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, you may proceed with the diagnostic workup; however, these factors must be noted and substantiated when submitting the diagnostic workup and treatment plan for prior authorization.

ii. Examples:

(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.

iii. For reimbursement of the Assessment Examination only, submit the contractor copy of a Dental Claim Form (MC–10) directly to:

The Prudential Insurance Company
Medicaid Claims Division II
P.O. Box 1900
Millville, New Jersey 08332

identifying, by procedure code 0140, the service that has been rendered. A copy of the Assessment Record Form (FD–10) must accompany this submission (Limitation—see N.J.A.C. 10:56–1.14(a)4i).

iv. Submission of requests for treatment with assessments below the minimum number of points required without sufficient justification (see N.J.A.C. 10:56–1.21(d)2 above), or due to incorrect calculation, will necessitate denial of reimbursement for the diagnostic materials submitted.

3. If the malocclusion meets or exceeds the minimum number of assessment points (24), the practitioner may proceed with the diagnostic workup without obtaining prior authorization.

(e) Rules concerning prior authorization for orthodontic treatment 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 form (MC–10) utilizing the proper code number 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 form (FD–10);

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

(1) Diagnostic models with the correct inter-arch relationship indicated;

(2) A cephalometric radiograph with a detailed tracing;

(3) A series of intra-oral radiographs consistent with policy as stated in section 1.14 of this subchapter (or a diagnostic panoramic radiograph);

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

(5) Photographs (minimum size 2 inches by 2 inches) or slides—maximum reimbursable—six.

(6) All the diagnostic aids will be returned to the practitioner, but shall be made available upon the request of the Division of Medical Assistance and Health Services, Bureau of Dental Services. It is suggested that models and X-rays be duplicated before submission to enable you to retain a set in your 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, will request a progress report from the provider, and if necessary progress models and any 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.

(g) Final records similar to diagnostic aids described in (e)1iv above, taken at termination of treatment must be submitted with the claim for the last six monthly visits to:

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

In no instance will any of the last six monthly visits be payable until final records are received.

(h) Failure to submit the records referred to in (g) above, may result in the recovery, by the Division of Medical Assistance and Health Services, of an amount not to exceed that paid for the previous 12 months of treatment actually reimbursed to the provider.

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).

[1] 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. The major 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.

10:56–1.22 Adjunctive general services

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

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

2. Analgesia: An inhalation anesthetic for the purposes of analgesia is considered as part of an operative or surgical procedure, and no additional fee will be allowed.

3. General anesthesia: In any setting exclusive of a hospital, when general anesthesia is provided by the dentist, such may be authorized 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 9220 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 subchapter 3 of this chapter.) Prior authorization is required.

(3) An anesthesia record is maintained and submitted along with both the dental forms (MC–10) for anesthesia and treatment.

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

(B) Elapsed anesthesia time means the time from induction of the general anesthesia to the completion of the operation, or in other words, table (chair) time only.

4. Intravenous sedation: Reimbursement for the administration of intravenous sedation is 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 demonstrate the need for this service.

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

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

(b) Within the scope of accepted dental practice, intradermal, subcutaneous, intramuscular, and intravenous injections are reimbursable in the following setting: office, home, and those independent clinics reimbursed for dental services on a fee for service basis.

1. Reimbursement for the above injections are on 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 is reimbursable for the injection only. If other dental procedures are performed that are reimbursable, an injection may, if medically indicated, be considered in addition to the other procedures. The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage, frequency, and route of administration.

3. Intravenous injections are reimbursable only when performed by the dentist.

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

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

6. No reimbursement will be made for an injection given as a preoperative medication 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 must be inserted on the dental claim form (MC–10).

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

(d) Prescription policies are as follows.

1. This section is intended to describe the practitioner's responsibility in the writing of prescriptions in order to maintain the traditional patient-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.

i. All practitioners licensed or authorized to prescribe by the State of New Jersey, and who comply with all rules and regulations of the New Jersey Health Services (Medicaid) Program are eligible to prescribe for eligible Medicaid recipients. Out–of–State practitioners may prescribe under this program, as herein outlined, if they meet the same requirements in their state.

ii. The New Jersey Medicaid Program has an approved generic formulary. The prescriber should give preference to nonproprietary or generic named drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brand named drugs. When prescribing a brand named drug, the prescriber must indicate either formulary alternate permitted or dispense as written (may be abbreviated FAP or DAW) on each written or telephone prescription.

2. The practitioner's individual Medicaid practitioner number (IMP number) must appear on all prescriptions, and must be given to the pharmacist with all telephone orders. The appearance of this number in addition to the practitioner's name serves to expedite the mechanical aspects of processing the prescription claim. This requirement is a necessary and efficient step in computing each claim.

3. Patient's full name, address, and age must appear on prescription.

4. Dosage and directions: The practitioner must include specific directions on all drug prescriptions or the prescription will not be eligible for payment. Examples of nonacceptable directions are prn, as directed, ad lib, and so forth.

i. Exception:

(1) Topical application;

(2) Aerosol inhalers;

(3) Nitroglycerin; or

(4) Pharmacy items for which specific directions for use are seldom possible.

5. The choice of prescription drugs remains at the discretion of the prescribing practitioner. However, the practitioner should be aware that pharmacies will not receive payment for certain prescription drugs. (See (d)8 below).

i. When prescribing a trade name multi-source drug product for which a maximum allowable cost (MAC) limitations has been established by the Pharmaceutical Reimbursement Board, Department of Health, Education and Welfare, limitation shall not apply in any case when a physician certifies in his own handwriting that in his medical judgment a specific brand is medically necessary for a particular patient. In this instance, the dentist must write brand necessary or dispense as written in his own handwriting on each written or telephone prescription.

ii. The practitioner should give preference to:

(1) Drugs listed in the latest edition of the United States Pharmacopoeia (U.S.P.), National Formulary (N.F.), A.M.A. Drug Evaluation, and Accepted Dental Therapeutics;

(2) Oral medication when as effective as injectable preparations.

6. Quantity of medication:

i. The quantity prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60 day supply.

ii. Any drug used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the patient for up to 60 days.

iii. In long term medical care facilities (that is, skilled nursing home, infirmary section of home for the aged, or public medical institution), if the quantity of sustaining drug or maintenance medication is not indicated in writing by the prescriber, the pharmacy provider must dispense an appropriate quantity of medication not to exceed a one month supply.

(1) Exception:

(A) Vitamins and vitamin-mineral combinations may be prescribed and dispensed in quantities up to a 100 day supply.

(B) Hypodermic syringes and/or needles may be prescribed and dispensed in quantities up to a 100 day supply (drugs to be administered to a patient by other than the prescriber or an employee of the prescriber. Written prescription must include this statement, "Medicaid authorized").

(C) Sodium fluoride drops, tablets, or oral rinse/supplement may be prescribed and dispensed in quantities up to a 100 day supply.

7. Services requiring prior authorization: The following therapeutic classes and dosage forms require prior authorization obtained by the prescribing practitioner from the local medical assistance unit. If the request is approved, an authorization number will be provided and must appear on the prescriber's original prescription. The pharmacist must check the box in the space provided on the prescription claim form (MC–6) identifying a prior authorized item and enter the authorization number in the proper space in this area.

i. Antiobesics and anorexics;

ii. Protein replacement products, such as (but not limited to) Probana, Portagen, Nutramigen, and Neo–Mullsoy;

iii. Preventive drugs when not available through the Department of Health or provided without charge by public or voluntary agencies;

iv. Injectable drugs: Drugs to be administered to a patient by other than the prescriber or an employee of the prescriber. Written prescription must include the statement, "Medicaid authorized".

v. Methadone:

(1) Exception: Not reimbursable for use in drug detoxification or for addiction.

8. Pharmaceutical services not eligible for payment:

i. Drugs for which adequate literature, that is, package inserts, and so forth and price catalogues are not readily available;

ii. Experimental drugs;

iii. Drugs administered or directly furnished by the practitioner. (Payment for drugs will be made only when dispensed by a registered pharmacist in a licensed pharmacy.)

iv. Preventive drugs and biologicals provided without charge through programs of other public or voluntary agencies (that is, New Jersey State Department of Health, and so forth).

v. Medications prescribed for use by hospital inpatients.

vi. Prescribed non-legend (OTC) drugs for patients in long-term medical care facilities (that is, skilled nursing homes, infirmary sections of a home for the aged or public medical institutions).

vii. Prescriptions written and dispensed with non-specific directions.

viii. Telephoned refill prescriptions.

ix. Medication prescribed for a Title XIX (Medicaid) covered person who is receiving benefits under part A of Title XVII (Medicare) as a patient in a long-term care facility.

x. Prescribed non-legend drugs unless specifically listed in Appendix B (Allowable non-legend drugs). (Appendix B is furnished separately as a loose-leaf section of the New Jersey Blue Cross Drug Code Register.) The register is available from Blue Cross.

xi. Food supplements, milk modifiers, infant formula, and therapeutic diets.

(1) Exception: Protein replacements.

xii. Methadone when used for drug detoxification or addiction.

xiii. Drugs for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA).

9. Telephoned original prescriptions:

i. Prescriptions may be telephoned to the pharmacist when in accordance with all applicable Federal and State laws and regulations, and must include prescriber's individual Medicaid practitioner number (IMP number).

ii. When a physician chooses to certify brand necessary or dispense as written or a MAC listed drug product, he must submit a written prescription order to the pharmacist, containing the certification within seven days of the date of the telephone order. The prescription must be retained by the pharmacist as the original prescription. Failure to comply will result in the claim for that prescription to be reduced to the MAC reimbursement level.

(1) For drugs listed in the New Jersey Medicaid formulary, the prescriber must indicate either formulary alternate permitted (FAP) or dispense as written (DAW) for each prescription transmitted. Then, the pharmacist shall transpose this information onto the written prescription.

10. Prescription refill:

i. Refill instructions must be indicated by the practitioner on his original prescription.

(1) Telephone orders for refills are not permitted.

ii. Prescriptions are limited to a maximum of two refills within a six month period. If additional quanti-

ties of the same medications are required, a new prescription must be written by the practitioner.

