

CHAPTER 56

MANUAL FOR DENTAL SERVICES

Authority

N.J.S.A. 30:4D-1 et seq., 30:4D-6b(4) and 30:4D-7.

Source and Effective Date

R.2001 d.268, effective July 10, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Chapter Expiration Date

Chapter 56, Manual for Dental Services, expires on July 10, 2006.

Chapter Historical Note

Chapter 56, Dental Services Manual, was adopted as R.1971 d.70, effective May 12, 1971. See: 3 N.J.R. 58(c), 3 N.J.R. 110(b).

Chapter 56, Manual for Dental Services, was adopted as R.1978 d.2, effective March 1, 1978. See: 9 N.J.R. 431(c), 10 N.J.R. 66(e).

Pursuant to Executive Order No. 66(1978), Subchapter 3, Procedure Codes and Descriptions, was readopted as R.1986 d.128, effective March 24, 1986. See: 18 N.J.R. 154(a), 18 N.J.R. 847(b).

Pursuant to Executive Order No. 66(1978), Chapter 56, Manual for Dental Services, was readopted as R.1986 d.385, effective August 26, 1986. See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

Subchapter 3, Procedure Codes and Descriptions, was repealed and a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1987 d.166, effective April 6, 1987. See: 19 N.J.R. 15(b), 19 N.J.R. 519(a).

Pursuant to Executive Order No. 66(1978), Chapter 56, Manual for Dental Services, was readopted as R.1991 d.473, effective August 21, 1991. See: 23 N.J.R. 1992(a), 23 N.J.R. 2862(a).

Pursuant to Executive Order No. 66(1978), Chapter 56, Manual for Dental Services, was readopted as R.1996 d.428, effective August 14, 1996. As part of R.1996 d.428, Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was repealed and a new Subchapter 2, Provisions for Services, was adopted, effective September 16, 1996. See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Chapter 56, Manual for Dental Services, was readopted as R.2001 d.268, effective July 10, 2001. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. DENTAL SERVICES; GENERAL PROVISIONS

10:56-1.1 Purpose and scope
10:56-1.2 Definitions
10:56-1.3 Provisions for provider participation
10:56-1.4 Prior authorization
10:56-1.5 Basis for reimbursement
10:56-1.6 Reimbursement based on specialist designation
10:56-1.7 Personal contribution to care requirements for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D
10:56-1.8 Non-covered services
10:56-1.9 Recordkeeping requirements
10:56-1.10 Utilization review, quality control, peer review, and TAMI review

SUBCHAPTER 2. PROVISIONS FOR SERVICES

10:56-2.1 Dental treatment plan
10:56-2.2 Standards of service
10:56-2.3 Special dental services
10:56-2.4 Place of service
10:56-2.5 Visit policies
10:56-2.6 Diagnostic services; general
10:56-2.7 Diagnostic services: radiography
10:56-2.8 Diagnostic services: Clinical laboratory services
10:56-2.9 Preventive dental care
10:56-2.10 Restorative services
10:56-2.11 Endodontia
10:56-2.12 Periodontal treatment
10:56-2.13 Prosthodontic treatment
10:56-2.14 Exodontia and oral surgery
10:56-2.15 Orthodontic treatment
10:56-2.16 Pedodontia; pediatric dentistry
10:56-2.17 Adjunctive general services: anesthesia
10:56-2.18 Adjunctive general services: prescriptions
10:56-2.19 Adjunctive general services: medical/dental/supplies
10:56-2.20 Consultations
10:56-2.21 Pharmaceutical; program restrictions affecting payment for prescribed drugs
10:56-2.22 Medical exception process (MEP)

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:56-3.1 Introduction
10:56-3.2 D0100-D0999 DIAGNOSTIC
10:56-3.3 D1000-D1999 PREVENTIVE
10:56-3.4 D2000-D2999 RESTORATIVE
10:56-3.5 D3000-D3999 ENDODONTICS
10:56-3.6 D4000-D4999 PERIODONTICS
10:56-3.7 D5000-D5899 PROSTHODONTICS (REMOVABLE)
10:56-3.8 D5900-D5999 MAXILLOFACIAL PROSTHETICS
10:56-3.9 D6000-D6999 PROSTHODONTICS, FIXED
10:56-3.10 D7000-D7999 ORAL SURGERY
10:56-3.11 D8000-D8999 ORTHODONTICS
10:56-3.12 D9000-D9999 ADJUNCTIVE GENERAL SERVICES

APPENDIX A. FISCAL AGENT BILLING SUPPLEMENT

SUBCHAPTER 1. DENTAL SERVICES; GENERAL PROVISIONS

10:56-1.1 Purpose and scope

This chapter (N.J.A.C. 10:56) describes the policies and procedures of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs pertaining to the provision of, and reimbursement for, medically-necessary dental services to eligible individuals. In addition to the private office, dental services may be provided in the home, hospital, approved independent clinic, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), residential treatment center, or elsewhere.

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

Former N.J.A.C. 10:56-1.1, "Definitions", recodified to 10:56-1.2.
Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Inserted "/NJ FamilyCare fee-for-service" preceding "programs".

10:56-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

“Attending dentist” means one who assumes the primary and continuing dental care of the beneficiary. The services of only one attending dentist will be recognized at a given time.

“Clinical laboratory services” means professional and technical laboratory services ordered by a dentist within the scope of practice as defined by the laws of the state in which the dentist practices and, which are provided by a laboratory.

“Concurrent care” means that type of service rendered to a beneficiary by practitioners where the dictates of dental necessity require the services of dentists of different specialties in addition to the attending dentist so that needed care can be provided.

“Consultation” means that service rendered by a qualified dentist upon request of another practitioner in order to evaluate through personal examination of the beneficiary, history, physical findings and other ancillary means, the nature and progress of a dental or related disease, illness, or condition and/or to establish or confirm a diagnosis, and/or to determine the prognosis, and/or to suggest treatment. A consultation should not be confused with “referral for treatment” when one practitioner refers a beneficiary to another practitioner for treatment, either specific or general, for example, “Endodontic treatment on teeth No.’s 3 and 5”; or “Extract teeth No.’s 7, 8, 9, and 10”; or “Extract tooth or teeth causing pain.”

“Dental Services” means any diagnostic, preventive, or corrective procedures administered by or under the direct personal supervision of a dentist in the practice of the practitioner’s profession. Such services include treatment of the teeth, associated structures of the oral cavity and contiguous tissues, and the treatment of disease, injury, or impairment which may affect the oral or general health of the individual. Such services shall maintain a high standard for quality and shall be within the reasonable limits of those services which are customarily available, accepted by, and provided to most persons in the community within the limitations, and exclusions hereinafter specified.

“Direct personal supervision” means the actual physical presence of the dentist on the premises.

“Division” means the Division of Medical Assistance and Health Services.

“Emergency” means a specific condition of the oral cavity and/or contiguous tissues which causes severe and/or intractable pain and/or could compromise the life, health, or safety of the beneficiary unless treated immediately. For example:

1. Pain or acute infection from a restorable or a non-restorable tooth;
2. Pain resulting from injuries to the oral cavity and related structures;
3. Extensive, abnormal bleeding;
4. Fractures of the maxilla or mandible or related structures or dislocation of the mandible.

“Non-routine dental service” means any dental service that requires prior authorization by a Medicaid dental consultant in order to be reimbursed by the New Jersey Medicaid program.

“Nursing facility” means a long-term care facility or an intermediate care facility for the mentally retarded (ICF/MR).

“Participating dentist” means any dentist licensed to and currently registered to practice dentistry by the licensing agency of the State where the dental services are rendered, who accepts the promulgated requirements of the New Jersey Division of Medical Assistance and Health Services, and signs a provider agreement with the Division.

“Program” means the New Jersey Medicaid program.

“Prior authorization” means approval by a dental consultant to the New Jersey Medicaid program before a service is rendered.

“Referral” means the directing of the beneficiary from one practitioner to another for diagnosis and/or treatment.

“Routine dental service” means any dental service that is reimbursable by the New Jersey Medicaid program without authorization by a Medicaid dental consultant.

“Specialist” means one who is licensed to practice dentistry in the state where treatment is rendered, who limits his or her practice solely to his or her specialty, which is recognized by the American Dental Association and is registered as such with the licensing agency in the state where the treatment is rendered.

“Transfer” means the relinquishing of responsibility for the continuing care of the beneficiary by one dentist and the assumption of such responsibility by another dentist.

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

Section substantially amended.

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

Specialist amended.

Amended by R.1992 d.98, effective March 2, 1992.
See: 23 N.J.R. 281(a), 24 N.J.R. 845(a).

Added definition of “bundled drug service.”
Recodified from 10:56-1.1 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

Former N.J.A.C. 10:56-1.2, "Dental treatment plan", recodified to 10:56-2.1.

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Substituted "beneficiary" for "recipient" throughout.

10:56-1.3 Provisions for provider participation

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

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

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

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

Unisys Corporation
 Provider Enrollment
 PO Box 4804
 Trenton, NJ 08640-4804

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

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

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

Former N.J.A.C. 10:56-1.3, "Prior authorization", recodified to 10:56-1.4.

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (a), inserted references to NJ FamilyCare fee-for-service preceding "participating" and "programs"; substituted "/NJ FamilyCare fee-for-service beneficiaries" for "recipients".

10:56-1.4 Prior authorization

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

Division of Medical Assistance and Health Services
 Dental Claims Review Unit
 PO Box 713
 Trenton, New Jersey 08625-0713
 Telephone: (609) 588-7136 or 1-800-782-0181

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

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

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

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

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

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

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

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

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

1. Diagnostic examination with required radiography, necessary to develop a treatment plan, limited to a maximum of \$65.00;

2. Emergency treatment with required radiography;

3. Adjustments to, or repair of, dentures when the Medicaid/NJ FamilyCare fee-for-service reimbursement does not exceed \$165.00, specialist fee, or \$150.00, non-specialist fee effective for repairs made on or after October 16, 2000; and

4. The dental services designated below may be performed to the extent that they are dentally necessary but within the limitations listed in this subchapter and N.J.A.C. 10:56-3.

- i. Oral prophylaxis;
- ii. Topical fluoride application for persons 20 years of age and under;
- iii. Restoration of carious permanent and primary teeth with silver amalgam, composite, or other plastic materials;
- iv. Impactions, fractures, and most surgical procedures;
- v. Pulpotomy for permanent and primary teeth;
- vi. All extractions of non-restorable teeth;

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

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

(c) Supplemental or amended prior authorization requirements include:

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

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

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

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

As amended, R.1974 d.53, eff. March 15, 1974.

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

As amended, R.1984 d.270, eff. July 2, 1984.

See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).

Section substantially amended.

Recodified from 10:56-1.3 and amended by R.1996 d.428, effective September 16, 1996.

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

Former N.J.A.C. 10:56-1.4, "Non-covered services", recodified to 10:56-1.7.

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

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

In (a), updated the address in the introductory paragraph.

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

In (b)1, increased the dollar amount of a diagnostic examination with radiography; in (b)3, increased the dollar amounts of specialist and nonspecialist fees for denture adjustment and repair, and amended the date of the increases.

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (b)3, inserted a reference to NJ FamilyCare fee for service preceding "reimbursement".

10:56-1.5 Basis for reimbursement

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

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

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

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

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

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

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

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

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

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

i. Prostheses (to include, for example, dentures, crowns, space maintainers, and appliances, but not comprehensive orthodontic appliances or services) 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 eligibil-

ity 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.

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

In (f)1i, inserted " , but not comprehensive orthodontic appliances or services" following "appliances".

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Rewrote (a); in (b), (c) and (e), substituted references to beneficiaries for references to recipients; in (c), inserted a reference to NJ FamilyCare fee-for-service.

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 and copayments for NJ KidCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D 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.

(d) Dentists shall not charge a copayment for services provided to newborns, who are covered under fee-for-service Plan D; or for preventive dental services provided to children under 12 who are covered under NJ KidCare-Plan D including oral examinations, oral prophylaxis and fluoride treatments.

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.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.

Amended by R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).

See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).

In (a), added reference to copayments for NJ KidCare-Plan D; added (d).

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.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998. See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

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/NJ FamilyCare fee-for-service programs beneficiary, 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/NJ FamilyCare Dental Services Claim Form (MC-10) shall not be an acceptable substitute. Such beneficiary 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/NJ FamilyCare fee-for-service programs or their agents as required.

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

i. The name, address, and telephone number of the beneficiary, the beneficiary's date of birth and HSP (health services program) 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) Beneficiary'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 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 beneficiary'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 beneficiary 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 beneficiary'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 beneficiary. 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 or her knowledge of the beneficiary and the beneficiary'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.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Rewrote the section.

Amended by R.2003 d.16, effective January 6, 2003.

See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

10:56-1.10 Utilization review, quality control, peer review, and TAMI review

(a) For the purposes of the New Jersey Medicaid/NJ FamilyCare fee-for-service program, utilization review, quality control and peer review are considered to be ongoing components in regard to the dental services provided to eligible beneficiaries.

