

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

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

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

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

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

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

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

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

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

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

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

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

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

Amended by R.1985 d.7, effective February 4, 1985.

See: 16 N.J.R. 1933(a), 17 N.J.R. 309(a).

(g) text added: "and to the . . . further information."

Amended by R.1986 d.385, effective September 22, 1986.

See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

Recodified from 10:56-1.11 and amended by R.1996 d.428, effective September 16, 1996.

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former N.J.A.C. 10:56-1.5, "Standards of service", recodified to 10:56-2.2.

10:56-1.6 Reimbursement based on specialist designation

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

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

2. In those states not requiring specialty certification:

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

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

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

UNISYS

Provider Enrollment Unit

PO Box 4801

Trenton, New Jersey 08650-4801

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

1. Oral and Maxillofacial Surgery;

2. Endodontics;

3. Pedodontics—Pediatric Dentistry;

4. Orthodontics;

5. Periodontics; and/or

6. Prosthodontics.

New Rule, R.1996 d.428, effective September 16, 1996.

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former N.J.A.C. 10:56-1.6, "Special dental services", recodified to 10:56-2.3.

Amended by R.1998 d.353, effective July 20, 1998.

See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).

In (b), updated the address.

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

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

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

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

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

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

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

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

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

10:56-1.8 Non-covered services

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

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

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

Amended by R.1974 d.53, effective March 15, 1974.

See: 6 N.J.R. 13(a), 6 N.J.R. 150(b).

Amended by R.1992 d.98, effective March 2, 1992.

See: 23 N.J.R. 281(a), 23 N.J.R. 1310(a), 24 N.J.R. 845(a).

Added subsection (b) on bundled drug services.

Recodified from 10:56-1.4 and amended by R.1996 d.428, effective September 16, 1996.

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former N.J.A.C. 10:56-1.7, "Utilization review, quality control and peer review", recodified to 10:56-1.9.

Recodified from N.J.A.C. 10:56-1.7 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:56-1.8, Recordkeeping requirements, recodified to N.J.A.C. 10:56-1.9.

10:56-1.9 Recordkeeping requirements

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

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

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

ii. Pertinent dental/medical history; and

iii. Detailed clinical examination data to include where applicable;

(1) Recipient's chief complaint

(2) Diagnosis

(3) Cavities

(4) Missing teeth; and

(5) Abnormalities;

iv. Preoperative, progress, and postoperative radiographs retained for a minimum of seven (7) years following the last date of service. Professional liability insurance companies should be contacted for possible retention for longer periods. The number and type of radiographs should be entered on the recipient's record. Postoperative radiographs should be taken only

when dentally necessary and must have diagnostic value.

v. Treatment plan with description of treatment rendered to include

- (1) Tooth number;
- (2) Surfaces involved;

- (3) Site and size of treatment area (lesion, laceration, fracture, and so forth);
- (4) Materials used;
- (5) Date(s) of service(s);
- (6) Description of treatment or services rendered at each visit to include the name of the dentist or hygienist rendering it.
- (7) All medications;
- (8) Diagnostic laboratory and/or radiographic procedure(s) ordered, including the result(s);
- (9) Copy of the dental prosthetic work authorization(s) (prescription(s)), and dental prosthetic laboratory receipt(s);
- (10) Explanation for any duplication of services within one year (prosthetic services within seven and one-half years);
- (11) Reasons for discontinuation of services (including attempts to complete treatment); and
- (12) Referral and consultation reports.

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

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

1. The results of an examination which will establish an admission record of the recipient's dental status.
 - i. If a current examination is required within six months of a previous examination performed by the same provider and billed to Medicaid, the results of the original examination shall be entered into the clinical record as the current dental status.
2. A time frame, established on an individual basis, for the next periodic examination of the recipient. The time frame shall be documented either at the time of examination, or at the completion of treatment. For example, it may be entered on the clinical record for six months, one year, two years, three years, or any other time period that the attending dentist has established per his knowledge of the recipient and the recipient's dental status.
3. A record of dental treatment provided at each encounter.
 - i. A photocopy of the completed and signed Medicaid Dental Services Claim Form (MC-10) for examination and treatment will be accepted in lieu of a separate

entry only if treatments (visits and description thereof) that preceded or followed the "dates of service" entered on the Medicaid Dental Services Claim Form MC-10 are listed separately on the recipient's clinical record in addition to the recordkeeping requirements described in this section.

As amended, R.1981 d.219, eff. July 9, 1981 (to become operative August 1, 1981).

See: 12 N.J.R. 700(a), 13 N.J.R. 430(b).

(a): New text substituted for old; (a)1: "include but not be limited to" was "consist of."

(b) and (c) added.

Amended by R.1986 d.385, effective September 22, 1986.

See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a)

Prosthetic service changed from five to seven and one-half years.

Amended by R.1996 d.428, effective September 16, 1996.

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Recodified from N.J.A.C. 10:56-1.8 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:56-1.9, Utilization review, quality control, peer review, and TAMI review, recodified to N.J.A.C. 10:56-1.10.

10:56-1.10 Utilization review, quality control, peer review, and TAMI 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 recipient by a qualified provider, in a setting, at a time, and in an amount which is appropriate and acceptable to the standards of the profession, at a cost described at N.J.A.C. 10:56-3.

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

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

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

(f) Peer review is the evaluation by practicing dentists as to the quality and efficiency of services ordered and/or performed by other practicing dentists and is considered to be the all-inclusive term for dental review efforts including dental practice analysis, inpatient hospital and extended care

utilization review and dental claims audit and review. In the accomplishment of the above, any or all reviews will include but not be limited to the following:

1. A clinical examination made on a sampling of cases. Such examination may be made prior to, during, or upon completion of treatment.
2. Additional diagnostic aids and data which may be requested to evaluate the case.
3. Adequate records which must be maintained by the dentist providing treatment and shall be available for inspection.
4. In the event a provider fails to respond to a request of the Division of Medical Assistance and Health Services for office records, radiographs, and/or other materials and correspondence within 30 days, the Division may recover any reimbursement related to the services involved, or if in reference to services not yet paid, reimbursement may be denied.

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

Recodified from 10:56-1.7 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Recodified from N.J.A.C. 10:56-1.9 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

SUBCHAPTER 2. PROVISIONS FOR SERVICES

10:56-2.1 Dental treatment plan

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

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

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

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

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

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

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

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

Section substantially amended.
Recodified from 10:56-1.2 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former section, "General billing procedures", repealed.

10:56-2.2 Standards of service

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

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

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

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

Recodified from 10:56-1.5 and amended by R.1996 d.428, effective September 16, 1996.

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former section, "Timeliness of claim submission and claim inquiry", repealed.

10:56-2.3 Special dental services

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

Amended by R.1986 d.385, effective September 22, 1986.

See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

Substantially amended.

Recodified from 10:56-1.6 by R.1996 d.428, effective September 16, 1996.

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former section, "Dental Services Claim form (MC-10)", repealed.

Amended by R.1998 d.353, effective July 20, 1998.

See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).

Updated the address.

10:56-2.4 Place of service

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

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