(1) Exception: Vitamins and vitamin/mineral combinations originally prescribed for a 100 day supply may be refilled two times within one year.

iii. Refill instructions indicating "refill PRN" or indicating more than two refills will be honored for payment only up to the limits imposed in this subsection.

11. Medical/dental supplies:

i. Medical/dental supplies and equipment and other devices that are essential for the patient's medical/dental condition are allowable unless otherwise available at no charge from community resources (that is, The American Cancer Society, service organizations, and so forth). A personally signed legible and dated order by the practitioner is required.

ii. Following receipt of a prescription from the dentist; prior authorization from the Medicaid District Office must be obtained by the provider (pharmacist or medical supply dealer) for certain medical/dental supplies; therefore, the practitioner must be prepared to certify and document medical/dental necessity to the dental consultant.

iii. Normally, claims for items under $30.00 require no prior authorization (unless specifically required in the provider manual and/or HSP newsletters).

iv. Exception: Oral hygiene devices require prior authorization regardless of cost.

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

(2) Standard tooth brushes, dental floss, and so forth are personal hygiene items and therefore not reimbursable.

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), 67 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.

10:56–1.23 Consultations

(a) Consultations are subject to the following conditions:

1. A written report must be provided to the referring practitioner which includes diagnosis and recommendations for future management. A copy must be retained with the patient's records and must be available, upon request, to the New Jersey Medicaid Program or any of its authorized representatives.

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

ii. When consultation services are requested, the referring practitioner must include in his clinical records and on the Dental Services Claim Form MC–10 (remarks) the name of the consulting practitioner to whom the patient is being referred. The consulting practitioner must note the name and the individual Medicaid practitioner number (IMP number) of the referring (attending) practitioner in his clinical records and on the Dental Services Claim Form (MC–10) (referring practitioner).

iii. A consultation will be disallowed if there is no referring practitioner, that is, the patient makes an appointment on his own.

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

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

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

vii. If a consultation is billed in an Emergency Room setting and the patient is then admitted to the consultant's service as a hospital inpatient, future visits of the consultant may be billed as a Hospital Day—Subsequent. If the patient is admitted to another practitioner's service, that practitioner may bill for Hospital Day—Initial. Future visits of the consultant for that inpatient hospitalization may be billed as a Hospital Day—Subsequent—and be considered as concurrent care IF concurrent care can be justified as dentally/medically necessary.

R.1984 d.270, eff. July 2, 1984.
See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).

SUBCHAPTER 2. PROVIDER INSTRUCTIONS FOR REQUESTING AUTHORIZATION AND PAYMENT FOR DENTAL SERVICES

10:56–2.1 General billing procedures

(a) A claim is a bill which indicates a request for payment for a Medicaid-reimbursable service provided to a Medicaid-eligible individual. The claim may be submitted hard copy or by means of an approved method of automated data exchange.

(b) This subchapter contains basic information necessary for the proper completion and submission of a claim.

As amended, R.1974 d.203, eff. August 15, 1974.
See: 6 N.J.R. 242(a), 6 N.J.R. 313(c).
Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).
See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).
Deleted text in (b) "(SSI eligibility is on a three month basis)."
New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Old rule was patient eligibility.

10:56–2.2 Timeliness of claim submission and claim inquiry

For timeliness of claim submission and claim inquiry, see N.J.A.C. 10:49–1.12.

New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Old rule was Dental services form (MC–10) recodified with amendments to 10:56–2.3.

10:56–2.3 Dental Services Claim form (MC–10)

(a) "Dental Services Claim" form (MC–10) must be used for recording proposed treatment and also for billing of treatment rendered. See Exhibit I at the end of this chapter, N.J.A.C. 10:56, for a copy of the "Dental Services Claim" form (MC–10) and the instructions for the proper completion of the form.

(b) Procedure code numbers and descriptions as they appear in subchapter 3 of this chapter shall be used on this form. A fee shall be requested for each procedure and shall be the usual and customary fee of the provider.

(c) When prior authorization is necessary (refer to subchapter 1 of this chapter for those treatment plans requiring prior authorization), the dental form MC–10 (both copies) should be sent to the Dental Claims Review Unit, CN–713, Trenton, New Jersey 08625.

1. Out-of-state providers shall submit their dental form (MC–10) to the Bureau of Dental Services, CN–713, Trenton, New Jersey 08625, for prior authorization.

(d) Preoperative X-ray films must accompany the dental form (MC–10) when requesting authorization.

(e) Rules for payment are as follows.

1. Routine dental services:

i. After the routine dental services are completed, the patient (or his/her authorized representative) shall sign the dental form MC–10, item 22. The provider shall personally sign and date the dental form MC–10, item 23.

ii. The top copy (Fiscal Agent) of the "Dental Services Claim" form (MC–10) shall be forwarded to:

The Prudential Insurance Company of America
Medicaid Claims Division II
P.O. Box 1900
Millville, New Jersey 08332

(1) The second copy (Provider) should be retained by the provider.

iii. Request for payment must be submitted within the time frames specified in N.J.A.C. 10:49–1.12.

2. Authorized treatment plans:

i. After previously authorized treatment plans are completed, the patient (or his/her authorized representative) shall sign the dental form MC–10, item 22. The provider shall personally sign and date the dental form MC–10, item 23.

ii. The top copy (Fiscal Agent) of the "Dental Services Claim" form (MC–10) shall be forwarded to:

The Prudential Insurance Company of America
Medicaid Claims Division II
P.O. Box 1900
Millville, New Jersey 08332

(1) The second copy (Provider) should be retained by the provider.

iii. Request for payment must be submitted within the time frames specified in N.J.A.C. 10:49–1.12.

2. Authorized treatment plans:

i. After previously authorized treatment plans are completed, the patient (or his/her authorized representative) shall sign the dental form MC–10, item 22. The provider shall personally sign and date the dental form MC–10, item 23.

ii. The top copy (Fiscal Agent) of the "Dental Services Claim" form (MC–10) shall be forwarded to:

The Prudential Insurance Company of America

Medicaid Claims Division II

P.O. Box 1900

Millville, New Jersey 08332

(1) The second copy (Provider) should be retained by the provider.

iii. Request for payment must be submitted within the time frames specified in N.J.A.C. 10:49–1.12.

(1) When the provider submits a dental form MC–10 for payment before completion of the prior authorized treatment plan because the recipient has not returned to complete the treatment plan as set forth on the dental form, it must be indicated on that dental form. In the event the same recipient returns at a later date to complete the prior authorized treatment (should not exceed one year from date of initial examination), the provider may submit the second dental form to Prudential without prior authorization provided that there is no change in the treatment plan and the second dental form is marked "continuation of previously authorized treatment plan".

3. Orthodontic treatment:

i. Following utilization of the Handicapping Malocclusion Assessment system, when the malocclusion does not meet the minimum number of points, the practitioner should not proceed with the diagnostic work-up but shall bill for the Assessment Examination only by submitting the Fiscal Agent copy of a Dental Form (MC 10–2)

The Prudential Insurance Company of America

Medicaid Claims Division II

P.O. Box 1900

Millville, New Jersey 08332

using the appropriate code for the assessment examination. A copy of the Assessment Record Form (FD–10) shall accompany this submission (limitation—see N.J.A.C. 10:56–1.14(a)4i).

ii. If the malocclusion meets or exceeds the minimum number of assessment points but the case does not fall within the parameters that have been established for orthodontic treatment under the Medicaid program, the dental form (MC–10) with authorization of the diagnostic services performed will be returned to the provider for completion of those sections requiring patient and provider signatures and dates. The Fiscal Agent copy may then be submitted to Prudential at the above address for reimbursement.

iii. If the orthodontic treatment is approved, proceed as follows: Immediately, submit the contractor copy of the authorized dental form (MC–10) with dates of service for those diagnostic services performed to Prudential at the address above. This will be a request for payment for the diagnostic services and will also be Prudential's record of the total authorized orthodontic treatment plan. Retain the provider copy for the office records.

iv. As each stage of authorized orthodontic treatment is finished, complete a new Dental Claim Form (MC–10), insert treatment dates, procedure codes and descriptions, complete sections requiring patient and provider signature and submit the contractor copy directly to the Prudential Insurance Company at the address above, for reimbursement. Claims may be submitted monthly or quarterly until the authorized treatment is completed.

v. Reimbursement for the monthly fee is based on one or more visits to the practitioner during any calendar month. Reimbursement must not be requested for any month in which there is no patient visit.

vi. When authorized, reimbursement for comprehensive orthodontic treatment will include retention, as required, at no additional charge.

vii. Request for payment must be submitted to the Fiscal Agent, The Prudential Insurance Company of America, within the time frames specified in N.J.A.C. 10:49–1.12.

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.
Amended by R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).
Recodified from section 2.

10:56–2.4 Patient eligibility

(a) Patient eligibility should be verified by examining the validation form each time patient is treated.

(b) Since eligibility is usually on a monthly basis and most dental treatment other than diagnostic and/or emergency procedures will usually extend for a longer period, it is possible that a patient could become ineligible during the course of treatment.

(c) Payment will be made only for dental treatment completed to the date the patient is no longer eligible for services.

1. For exceptions, see subchapter 1 of this chapter.

New Rule, R.1987 d.408, effective October 5, 1987.
See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:56–3.1 Introduction

(a) The New Jersey Medicaid Program has adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). Dental HCPCS follows the American Dental Association's Codes on Dental Procedures and Nomenclature in order to "identify and categorize dental procedures covered under all types of third party programs. It is intended to facilitate the filing and processing claims, data tabulation, and the collection of statistics for third party program operation."[1] The HCFA assigned codes and modifiers may contain both alphabetic and numeric characters.