(b) Utilization refers to that service, procedure or item provided to a beneficiary 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).

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (a), inserted "/NJ FamilyCare fee-for-service" preceding "program" and substituted "beneficiaries" for "recipients"; in (b), substituted "beneficiary" for "recipient".

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/NJ FamilyCare dental consultant may modify the provider's treatment plan in accordance with the guidelines of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs specified in this chapter. Such modifications are designed to provide dental treatment to the beneficiary 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/NJ FamilyCare fee-for-service reimbursement. If in the professional judgment 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 beneficiary 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 beneficiary 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 beneficiary 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/NJ FamilyCare fee-for-service programs. The monthly Medicaid/NJ FamilyCare eligibility identification card should be examined carefully on each visit to be certain

the beneficiary 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 beneficiary's record.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (c) and (f), inserted references to NJ FamilyCare and NJ FamilyCare fee-for-service; in (g), inserted a reference to NJ FamilyCare; in (c), (f) and (g), substituted references to beneficiaries for references to recipients.

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 beneficiary 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, N.J.A.C. 10:52 and N.J.A.C. 10:66, respectively.

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 (see N.J.A.C. 10:52-2.3(a).)

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

i. Dental services are also reimbursable if the beneficiary 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 beneficiary'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 nursing 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 nursing 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 recipients examined or treated during the visit.

4. The dentist who examines a nursing facility beneficiary shall 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).

Recodified from 10:56-1.12 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, "Patient eligibility", repealed.

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Substituted references to beneficiaries for references to recipients throughout.

10:56-2.5 Visit policies

(a) A provider may be reimbursed for a house call (procedure code D9410) in addition to any other services provided on that day.

(b) The following apply to reimbursement for nursing facility visits (D9410):

1. Nursing facility visits can be billed in addition to any other services provided on that day; and

2. Nursing facility visits are limited to once per trip to the facility regardless of the number of patients examined or treated.

(c) Reimbursement for hospital calls (D9420 and D9420 22) can be billed for an inpatient or outpatient hospital visit in addition to any other services provided on that day, and shall be billed in accordance with the following:

1. Procedure code D9420 22 is not reimbursable if billed in conjunction with a consultation or other hospital calls on the same day.

2. Procedure code D9410 is limited to once per trip to the facility regardless of the number of patients examined or treated.

3. For a provider to be reimbursed for an initial hospital call or same day surgery, the hospital record must include, at a minimum:

- i. The chief complaint(s);
- ii. A complete history of the present illness and related systematic review including recording of pertinent negative findings;
- iii. A complete pertinent past medical history;
- iv. Pertinent family history;
- v. A description of a full examination pertaining to the history of the present condition including the recording of pertinent negative findings, and;
- vi. A record of a working diagnosis and treatment plan, and preparation of an "order sheet."

4. If a history and examination required for reimbursement for procedure code D9420 is not personally performed by the billing practitioner, the provider should bill for procedure code D9420 22 (hospital call), provided the criteria for that code are met.

5. An initial hospital call or same day surgery call (D9420) will not be reimbursed for the same recipient if the same practitioner, members of a same group, members of a shared health care facility, or practitioner sharing a common record also bill for this procedure code.

6. An initial hospital call or same day surgery call (D9420) will not be reimbursed in conjunction with a consultation (D9310) for same hospital admission and/or stay, if billed by the same practitioner, members of the same group, members of a shared health care facility, or practitioner sharing a common record.

7. In order to bill for a subsequent hospital call (D9420 22), the following may be included in the progress notes:

- i. An update of symptoms;
- ii. An update of physical findings;
- iii. A resume of findings of procedures, if any done;
- iv. Laboratory, radiographs, and consultation results, including pertinent positive or negative findings;

v. Changes or confirmations of diagnosis and progress of care;

vi. Any additional planned studies, and reasons why; and/or

vii. Any treatment changes.

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

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

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (c)5, substituted "beneficiary" for "recipient".

Amended by R.2003 d.16, effective January 6, 2003.

See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

Rewrote the section.

10:56-2.6 Diagnostic services; general

(a) A complete examination of the oral cavity shall be a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development and recording of a complete treatment plan. It should permit a Dental Consultant (with accompanying radiographs) to determine the appropriateness of the treatment plan.

1. 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.);" under Remarks (Item 20) on the Dental Services Claim Form (MC-10).

2. Except as provided in N.J.A.C. 10:78-7.1, for reimbursement purposes, a comprehensive dental examination shall be limited to once every six months for those beneficiaries through age 17 and once every 12 months for those beneficiaries 18 years of age or older except as prior authorized by a Dental Consultant of the Medicaid/NJ Family Care fee-for-service programs.

(b) 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.

(c) The dentist who examines a nursing facility beneficiary shall provide the treatment necessary unless the examination indicates that a specialist is needed.

(d) Handicapping Malocclusion Assessment Examination (refer to N.J.A.C. 10:56-2.15).

1. Since orthodontic treatment will not be authorized for individuals age 21 or older, (see N.J.A.C. 10:56-2.15) the Handicapping Malocclusion Assessment Examination is not reimbursable for individuals age 21 or older.

2. For reimbursement purposes, a Handicapping Malocclusion Assessment Examination is limited to once every 12 months unless authorized. In addition, reimburse-

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

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.

Recodified from 10:56-1.14 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (a)2, substituted "Except as provided in N.J.A.C. 10:78-7.1, for" for "For", inserted "/NJ Family Care fee-for-service" preceding "programs", and substituted "beneficiaries" for "recipients"; in (c), substituted "beneficiary" for "recipient".

10:56-2.7 Diagnostic services: radiography

(a) Radiological procedures shall be limited to those normally required to make a diagnosis and must show all areas where treatment is anticipated with the exception of soft tissue lesions.

(b) All radiographs should be examined carefully by the provider to assure quality care and to make certain that all necessary treatment has been diagnosed, planned for and/or completed.

(c) Radiographs may be reviewed by dental consultants of the Medicaid/NJ Family Care fee-for-service programs and/or a dentist in private practice not employed by New Jersey Medicaid/NJ Family Care fee-for-service programs, if appropriate. It is recommended that the two film packet be used or a copy may be made by those dentists who wish to retain a set of radiographs in their office at all times.

(d) The originals of all radiographic films shall be available to authorized representatives of the New Jersey Medicaid/NJ Family Care fee-for-service programs. Radiographs shall be forwarded to the Division of Medical Assistance and Health Services in the following situations:

1. When prior authorization is requested; or
2. Upon request by the Medicaid/NJ Family Care fee-for-service programs for utilization review or adjudication purposes.

(e) All radiographic films shall be suitable for interpretation and when submitted to the New Jersey Medicaid/NJ Family Care fee-for-service programs or their agents shall be properly mounted, marked "Right" and "Left" and identified with the beneficiary'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/NJ Family Care fee-for-service programs. No reimbursement shall be made for the new set of radiographs that the dentist is required to provide. When already reimbursed, recoupment will be made, unless a replacement set of radiographs is sent to the Division for review.

(f) Reimbursement for dental radiographs shall be limited according to the following standards:

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

i. Up to and including age six: eight films (six periapical plus two bitewing films);

ii. Age seven, up to and including age 14: 12 films (10 periapical films, plus two bitewing films) or a panorex and two posterior bite wing films;

iii. For those beneficiaries 15 years of age or older: 16 radiographs (at least 14 periapical plus two posterior bitewing films) or a panorex plus four posterior bite wing films;

iv. A complete series radiographic study may include two bitewing or more radiographs. Any additional films over and above that number, as limited by age, are considered to be part of that complete series and no additional reimbursement can be made. If, however, extenuating circumstances exist, the need for additional films in (f)1i through iii above must be substantiated and a specific authorization obtained from the Medicaid dental consultant.

v. The three year limitation in (b)4i(1), (2), and (4) above will continue to apply even though an age change transfers the beneficiary from one age category to another. For example, a beneficiary who has eight radiographs at age six is not eligible for the 12 film series until he or she has reached age nine and three years have passed;

vi. The maximum amount reimbursable for radiographs billed individually or in groups in conjunction with an initial examination, and/or one treatment plan and/or within a six month period is that amount paid for a complete series as outlined in (b)4 above. During any 12 month period subsequent to a complete radiography series study within the three year period, the maximum number of radiographs permitted shall be as follows:

(1) Up to and including age six—four films;

(2) Age seven and up to and including age 14—four films;

(3) Age 15 years of age or older—six films.

vii. If the provider requires additional films, he or she shall first secure prior authorization by the Medicaid/NJ Family Care fee-for-service dental consultant.

(g) In an emergency situation, in order to establish a diagnosis which must be recorded under Remarks (Item 20) of the Dental Services Claim Form (MC-10) a radiograph may be taken at any time, as dentally necessary.

(h) Postoperative radiographs normally taken at the conclusion of dental treatment by a dental provider shall be maintained as part of the beneficiary's dental records (for example, final radiographs at completion of endodontic treatment, or certain surgical procedures).

(i) Radiological services other than those ordinarily provided by a practitioner in his or her own office may be referred to a dental specialist who will provide radiological services limited to his or her 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 shall be billed directly to the Medicaid/NJ Family Care fee-for-service programs by that provider and not by the referring dentist.

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

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (e), substituted "their" for "its"; in (f)1, rewrote ii and iii; inserted references to NJ Family Care fee-for-service and substituted references to beneficiaries for references to recipients throughout.

10:56-2.8 Diagnostic services: Clinical laboratory services

(a) "Clinical laboratory services" includes services provided by:

1. Independent clinical laboratories, including physician/dentist operated, out of hospital laboratories which perform primarily diagnostic work referred by other practitioners; and
2. Hospital laboratories and laboratories of educational institutions which provide laboratory services to ambulatory beneficiaries as requested by a licensed practitioner.

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

(c) All facilities or entities that perform clinical laboratory testing shall have certification for the services they are performing (see N.J.A.C 10:61). Reimbursement for laboratory testing performed shall not be made to any facility without such CLIA certification. It shall be the initiating entity's responsibility to refer tests to laboratories which are New Jersey Medicaid/NJ Family Care fee-for-service providers and have a valid CLIA identification number.

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.

Recodified from 10:56-1.14 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (a)2, substituted "beneficiaries" for "recipients"; in (c), inserted "/NJ Family Care fee-for-service" preceding "providers".

10:56-2.9 Preventive dental care

(a) In addition to a dental examination every six months for those recipients through age 17 and once every 12 months for those recipients 18 years of age or older, preventive dental care encompasses the following recommended services:

1. Prophylaxis, as follows:

- 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 recipients through age 17 and once every 12 months for those recipients 18 years of age or older, except as otherwise prior authorized by a dental consultant of the Medicaid/NJ FamilyCare fee-for-service programs, and except as provided in (a)1ii(1) below.

- (1) Beneficiaries with developmental disabilities, neurological impairments, or other disabilities, regardless of age, shall be eligible for examination, radiographs as appropriate, prophylaxis, extra-scaling and topical application of fluoride including prophylaxis, as often as every three months. Claims may be submitted directly to the fiscal agent for payment, without prior authorization. The nature of the recipient's disability must be recorded under Remarks (Item 20) on the Dental Services Claim Form. Special procedure codes with the modifier "76" must be submitted for reimbursement, for example: D0150 76 (oral evaluation), D0110 76 (prophylaxis—child), D4355 76 (debridement, additional scaling) and D1201 76 and D1205 76 (fluoride including prophylaxis for child and adult respectively). See N.J.A.C. 10:56-3.2(a) and 3.3(a). In the event any of these services are required more often than every three months, prior authorization by the Medicaid/NJ FamilyCare fee-for-service dental consultant is required.

2. Fluoride Treatment, as follows:

- 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.

- ii. A complete prophylaxis shall be performed prior to and in conjunction with the topical fluoride treatment.

- iii. Reimbursement for topical fluoride treatment shall be limited to once every six months without need for prior authorization for those beneficiaries through

age 17 and once every 12 months for those beneficiaries 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. 10:56-2.17).

vi. Use of a prophylaxis paste containing fluoride shall not be billed as "topical fluoride treatment." For reimbursement purposes, this is considered to be only a prophylaxis.

3. To encourage the maintenance of dental health, the same type of recall procedure as used in dental practice in the community shall be extended to eligible Medicaid/NJ Family Care fee-for-service beneficiaries.

4. Beneficiary education for Medicaid/NJ Family Care fee-for-service beneficiaries should consist of dental health orientation identical to that given all patients.

5. Sealants shall be a covered service of the Medicaid/NJ Family Care fee-for-service programs, subject to the following limitations:

i. Application of sealants shall be limited to a one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars.

ii. Application of sealants shall be limited to beneficiaries up to and including 16 years of age.

iii. Sealants applied, other than as outlined above, are not reimbursable unless authorized by a Medicaid/NJ Family Care dental consultant. A complete explanation of the request must be attached to the prior authorization request.

iv. Since sealants may be reimbursed only once for each tooth, the provider should make certain that sealants have not been applied previously.

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)11 deleted and new text substituted.

Recodified from 10:56-1.15 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Rewrote the section.

Amended by R.2003 d.16, effective January 16, 2003.

See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

Rewrote the section.

10:56-2.10 Restorative services

(a) Restorative treatment shall be limited to those services necessary to adequately restore and maintain the integrity and contours of the natural tooth, as follows:

1. Filling restorations shall be reimbursed as follows:

i. Reimbursement for restorations in primary teeth shall be limited to primary cuspids and molars of children up to and including age nine, or in primary incisors up to and including age five, but not where exfoliation is imminent, except when prior authorization by a Medicaid/NJ Family Care dental consultant has been obtained by the provider.

ii. Silver amalgam and composite restorations may be provided on anterior and posterior teeth (numbers 1 through 16 and 17 through 32). The provider should select the restorative material most appropriate for the beneficiary's dental needs.

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

iv. Plastic, acrylic, or unfilled resin restorative material shall be reimbursable only when utilized for the six anterior teeth in each arch.

v. Silicate restorations shall not be covered by the New Jersey Medicaid/NJ Family Care fee-for-service programs.

vi. A procedure code shall 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 shall include one or more restorations on that surface.

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

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

ix. Extension of interproximal restorations 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 of the buccal (facial) and/or lingual surface(s).

2. Crown restorations shall be reimbursed as follows:

i. Prior authorization for crowns shall be granted only when there is substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue justify this treatment. Radiographic studies shall be submitted with the prior authorization request. Prior authorization is not necessary for beneficiaries up to and including age 20. Prior authorization is necessary for beneficiaries age 21 and older.

ii. Generally, temporary (quick cure) acrylic or plastic (prefabricated) crowns shall be reimbursable only for badly broken down anterior teeth up to and including age 15. Likewise, preformed stainless steel crowns shall be reimbursable only for primary teeth and permanent posterior teeth up to and including age 17.

- iii. Acrylic or porcelain veneer on metal shall be authorized when aesthetically necessary.
 - iv. Porcelain jackets will not be authorized.
3. Post and post and core shall be reimbursable under the following conditions:
- i. A post is reimbursable on an endodontically treated tooth in conjunction with amalgam, composite, other resin or crown restorations.
 - ii. A post and core is reimbursable on an endodontically treated tooth only in conjunction with a crown as the final restoration.
 - iii. A post or post and core on an endodontically treated tooth must extend into at least one-half, and preferably two-thirds, of the length of the endodontically treated canal. Failure of a post or post and core which results in the concurrent failure of a crown will be subjected to recovery of the reimbursement for both services based on this standard.

As amended, R.1975 d.262, eff. September 1, 1975.
 See: 7 N.J.R. 318(a), 7 N.J.R. 466(a).
 Recodified from 10:56-1.16 and amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2001 d.268, effective August 6, 2001.
 See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
 In (a)1i, inserted "NJ Family Care" preceding "dental"; (a)1ii, substituted "beneficiary's" for "recipient's"; in (a)1v, inserted "fee-for-service" preceding "programs"; in (a)2i, substituted "beneficiaries" for "recipients".

10:56-2.11 Endodontia

(a) Some endodontic treatment shall require PA, as indicated in N.J.A.C. 10:56-3.5. Prior authorization will be at the discretion of the Medicaid/NJ Family Care fee-for-service dental consultant and will be influenced by the age and general health of the beneficiary; the status of the tooth in the arch; and the condition of the remaining dentition and supporting structures.

(b) Reimbursement for root canal therapy for all teeth shall include pulpal extirpation, endodontic treatment to include complete filling of the root canal(s) with permanent material, all necessary radiographs during treatment, a radiograph demonstrating proper completion, and follow-up care.

1. Prior authorization is necessary for beneficiaries 21 and older. When the beneficiary is in pain, the dentist should institute emergency measures to extirpate the pulp and/or relieve the pain only until authorization is requested and received. Authorization shall not be necessary for beneficiaries up to and including age 20.
2. Silver points are not acceptable as the "permanent material" for filling the root canal.
3. Complete filling of the root canal is defined as filling of the canal to within 0.5 millimeters of the apex.

(c) A pulpotomy shall be limited to a primary tooth or a permanent tooth with incompletely formed roots.

1. The pulpotomy code is also reimbursable as an emergency endodontic procedure.

(d) Root canal therapy for primary teeth (with permanent successors only) shall include pulpal extirpation, and endodontic treatment to include complete filling of the root canal(s) with resorbable filling material. A radiograph(s) demonstrating proper completion must be available for review by Division staff.

(e) 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 restoration. Pulp capping is not a separate reimbursable procedure.

(f) Apicoectomy will be considered for prior authorization and/or 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. Displaced 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 in the practitioner's judgment will not be resolved by endodontic therapy alone;
9. A post, post and core, or post-crown which cannot be removed.

(g) 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.

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

(i) Reimbursement includes those post-treatment radiographs determined necessary by the practitioner and must be available to the Medicaid/NJ Family Care fee-for-service programs upon request.

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.

Recodified from 10:56-1.17 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (a), inserted "/NJ Family Care fee-for-service" preceding "dental" and substituted "beneficiary" for "recipient"; in (b)1, substituted references to beneficiaries for references to recipients; in (i), inserted "/NJ Family Care fee-for-service" preceding "programs".

10:56-2.12 Periodontal treatment

(a) Periodontal treatment may be prior authorized by the Division on a very selective basis. Such prior authorization shall be based on the requirements of this section and on the professional judgment of the Division dental consultant. A detailed description of the condition, including radiographs, and photographs where appropriate, shall be submitted to the dental consultant. Photographs or slides are an excellent means of presenting the condition of the oral tissues to the consultant and shall be reimbursable.

(b) When requesting periodontal treatment, consideration should be given to the age and health of the beneficiary, the amount of bone loss, the condition of the remaining dentition, the desire, ability, and motivation of the beneficiary to follow through with necessary home and follow-up care, and the prognosis for the remaining teeth.

(c) When requesting prior authorization of the code for periodontal scaling and root planing, the provider should submit, in addition to radiographs and photographs, a narrative, to include periodontal pocket depth for each tooth in the quadrant(s) requested.

(d) Reimbursement will be based upon quadrants, a portion thereof, or the equivalent thereof, as determined by Medicaid/NJ Family Care dental consultant in accordance with N.J.A.C. 10:56-3.1(d)6vi.

Recodified from 10:56-1.18 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (b), substituted "beneficiary" for "recipient"; in (d), inserted a reference to NJ Family Care.

10:56-2.13 Prosthodontic treatment

(a) Removable denture policies are as follows:

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

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

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

ii. Medical status of beneficiary (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, prior authorization for partial dentures to replace posterior teeth will not be granted if there are at least eight posterior teeth which in the opinion of a dental consultant are in reasonably good periodontal condition, occlusion and position, or where a prosthesis in one arch will produce equivalent dentition.

4. There must be a three month wait (for healing) between the date of the 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, the dentist shall 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 prior authorized in toto. As soon as the extractions are completed, the claim should be submitted for payment for the diagnostic and/or surgical services. 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 the fiscal agent marked "continuation of previously authorized treatment plan".

5. The fee for a partial denture shall include payment for all necessary clasps and rests regardless of the number. A minimum of two (2) clasps and rests must be provided.

6. The fee for complete maxillary and/or mandibular dentures shall 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.

7. Partial dentures shall 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.

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

9. Dentures shall not be prior 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 year period prior to the date of the current request; or

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

(b) Fixed bridges will not normally be prior authorized. If extenuating circumstances exist, any request must be submitted to the Medicaid/NJ Family Care dental consultant accompanied by all supporting documentation. Two examples of extenuating circumstances include:

1. Existing defective fixed bridge; and
2. A patient who is mentally or physically compromised to the extent that a removable prosthesis cannot be tolerated.

(c) Repairs to complete or partial dentures includes adjustments for three months. Prior authorization shall be required when the repair exceeds \$165.00 for a specialist or \$150.00 for a non-specialist.

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

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.

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

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

4. Adjustments prior to and in conjunction with denture relining, rebasing (jumping) and repair shall not be reimbursable. Adjustments, repairs, relining, and rebasing shall not be reimbursable when new or replacement dentures have been prior authorized.

5. Rebases and relines shall not be reimbursable within 12 months of initial insertion of a denture without prior authorization, and shall thereafter be limited to once every 12 months without prior authorization.

6. The beneficiary'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 (repair, reline, rebase, and so forth). The social security number shall also be included if space permits. This requirement is consistent with the "Denture I.D. Law" (N.J.S.A. 45:6-19.1 et seq.).

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".

Recodified from 10:56-1.19 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

In (c), increased the dollar amount of fees for repair of complete or partial dentures.

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

Substituted references to beneficiaries for references to recipients throughout; in (b), inserted a reference to NJ Family Care.

10:56-2.14 Exodontia and oral surgery

(a) Exodontia rules are as follows:

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

i. Where any extraction is being considered which will necessitate the insertion of a dental prosthesis, prior authorization is required. Reimbursement for such an extraction(s) rendered without prior 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. 10:56-2.13) it may be impossible to replace a denture(s) following such extraction(s). Therefore, careful consideration should be given to the condition of teeth prior to a request for dentures initially; and 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 shall determine:

(1) That such orthodontic treatment has met the Salzmann Handicapping Malocclusion Guidelines established by the New Jersey Medicaid Program or has been prior 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 met the New Jersey Medicaid guidelines or has not been prior authorized by the Chief, Bureau of Dental Services; or

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

2. Reimbursement for dental extraction(s) includes local anesthesia, indicated alveoloplasty and routine post-operative care. Alveoloplasty is reimbursable in conjunction with the extraction of at least three teeth or the roots of at least three teeth in the same quadrant during the same operative session.

3. Alveoloplasty, not related to current dental extraction(s), is reimbursable based on demonstrated dental necessity. Prior authorization shall not be required.

(b) Prior authorization shall not be required for the extraction of impacted teeth for beneficiaries age 18 and older. Extraction of impacted teeth should be undertaken only when conditions arising from such impactions warrant their removal. The extraction of asymptomatic impacted teeth or those teeth where dental/medical necessity cannot be demonstrated will not be accepted for reimbursement.

1. In order to qualify for surgical removal of a tooth with partial or complete bony impaction, the following shall be required:

- i. Incision of overlying soft tissue;
- ii. Removal of bone; and/or
- iii. Sectioning of the tooth.

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

(c) Oral surgery rules are as follows:

1. Requests for reimbursement or prior authorization of oral surgical procedures, when such authorization is necessary, must include a detailed description giving dates, diagnosis, site, and size of the operative area (number of lesions, and/or number and size of lacerations). For prior authorization, preoperative and any radiographs taken postoperatively, radiological, operative, and laboratory reports should be submitted directly to the dental consultant with the Dental Services Claim Form (MC-10). The dentist shall also be responsible for making available all other reports, including hospital radiographs 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 Services Claim Form (MC-10A) 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) shall bill the program directly for their diagnostic services.

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.

(d) Extractions to be performed for orthodontic purposes only shall be submitted to the Division for prior authorization. Referrals for prior authorization shall be noted in section 14 of the Medicaid/NJ Family Care Dental Services Claim form MC-10.

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 10:56-1.20 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (b), substituted "beneficiaries" for "recipients"; added (d).

10:56-2.15 Orthodontic treatment

(a) The procedures in this section shall be followed for orthodontic referral, evaluation, and treatment.

(b) Orthodontic treatment shall be selective and limited to handicapping malocclusions. Cases with 24 or more points on the New Jersey Handicapping Malocclusion Assessment System shall be considered as having a handicapping malocclusion and prior authorization shall not be required.

1. Orthodontic treatment shall not be reimbursed for the following:

- i. For cosmetic purposes only;
- ii. For individuals age 21 or older; and
- iii. Except as specified at (d) below, for individuals with less than 24 points on the New Jersey Handicapping Malocclusion Assessment System (see (c) below).

2. The following factors shall be considered by a dentist before making any referral and also by the practitioner who may render orthodontic treatment before assessing the beneficiary and performing the diagnostic work-up:

- i. The assessment system is a modification of the work of Dr. J. A. Salzmann who has consented to allow the New Jersey Medicaid program to modify and utilize it.
- ii. The difference from Dr. Salzmann's original work is that the New Jersey Medicaid program does not allow the eight additional points to denote aesthetic handicap for the anterior segment.

iii. Referrals for orthodontics and initiation of orthodontic treatment should be delayed until the beneficiary has all permanent teeth unless prior authorized by a dental consultant of the Bureau of Dental Services.