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

N.J.A.C. 10:56–3.2 —Diagnostic

N.J.A.C. 10:56–3.3 —Preventive

N.J.A.C. 10:56–3.4 —Restorative

N.J.A.C. 10:56–3.5 —Endodontics

N.J.A.C. 10:56–3.6 —Periodontics

N.J.A.C. 10:56–3.7 —Prosthodontics, Removable

N.J.A.C. 10:56–3.8 —Maxillofacial Prosthetics

N.J.A.C. 10:56–3.9 —Prosthodontics, Fixed

N.J.A.C. 10:56–3.10—Oral Surgery

N.J.A.C. 10:56–3.11—Orthodontics

N.J.A.C. 10:56–3.12—Adjunctive General Services

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

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

(d) Specific elements of the HCPCS Coding System which require the attention of the dental provider.

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

COLUMN TITLE

1. IND—(Indicator) Lists symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or service code is used.

Explanation of indicators used in this column is given below:

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

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

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

iv. "# " The cross-hatch (#) denotes those procedures for which special authorization requirements exist. Those requirements are listed adjacent to the procedure codes involved.

2. HCPCS CODES—Lists the HCPCS procedure code numbers.

3. MOD—(Modifier) Lists alphabetic or numeric characters. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed with appropriate procedure codes in this Subchapter 3. The Modifiers "22" and "52" are the copyright 1985, American Medical Association, Physicians' Current Procedural Terminology, Fourth Edition. The modifiers with definitions as designated for use in the New Jersey Medicaid Dental Manual are as follows:

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

NOTE: This modifier has also been applied when a dental laboratory procedure is used in conjunction with specified chairside procedures or where an adjunctive service is rendered in addition to the basic service.

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

iii. YL—Mandibular–Lower.

iv. YU—Maxillary–Upper.

When it is necessary for the New Jersey Medicaid Program to distinguish between services rendered in the mandibular arch as opposed to the maxillary arch and the basic codes do not make this differentiation, the modifiers "YL" and "YU" have been assigned to make this distinction.

4. DESCRIPTION—Lists the code narrative.

5. MAXIMUM FEE ALLOWANCE—Lists the New Jersey Medicaid Program's maximum reimbursement schedule for Specialist and Non–Specialist.

i. S—denotes specialist fee.

ii. NS—denotes non-specialist fee.

iii. BR—denotes by report (individual consideration of procedure and fee).

This means that additional information will be required in order to properly evaluate the service and determine an appropriate fee. A copy of this report must be attached to the Dental Services Claim form (MC–10).

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

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

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

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

(f) Policies and procedures regarding use of HCPCS: Listed below and throughout subchapter 3 are both some general and specific policies of New Jersey Medicaid Program relevant to HCPCS. These are not necessarily complete but may have been paraphrased from the complete policies as outlined in Subchapter 1 (Chapter II, 3/78) and Subchapter 2 (Chapter III, 3/78). This has been done so that the provider will have pertinent information available in conjunction with the procedures to be requested and/or delivered. For complete and specific policies in addition to those outlined herein, the practitioner must consult Subchapter 1 and/or 2.

1. General requirements:

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

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

iii. For purposes of reimbursement, a dentist, dental group, shared health care facility or dentists sharing a common record are considered as a single provider.

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

v. Date(s) of service(s) must be indicated on the Dental Services Claim form (MC–10), in the records of a facility when treatment is rendered to one of its residents, and in the practitioner's own record for each service billed.

vi. When submitting a claim, the dentist must always use her or his usual and customary fee. The fee designated for the HCPCS procedure codes represents the New Jersey Medicaid Program's maximum reimbursement for the given procedure.

Administrative Correction to (f)1iv.
See: 22 N.J.R. 1375(a).
Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (d): added new (d)1iv.

[1] Journal of the American Dental Association, Volume 85, October 1972 page 789.

10:56–3.2 00100–00999 I. DIAGNOSTIC

(a) Clinical oral examination

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S $	NS
	00110		Initial Oral Examination NOTE 1: This is the code to be used for a Comprehensive Clinical Oral Examination of Medicaid recipients, both Initial and Periodic. NOTE 2: This code requires a thorough observation of all conditions present in the oral cavity and contiguous structures to include: a. Charting of all abnormalities; b. Development of a complete treatment plan to be recorded in its entirety on the Dental Services Claim form (MC–10). NOTE 3: For reimbursement of the examination: a. A comprehensive clinical oral examination shall be limited to once every six months for those patients through age 17, and once every 12 months for those patients 18 years of age or older except as authorized by a Dental Consultant of the New Jersey Medicaid Program; b. All items on the Dental Services Claim form (MC–10) must be completed; c. If No Other Treatment is Necessary, this fact must be noted on the Dental Services Claim form (MC–10) in the diagnosis box. The abbreviation "NOTN" may be used.	7.00	6.00
	00110	22	Initial Oral Examination NOTE 1: This code is only to be used for EPSDT DENTAL EXAMINATIONS (FORMERLY CODE 0119). NOTE 2: Reimbursement is contingent upon: a. The completed MC–19D Form (Fiscal Agent's Copy) must accompany the Dental Services Claim form (MC–10) when submitted to the Fiscal Agent for reimbursement. b. For reimbursement, the Dental Services Claim form (MC–10) must be received by the Fiscal Agent no later than 30 days from the date of service of that exam. c. Failure to attach the MC–19D Form to the Dental Service Claim form (MC–10) or to meet the timely billing requirement will result in reduction of the reimbursement by $1.00.	8.00	7.00
d	00130		Emergency Oral Examination NOTE: For diagnosis and/or observation of a specific complaint—make note of diagnosis and/or observation(s) on Dental Service Claim form (MC–10). This code is not reimbursable as an adjunct to any reimbursable service except for diagnostic radiographs.	4.00	3.00

(b) Radiographs

1. Radiographs should be limited to those normally required to make a diagnosis, but must show all areas where treatment is anticipated with the exception of soft tissue lesions. The originals of all radiographs must be forwarded to the Dental Consultant for evaluation of the treatment or treatment request.

i. For complete limitations according to age and time, see (b)2ii below;

ii. As part of an examination, posterior bitewings and single anterior films may be taken as needed;

iii. In an emergency situation, a radiograph(s) may be taken at any time in order to establish a diagnosis.

2. Intraoral Radiographs: (Periapical/Bitewing/Occlusal)

i. Indicate number of films in items 13 and 15F of the Dental Services Claims form (MC–10);

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

00210	52	Intraoral—Complete Series (including bitewings) NOTE 1: Limited to patients up to and including age 6. NOTE 2: 8 films.	9.00	9.00
00210		Intraoral—Complete Series (including bitewings) NOTE 1: Limited to patients age 7 up to and including age 14. NOTE 2: 12 films.	13.00	13.00
00210	22	Intraoral—Complete Series (including bitewings) NOTE 1: Limited to patients age 15 or older. NOTE 2: Minimum of 16 films.	17.00	17.00

	00220		Intraoral—Periapical—First Film NOTE: Or bitewing.	2.00	2.00
	00230		Intraoral—Periapical—Each Additional Film NOTE 1: Or each additional bitewing. NOTE 2: Indicate complete number of films (00220 Plus 00230) in items 13 and 15F.	1.00	1.00
	00240		Intraoral—Occlusal Film NOTE 1: Per film (maximum—two (2) films). NOTE 2: Indicate number of films in item 15F.	5.00	5.00

3. Extraoral Radiographs

	00250	52	Extraoral, First Film NOTE 1: Indicate number of views in item 15F of the Dental Services Claim form (MC-10). NOTE 2: Code to be used for lateral, anterioposterior, temporomandibular radiographs, etc. (one view).	10.00	10.00
	00260		Extraoral—Each Additional Film NOTE: Maximum reimbursable—2 additional views.	5.00	5.00
	00310		Sialography	15.00	15.00
	00310	22	Sialography NOTE: Includes injection of contrast material (filling and/or emptying phases).	30.00	30.00
	00330		Panoramic Film	10.00	10.00
*	00340		Cephalometric Film	10.00	10.00
*	00340	22	Cephalometric Film NOTE: Includes tracing.	15.00	15.00

(c) Test and laboratory examinations:

*	00470		Diagnostic Casts NOTE: Casts must have bases and be trimmed to permit articulation, per cast.	11.50	10.00
*	00471		Diagnostic Photographs NOTE: Or slide, per view.	1.00	1.00
d	00501		Histopathologic Examination NOTE 1: The gross and microscopic examination of oral tissues, both hard and soft. NOTE 2: Limited to specialists in oral pathology, and Oral Diagnosis (Pathology) Department of dental schools.	10.00	—
d*	00999		Unspecified Diagnostic Procedure, By Report NOTE: Complete description of procedure and why.	BR	BR

10:56-3.3 01000-01999 II. PREVENTIVE

(a) Dental prophylaxis

1. Dental prophylaxis is the removal of calculus and stains from the supragingival and subgingival surfaces of the teeth by scaling and polishing.

i. For reimbursement purposes, dental prophylaxis shall be limited to once every six months for those patients up to and including age 17 and once every 12 months for those patients 18 years of age or older except as authorized by a Dental Consultant of the Medicaid Program.

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S $	NS
	01110		Prophylaxis—Adult NOTE: Patients 16 years of age or older, maxillary and mandibular arches.	11.00	10.00
	01110	52	Prophylaxis—Adult NOTE 1: Patients 16 years of age or older, maxillary or mandibular arch. NOTE 2: Code to be used if patient is edentulous in one arch.	5.50	5.00
	01120		Prophylaxis—Child NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.	8.00	7.00

2. Scaling over and above that necessary under prophylaxis (see codes 01110 and 01110 52 above). The calculus must be abnormally heavy and visible to the Dental Consultant on radiograph(s). Such scaling must be authorized for those recipients up to and including 17 years of age as denoted by codes with the "#" (crosshatch) indicator.

#	Y2105		ADDITIONAL SCALING NOTE: Maxillary and mandibular arches	11.00	10.00
#	Y2105	52	ADDITIONAL SCALING—ONE ARCH NOTE 1: Maxillary or mandibular arch NOTE 2: Code to be used if patient is edentulous in one arch.	5.50	5.00

(b) Topical fluoride treatment (office procedure)

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

i. Reimbursement for topical fluoride treatment shall be limited to once every six months without authorization for those patients up to and including age 17, and once every 12 months for those patients 18 years of age, up to and including 20 years of age. (Not a covered service for persons 21 years of age and over). A complete prophylaxis must be performed immediately prior to the topical fluoride treatment.

01201		Topical Application of Fluoride (Including Prophylaxis)—Child NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.	14.00	12.00
01202		Topical Application of Fluoride (Including Prophylaxis)—Adult NOTE: Patients age 16, up to and including 20 years of age, maxillary and mandibular arches.	17.00	15.00
01202	52	Topical Application of Fluoride (Including Prophylaxis)—Adult 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 one arch.	8.50	7.50

(c) Other preventive services:

01351		Sealant—Per Tooth NOTE 1: Application of sealants is limited to a one time application to all occlusal surfaces that are unfilled and caries free, in bicuspids and permanent molars. NOTE 2: Application of sealants is limited to recipients up to and including 16 years of age. NOTE 3: Sealants applied other than as detailed above are not reimbursable unless authorized by a Medicaid Dental Consultant. A complete explanation of the request must be attached. NOTE 4: Since the sealants may be reimbursed only once for each tooth, the provider should make certain that sealants have not been applied previously.	7.00	6.00

(d) Space maintenance (passive appliances):

* 01510		Space Maintainer—Fixed—Unilateral NOTE: Utilizing band(s).	40.00	35.00
* 01510	22	Space Maintainer—Fixed—Unilateral NOTE: Utilizing single stainless steel crown.	59.00	51.00
* 01515		Space Maintainer—Fixed—Bilateral NOTE: Lingual or palatal arch utilizing bands.	61.00	53.00
* 01515	22	Space Maintainer—Fixed—Bilateral NOTE: Lingual or palatal arch utilizing stainless steel crowns.	105.00	91.00
* Y2115		Tooth Processed to Arch Bar (Wire), Per Tooth	6.00	5.00
* 01525		Space Maintainer—Removable—Bilateral	69.00	60.00
01550		Recementation of Space Maintainer	7.00	6.00
* Y2125		Unspecified Preventive Procedure, By Report NOTE: Complete description of procedure(s) and why.	BR	BR

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.

10:56–3.4 02000–02999 III. RESTORATIVE

(a) Reimbursement for restorations in deciduous teeth is limited to deciduous cuspids and molars of children up to and including age nine or in deciduous incisors up to and including age five, but not where exfoliation is imminent.

1. Exception: Prior authorization by a Medicaid Dental Consultant.

(b) Amalgam restorations (including polishing)

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

2. Procedure code must be selected on the basis of the number of surfaces restored per individual tooth (not on the basis of individual restorations); therefore, the fee for any surface will include one or more restorations on that surface.

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

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

5. Extensions of interproximal fillings into self cleansing areas will not be considered as additional surfaces. An additional surface will be reimbursable only when the buccal (facial) or lingual margin extends beyond the proximal one-third (⅓) of the buccal (facial) and/or lingual surface(s).

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance S	$	NS
	02110		Amalgam—One Surface, Primary	17.00		15.00
	02120		Amalgam—Two Surfaces, Primary	23.00		20.50
	02130		Amalgam—Three Surfaces, Primary	29.00		26.00
	02131		Amalgam—Four Surfaces, Primary	36.00		31.50
			NOTE: Code to be utilized for four or more surfaces.			
	02140		Amalgam—One Surface, Permanent	17.00		15.00
	02150		Amalgam—Two Surfaces, Permanent	23.00		20.50
	02160		Amalgam—Three Surfaces, Permanent	29.00		26.00
	02161		Amalgam—Four or More Surfaces, Permanent	36.00		31.50

(c) Silicate restorations: Silicate restorations are NOT a covered service of the New Jersey Medicaid Program.

(d) Filled or unfilled resin restorations:

1. Filled or unfilled resin filling material is reimbursable only when that material is utilized for teeth numbers 4 through 13 and 20 through 29 and/or C through H and M through R in each arch.

i. Exception: Prior authorization by a Medicaid Dental Consultant.

2. 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 (2) or three (3) surface proximal restoration will be reimbursed only when the facial and/or lingual margin(s) of the restoration extends beyond the proximal one-third (⅓) of the facial and/or lingual surface(s).

3. Extension of proximal fillings into self-cleansing areas will not be considered as additional surfaces.

4. In selecting the code to be submitted for an individual tooth, please note that only one code is reimbursable per tooth except when amalgam and resin restorations are placed on the same tooth.

5. The fee for any surface will include one or more restorations on that surface.

6. Reimbursement for an occlusal one-third of the buccal (facial) or lingual surface(s) of the tooth.

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

8. Reimbursement will include acid etch where appropriate.

	02330	Resin—One Surface	20.50	18.00
	02331	Resin—Two Surfaces	27.50	24.00
	02332	Resin—Three Surfaces	34.50	30.00
	02335	Resin—Four or More Surfaces or Involving Incisal Angle	41.50	36.00

(e) 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.		

(f) 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

(g) Crowns—single restoration only:

1. Authorization for crowns will be granted only when substantial loss of tooth structure exists and conditions of remaining teeth and supporting tissues justify this treatment.

2. Acrylic or porcelain veneer on metal will be authorized only when esthetically necessary.

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

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

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

*	02710	Crown—Resin (Laboratory)	98.00	85.00
		NOTE: Laboratory processed.		
		NOTE: Laboratory processed.		
*	02720	Crown—Resin with High Noble Metal	161.00	140.00

		NOTE: Acrylic veneer.		
*	02721	Crown—Resin with Predominantly Base Metal	161.00	140.00
		NOTE: Acrylic veneer.		
*	02722	Crown—Resin with Noble Metal	161.00	140.00
		NOTE: Acrylic veneer.		
*	02750	Crown—Porcelain Fused to High Noble Metal	201.00	175.00
*	02751	Crown—Porcelain Fused to Predominantly Base Metal	201.00	175.00
*	02752	Crown—Porcelain Fused to Noble Metal	201.00	175.00
*	02790	Crown—Full Cast High Noble Metal	161.00	140.00
*	02791	Crown—Full Cast Predominately Base Metal	161.00	140.00
*	02792	Crown—Full Cast Noble Metal	161.00	140.00

(h) Other restorative services:

	02910	Recement Inlay	7.00	6.00
	02920	Recement Crown	7.00	6.00
*	02930	Prefabricated Stainless Steel Crown—Primary Tooth	41.00	35.00
		NOTE: Authorized only for deciduous teeth.		
*	02931	Prefabricated Stainless Steel Crown—Permanent Tooth	41.00	35.00
		NOTE: Generally authorized only for permanent posterior teeth up to and including 17 years of age.		
*	02932	Prefabricated Resin Crown	40.00	35.00
		NOTE: E.G., Polycarbonate—generally authorized only for deciduous and permanent anterior teeth up to and including 15 years of age.		
*	02950	Crown Buildup Including Any Pins	34.00	30.00
		NOTE 1: And/or post.		
		NOTE 2: Core of composite or amalgam.		
	02951	Pin Retention—Per Tooth, In Addition To Restoration	4.00	3.00
		NOTE 1: Per pin.		
		NOTE 2: Maximum reimbursable—three (3) pins.		
*	02952	Cast Post And Core In Addition To Crown	52.00	45.00
		NOTE: Post and core fabricated (cast) and cemented as a separate unit from crown.		
*	02954	Prefabricated Post And Core In Addition To Crown	34.00	30.00
*	02970	Temporary (Fractured Tooth)	29.00	25.00
		NOTE: Temporary crown—not reimbursable in conjunction with any other restorative procedure on same tooth.		
*	02980	Crown Repair, By Report	BR	BR
*	02999	Unspecified Restorative Procedure, By Report	BR	BR

Public notice: Pursuant to N.J.S.A. 30:4D–2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowances increased in (b) and (d)8, effective August 1, 1988.
See: 20 N.J.R. 2101(a).
Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (h): added "02980—Crown Repair".

10:56–3.5 03000–03999 IV. ENDODONTICS

(a) Authorization of endodontic treatment will be at the discretion of the Medicaid Dental Consultant, and will be influenced by the:

1. Age and general health of the patient;

2. Status of the tooth in the arch; and

3. Condition of the remaining dentition and supporting structures.

(b) Pulp capping—direct/indirect:

1. Pulp capping is no longer a separately covered service under the Medicaid Program.

(c) Therapeutic pulpotomy:

1. A pulpotomy will be limited to a deciduous tooth, or a permanent tooth with incompletely formed roots.

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	$	NS
d*	03220		Therapeutic Pulpotomy (Excluding Final Restoration)	15.00		13.00

(d) Pulpectomy:

1. A pulpectomy for deciduous teeth includes extirpation, treatment and filling of all the root canal(s) with resorbable filling material. Postoperative radiograph(s) must be available. Reimbursable only for deciduous teeth with permanent successors.

*	Y2310	Pulpectomy (Excluding Final Restoration)	17.00	15.00

(e) Root canal therapy (including treatment plan, clinical procedures, and follow-up care):

1. The fee for root canal therapy includes the extirpation, treatment (complete filling of all the root canal(s) with permanent material), all necessary radiographs during treatment and post-operatively, and follow-up care (excludes final restoration).

2. For emergency endodontic procedures, use code 09110.

d*	03310	One Canal (Excluding Final Restoration)	103.00	90.00

		NOTE: Code to be used for incisors and cuspids (permanent).		
d*	03320	Two Canals (Excluding Final Restoration)	132.00	115.00
		NOTE: Code to be used for bicuspids and all deciduous teeth without permanent successors.		
d*	03330	Three Canals (Excluding Final Restoration)	172.00	150.00
		NOTE: Code to be used for molars (permanent).		
d*	03350	Apexification (Per Treatment Visit)	31.00	27.00
		NOTE 1: Treatment may extend over a period of 6 to 18 months.		
		NOTE 2: Maximum—two (2) visits.		

(f) Periapical services:

1. Apicoectomy will be considered for authorization and reimbursement only if one or more of the following conditions exist:

i. Overfilled canal (previously treated tooth);

ii. Canal cannot be filled properly because of excessive root curvature or calcification;

iii. Fractured root tip that cannot be reached endodontically;

iv. Broken instrument in canal;

v. Perforation of apical third of canal;

vi. Broken root canal filling lying free in periapical tissues and acting as an irritant;

vii. Periapical pathology not resolved by previous endodontic therapy;

viii. Periapical pathology which will not be resolved by endodontic therapy alone;

ix. A post, post and core, or post-crown which cannot be removed.