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

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

vi. The practitioner should be aware of the following:

(1) The Medicaid/NJ FamilyCare Eligibility Identification card should be examined on the first visit of each month. Make certain that the beneficiary being treated is listed as eligible and that the Medicaid/NJ FamilyCare number has not changed. If possible, a photocopy should be retained as part of the beneficiary's records on a monthly basis.

(c) The New Jersey Medicaid Program Handicapping Malocclusion Assessment System shall be utilized to determine if the case fulfills the requirements for a diagnostic workshop and subsequent orthodontic treatment.

1. A reprint from the American Journal for Orthodontics (10/68) entitled "Handicapping Malocclusion Assessment to Establish Treatment Priority" provides comprehensive instructions for completion of the Handicapping Malocclusion Assessment Record Form (FD-10). A copy of the reprint can be ordered from the Medicaid fiscal agent:

UNISYS
PO Box 4811
Trenton, New Jersey 08650-4811

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

1. The practitioner, considering the factors in this section, shall perform a visual/oral examination of the beneficiary, and complete the Handicapping Malocclusion Assessment Record Form (FD-10) to determine if the severity of the malocclusion will qualify (24 points or more) for diagnostic work-up and initiation of treatment.

2. If the malocclusion does not meet the minimum number of assessment points (24), the practitioner should not proceed with the diagnostic workup since the case does not qualify and reimbursement will be denied.

i. Exception: If the malocclusion does not meet the minimum number of Assessment points (24), but there are other extenuating circumstances that should be considered, the practitioner should proceed with the diagnostic workup; however, the extenuating factors shall be recorded and substantiated and submitted with the diagnostic workup and treatment plan to the Bu-

reau of Dental Services for prior authorization. Examples of possible extenuating circumstances are:

- (1) Facial or oral clefts;
- (2) Extreme antero-posterior relationships;
- (3) Extreme mandibular prognathism;
- (4) A deep overbite where incisor teeth contact palatal tissue;
- (5) Extreme bi-maxillary protrusion.

ii. For reimbursement of the Handicapping Malocclusion Assessment Examination only, the practitioner shall submit the Dental Services Claim Form (MC-10) directly to the Medicaid fiscal agent:

UNISYS
PO Box 4811
Trenton, New Jersey 08650-4811

identifying, by procedure code D8660, the service that has been rendered. A copy of the Handicapping Malocclusion Assessment Record Form (FD-10) shall accompany this submission (Limitation—see N.J.A.C. 10:56-2.6).

iii. Submission of requests for treatment with assessments below the minimum number of points required without sufficient justification (see (d)2 above), or due to incorrect calculation, will necessitate denial of reimbursement for the diagnostic materials submitted, or recovery, if payment has already been made.

3. If the malocclusion meets or exceeds the minimum number of assessment points (24), the practitioner may proceed with the diagnostic workup and subsequent orthodontic treatment.

(e) Certain procedures set forth in (d) above require prior authorization. The rules concerning prior authorization for special orthodontic cases are:

1. Upon completion of the diagnostic work-up, submit the following to the Division of Medical Assistance and Health Services, Bureau of Dental Services, PO Box 713, Trenton, New Jersey 08625-0713.

i. The Dental Services Prior Authorization Form (MC-10A) part 1 of 2 and the Dental Claim Form MC-10 part 2 of 2 utilizing the proper code number(s) with requested fees for:

- (1) Assessment examination;
- (2) Diagnostic aids utilized;
- (3) Treatment necessary to carry the case to completion.

ii. A brief description of the proposed plan of treatment on provider's personal letterhead;

iii. A copy of the Handicapping Malocclusion Assessment Record Form (FD-10);

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

(1) Photographs or slides of the diagnostic models with the correct inter-arch relationship indicated and/or photographs of the beneficiary which demonstrate the malocclusion and/or extenuating circumstance(s). The maximum number of photographs or slides which is reimbursable is eight;

(A) The actual diagnostic models should only be submitted if it is impossible to demonstrate the orthodontic problem and extenuating circumstances by photographs, or if requested;

(2) A cephalometric radiograph with a detailed tracing;

(3) A series of intra-oral radiographs consistent with N.J.A.C. 10:56-2.7 (or a diagnostic panoramic radiograph);

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

(5) Photographs (minimum size two inches by two inches) or slides—maximum reimbursable—eight.

(6) All the diagnostic aids will be returned to the practitioner, but shall continue to be available upon request of the Division of Medical Assistance and Health Services. It is suggested that models, radiographs, and photographs be duplicated before submission to enable the practitioner to retain a set in the office should there be breakage or loss in mailing.

2. A consultant of the New Jersey Medicaid program will review the plan of requested treatment utilizing the diagnostic aids submitted and render a decision.

3. The practitioner will be notified by the Medicaid program of the action taken on the treatment request following review by the Medicaid dental consultants.

(f) Periodically, the Division of Medical Assistance and Health Services, Bureau of Dental Services, may request a progress report from the provider, and, as necessary, progress photographs and other appropriate records to determine whether authorization should be continued. Failure to respond to this request in writing, personally signed by the provider, may result in suspension of authorization and reimbursement to the provider.

1. Reimbursement for the monthly fee for comprehensive orthodontic treatment shall be based on one or more visits during any calendar month. Reimbursement shall not be requested for any month in which there is no visit.

(g) If the beneficiary's eligibility continues through completion of treatment, final records similar to diagnostic aids described in (e)1iv above, shall be taken at termination of treatment and shall be submitted upon request, to:

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

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

(i) Reimbursement for comprehensive orthodontic examinations and/or orthodontic assessment examinations rules shall be as follows:

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

2. Reimbursement shall be limited to once every 12 months, unless prior authorized.

3. Orthodontic examinations shall not be reimbursable for individuals age 21 or older.

(j) All orthodontic cases are subject to Post-Utilization Review by the Division. Therefore, it shall be necessary for all providers to maintain all pre and post-treatment records for at least seven years following completion.

(k) The following orthodontic cases require prior authorization and/or post service, prepayment review by the Division before reimbursement will be remitted to the provider:

1. Orthodontic cases below 24 points on the Salzmann Assessment;

2. All limited orthodontic treatment cases;

3. All transfer orthodontic cases; and

4. All orthodontic cases in which the beneficiary has discontinued treatment for a period of six months or more and then returns for treatment.

As amended, R.1983 d.584, eff. January 1, 1984.

See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).

Deletion of references to orthodontists and replacement by references to general practitioners.

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

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

Note recodified to (e)1iv(6).

Recodified from 10:56-1.21 and amended by R.1996 d.428, effective September 16, 1996.

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

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

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

Updated addresses throughout the section.

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (b)2vi(1), inserted references to NJ FamilyCare; in (e)1iv(1), rewrote the last sentence; rewrote (g) as (g) and (h); recodified former (h) through (j) as (i) through (k); and substituted "beneficiary" for "recipient" and "beneficiary's" for "recipient's", throughout.

Amended by R.2003 d.16, effective January 6, 2003.
See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

Rewrote the section.

10:56-2.16 Pedodontia: pediatric dentistry

(a) In recognition of the unique needs of providing dental care for children, and in conformance with the Federally mandated Early and Periodic Screening, Diagnosis and Treatment program for providing services for children, a special HCPCS code has been defined, "D0150 EP," to be used by dental providers when billing for comprehensive clinical oral examinations of children.

(b) On or after January 15, 1995, a dental provider may bill using the HCPCS code for a comprehensive clinical oral examination provided to a child.

1. This may be an initial or periodic examination.
2. For determining when this HCPCS code may be used, a child is defined as a person under the age of 21 years.

(c) The HCPCS code D0150 EP is reimbursed at an enhanced rate of \$25.00 for a specialist and \$21.00 for a non-specialist. Reimbursement for a comprehensive clinical oral examination of a child, through age 20 years, is limited to once every six months, except as authorized by a Dental Consultant of the New Jersey Medicaid program. As a minimum, the examination must include:

1. Thorough observation of all conditions present in the oral cavity and contiguous structures including an oral cancer screening;
2. Assessment of dental development;
3. Charting of all abnormalities;
4. Development of a complete treatment plan to be recorded in its entirety, including provisions for further treatment and follow-up, by referral if necessary;
5. Anticipatory guidance concerning dental health to the patient or parent/guardian;
6. Assessment of the caries index and nutritional needs relating to oral health and oral hygiene practices; and
7. Assessment of systemic or topical fluoride needs.

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

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

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

In (c), increased the dollar amounts for specialist and nonspecialist reimbursement.

Amended by R.2003 d.16, effective January 6, 2003.

See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

Substituted "D0150 EP" for "00110 WT" (a) and (c).

10:56-2.17 Adjunctive general services: anesthesia

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

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

2. In any setting exclusive of a hospital, when general anesthesia is provided by the dentist, such may be reimbursed subject to the following:

- i. Necessity for same is demonstrated.

- ii. Reimbursement can only be made to a dentist who satisfies all the established rules and regulations and has such written certification (permit) as may be required by the State of New Jersey or the state in which the service is being rendered.

- (1) A valid copy of the general anesthesia permit issued by the New Jersey State Board of Dentistry must be on file with Unisys, the Division's fiscal agent, in order for the Medicaid/NJ KidCare/NJ FamilyCare fee-for-service programs to reimburse a dentist for administering anesthesia. Providers of dental services have 30 days after receiving the original renewal permit issued by the New Jersey State Board of Dentistry, to forward a copy by certified mail—return receipt requested to the following address:

Provider Enrollment Unit
Unisys
PO Box 4804
Trenton, New Jersey 08650-4804

- iii. When the dentist performing the dental service (attending dentist) also administers the general anesthesia, then procedure code D9220 only is used and reimbursement will be limited to one general anesthesia charge per visit.

- iv. When general anesthesia is administered by a dentist whose sole function is to administer general anesthesia, such service is reimbursable provided:

- (1) Anesthetic management is necessary to perform restorative dentistry alone or restorative dentistry in conjunction with other dental services.

- (2) Special general anesthesia codes are utilized (see N.J.A.C. 10:56-3).

- (3) An anesthesia record is maintained and submitted with the Dental Services Claim Form (MC-10) for anesthesia and treatment.

- (A) The anesthesia record submitted shall show elapsed anesthesia time, pinpoint the time and

amounts of drugs administered, pulse rate and character, blood pressure, and respiration.

(B) Elapsed anesthesia time means the time from induction of the general anesthesia to the point in time when the anesthetist is no longer in personal attendance.

3. Reimbursement for the administration of intravenous sedation shall be subject to the following conditions:

i. Such sedation is administered continuously during the operative or surgical procedure.

ii. No reimbursement will be made for injections given as preoperative medication.

iii. The practitioner shall record the need for this service.

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

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

4. An inhalation anesthetic for the purposes of analgesia shall be reimbursable as part of an operative or surgical procedure, subject to the following conditions:

i. Analgesia is administered, as needed, continuously during the operative or surgical procedure.

ii. No reimbursement shall be made for an injection given as pre-operative medication.

iii. The practitioner shall state the need for this service.

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

v. There can be only one charge for analgesia per visit.

(b) Within the scope of accepted dental practice, intradermal, subcutaneous, intramuscular, and intravenous injections shall be reimbursable in the office or home as follows:

1. Reimbursement for the above injections shall be on a flat fee basis and are all inclusive for the cost of the service and the drug.

2. A visit for the sole purpose of an injection shall be reimbursable for the injection only. If other dental procedures are performed that are reimbursable, an injection may, if medically indicated, be reimbursed in addition to the other procedures. The drug administered shall be consistent with the diagnosis and shall conform to accepted medical and pharmacological principles in respect to dosage, frequency, and route of administration.

3. Intravenous injections shall be reimbursable only when performed by the dentist.

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

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

6. No reimbursement shall be made for an injection given as a preoperative medication in conjunction with general anesthesia or as a local anesthetic which is part of an operative or surgical procedure.

7. The appropriate procedure code, name of the drug injected, dosage and route of administration, along with the complete diagnosis for which the injection was given shall be inserted on the Dental Services Claim Form (MC-10) under remarks (Item 20).

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

As amended, R.1972 d.35, eff. February 23, 1972.

See: 3 N.J.R. 154(a), 4 N.J.R. 49(a).

As amended, R.1972 d.164, eff. August 21, 1972.

See: 4 N.J.R. 125(b), 4 N.J.R. 219(a).

As amended, R.1973 d.163, eff. June 20, 1973.

See: 5 N.J.R. 144(d), 5 N.J.R. 228(c).

As amended, R.1973 d.259, eff. October 1, 1973.

See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).

As amended, R.1974 d.53, eff. March 15, 1974.

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

As amended, R.1974 d.114, eff. May 15, 1974.

See: 6 N.J.R. 141(b), 6 N.J.R. 246(a).

As amended, R.1975 d.262, eff. September 1, 1975.

See: 7 N.J.R. 318(a), 7 N.J.R. 466(a).

As amended, R.1975 d.339, eff. November 10, 1975.

See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).

As amended, R.1976 d.215, eff. July 12, 1976.