2. Apicoectomy should not be performed for convenience. If endodontic treatment is necessary, but none of the above conditions exist, authorization for the apicoectomy will not be granted.

3. When more than one apical curettage and/or apicoectomy is performed through the same operative site, the maximum amount reimbursable by the New Jersey Medicaid Program 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.

4. Retrograde filling(s) will be inserted when necessary in conjunction with appropriate endodontic treatment, but not in lieu of a properly filled canal.

5. The fee includes those post-treatment radiographs determined necessary by the practitioner and must be available to the Medicaid Program upon request.

d*	03410	Apicoectomy (Per Tooth)—First Root	55.00	48.00
d*	03411	Apicoectomy (Per Tooth)—Each Additional Root	28.00	24.00
		NOTE: Maximum—two (2) additional roots.		

(g) 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	111.50	98.50
d*	03411	22	Apicoectomy/Endodontic Procedure (Per Tooth)—Each Additional Root	44.00	36.00
			NOTE: Maximum—two (2) additional roots.		
d*	03430		Retrograde Filling—Per Root	9.00	7.50
			NOTE 1: On addition to apicoectomy.		
			NOTE 2: Maximum—per tooth—three (3) roots.		
d*	03440		Apical Curettage	49.00	42.00
			NOTE: Per Tooth.		
*	03450		Root Amputation—Per Root	55.00	48.00
			NOTE 1: Surgical resection of entire root(s).		
			NOTE 2: Per tooth.		

(h) Other endondontic procedures:

*	03920		Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	55.00	48.00
*	03950		Canal Preparation and Fitting of Preformed Dowel or Post	16.00	14.00
			NOTE: Without cementation.		
*	03950	22	Canal Preparation and Fitting of Preformed Dowel or Post	23.00	20.00
			NOTE: With cementation.		
*	03960		Bleaching Discolored Tooth	11.00	10.00
			NOTE 1: Limited to non-vital teeth.		
			NOTE 2: Per visit.		
			NOTE 3: Reimbursement limited to 2 visits.		
d*	03999		Unspecified Endodontic Procedure, By Report	BR	BR

10:56–3.6 04000–04999 V. PERIODONTICS

(a) Treatment for periodontics will be authorized on a very selective basis. Detailed description, radiographs, and periodontal charting are required. Reimbursement will be based upon quadrants, a portion thereof or the equivalent thereof as determined by the Medicaid Dental Consultant.

(b) Surgical services (including usual postoperative services):

Ind	HCPCS Code	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
*	04220		Gingival Curettage, By Report	22.60	19.50
			NOTE: Per quadrant.		
*	04260		Osseous Surgery (Including Flap Entry and Closure)—Per Quadrant	75.00	64.50
*	04261		Osseous Graft—Single Site (Including Flap Entry, Closure, and Donor Sites)	BR	BR
*	04262		Osseous Graft—Multiple Sites (Including Flap Entry, Closure and Donor Sites)	BR	BR
*	04270		Pedicle Soft Tissue Graft Procedure	32.00	28.00
			NOTE: Per site.		
*	04271		Free Soft Tissue Graft Procedure (Including Donor Site)	49.00	42.00
			NOTE: Per site.		
*	04272		Apically Repositioning Flap Procedure	36.00	31.50
			NOTE: Per quadrant.		

(c) Adjunctive periodontal services:

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S $	NS
*	04320		Provisional Splinting—Intracoronal	18.00	16.00
			NOTE: Per tooth.		
*	04321		Provisional Splinting—Extracoronal	11.00	10.00
			NOTE 1: Per tooth.		
			NOTE 2: This code may also be used for stabilization of traumatized teeth.		
*	04340		Periodontal Scaling and Rooting Planing—Entire Mouth	102.00	90.00
*	04341		Periodontal Scaling and Root Planing—Per Quadrant	25.50	22.50
*	04999		Unspecified Periodontal Service, By Report	BR	BR

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

(a) Dentures, both partial and complete, may be authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the patient.

(b) Normally, there must be a three month wait (for healing) between the date of the last extraction and initiation of the denture(s), partial and/or complete, except immediate denture(s).

(c) The fee for partial and complete dentures will include the necessary adjustments, relines and/or rebases for a six month period following insertion.

(d) The fee for immediate dentures will also include the necessary adjustments, relines and/or rebases for a six month period following insertion.

(e) Partial dentures must be described on the Dental Services Claim form (MC–10) indicating material to be used, position of clasps, and teeth to be replaced.

(f) Payment for dentures will be denied unless all dental procedures in both arches are completed before impressions are taken for authorized dentures (complete and partial).

(g) Denture relining, rebasing (jumping), or repairing are reimbursable. No additional reimbursement will be made for repair procedures in conjunction with a rebase or reline of a denture except for the replacement of missing or fractured teeth and/or clasp(s) and/or welding, and then only code(s) 05520, 05620, 05640, and/or Y2510 can be used.

1. The fee will include all necessary adjustments for a six (6) month period following insertion for relining and rebasing, and three (3) months for repairs.

(h) The patient's name must be processed into all dentures during the original fabrication or where possible during any subsequent processing procedure (repair, rebase, reline, and so forth). The Social Security number must also be included if space permits. This is MANDATORY and complies both with New Jersey Medicaid regulations in effect since May, 1978 and the "Denture I.D. Law" which became effective April 16, 1984 (N.J.S.A. 45:6–19.1 et seq.).

(i) Complete dentures (including routine post delivery care):

Ind	HCPCS Code	Mod	Procedure description	Maximum Fee Allowance 10/1/88 S	$ NS	S	$ NS
*	05110		Complete Upper NOTE: Maxillary.	197.00	171.00	231.00	201.00
*	05120		Complete Lower NOTE: Mandibular.	202.00	176.00	238.00	207.00

(j) Immediate complete dentures (including six months post delivery care):

1. Reimbursement also includes necessary rebases and/or relines, and so forth.

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

*	05130		Immediate Upper NOTE 1: Maxillary. NOTE 2: 1 through 4 teeth.	215.00	186.00	253.00	220.00
*	05130	22	Immediate Upper NOTE 1: Maxillary. NOTE 2: 5 through 8 teeth.	239.00	206.00	280.00	243.00
*	05140		Immediate Lower NOTE 1: Mandibular. NOTE 2: 1 through 4 teeth.	220.00	191.00	258.00	224.00
*	05140	22	Immediate Lower NOTE 1: Mandibular. NOTE 2: 5 through 8 teeth.	244.00	211.00	286.00	249.00

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

*	05211		Upper Partial—Acrylic Base (Including Any Conventional Clasps and Rests) NOTE: Includes a minimum of two (2) cast chrome clasps with rests.	161.00	140.00	190.00	165.00
*	05211	52	Upper Partial—Acrylic Base—Without Clasps (Flipper)	86.00	75.00	101.00	88.00
*	05212		Lower Partial—Acrylic Base (Including Any Conventional Clasps and Rests) NOTE: Includes a minimum of two (2) cast chrome clasps with rests	161.00	140.00	190.00	165.00
*	05212	52	Lower Partial—Acrylic Base—Without Clasps (Flipper)	86.00	75.00	101.00	88.00
*	05213		Upper Partial—Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests) NOTE: Includes a minimum of two (2) cast chrome clasps with rests.	213.00	185.00	250.00	217.00
*	05214		Lower Partial—Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests) NOTE: Includes a minimum of two (2) cast chrome clasps with rests.	201.00	175.00	237.00	206.00

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

1. Immediate partial dentures also include necessary rebases and/or relines, and so forth.

*	Y2505		Immediate Replacement of Anterior Teeth—Per Tooth	6.00	5.00		

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

(m) Adjustments to dentures—other than dentist providing denture or after the required period of post delivery care (for example, new dentures, relines, rebases—six months; repairs—three months, and so forth).

05410		Adjust Complete Denture—Upper	7.00	6.00
05411		Adjust Complete Denture—Lower	7.00	6.00
05421		Adjust Partial Denture—Upper	7.00	6.00
05422		Adjust Partial Denture—Lower	7.00	6.00

(n) Repairs to complete dentures—includes adjustments for three (3) months. Prior authorization is not normally necessary when Medicaid reimbursement for a repair to a denture does not exceed $53.00 specialist fee or $48.00 non-specialist fee.

1. Repair Broken Complete Denture Base:

i. Includes replacing undamaged teeth on denture.

05510	YU	Repair Broken Complete Denture Base	34.50	30.00
		NOTE: Maxillary—Upper.		
05510	YL	Repair Broken Complete Denture Base	34.50	30.00
		NOTE: Mandibular—Lower.		
05520		Replace Missing or Broken Teeth—Complete Denture (Each Tooth)	5.00	5.00
		NOTE 1: Code may be used in addition to codes 05510 YU or YL above.		
		NOTE 2: List tooth codes of teeth being replaced.		

(o) Repairs to partial denture—includes adjustments for three (3) months. Prior authorization is not normally necessary when Medicaid reimbursement for a repair to a denture does not exceed $53.00 specialist fee or $48.00 non-specialist fee.

05610	YU	Repair Acrylic Saddle or Base	34.50	30.00
		NOTE: Maxillary.		
05610	YL	Repair Acrylic Saddle or Base	34.50	30.00
		NOTE: Mandibular.		
05620		Repair Cast Framework	23.00	20.00
		NOTE: Welding in addition to repair procedure(s), limit two (2) per denture.		
05630	YU	Repair or Replace Broken Clasp	52.50	48.00
		NOTE: Maxillary.		
05630	YL	Repair or Replace Broken Clasp	52.50	48.00
		NOTE: Mandibular.		
05640		Replace Broken Teeth—Per Tooth	5.00	5.00
		NOTE: Code 05640 may be used in addition to repair procedure(s).		
05650		Add Tooth to Existing Partial Denture	46.00	40.00
		NOTE: To replace extracted tooth (list tooth being replaced).		
05660	YU	Add Clasp to Existing Partial Denture	52.50	48.00
		NOTE: Maxillary.		
05660	YL	Add Clasp to Existing Partial Denture	52.50	48.00
		NOTE: Mandibular.		
Y2510		Each Additional Clasp—For Repair	21.00	18.00
		NOTE 1: List tooth being clasped.		
		NOTE 2: Code Y2510 may be used in addition to repair procedure(s).		

(p) Denture rebase procedures:

1. Rebasing is the process of refitting a denture by the complete replacement of the denture base material without changing the occlusal relationship of the teeth. Includes adjustments for six (6) months.

*	05710	Rebase Complete Upper Denture	92.00	80.00
*	05711	Rebase Complete Lower Denture	92.00	80.00
*	05720	Rebase Upper Partial Denture	86.00	75.00
*	05721	Rebase Lower Partial Denture	86.00	75.00

(q) Denture reline procedures:

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

*	05730	Reline Upper Complete Denture (Chairside)	20.00	17.00
*	05731	Reline Lower Complete Denture (Chairside)	20.00	17.00
*	05740	Reline Upper Partial Denture (Chairside)	20.00	17.00
*	05741	Reline Lower Partial Denture (Chairside)	20.00	17.00
*	05750	Reline Upper Complete Denture (Laboratory)	69.00	60.00
*	05751	Reline Lower Complete Denture (Laboratory)	69.00	60.00
*	05760	Reline Upper Partial Denture (Laboratory)	63.00	55.00
*	05761	Reline Lower Partial Denture (Laboratory)	63.00	55.00

(r) Other removable prosthetic services:

1. Insertion of name and Social Security number of recipient into base material of complete or partial denture during initial fabrication, rebasing, relining or repair, per denture. This is required to comply with New Jersey Medicaid regulations in effect since May, 1978 and the "Denture I.D. Law" which became effective April 16, 1984. (N.J.S.A. 45:6–19.1 et seq.)

	Y2515	YU	Insertion of Identification into Denture—Maxillary—Upper	4.00	4.00
	Y2515	YL	Insertion of Identification into Denture—Mandibular—Lower	4.00	4.00
*	05899		Unspecified Removable Prosthodontic Procedure, By Report	BR	BR

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D–2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowances increased at (i), (j) and (k) effective October 1, 1988, January 1, 1989 and April 1, 1989.
See: 20 N.J.R. 2101(a).
Administrative Correction: In (k) 05212 effective April 1, 1989 corrected 140.00 to 165.00.
As amended by R.1989 d.135.
See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).
(k)1 deleted and NOTE changed to "a minimum of 2 cast chrome casts with rests".

10:56–3.8 05900–05999 VII. MAXILLOFACIAL PROSTHETICS

(a) Treatment prostheses:

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

10:56–3.9 06000–06999 VIII. PROSTHODONTICS, FIXED

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

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

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

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

(b) Bridge pontics:

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	$	NS
*	06210		Pontic—Cast High Noble Metal	76.00		66.00
*	06211		Pontic—Cast Predominantly Base Metal	76.00		66.00
*	06212		Pontic—Cast Noble Metal	76.00		66.00
*	06240		Pontic—Porcelain Fused to High Noble Metal	115.00		110.00
*	06241		Pontic—Porcelain Fused to Predominantly Base Metal	115.00		110.00
*	06242		Pontic—Porcelain Fused to Noble Metal	115.00		110.00
*	06250		Pontic—Resin with High Noble Metal	90.00		80.00
*	06251		Pontic—Resin with Predominantly Base Metal	90.00		80.00
*	06252		Pontic—Resin with Noble Metal	90.00		80.00

(c) Bridge retainers—crowns:

*	06720		Crown—Resin with High Noble Metal	161.00	140.00
*	06721		Crown—Resin with Predominantly Base Metal	161.00	140.00
*	06722		Crown—Resin with Noble Metal	161.00	140.00
*	06750		Crown—Porcelain Fused to High Noble Metal	201.00	175.00
*	06751		Crown—Porcelain Fused to Predominantly Base Metal	201.00	175.00
*	06752		Crown—Porcelain Fused to Noble Metal	201.00	175.00
*	06790		Crown—Full Cast High Noble Metal	161.00	140.00
*	06791		Crown—Full Cast Predominantly Base Metal	161.00	140.00
*	06792		Crown—Full Cast Noble Metal	161.00	140.00

(d) Other fixed prosthetic services:

	06930		Recement Bridge NOTE 1: One abutment. NOTE 2: Code may be used when recementing facing.	8.00	7.00
	06930	22	Recement Bridge NOTE: Two or more abutments.	14.00	12.00
*	06970		Cast Post and Core in Addition to Bridge Retainer NOTE: Post and core fabricated (cast) and cemented as a separate unit from crown.	52.00	45.00
*	06972		Prefabricated Post and Core in Addition to Bridge Retainer	34.00	30.00
*	06980		Bridge Repair, By Report	BR	BR
*	06999		Unspecified Fixed Prosthodontic Procedure, By Report	BR	BR

10:56–3.10 07000–07999 IX. ORAL SURGERY

(a) In the event that the oral surgery service to be performed is of an emergency nature and prior authorization is normally required but not feasible, then the Dental Services Claim form (MC–10) with all necessary information should be forwarded to the Dental Consultant for authorization after completion of the service but prior to submission for reimbursement.

(b) Exodontia:

1. Reimbursement for dental extraction(s) will include local anesthesia, indicated alveoloplasty, and routine postoperative care.

2. Reimbursement will be denied for the following treatment rendered without prior authorization:

i. Extraction of teeth other than those classified as non-restorable;

ii. Extraction of one or more teeth which will necessitate a dental prosthesis; or

iii. All extractions preparatory to or in conjunction with orthodontic care.

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

(c) Extractions—includes local anesthesia and routine postoperative care:

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance Effective Date 8/1/88 S $	NS
	07110		Single Tooth	17.00	15.00
	07130		Root Removal—Exposed Roots NOTE 1: Per tooth. NOTE 2: Root partially imbedded in bone.	15.00	13.00
	07130	52	Root Removal—Exposed Roots NOTE 1: Per tooth. NOTE 2: Root completely located in soft tissue.	10.50	9.00

(d) Surgical extractions—includes local anesthesia and routine postoperative care:

1. Reimbursement will be made for the extraction of impacted teeth only when conditions arising from such impactions warrant their removal. Extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be considered as reimbursable.

2. In order to qualify for a surgical removal of a tooth with partial or complete bone impaction, the following is required:

i. Incision of overlying soft tissue;

ii. Removal of bone; and/or

iii. Sectioning of tooth.

3. Authorization for the removal of impacted teeth is necessary for those recipients up to and including 17 years of age as denoted by those codes with the "#" (crosshatch) indicator.

	07210		Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	17.00	15.00
#	07220		Removal of Impacted Tooth—Soft Tissue	21.00	18.00
#	07230		Removal of Impacted Tooth—Partially Bony	61.00	53.00
#	07240		Removal of Impacted Tooth—Completely Bony	61.00	53.00
#	07250		Surgical Removal of Residual Tooth Roots (Cutting Procedure) NOTE: Completely covered by bone.	30.00	26.00

(e) Other surgical procedures:

**	07260		Oroantral 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 Evulsed 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

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

1. Reimbursement will be based upon quadrants, a portion thereof or the equivalent thereof as determined by the Medicaid Dental Consultant.

	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.	43.50	37.50

			NOTE 2: Specify quadrant.		
*	07320		Alveoloplasty Not in Conjunction With Extraction—Per Quadrant	43.50	37.50

(g) 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, a portion thereof or the equivalent thereof as determined by the Medicaid Dental Consultant.

*	07340		Vestibuloplasty—Ridge Extension (Secondary Epithelialization)	45.00	39.00
			NOTE: Including management of hypertrophied and hyperplastic tissue, Per Quadrant.		
*	07350		Vestibuloplasty—Ridge Extension (Including Soft Tissue Grafts, Muscle Re-attachments, Revision of Soft Tissue Attachment, and Management of Hypertrophied and Hyperplastic Tissue)	118.00	102.00
			NOTE: Per Quadrant.		

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

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

d*	07410		Radical Excision—Lesion Diameter Up To 1.25 cm.	30.00	26.00
d*	07420		Radical Excision—Lesion Diameter Over 1.25 cm.	42.00	37.00
			NOTE: Up to and including 3 cm.		
d*	07420	22	Radical Excision—Lesion Diameter Over 3 cm.	100.00	86.00

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

1. In the excision and management of this type of lesion a biopsy report must be available.

d*	07430		Excision of Benign Tumor—Lesion Diameter Up To 1.25 cm.	30.00	26.00
d*	07431		Excision of Benign Tumor—Lesion Diameter Over 1.25 cm.	42.00	37.00
			NOTE: Up to and including 3 cm.		
d*	07431	22	Excision of Benign Tumor—Lesion Diameter Over 3 cm.	100.00	86.00
d**	07440		Excision of Malignant Tumor—Lesion Diameter Up To 1.25 cm.	100.00	86.00
d**	07441		Excision of Malignant Tumor—Lesion Diameter Over 1.25 cm.	274.00	256.00
			NOTE: Up to and including 3 cm.		
d**	07441	22	Excision of Malignant Tumor—Lesion Diameter Over 3 cm.	473.00	413.00
d*	07450		Removal of Odontogenic Cyst or Tumor—Lesion Diameter Up To 1.25 cm.	50.00	43.00
d*	07451		Removal of Odontogenic Cyst or Tumor—Lesion Diameter Over 1.25 cm.	100.00	87.00
			NOTE: Up to and including 3 cm.		
d*	07451	22	Removal of Odontogenic Cyst or Tumor—Lesion Diameter Over 3 cm.	150.00	130.00
d*	07460		Removal of Non–Odontogenic Cyst or Tumor—Lesion Diameter Up To 1.25 cm.	50.00	43.00
d*	07461		Removal of Non–Odontogenic Cyst or Tumor—Lesion Diameter Over 1.25 cm.	100.00	87.00
			NOTE: Up to and including 3 cm.		
d*	07461	22	Removal of Non–Odontogenic Cyst or Tumor—Lesion Diameter Over 3 cm.	150.00	130.00
d*	07465		Destruction of Lesion(s) by Physical Methods: Electrosurgery, Chemotherapy, Cryotherapy or Laser	18.00	15.00

(j) Excision of bone tissue:

1. Reimbursement will be based upon quadrants, a portion thereof, of [1] the equivalent thereof as determined by the Medicaid Dental Consultant.