See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).

As amended, R.1977 d.302, eff. October 1, 1977.

See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).

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

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

(a) substantially amended.

Recodified from 10:56-1.22 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

Amended by R.2001 d.10, effective January 2, 2001.

See: 32 N.J.R. 3377(a), 33 N.J.R. 65(a).

In (a), added 2ii(1).

Amended by R.2003 d.16, effective January 6, 2003.

See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

In (a)2iii, substituted "D9220" for "09220"; and in (a)2iv(3), inserted "Services" preceding "claim form".

10:56-2.18 Adjunctive general services: prescriptions

(a) This section is intended to describe the practitioner's responsibility in the writing of prescriptions in order to

maintain the traditional beneficiary-prescriber-provider relationship, and to insure the beneficiary free choice of provider. Practitioners are urged to familiarize themselves with all aspects of this section in order to effect economies consistent with good medical/dental practices and to facilitate prompt payment to the provider.

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

2. The New Jersey Medicaid program has an approved generic formulary (see N.J.A.C. 8:71). The prescriber shall give preference to generic drugs of equal therapeutic effectiveness if available at a lower cost than proprietary or brand named drugs. When prescribing a brand named multi-source drug product for which a maximum allowance cost (MAC) limitation has been established by the Secretary of the Department of Health and Human Services, the prescriber must indicate either substitution allowed or write brand medically necessary on each written prescription. When prescribing a non-MAC brand named drug, the prescriber may indicate either substitution allowed or dispense as written (DAW) on each written prescription.

i. For claims with service dates on or after July 1, 1999, the pharmacist shall dispense the least expensive, therapeutically effective nutritional supplement or specialized infant formula, at the time of dispensing, unless the prescriber indicates in his or her own handwriting on each written prescription, or follow-up written prescription to a telephone rendered prescription, the phrase "Brand Medically Necessary."

(b) The practitioner's individual Medicaid Provider Service Number shall appear on all prescriptions, and shall 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.

(c) The beneficiary's full name, address, and age shall appear on all prescriptions.

(d) The practitioner shall include specific directions on all drug prescriptions or the prescription will not be eligible for payment. Examples of non-acceptable directions are prn, as directed, and ad lib.

(e) 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 (g) below.)

1. The practitioner should give preference to:

i. 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;

ii. Oral medication, when as effective as injectable preparations.

(f) The quantity of medication 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 or 100 dosage units, whichever is greater.

1. 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 beneficiary for up to 60 days/or provide 100 dosage units, whichever is greater.

2. In long term medical care facilities (that is, nursing facilities, intermediate care facilities, or inpatient psychiatric programs for children under the age of 21), if the quantity of sustaining drug or maintenance medication is not indicated in writing by the prescriber, the pharmacy provider shall dispense an appropriate quantity of medication not to exceed a one month supply.

3. For claims with service dates on or after July 1, 1998, but prior to July 1, 1999, the quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or, if required, an amount sufficient to provide medication during intervals between prescriber visits. The amount of medication dispensed shall not exceed a 34-day supply.

4. For claims with service dates on or after July 1, 1999, the quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or, if required, an amount sufficient to provide medication during intervals between prescriber visits. The amount of medication dispensed shall not exceed a 34-day supply for initial prescriptions and a 34-day supply or 100 unit doses, whichever is greater, for refill prescriptions.

(g) Pharmaceutical services not eligible for payment shall be as follows:

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

2. Experimental drugs;

3. 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).

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

5. Medications prescribed for use by hospital inpatients.

6. Prescribed non-legend over-the-counter drugs for beneficiaries in nursing facilities.

7. Prescriptions written and dispensed with nonspecific directions.

8. Medications prescribed for a Title XIX (Medicaid) covered person who is receiving benefits under part A of Title XVIII (Medicare) as a beneficiary in a nursing facility.

9. Prescribed non-legend drugs unless listed below:

i. Exceptions shall include non-legend drugs other than antacids; contraceptive devices and contraceptive supplies; diabetic testing materials; over-the-counter (OTC) family planning supplies; inhalation devices (pharmaceutical); insulin; and insulin needles and/or syringes;

ii. Coverage of non-legend drugs for beneficiaries under the age of 21 shall include: Analgesics, Salicylates; Analgesics/Antipyretics, Non-salicylate; Antidiarrheals; Anti-Emetics; Antiflatulents; Antihistamines; Antipruritics; Antitussives, non-narcotic; Cathartics; Cough and cold preparations; Emetics; Expectorants; Hematinics; Iron replacement supplements; Laxatives; Multiple vitamin preparations; Pediatric vitamin preparations; Vitamins A, B, C, D, E, K, B1, B2, B6, B12 preparations; Polymyxin and derivatives; Topical preparations, antibacterial; Topical antibiotics; and Topical anti-inflammatory preparations.

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

(h) Prescriptions may be telephoned to the pharmacist when in accordance with all applicable Federal and State laws and regulations, and shall include the prescriber's individual Medicaid/NJ FamilyCare Provider Service Number.

1. When a dentist chooses to certify brand medically necessary, for a MAC listed drug product, the dentist must submit a written prescription order to the pharmacist, containing the certification within seven days of the date of the telephone order.

(i) Prescription refill requirements are as follows:

1. Refill instructions shall be indicated by the practitioner on the original prescription.

2. Prescriptions shall be limited to a maximum of five refills within a six month period. If additional quantities of the same medications are required, a new prescription shall be written by the practitioner.

3. Refill instructions indicating "refill PRN" shall be honored for payment only up to the limits imposed in this subsection.

As amended, R.1972 d.35, eff. February 23, 1972.
See: 3 N.J.R. 154(a), 4 N.J.R. 49(a).
As amended, R.1972 d.164, eff. August 21, 1972.
See: 4 N.J.R. 125(b), 4 N.J.R. 219(a).

As amended, R.1973 d.163, eff. June 20, 1973.
See: 5 N.J.R. 144(d), 5 N.J.R. 228(c).
As amended, R.1973 d.259, eff. October 1, 1973.
See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).
As amended, R.1974 d.53, eff. March 15, 1974.
See: 6 N.J.R. 13(a), 6 N.J.R. 150(b).
As amended, R.1974 d.114, eff. May 15, 1974.
See: 6 N.J.R. 141(b), 6 N.J.R. 246(a).
As amended, R.1975 d.262, eff. September 1, 1975.
See: 7 N.J.R. 318(a), 7 N.J.R. 466(a).
As amended, R.1975 d.339, eff. November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
As amended, R.1976 d.215, eff. July 12, 1976.
See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).
As amended, R.1977 d.302, eff. October 1, 1977.
See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
(a) substantially amended.
Recodified from 10:56-1.22 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Amended by R.2001 d.124, effective April 16, 2001.
See: 32 N.J.R. 4392(a), 33 N.J.R. 1201(a).
In (a), added 2ii; in (e), substituted "(g)" for "(h)8"; in (f), substituted references to 34 days for references to 60 days and added 3 and 4; substituted references to beneficiaries for references to recipients throughout.
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
Substituted references to beneficiaries for references to recipients throughout; in (h), inserted a reference to NJ FamilyCare.

10:56-2.19 Adjunctive general services; medical/dental/supplies

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.

As amended, R.1972 d.35, eff. February 23, 1972.
See: 3 N.J.R. 154(a), 4 N.J.R. 49(a).
As amended, R.1972 d.164, eff. August 21, 1972.
See: 4 N.J.R. 125(b), 4 N.J.R. 219(a).
As amended, R.1973 d.163, eff. June 20, 1973.
See: 5 N.J.R. 144(d), 5 N.J.R. 228(c).
As amended, R.1973 d.259, eff. October 1, 1973.
See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).
As amended, R.1974 d.53, eff. March 15, 1974.
See: 6 N.J.R. 13(a), 6 N.J.R. 150(b).
As amended, R.1974 d.114, eff. May 15, 1974.
See: 6 N.J.R. 141(b), 6 N.J.R. 246(a).
As amended, R.1975 d.262, eff. September 1, 1975.
See: 7 N.J.R. 318(a), 7 N.J.R. 466(a).
As amended, R.1975 d.339, eff. November 10, 1975.
See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
As amended, R.1976 d.215, eff. July 12, 1976.
See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).
As amended, R.1977 d.302, eff. October 1, 1977.
See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
(a) substantially amended.
Recodified from 10:56-1.22 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

10:56-2.20 Consultations

(a) Consultations shall be subject to the following conditions:

1. A written report which includes diagnosis and recommendations for future management shall be provided to the referring practitioner. A copy shall be retained with the beneficiary's records and must be available, upon request, to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs or any of their authorized representatives.

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

ii. When consultation services are requested, the referring practitioner must include on the clinical records the name of the consulting practitioner to whom the beneficiary is being referred. The consulting practitioner must note the diagnosis under Remarks (Item 20) the name and the Medicaid/NJ FamilyCare Provider Services number of the referring practitioner on the clinical records and on the Dental Services Claim Form (MC-10) under Referring Practitioner (Item 14).

iii. A consultation will be disallowed if either or both diagnosis or referring practitioner is missing. However, an examination may be billed alone or in conjunction with other treatment if the beneficiary makes an appointment on his or her own.

iv. A consultation will be disallowed if performed on the same beneficiary 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 beneficiary is then transferred to the service of the consultant, the consultation 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 recipient is then admitted to the consultant's service as a hospital inpatient, the consultant may not bill for a Hospital Day—Initial, HCPCS procedure code D9420, but future visits of the consultant may be billed as a Hospital Day—Subsequent. If the recipient 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 Hospital Day—Subsequent and be considered as concurrent care if concur-

rent care can be justified as being dentally/medically necessary.

R.1984 d.270, eff. July 2, 1984.

See: 15 N.J.R. 813(a), 16 N.J.R. 1788(b).

Recodified from 10:56-1.23 and amended by R.1996 d.428, effective September 16, 1996.

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

Amended by R.2001 d.268, effective August 6, 2001.

See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (a)1, inserted references to NJ FamilyCare and to NJ FamilyCare fee-for-service, neutralized gender references, and substituted references to beneficiaries for references to recipients throughout.

Amended by R.2003 d.16, effective January 6, 2002.

See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

In (a)1vii, substituted "D9420" for "09420-22".

10:56-2.21 Pharmaceutical; program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement shall be denied (except for dentist's prescriptions) if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in the Pharmaceutical Services chapter at N.J.A.C. 10:51-1.11 and 1.12, respectively, incorporated herein by reference;

2. Pharmaceutical services requiring prior authorization (see N.J.A.C. 10:51-1.13, incorporated herein by reference);

3. Quantity of medication (see N.J.A.C. 10:51-1.14, incorporated herein by reference);

4. Dosage and directions (see N.J.A.C. 10:51-1.15, incorporated herein by reference);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-1.16, incorporated herein by reference);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51-1.17, incorporated herein by reference);

7. Prescription refill (see N.J.A.C. 10:51-1.18, incorporated herein by reference);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-1.20, incorporated herein by reference);

i. Products listed in the New Jersey Drug Utilization Review Council (DURC) Formulary, N.J.A.C. 8:71, (hereafter referred to as, "the Formulary"); and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-1.9, incorporated herein by reference).

9. Federal regulations (42 CFR 447.301, 447.331-447.333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The

limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-1.5, Basis of payment, incorporated herein by reference);

10. Drug Efficacy Study Implementation (DESI): "less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-1.20 and listing of DESI drugs in Appendix A of N.J.A.C. 10:51, incorporated herein by reference);

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (see N.J.A.C. 10:51-1.21, incorporated herein by reference);

12. Medical exception process (see N.J.A.C. 10:56-2.22); and

13. Diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by Medicaid. These services require prior authorization from the Medicaid District Office (MDO). (See Medical Supplier Services chapter, N.J.A.C. 10:59.)

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).
See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

10:56-2.22 Medical exception process (MEP)

(a) For pharmacy claims with service dates on or after September 1, 1999, which exceed PDUR standards recommended by the New Jersey DUR Board and approved by the Commissioners of DHS and DHSS, the Division of Medical Assistance and Health Services has established a Medical Exception Process (MEP).

(b) The medical exception process (MEP) shall be administered by a contractor, referred to as the MEP contractor, under contract with the Department of Human Services.

(c) The medical exception process shall apply to all pharmacy claims, regardless of claim media, unless there is a recommended exemption by the New Jersey DUR Board which has been approved by the Commissioners of DHS and DHSS, in accordance with the rules of those Departments.

(d) The medical exception process (MEP) is as follows:

1. The MEP contractor shall contact prescribers of conflicting drug therapies, or drug therapies which exceed established PDUR standards, to request written justification to determine medical necessity for continued drug utilization.

i. The MEP contractor shall send a Prescriber Notification Letter which includes, but may not be limited to, the beneficiary name, HSP identification number, dispense date, drug quantity, drug description. The prescriber shall be requested to provide the reason for medical exception, diagnosis, expected duration of therapy, and expiration date for medical exception.

ii. The prescriber shall provide information requested on the Prescriber Notification to the MEP contractor.