*	07470		Removal of Exostosis—Maxilla or Mandible	43.50	37.50
			NOTE: Per quadrant.		
*	07470	22	Removal of Exostosis	90.00	79.00
			NOTE: Torus palatinus.		
d*	07480		Partial Ostectomy (Guttering or Saucerization)	211.00	184.00
d*	07490		Radical Resection of Mandible with Bone Graft	BR	BR

(k) 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
			NOTE: Intraoral.		

**	07550		Sequestrectomy for Osteomyelitis	90.00	75.00
			NOTE: Extraoral.		
d**	07560		Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	242.00	210.00
			NOTE: Sinusotomy, maxillary (antrotomy, Caldwell–Luc), unilateral.		

(*l*) 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 (3) or more) including internal fixation, interdental fixation, skeletal pinning with extraoral fixation, and so forth.		
**	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, application of arch bar or splint, and so forth.		
**	07670	YL	Alveolus—Stabilization of Teeth, Open Reduction Splinting	92.00	80.00
			NOTE 1: Mandibular alveolar fracture.		
			NOTE 2: Reduction with wiring, application of arch bar or splint, and so forth.		
**	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 (3) or more), fixation, traction, head-frame, multiple internal and/or external fixation, head cap, and so forth.		

(m) 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
			NOTE: Teeth immobilized if present.		
**	07720	52	Maxilla—Closed Reduction	30.00	26.00
			NOTE: No manipulation or fixation.		
**	07730		Mandible—Open Reduction	242.00	210.00
			NOTE: Teeth immobilized if present.		
**	07730	22	Mandible—Open reduction	303.00	263.00
			NOTE: Complicated—multiple surgical approaches (three (3) or more) including internal fixation, inter-dental fixation, skeletal pinning with extraoral fixation, and so forth.		
**	07740		Mandible—Closed Reduction	121.00	105.00
			NOTE: Teeth immobilized if present.		
**	07740	52	Mandible—Closed Reduction	30.00	26.00
			NOTE: No manipulation or fixation.		
**	07750		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, application of arch bar or splint, and so forth.		
**	07770	YL	Alveolus—Stabilization of Teeth, Open Reduction Splinting	92.00	80.00
			NOTE 1: Mandibular alveolar fracture.		
			NOTE 2: Reduction with wiring, application of arch bar or splint, and so forth.		
**	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 (3) or more), fixation, traction, head-frame, multiple internal and/or external fixation, head cap, and so forth.		

(n) 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
d**	07830	Manipulation under Anesthesia	18.00	16.00
		NOTE: Anesthesia additional.		
d*	07840	Condylectomy	362.00	315.00
d*	07850	Meniscectomy	362.00	315.00
d*	07860	Arthrotomy	362.00	315.00
d**	07870	Arthrocentesis	18.00	16.00
		NOTE: Injection or aspiration (Give complete details).		

(*o*) Repair of traumatic wounds:

1. Describe completely, giving size and site, and so forth.

2. Fee includes suture removal.

**	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
			NOTE: 2.5 cm. up to 5 cm.		
**	07910	22	Suture of Recent Small Wounds	30.00	26.00
			NOTE: Over 5 cm. up to 7.5 cm.		

3. Lacerations over 7.5 cm. use code 07999.

(p) 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

(q) 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
d**	07980	Sialolithotomy	48.00	42.00
d*	07981	Excision of Salivary Gland	182.00	158.00
d*	07982	Sialodochoplasty	151.00	131.00
d*	07983	Closure of Salivary Fistula	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 why.		

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".

[1] So in original.

10:56–3.11 08000–08999 X. ORTHODONTICS

(a) Minor treatment for tooth guidance:

1. Includes all necessary adjustments.

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

Ind	HCPCS Code	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 adjustment.

*	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. Case type—fixed or removable appliances. Itemize fee for diagnostic procedures and formal treatment separately. Indicate anticipated time under treatment—maximum treatment reimbursable including retention—three (3) years. When authorized, reimbursement for comprehensive orthodontic treatment will include retention as required at no additional charge.

2. Reimbursement for the monthly fee is based on one or more visits to the practitioner during any calendar month. Reimbursement must not be requested for any month in which there is no monthly visit.

*	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. Comprehensive orthodontic examination and/or orthodontic assessment examination:

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

ii. Reimbursement is limited to once every 12 months unless authorized.

iii. Orthodontic examinations are not reimbursable for individuals age 20 or older.

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

	Y2965	Orthodontic Examination (Comprehensive) and (Complete Orthodontic) Treatment Plan	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).

10:56–3.12 09000–09999 XI. ADJUNCTIVE GENERAL SERVICES

(a) Unclassified treatment:

Ind	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance S	$	NS
d	09110		Palliative (Emergency) Treatment of Dental Pain—Minor Procedures	7.00		6.00
			NOTE 1: Emergency treatment of dental pain or infection, palliative (flat fee for all services performed, when not covered by separately listed procedure). Diagnosis and description of treatment is required.			
			NOTE 2: Code to be used for initial endodontic emergency procedure. Diagnosis and description of treatment is required.			

(b) Anesthesia:

d**	09210		Local Anesthesia Not in Conjunction with Operative or Surgical Procedures	13.00	11.00
			NOTE: Infiltration and/or nerve block for diagnostic purposes or purposes other than anesthesia.		
	09220		General Anesthesia	25.00	25.00
			NOTE 1: This code applies when the dentist performing the services (attending dentist) also administers the general anesthesia or in conjunction with oral surgery services only.		
			NOTE 2: Reimbursement will be made for the administration of only one general anesthesia per visit.		

(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
*	09220	52	Time units: Each additional 15 minute period or major portion thereof. (Limited to "table" or "chair" time only). Maximum reimbursable two hours	5.50	5.50

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, and must receive prior authorization from the Office of the Chief, Bureau of Dental Services. These codes apply to those dentists appropriately qualified in general anesthesia and are reimbursable only to the dentist whose sole function is to administer general anesthesia.

NOTE 2: An anesthesia record must be submitted which shows elapsed anesthesia time, and pinpoints time and amounts of drugs administered, pulse rate and character, blood pressure, respiration, and so forth. The Dental Services Claim form (MC–10) for anesthesia and treatment must accompany this record to permit authorization for reimbursement.

09240	Intravenous 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.

09310	Consultation—Per Session	22.00	17.00

(e) Professional visits:

09410	House Call NOTE: In addition to fee for service provided.	10.50	9.00
Y3005	Long Term Care Facility Visits NOTE 1: In addition to fee for service provided. NOTE 2: This code is reimbursable only once per trip per facility regardless of the number of patients examined or treated.	10.50	9.00
09420 52	Hospital Call NOTE 1: Hospital visit, Inpatient or Outpatient, in addition to fee for service provided. NOTE 2: Code 09420 52 will not be reimbursable in conjunction with Code 09310 or Codes 09420 22 or 09420. NOTE 3: Code 09420 52 is reimbursable only once per trip per facility regardless of number of patients examined or treated.	9.00	7.00
09420 22	Hospital Call NOTE 1: Code to be used for Hospital Day—Initial—Inpatient or Same Day Surgery. NOTE 2: Hospital record must include as a minimum: a. Chief complaint(s); b. Complete history of the present illness and related systemic review including recording of pertinent negative findings; c. Complete pertinent past medical history; d. Pertinent family history; e. A full examination pertaining to the history of the present condition and including recording of pertinent negative findings; and f. Working diagnosis and treatment plan, including preparation of the "order sheet". g. If history and examination noted above are not personally done by the "billing" practitioner then this code will be downgraded to code 09420, provided that code's criteria are met. NOTE 3: Code 09420 22 will not be reimbursed again if performed on the same recipient by the same practitioner, members of same group, members of a shared health care facility, practitioners sharing a common record or when Code 09310 has been billed in conjunction with the same hospital admission and/or stay by the same practitioner, members of the same group, members of a shared health care facility, or practitioners sharing a common record.	22.00	17.00
09420	Hospital Call NOTE 1: Code to be used for Hospital Day—Subsequent. NOTE 2: Consisting of care and treatment by the Practitioner subsequent to date of "Hospital Day—Initial" and including those procedures ordinarily performed during a hospital visit dependent upon the practitioner's discipline. The following may be included in the progress notes: a. Update of symptoms; b. Update of physical findings; c. Resume of findings of procedures, if any done; d. Laboratory, X-ray, consultations, etc., pertinent positive and negative findings;	9.00	7.00

			e. Changes or confirmations of diagnosis and progress of case; f. Additional planned studies, if any, and why; and g. Treatment changes, if any.		
			NOTE 3: Not reimbursable for those services that include follow-up days.		
	09430		Office Visit for Observation (During Regularly Scheduled Hours)—No Other Services Performed.	9.00	7.00
			NOTE: Code may also be used when post-operative services are necessary following a major surgical procedure (for example, bony impactions, fractures, etc.).		

(f) Drugs:

d	09610		Therapeutic Drug Injection, By Report	2.50	2.50
d**	09610	22	Therapeutic Drug Injection, By Report	13.00	11.00
			NOTE: Injection of one or more muscles of mastication in conjunction with treatment of T.M.J. dysfunction.		
d*	09630		Other Drugs and/or Medicaments, By Report	BR	BR

(g) Miscellaneous services:

	09910		Application of Desensitizing Medicaments	6.00	5.00
			NOTE 1: Application to a tooth, i.e., cervical sensitivity, erosions, etc.		
			NOTE 2: Specify tooth code(s).		
**	09920		Behavior Management, By Report	15.00	13.00
			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, for example, 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: 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.		
*	09930		Treatment of Complications (Post Surgical)—Unusual Circumstances, By Report	6.00	5.00
			NOTE: This code may also be used for post-operative treatment beyond that normally provided as part of the basic procedure or when provided by practitioner other than one who provided the original service or in excess of "follow-up days" (California Relative Value Study—1964), per visit.		
*	09940		Occlusal Guards, By Report	35.00	30.00
			NOTE 1: Special periodontal appliances (including occlusal guards, athletic mouth guards and so forth).		
			NOTE 2: Office procedure.		
*	09940	22	Occlusal Guards, By Report	50.00	43.00
			NOTE 1: Special periodontal appliances (including occlusal guards, athletic mouth guards and so forth).		
			NOTE 2: Laboratory procedure.		
*	09951		Occlusal Adjustment—Limited	6.00	5.00
			NOTE: 1 to 3 Teeth.		
*	09951	22	Occlusal Adjustment	17.00	15.00
			NOTE: Per quadrant (minimum six teeth).		
*	09952		Occlusal Adjustment—Complete	69.00	60.00
d**	09999		Unspecified Adjunctive Procedure, By Report	BR	BR
			NOTE: To be used only where no code number exists or existing code is not precisely applicable. Complete description of condition and proposed treatment must be submitted.		

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: 22 N.J.R. 1375(a).

EXHIBIT B

For dentists, hospital outpatient departments, independent clinics located in:		Submit request for authorization to:
1	Passaic Middlesex Morris Sussex Hunterdon Warren Somerset	Dental Section Middlesex Medical Assistance Unit 75 Paterson Street (basement) P.O. Box 1274 New Brunswick 08903 Telephone: 201–246–0653

2	Bergen Hudson Union	Dental Section Hudson Medical Assistance Unit 880 Bergen Avenue (3rd floor) Jersey City 07306 Telephone: 201–792–6390
3	Essex	Dental Section Essex Medical Assistance Unit 155 Washington Street Newark 07102 Telephone: 201–648–3700
4	Ocean Monmouth Mercer Atlantic Cape May	Dental Section Mercer Medical Assistance Unit 1424 South Broad Street Trenton 08610 Telephone: 609–292–7415
5	Burlington Camden Cumberland Gloucester Salem	Dental Section Camden Medical Assistance Unit 530 Cooper Street (3rd floor) P.O. Box 1089 Camden 08101 Telephone: 609–757–2873
Out-of-State providers submit requests for authorization to:		Dental Section New Jersey Division of Medical Assistance and Health Services 324 East State Street P.O. Box 2706 Trenton, New Jersey 08625 Telephone: 609–292–7420 Prudential Insurance Company Medicaid Claims Division P.O. Box 1900 Millville, New Jersey 08332 Telephone: 609–293–2176 201–887–3777

EXHIBIT I

Instructions for the completion of the "Dental Services Claim" form (MC–10).

Item 1: Patient's Name: Print patient's name, last name first, as it appears on the patient's Validation Form or Medicaid Eligibility Identification Card.

Item 2: Patient's Address: Print complete address, include zip code. Enter patient's telephone number in appropriate space.

Item 3: Health Service Program Case No.: Enter patient's Health Service Case Number exactly as it appears on the Validation Form or Medicaid Eligibility Identification Card.

Item 4: Patient Person No.: Enter number as it appears on the Validation Form or Medicaid Eligibility Identification Card. Patient person numbers 1 through 9 must be shown as 01, 02, 03, and so forth.

Item 5: Date of Birth: Enter patient's date of birth.

Item 6: Sex: Indicate the patient's sex by placing an X in the appropriate box.

Item 7: Other Dental Insurance or Liability Coverage: Indicate other dental health insurance coverage by entering an X in the appropriate box.

No Fault Auto Coverage: Indicated by placing an X in the appropriate box if the treatment was necessary as a result of an auto accident.

If answer is yes to either question, attach a copy of the explanation of payment or the decline notice from the appropriate insurance carrier. If no payment has been received, a complete report of the current status of the claim should be attached.

Claims collectible under the New Jersey No Fault Law are not reimbursable under the New Jersey Medicaid Program, however, supplemental payments can be made if the provider has received less than he would obtain from the Medicaid Program.

Item 8: Illness or Injury—employment related or injury due to automobile accident. Indicate if patient's illness or injury is employment related or result of auto accident by entering an X in the appropriate box. If yes is indicated in employment related questions, enter the name and address of the employer.

Item 9: Place of Service: Indicate the place of service by placing an X in the appropriate box.

Item 10: EPSDT Program Referral:

This question must be answered for recipients under 21 years of age.

Early and periodic screening, diagnosis and treatment (EPSDT), is an aspect of the Medicaid Program which ensures that recipients under 21 years of age receive early detection of disease and illness, as well as diagnostic and treatment services. If an EPSDT screening uncovers a health problem or defect, the patient may be referred to another practitioner for further diagnosis and/or treatment.

It is essential that the Medicaid Program be able to relate diagnostic and/or treatment services to the original screening. Therefore, when a patient under 21 years of age visits your office, a reasonable effort should be made to determine whether it is as a result of an EPSDT Program Referral by asking the referring physician or clinic or the patient. If you are unable to obtain the information, check No.

Item 11: Provider Name, Address, Telephone Number and Medicaid Provider Number (Enter only when not preprinted): This area is preprinted for the convenience of the provider who only needs to enter his telephone number in the appropriate box.

Inform Prudential Insurance Company of America immediately of any errors in preprinting.

Item 12: Existing or Previous Dentures: Indicate whether or not the patient has existing or previous dentures by placing an X in the appropriate box. If yes, indicate whether partial or full dentures and date inserted.

When prior authorization for dentures is requested, the claim will not be reviewed by the Dental Consultant if this section is not completed.

Item 13: Number of Radiographs: Indicate the number of pre-treatment and post-treatment radiographs on appropriate line.

Item 14:

14A: Date of Initial Impressions (Dentures, Appliances, Space Maintainers, etc.): Insert date of initial impressions for maxillary and mandibular denture(s), appliances, space maintainers, etc., on appropriate line, if applicable.

14B: Date of Initial Preparation(s) (Crowns): Place the tooth code in the box provided and the date of initial preparation on the line adjacent to that code when the initial preparation is made for the crown.

14C: Date of Initial Treatment(s) (Endodontic): When initial treatment for authorized endodontic treatment is commenced, place the tooth code in the box and enter the date of initial treatment on the line adjacent to that tooth code.

Item 15: Record Recommended Treatment (11 Services Only): Do not make any entries in the shaded area. Use one line for each procedure. Print clearly.

15A: Date of Service: Date procedure was completed—month, day and year. Numbers 1 through 9 are to be shown as 01, 02, 03, and so forth. Example: May 9, 1978 will be entered as 05 09 78.

15B: Procedure and Modifier Codes: Enter the appropriate procedure (5–digit) code and modifier (2–digit, if applicable) code for service proposed or performed. Since amount of payment will be determined from the procedure and modifier code, accuracy is most important. The procedure and modifier codes and corresponding schedule of maximum fee allowances can be found in N.J.A.C. 10:56–3.

15C: Fee Requested: Providers must indicate their usual and customary charge for each procedure. Each charge should contain six numerals.

Examples:

(A) $1.00 written as 0001.00;

(B) $20.00 written as 0020.00;

(C) $300.00 written as 0300.00.

Amount B, Code and Jam: Do not use. These spaces for Fiscal Agent use only.

15D: Tooth Code: Identify tooth treated by utilizing tooth numbers from dental chart (Item 15G).

15E: Surface: Indicate each surface treated for each procedure. Use abbreviations as shown in Item 19.

15F: Description of Service (Including radiographs, prophylaxis, materials used, etc.): Briefly describe service rendered. Include materials used in all pertinent information using the abbreviations shown in Item 19 as appropriate.

Authorization for Services Only: Do not use.

The Dental Consultant will indicate by initials, date, and possibly by a line connecting initials those services which are authorized and, therefore, reimbursable under the New Jersey Medicaid Program. The Dental Consultant will indicate by an "X" those dental services which are denied.

15G: Dental Chart: Complete dental chart accurately and in detail: Indicate missing teeth, extractions, restorations to be placed indicating all areas where treatment is proposed or has been completed as part of the current treatment plan.

Item 16: Diagnosis(es): Enter a diagnosis for those procedure codes prefixed with a "d" in N.J.A.C. 10:56–3. Where possible, select the diagnosis from the International Classification of Diseases (ICD). (Do not confuse the diagnosis with the patient's complaint or symptoms—pain, swelling, and so forth is not acceptable as a diagnosis.)

Item 17: Referral: Indicate in the appropriate box whether this patient was a referral from another practitioner. If yes, the name and Individual Medicaid Practitioner (IMP) Number of the referring practitioner must be provided.

Item 18: Remarks: This space is for provider use, should a remark be necessary. Box should be checked if additional information is attached.

Item 19: Abbreviations: To be used when describing the services rendered.

Item 20: Charting Symbols: To be used when charting services on the dental chart in Item 15G.

Item 21: This section is to be completed on each claim form. If one page is the complete claim, place an X in the top block. If there is more than one page to the complete claim, place an X in the second box and fill in blanks to the right.

For example: Page 1 of 3, page 2 of 3, and so forth.

Item 22: Patient Certification: See N.J.A.C. 10:49–1.26, "Patient certification".

Item 23: Provider Certification: The signature and IMP Number of the dentist actually performing or supervising the service(s) described on the claim is required in Item 23.

Exception: Dental Groups: When practitioners in a group practice (whether sole ownership, association, partnership, or corporation) submit claims for Medicaid reimbursement, the signature of any member of the group will be accepted on the claim form for billing purposes.

However, the group will be required to enter the IMP Number of the practitioner who personally performed the services represented on the claim. If a claim covers services performed by more than one practitioner, the IMP Number of any one of the performing practitioners will be accepted.

The "Dental Services Claim" form (MC–10) is available from the Medicaid Claims Division II, Prudential Insurance Company, P.O. Box 1900, Millville, New Jersey 08332.

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.