2. Following review and approval of a prescriber's written justification, if appropriate, the MEP contractor shall override existing PDUR edits through the issuance of a prior authorization number.

3. The MEP contractor shall notify the pharmacy and prescriber of the results of their review and include at a minimum, the beneficiary's name, mailing address, HSP number, the reviewer, service description, service date, and prior authorization number, if approved, the length of the approval and the appeals process if the pharmacist does not agree with the results of the review.

4. Prescribers may request a fair hearing to appeal decisions rendered by the MEP contractor concerning denied claims (see N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings).

New Rule, R.1999 d.232, effective July 19, 1999 (operative September 1, 1999).
See: 31 N.J.R. 245(a), 31 N.J.R. 1956(a).

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:56-3.1 Introduction

(a) The New Jersey Medicaid program utilizes the level 3 HCPCS coding system. This system is patterned after the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The dental HCPCS, although a level 3 state-defined HCPCS, are patterned after some of the Medicare level 2 HCPCS. The allowable assigned codes and modifiers which contain both alphabetic and numeric characters follow the HCPCS rules.

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

Section 3.2—Diagnostic

Section 3.3—Preventive

Section 3.4—Restorative

Section 3.5—Endodontics

Section 3.6—Periodontics

Section 3.7—Prosthodontics, Removable

Section 3.8—Maxillofacial Prosthetics

Section 3.9—Prosthodontics, Fixed

Section 3.10—Oral Surgery

Section 3.11—Orthodontics

Section 3.12—Adjunctive General Services

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

Category of Service	HCPCS Codes
I. Diagnostic	D0100–D0999 and Y2000–Y2099
II. Preventive	D1000–D1999 and Y2100–Y2199
III. Restorative	D2000–D2999 and Y2200–Y2299
IV. Endodontics	D3000–D3999 and Y2300–Y2399
V. Periodontics	D4000–D4999 and Y2400–Y2499
VI. Prosthodontics, Removable	D5000–D5899 and Y2500–Y2599
VII. Maxillofacial Prosthetics	D5900–D5999 and Y2600–Y2699
VIII. Prosthodontics, Fixed	D6000–D6999 and Y2700–Y2799
IX. Oral and Maxillofacial Surgery	D7000–D7999 and Y2800–Y2899
X. Orthodontics	D8000–D8999 and Y2900–Y2999
XI. Adjunctive General Services	D9000–D9999 and Y3000–Y3099

(d) Specific elements of the HCPCS which require the attention of the dental provider are as follows:

1. The lists of HCPCS 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 in (d)2 through 6.

Column	Title
2. 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: <ul style="list-style-type: none"> 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. 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 prior authorization requirements exist. Those requirements are listed with the procedure codes involved or in N.J.A.C. 10:56-2.
- 3. HCPCS Codes Lists the HCPCS procedure code numbers.
- 4. 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/FamilyCare fee-for-service programs recognized modifier codes are listed with appropriate procedure codes in this subchapter. The modifiers “22,” “52” and “76” are designated for use in the New Jersey Manual for Dental Services 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.
 - (1) This modifier may also be 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. 76— Repeat Procedure by Same Practitioner: The practitioner may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier “76” to the procedure code of the repeated service.
 - iv. YL Mandibular—Lower.
 - v. YU Maxillary—Upper.

(1) When it is necessary for the New Jersey Medicaid/FamilyCare fee-for-service programs to distinguish between services rendered in the mandibular arch as opposed to the maxillary arch and the basic codes do not make the differentiation, the modifiers “YL” and “YU” have been assigned to make this distinction.

vi. The appropriate quadrant codes shall be entered on the Dental Claim Form, MC-10, for the dental procedures listed below. Acceptable quadrant values are as follows:

- UL—Upper Left
- UR—Upper Right

LL—Lower Left

LR—Lower Right

The codes requiring the quadrant values are:

- D4210 Gingivectomy or Gingivoplasty
- D4220 Gingival Curettage
- D4260 Osseous Surgery
- D4341 Periodontal Scaling and Root Planing
- D4272 Apically Repositioning Flap Procedure
- D7310 Alveoloplasty in Conjunction with Extraction
- D7320 Alveoloplasty not in Conjunction with Extraction
- D7340 Vestibuloplasty—Ridge Extension—Secondary Epithelialization
- D7350 Vestibuloplasty—Ridge Extension
- D7471 Removal of Exostosis

5. Description Lists the code narrative.

6. Maximum Fee lists the New Jersey Medicaid/FamilyCare fee-for-service programs' maximum reimbursement allowance 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).
 - (1) 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 Prior Authorization Form MC-10A part 1 of 2 and Dental Claim Form MC-10 part 2 of 2.

(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) Listed throughout this subchapter are some general and specific policies of New Jersey Medicaid program relevant to HCPCS. For complete and specific policies in addition to those outlined herein, the practitioner must consult subchapter 1 and/or 2.

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

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

3. For purposes of reimbursement, a dentist, dental group, shared health care facility or dentists sharing a common record shall be considered a single provider.

4. When billing, the provider shall enter into the procedure code column (Item 17B) of the Dental Services Claim Form (MC-10), a HCPCS code as listed in this subchapter. If an appropriate code cannot be found, the provider shall leave the procedure code column blank and shall submit a narrative description of the service for authorization and fee assignment on the Dental Prior Authorization Form MC-10A part 1 of 2 and the Dental Claim Form MC-10 part 2 of 2.

5. Date(s) of service(s) must be indicated on the Dental Services Claim form (MC-10).

6. When submitting a claim, the dentist shall always use her or his usual and customary fee. The fee designated for the HCPCS procedure codes represents the New Jersey Medicaid/NJ FamilyCare fee-for-service programs' maximum reimbursement for the given procedure.

(g) This subsection sets forth an index by dental procedure of codes in this subchapter.

<u>Description</u>	<u>HCPCS Procedure Codes (Dental)</u>
Alveoloplasty	D7310-D7320
Amalgam Restoration	
Permanent Teeth	D2140-D2161
Primary Teeth	D2110-D2131
Analgesia	D9230
Anesthesia	
General	D9220 22
Intravenous Sedation	D9241-D9242
Local (not in conjunction with operative or surgical procedure)	D9210
Non I.V. sedation	D9248
Regional block	D9211
Special General	D9220-D9221
Trigeminal division block	D9212
Apexification	D3551
Apically Repositioning Flap Procedure	D4245
Apicoectomy/Periradicular Surgery	D3410-D3426
Appliance, Orthodontic	
Comprehensive	D8080

<u>Description</u>	<u>HCPCS Procedure Codes (Dental)</u>	<u>Description</u>	<u>HCPCS Procedure Codes (Dental)</u>
Harmful Habit	D8210-D8220	Biopsy Soft Tissue	D04720-D0474, D7286
Tooth Guidance	D8010-D8040, D8050-D8060	Casts, Diagnostic	D0470
Arthrocentesis	D7870	Cytologic Smear	D0480
Arthrotomy	D7860	Histopathologic	D0501
Behavior Management	D9920	Oral Evaluation	D0150-D0170
Biopsy		Orthodontic Assessment	D8660
Hard Tissue	D7285	Photographs Diagnostic	D0350
Soft Tissue	D7286	Slides, Diagnostic	D0350
Bleaching, Discolored Tooth	D9974	Unspecified Diagnostic Procedure	D0999
Bridge, Fixed		Dislocation-Reduction	D7810-D7830
Abutments	D6056, D6059-D6064, D6069-D6074	Drugs or Medicaments	D9630
Coping	D6975	Drug Injection, Therapeutic	D9610-D9610 22
Pontics	D6210-D6252	Emergency Procedures (Palliative)	D9110
Post + Core Cast	D6970	Endodontic Services	
Post + Core Prefabricated	D6972, D6973	Apexification	D3351
Recementation	D6930-D6932 22	Apicoectomy/Periradicular Surgery	D3410-D3426
Repairs	D6980	Bleaching Discolored Tooth	D9974
Retainer	D6545	Canal Preparation and fitting of preformed dowel or post	D3950-D3950 22
Canal, Preparation and Fitting of Preformed Post	D3950-D3950 22	Emergency (palliative)	D3220
Casts, Diagnostic	D0470	Hemisection	D3920
Cephalometric Film	D0340	Pulpal Debridment	D3221
Including Tracing	D0340 22	Pulpal Therapy	D3220-D3241
Complications, Post Surgical	D9930	Pulpotomy, Therapeutic	D3220
Composite Restorations	02385-02387	Retreatment Root Canal	D3346-D3348
Anterior	D2330-D2335	Retrograde Filling	D3430
Posterior Permanent	D2385-D2388	Root Amputation	D3450
Posterior Primary	D2380-D2382	Root Canal Therapy	D3310-D3330
Condylectomy	D7840	Unspecified Endodontic Procedure	D3999
Consultation, Professional	D9310	Examination	
Crowns		Comprehensive	D0150-D0150 EP
Bridge Abutments	D6056-D6064, D6066-D6067, D6069-D6074	Detailed-Problem Focused	D0160
Buildup, Including Pins	D2950	Histopathologic	D0501
Individual	D2336-D2337, D2710-D2792, D2932	Limited	D0140
Recement	D2920	Orthodontic Assessment	D8660
Resin, Prefabricated	D2932	Periodic	D0120-D0120 EP
Stainless Steel	D2930-D2931, D2933	Reevaluation	D0170
Temporary (fractured tooth)	D2970	Excisions, Surgical	D7970-D7971
Curettage		Exostosis, Removal	D7471-D7471 22
Gingival	D4220	Exposure, Surgical, of Tooth	D7280-D7281
Cysts, Removal	D7430-D7461 22	Extractions	
Dentures		Uncomplicated Root Removal	D7130
Complete	D5110-D5120	Tooth, Single	D7110-D7120
Complete, Immediate	D5130-D5140 22	Surgical Roots, Residual	D7250
Complete, Overdenture	D5860	(Completely covered by bone)	
Partial, Removable	D5211-D5214	Surgical Tooth, Single	D7210
Partial, Removable, Immediate Tooth Replacement	Y2505	Impactions:	
Denture Adjustments		Complete Bony	D7240
Complete Dentures	D5410-D5411	Partial Bony	D7230
Partial Dentures	D5421-D5422	Soft Tissue	D7220
Denture Rebasing		Extraoral Radiographs	D0250-D0260
Complete Dentures	D5710-D5711	Fluoride, only	D1203-D1204
Partial Dentures	D5720-D5721	Fluoride-Topical with prophylaxis	D1201-D1205 52
Denture Relining		Fluoride-Topical-Handicapped with prophylaxis	D1201 76-D1202 76
Complete Dentures	D5730-D5731, D5750-D5751	Foreign Body, Removal	D7530-D7540
Partial Dentures	D5740-D5741, D5760-D5761	Fractures	
Denture Repair (Complete and Partial)	D5510 YU-D5660 YL	Compound	D7710-D7780
Desensitizing Medicaments	D9910	Simple	D7610-D7680
Desensitizing Resin	D9911	Frenulectomy	D7960
Destruction of Lesions by Physical Methods	D7465	Gingivectomy	D4210-D4211
Diagnostic Services		Gingivoplasty	D4210-D4211
Biopsy Hard Tissue	D7285	Gold Foil	D2410-D2430
		Grafts	
		Bone Replacement, multiple sites	D4264
		Bone Replacement, single site	D4263
		Free Soft Tissue	D4271
		Osseous, Osteoperiosteal or cartilage	D7950
		Pedicle Soft Tissue	D4270
		Skin	D7920
		Synthetic, facial	D7995
		Habit Appliances, Orthodontic	D8210-D8220

Description	HCPCS Procedure Codes (Dental)
Hemisection	D3920
Histopathologic Examination	D0501
Hospital Visits	D9410-D9420 22
Incision and Drainage	
Extraoral	D7520
Intraoral	D7510
Injection	
Therapeutic Drug	D9610
TMJ	D9610 22
Inlay, Gold	D2510-D2530
Intraoral Radiographs	D0210 52-D0210, D0220-D0230, D0270-D0274
Maxillofacial Tissue Defect, Repair	D7955
Medications	D9630
Menisectomy	D7850
Occlusal Adjustment	D9951-D9952
Occlusal Guards, Periodontal	D9940-D9940 22
Occlusal Radiograph	D0240
Onlay	D2542-D2543
Oral Surgery Services	
Alveoplasty	D7320
Antro-Oral Fistula Closure	D7260
Arthrocentesis	D7870
Arthroplasty	D7865
Arthroscopy	D7872-D7877
Arthrotomy	D7860
Biopsy Hard Tissue	D7285
Biopsy Soft Tissue	D7286
Condylectomy	D7840
Coronoidectomy	D7991
Cysts, Tumors and Neoplasms, Removal	D7430-D7461 22
Destruction of Lesions, by physical methods	D7465
Dislocation—Reduction	D7810-D7830
Excision, Surgical	D7410-D7420 22, D7970-D7971
Exostosis, Removal	D7471-D7471 22
Exposure, Surgical, of Tooth	D7280-D7281
Extractions Uncomplicated Root Removal	D7130
Tooth, Single	D7110-D7120
Surgical Roots, Residual (Completely covered by bone)	D7250
Surgical Tooth, Single	D7210
Impactions:	
Complete Bony	D7240
Partial Bony	D7230
Soft Tissue	D7220
Foreign Body, Removal	D7530-D7540
Fracture:	
Compound	D7710-D7780
Simple	D7610-D7680
Frenulectomy	D7960
Implant, ridge augmentation	D7996
Incision and Drainage:	
Extraoral	D7520
Intraoral	D7510
Le Fort procedures	D7946-D7949
Manipulation of TMJ, Under Anesthesia	D7830
Maxillofacial Tissue Defect, Repair	D7955
Meniscectomy	D7850
Operculectomy	D7410
Orantral Fistula Closure	D7260
Ostectomy, Partial	D7480
Osteomyelitis, Sequestrectomy	D7550-D7550 22
Osteoplasty, Orthognathic Deformities	D7940
Osteotomy	D7941-D7945
Re-implantation, Tooth	D7270
Resection, Radical of Mandible	D7490
Salivary Gland Excision	D7981
Fistula Closure	D7983
Sialodochoplasty	D7982
Sialolithotomy	D7980

Description	HCPCS Procedure Codes (Dental)
Sinusotomy	D7560
Stabilization, Tooth	D7270
Stent, Surgical	D5982
Suturing	D7911-D7912
TMJ Surgery	D7852-D7865
Torus Palatinus, Removal	D7471 22
Tracheotomy	D7990
Tumors Benign, Excision	D7430-D7431 22
Malignant, Excision	D7440-D7441 22
Unspecified Oral Surgery Procedure	D7999
Vestibuloplasty	D7340-D7350
Orthodontic Services	
Appliances Comprehensive Orthodontic	D8080
Harmful Habit	D8210-D8220
Retention, replacement	D8692
Tooth Guidance, Interceptive	D8050-D8060
Tooth guidance, Limited	D8010-D8040
Examination Assessment System (Using Handicapping Malocclusion)	D8660
Unspecified Orthodontic Treatment	D8999
Osseous Surgery, Periodontal	D4260
Ostectomy, Partial	D7480
Osteomyelitis, Sequestrectomy	D7550-D7550 22
Osteoplasty, Orthognathic Deformities	D7940
Palliative Treatment, Emergency	D9110
Panoramic Radiograph	D0330
Periodontal Appliances—Special	D9940-D9940 22
Periodontal Services	
Apically Repositioning Flap Procedure	D4272
Curettage, Gingival	D4220
Gingivectomy	D4210-D4211
Gingivoplasty	D4210-D4211
Grafts Free Soft Tissue	D4271
Osseous, Single Site	D4261
Osseous, Multiple Sites	D4262
Pedicle Soft Tissue	D4270
Occlusal Adjustment	D9951-D9952
Occlusal Guards	D9940-D9940 22
Osseous Surgery	D4260
Periodontal Appliance—Special	D9940-D9940 22
Scaling and Root Planing	D4341
Splinting, Provisional	D4320-D4321
Unspecified Periodontal Services	D4999
Photographs, Diagnostic	D0350
Pin Retention	D2951
Plastic Crowns	
Laboratory Processed	D2710
Prefabricated	D2932
Post and Core	
Bridge Retainer: Cast	D6970
Prefabricated	D6972
Single Unit Cast	D2952
Prefabricated	D2954
Prefabricated Resin Crown (Polycarbonate)	D2932
Preventive Services	
Fluoride Only	D1203-D1204
Fluoride Topical with Prophylaxis	D1201-D1202 52
Prophylaxis Only	D1110-D1120
Sealants	D1351
Prophylaxis with Fluoride—Handicapped Recipient	D1201 76-D1202 76
Prophylaxis—Handicapped Recipient	D1110 76-D1120 76
Prosthodontics	
Fixed	
Abutments (Bridge Retainers)	D6056-D6064, D6066-D6067, D6069-D6074
Crowns, Individual	D2710-D2792, D2932
Pontics	D6210-D6252
Post and Core	
Bridge Retainer Cast	D6970
Prefabricated	D6972

Description	HCPCS Procedure Codes (Dental)	Description	HCPCS Procedure Codes (Dental)
Single Unit Cast	D2952	Root Amputation	D3450
Prefabricated	D2954	Salivary Gland	
Recementation Crowns, Individual	D2920	Excisions	D7981
Bridges	D6930-D6930 22	Fistula Closure	D7983
Repairs	D6980	Scaling (Additional to Prophy) Handicapped ...	D4355 76
Unspecified	D6999	Scaling and Root Planing	D4341
Removable Adjustments		Sealants	D1351
Complete Denture	D5410-D5411	Sedation, Intravenous	D9240
Partial Denture	D5421-D5422	Sequestrectomy for Osteomyelitis	D7550-D7550 22
Removal Prosthodontics		Sialodochoplasty	D7982
Complete	D5110-D5120	Sialography	D0310
Complete Immediate	D5130-D5140 22	Including Contrast Material	D0310 22
Complete Overdenture	D5860	Sialolithotomy	D7980
Partial Removable	D5211-D5214	Sinusotomy	D7560
Partial, Immediate Tooth Replacement ...	Y2505	Slides, Diagnostic Photographs	D0350
Rebasing Complete Denture	D5710-D5711	Space Maintainers	D1510-D1525
Partial Denture	D5720-D5721	Splinting, Provisional	D4320-D4321
Relining Complete Denture	D5730-D5731,	Stabilization, Tooth	D4320-D4321
Partial Denture	D5750- D5751	Stainless Steel Crown (Prefabricated)	D2930-D2931
Repairs Complete/Partial Denture	D5740-D5741,	Stent, Surgical	D5982
Stent, Surgical	D5760-D5761	Stomatoplasty	D7340-D7350
Unspecified Removal Prosthodontic Proce-	D5510 YU-D5660	Study Models—See Diagnostic Casts	
...dure	YL	Suturing	D7910-D7912
Pulpotomy, Therapeutic	D5899	Temporary Crown (Fractured Tooth)	D2970
Radiographic Services	D3220	Temporo-Mandibular Joint	
Cephalometric Film	D0340	Injection of muscles of mastication	D9610 22
Including Tracing	D0340 22	Manipulation under anesthesia	D7830
Radiographics Complete Series	D0210 52-D0210 22	Tooth Guidance Appliances	D8110-D8120
Extraoral	D0250-D0260	Tooth Processed to Arch Bar (Wire)	Y2115
Intraoral	D0220-D0230,	Torus Palatinus, Removal	D7471 22
Occlusal	D0270-D0274	Tracheotomy	D7990
Panoramic	D0240	Tumors	
Sialography	D0330	Benign, Excision	D7430-D7431 22
Including Contrast Material	D0310 22	Malignant, Excision	D7440-D7441 22
Rebasing		Unspecified Procedures	
Complete Dentures	D5710-D5711	Adjunctive Procedure	D9999
Partial Dentures	D5720-D5721	Bridge, Repair, Fixed	D6980
Recent		Diagnostic Procedure	D0999
Bridge, Fixed	D6930-D6930 22	Endodontic Procedure	D3999
Crown	D2920	Maxillofacial Prosthesis	D5999
Inlay	D2910	Oral Surgery Procedure	D7999
Space Maintainer	D1550	Orthodontic Procedure	D8999
Relining		Periodontal Procedure	D4999
Complete Dentures	D5730-D5731,	Preventive Procedure	Y2125
Partial Dentures	D5750-D5751	Prosthodontic, Fixed, Procedure	D6999
Repairs		Removable Prosthodontic Procedure	D5899
Fixed Bridge	D6980	Restorative Procedure	D2999
Removable Prosthetics	D5510 YU-D5660	Service, Unspecified	09999
Resection, Radical, of Mandible	D7490	Vestibuloplasty	D7340-D7350
Restorative Services		Visits, Professional	D9410-D9420 22
Amalgam		Wounds, Traumatic, Repair	D7910
Permanent Teeth	D2140-D2161	X-Rays (See Radiographs)	
Primary Teeth	D2110-D2131		
Anterior	D2330-D2335	Administrative Correction to (f)1iv.	
Posterior Permanent	D2385-D2388	See: 22 N.J.R. 1375(a).	
Posterior Primary	D2380-D2382	Amended by R.1990 d.456, effective September 4, 1990.	
Gold Foil	D2410-D2430	See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).	
Inlay, Gold	D2510-D2530	In (d): added new (d)1iv.	
Onlay, Gold	D2542-D2543	Amended by R.1996 d.428, effective September 16, 1996.	
Pin Retention	D2951	See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).	
Unspecified Restorative Procedure	D2999	Amended by R.2000 d.426, effective October 16, 2000.	
Retrograde Filling	D3430	See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).	
Root Canal Therapy Initial	D3310-D3330	In (g), deleted references to Denture Identification, Identification	
Root Canal Therapy Retreat	D3346-D3348	and Scaling (Additional to Prophy).	
Root Planing and Scaling	D4341	Amended by R.2001 d.268, effective August 6, 2001.	
		See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).	
		Rewrote (d)4 and (d)6; in (f), rewrote the introductory paragraph,	
		inserted a reference to NJ FamilyCare in 2, and inserted a reference to	
		NJ FamilyCare fee-for-service in 6.	
		Amended by R.2003 d.16, effective January 6, 2002.	
		See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).	
		Rewrote the section.	

10:56-3.2 D0100-D0999 DIAGNOSTIC

(a) Clinical Oral Examination:

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	D0150		Comprehensive oral evaluation	14.00		13.00

NOTE 1: This code is to be used for comprehensive clinical oral evaluation of a Medicaid/NJ FamilyCare fee-for-service beneficiary.

NOTE 2: This code requires a thorough observation of all conditions present in the oral cavity and contiguous structures to include:

- a. An oral cancer screening;
- b. Charting of all abnormalities;
- c. Development of a complete treatment plan to be recorded in its entirety, including provisions for further treatment and follow-up, by referral if necessary;

NOTE 3: For reimbursement of the comprehensive oral evaluation with code D0150:

- a. The examination is limited to once every six months for patients under 21 years of age and every 12 months for patients over 21 years of age, except as authorized by a dental consultant of the New Jersey Medicaid program;
- b. All items on the Dental Services Claim form (MC-10) should 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 (20). The abbreviation "NOTN" may be used to indicate no other treatment needed.

D0150	76	Comprehensive oral evaluation	14.00	13.00
-------	----	-------------------------------	-------	-------

NOTE 1: This code is to be used only if a beneficiary is developmentally disabled or neurologically impaired (see N.J.A.C. 10:56-2.9(a)1ii), in which case an examination may be provided as often as every three months and may be submitted directly to the fiscal agent for payment without prior authorization. The nature of the beneficiary's disability must be recorded under "Remarks" on the Dental Services Claim form (MC-10).

D0150	EP	Comprehensive oral evaluation	25.00	21.00
-------	----	-------------------------------	-------	-------

NOTE 1: a. This code is to be used for comprehensive oral evaluation of a Medicaid/NJ FamilyCare fee-for-service beneficiary through and including the age of 20.

b. This code is to be used for comprehensive oral evaluation referred from EPSDT screenings.

NOTE 2: This code requires a thorough observation of all conditions present in the oral cavity and contiguous structures to include:

- a. An oral cancer screening;
- b. Assessment of dental development;
- c. Charting of all abnormalities;
- d. Development of a complete treatment plan to be recorded in its entirety, including provisions for further treatment and follow-up, by referral if necessary;
- e. Anticipatory guidance concerning dental health to the patient or parent/guardian;
- f. Assessment of the caries index and nutritional needs relating to oral health and oral hygiene practices;
- g. Assessment of systemic or topical fluoride needs.

NOTE 3: For reimbursement of the comprehensive oral evaluation with code D0150 EP:

- a. The examination is limited to once every six months for patient under 21 years of age, except as authorized by a dental consultant of the New Jersey Medicaid program;
- b. All items on the Dental Services Claim form (MC-10) should 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 (20). The abbreviation "NOTN" may be used to indicate no other treatment needed.

D0120		Periodic Oral Evaluation	14.00	13.00
-------	--	--------------------------	-------	-------

NOTE: An evaluation performed on a patient of record to determine any changes in the patient's oral health status since a previous initial or periodic examination.

D0120	EP	Periodic Oral Evaluation	14.00	13.00
-------	----	--------------------------	-------	-------

NOTE: This code is to be used with an EPSDT referral on a patient of record to determine any changes in the patient's oral health status since a previous initial or periodic examination.

d	D0140	Limited oral evaluation	4.00	3.00
---	-------	-------------------------	------	------

NOTE: Make note of diagnosis and/or observation(s) on the Dental Services Claim form (MC-10).

	D0160	Detailed and extensive oral evaluation problem focused by report.	14.00	13.00
	D0170	Re-evaluation—limited, problem focused (Established patient; not post-operative visit)	14.00	13.00

(b) Radiographs:

1. Intraoral Radiographs: (Periapicals/Bitewing/Occlusal)

- i. Indicate number of films in item 13 of the Dental Services Claim 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.

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	D0210	52	Intraoral—Complete Series	18.00		18.00

NOTE 1: Limited to patients up to and including age six.

NOTE 2: Eight films.

D0210	Intraoral—Complete Series (including bitewings)	22.00	22.00
-------	---	-------	-------

NOTE 1: Limited to patients age seven up to and including age 14.

NOTE 2: Twelve films.

D0210	22 Intraoral—Complete Series (including bitewings)	26.00	26.00
-------	--	-------	-------

NOTE 1: Limited to patients age 15 or older.

NOTE 2: Minimum of 16 films.

D0220	Intraoral—Periapical—First Film	3.75	3.75
D0230	Intraoral—Periapical—Each Additional Film	2.75	2.75

NOTE 1: Indicate complete number of films (D0220 Plus D0230) in item 13.

D0240	Intraoral—Occlusal Film	5.00	5.00
-------	-------------------------	------	------

NOTE 1: Per film (maximum—two films).

NOTE 2: Indicate number of films in item 13.

2. Extraoral Radiographs

D0250	Extraoral, First Film	10.00	10.00
-------	-----------------------	-------	-------

NOTE: Code to be used for lateral, anteroposterior, temporo-mandibular radiographs, etc. (one view).

D0260	Extraoral—Each Additional Film	5.00	5.00
-------	--------------------------------	------	------

NOTE 1: Indicate number of views in item 13.

NOTE 2: Maximum reimbursable—two additional views.

D0270	Bitewing—Single film	3.00	3.00
D0272	Bitewings—Two films	5.00	5.00
D0274	Bitewings—Four films	9.00	9.00
D0290	Posterior—anterior or lateral skull and facial bone survey film	10.00	10.00

D0310	Sialography	15.00	15.00
D0310	22 Sialography	30.00	30.00

NOTE: Includes injection of contrast material (filling and/or emptying phases).

D0320	Temporomandibular joint anthrogram, including injection	30.00	30.00
D0321	Other temporomandibular joint films, by report	BR	BR
D0322	Tomographic survey	125.00	90.00
D0330	Panoramic Film	15.75	15.75
D0340	Cephalometric Film	15.00	15.00
D0340	22 Cephalometric Film	22.50	22.50

NOTE: Includes tracing.

(c) Test and laboratory examinations:

D0470	Diagnostic Casts	11.50	10.00
-------	------------------	-------	-------

NOTE 1: Casts must have bases and be trimmed to permit articulation, per cast.

NOTE 2: Code not to be used in conjunction with denture construction.

D0472	Accession of tissue, gross examination, preparation and transmission of written report	9.35	9.35
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	20.85	20.85
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	40.00	40.00
D0480	Processing and interpretation of cytologic smears, including the preparation and transmission of written report	12.00	12.00
D0350	Oral/facial images (includes intra and extraoral images)	1.00	1.00

NOTE: Or slides, per view.

d D0501	Histopathologic Examination	10.00	10.00
---------	-----------------------------	-------	-------

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) Departments of dental schools.

D0502	Other oral pathology procedures, by report	BR	BR
d° D0999	Unspecified Diagnostic Procedure, By Report	BR	BR

NOTE: Complete description of procedure and the reason the procedure was performed.

Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Rewrote (a) and (b).
Amended by R.2001 d.268, effective August 6, 2001.
See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (a) NOTE 1, substituted "NJ FamilyCare" for "NJ KidCare"; in (a)b NOTE 1, substituted "beneficiary" for "recipient" and "beneficiary's" for "recipient's".
 Amended by R.2003 d.16, effective January 6, 2002.
 See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).
 Rewrote the section.

10:56-3.3 D1000-D1999 PREVENTIVE

(a) Dental prophylaxis:

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				S	NS	NS
	D1110		Prophylaxis—Adult	17.00		16.00

NOTE: Patients 16 years of age or older, maxillary and mandibular arches; includes additional scaling.

D1110	52	Prophylaxis—Adult	8.50	8.00
-------	----	-------------------	------	------

NOTE 1: Patients 16 years of age or older, maxillary or mandibular arch, includes additional scaling.

NOTE 2: Code to be used if patient is edentulous in one arch.

D1120		Prophylaxis—Child	14.00	13.00
-------	--	-------------------	-------	-------

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches; includes additional scaling, includes additional scaling.

1. The following codes should be used when a beneficiary is developmentally disabled or neurologically impaired. (See N.J.A.C. 10:56-2.9(a)1ii.)

D1110	76	Prophylaxis—Adult	17.00	16.00
-------	----	-------------------	-------	-------

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

D1120	76	Prophylaxis—Child	14.00	13.00
-------	----	-------------------	-------	-------

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

(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).

D1201		Topical Application of Fluoride (Including Prophylaxis)—Child	24.00	22.00
-------	--	---	-------	-------

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

D1203		Topical application of fluoride (Prophylaxis not included)—child	10.00	9.00
-------	--	--	-------	------

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

D1204		Topical application of fluoride (prophylaxis not included)—adult	10.00	9.00
-------	--	--	-------	------

NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.

D1205		Topical Application of Fluoride (Including Prophylaxis)—Adult	27.00	25.00
-------	--	---	-------	-------

NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.

D1205	52	Topical Application of Fluoride (Including Prophylaxis)—Adult	13.50	12.50
-------	----	---	-------	-------

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.

2. The following codes should be used when a beneficiary is developmentally disabled or neurologically impaired (see N.J.A.C. 10:56-2.9(a)1ii) when the topical application of fluoride in conjunction with a complete prophylaxis (code includes both services) is necessary.

D1201	76	Topical Application of Fluoride (Including Prophylaxis)—Child	24.00	22.00
-------	----	---	-------	-------

NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

D1205	76	Topical Application of Fluoride (Including Prophylaxis)—Adult	27.00	25.00
-------	----	---	-------	-------

NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.

(c) Other Preventive Services

D1351		Sealant—Per Tooth	10.00	9.00
-------	--	-------------------	-------	------

NOTE 1: Unfilled premolars and permanent molars.

NOTE 2: Beneficiaries up to and including 16 years of age.

(d) Space Maintenance (passive appliances)

D1510		Space Maintainer—Fixed—Unilateral	85.00	80.00
-------	--	-----------------------------------	-------	-------

NOTE: Utilizing band(s) or stainless steel crowning.

D1515		Space Maintainer—Fixed—Bilateral	123.00	115.00
-------	--	----------------------------------	--------	--------

NOTE: Lingual or palatal arch utilizing bands or stainless steel crowning.

D1525		Space Maintainer—Removable—Bilateral	69.00	60.00
D1550		Recementation of Space Maintainer	7.00	6.00
Y2115		Tooth processed to arch bar/per tooth	6.00	5.00
* Y2125		Unspecified Preventive Procedure, By Report	BR	BR

NOTE: The complete description of procedure(s) and the reason(s) the procedure was performed must be included in the report.

D3320	Bicuspid (excluding final restoration)	190.00	173.00
-------	--	--------	--------

NOTE: Code to be used for premolars and all primary teeth without permanent successors.

D3330	Molar (excluding final restoration)	247.00	225.00
-------	-------------------------------------	--------	--------

NOTE: Code to be used for molars (permanent).

D3346	Retreatment of previous root canal therapy—anterior	148.00	135.00
D3347	Retreatment of previous root canal therapy—bicuspid	190.00	173.00
D3348	Retreatment of previous root canal therapy—molar	247.00	225.00
D3351	Apexification/ recalcification—Initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	31.00	27.00

NOTE 1: Treatment may extend over a period of six to 18 months.

NOTE 2: Maximum—two visits.

(c) Apicoectomy/periradicular Services:

1. Periradicular surgery is a term used to describe surgery to the root surface, for example, apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

D3410	Apicoectomy/periradicular gery—anterior	sur-	79.00	72.00
-------	---	------	-------	-------

(d) Apicoectomy performed in conjunction with endodontic procedure:

1. Single stage nerve extirpation and canal filling. Services provided at same visit.

D3421	Apicoectomy/periradicular gery—Bicuspid (first root)	sur-	79.00	72.00
D3425	Apicoectomy/periradicular gery—Molar (first root)	sur-	79.00	72.00
D3426	Apicoectomy/periradicular gery—(Each additional root)	sur-	44.00	36.00
D3430	Retrograde Filling—Per Root		9.00	7.50

NOTE 1: Reimbursable only in addition to apicoectomy.

NOTE 2: Maximum per tooth—three roots.

D3450	Root Amputation—Per Root		55.00	48.00
-------	--------------------------	--	-------	-------

NOTE 1: Surgical resection of entire root(s).

NOTE 2: Maximum two roots.

(e) Other endodontic procedures:

D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	55.00	48.00
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	16.00	14.00

NOTE: Should not be in conjunction with D2952, D2954, by the same practitioner.

D3950	22	Canal Preparation and Fitting of Preformed Dowel or Post	23.00	20.00
-------	----	--	-------	-------

NOTE 1: Can be used when the final restoration is an amalgam or composite resin.

NOTE 2: With cementation.

d°	D3999	Unspecified Endodontic Procedure, By Report	BR	BR
----	-------	---	----	----

Amended by R.1996 d.428, effective September 16, 1996. See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a). Amended by R.2000 d.426, effective October 16, 2000. See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

Changed Maximum Fee Allowances throughout; and in (d), inserted a reference to NJ KidCare fee-for-services programs. Amended by R.2001 d.268, effective August 6, 2001. See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).

In (c)2, substituted references to beneficiaries for references to recipients; in (d)1, substituted "NJ FamilyCare" for "NJ KidCare." Amended by R.2003 d.16, effective January 6, 2002. See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

Rewrote the section.

10:56-3.6 D4000-D4999 PERIODONTICS

(a) Surgical services (including usual post-operative services):

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				S	S	NS
	D4210		Gingivectomy or Gingivoplasty—Per Quadrant	43.60		37.50
*	D4211		Gingivectomy or Gingivoplasty—Per Tooth	6.00		5.50

NOTE: Maximum number of teeth reimbursable—Threc.

*	D4220		Gingival Curettage, Surgical—Per Quadrant	22.50		19.50
*	D4260		Ossceous Surgery (Including Flap Entry and Closure)—Per Quadrant	75.00		64.50
*	D4263		Bone Replacement Graft—First Site in Quadrant	261.00		261.00
*	D4264		Bone Replacement Graft—Each Additional Site in Quadrant (Use if Performed on Same Date of Service)	130.50		130.50
*	D4270		Pedicle Soft Tissue Graft Procedure	32.00		28.00

NOTE: Per site.

*	D4271		Free Soft Tissue Graft Procedure (Including Donor Site)	49.00		42.00
---	-------	--	---	-------	--	-------

NOTE: Per site.

*	D4245		Apically Positioned Flap	36.00		31.50
---	-------	--	--------------------------	-------	--	-------

NOTE: Per quadrant.

*	D4249		Clinical Crown Lengthening—Hard Tissue	75.00		64.50
---	-------	--	--	-------	--	-------

NOTE: Per quadrant.

°	D4274	Distal or Proximal Wedge Procedure (When Not Performed in Conjunction with Surgical Procedures in the same Anatomical Area)	169.00	153.00
---	-------	---	--------	--------

(b) Adjunctive periodontal services:

	D4320	Provisional Splinting—Intracoronal	18.00	16.00
--	-------	------------------------------------	-------	-------

NOTE: Per tooth.

	D4321	Provisional Splinting—Extracoronal	11.00	10.00
--	-------	------------------------------------	-------	-------

NOTE 1: Per tooth.

NOTE 2: This code may also be used for stabilization of traumatized teeth.

°	D4341	Periodontal Scaling and Root Planing—Per Quadrant	37.50	34.50
	D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	11.00	10.00
	D4355	76 Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	11.00	10.00

NOTE 1: Code to replace Y2105-76—additional scaling.

NOTE 2: Code to be used when the beneficiary is developmentally disabled *[on]* *or* neurologically impaired (see N.J.A.C. 10:56-2.9(a)1ii).

d°	D4999	Unspecified Periodontal Procedure, By Report	BR	BR
----	-------	--	----	----

Amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2000 d.426, effective October 16, 2000.
 See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
 In (b), changed Maximum Fee Allowances for Periodontal Scaling and Root Planing—Per Quadrant.
 Amended by R.2003 d.16, effective January 6, 2002.
 See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).
 Rewrote the section.

10:56-3.7 D5000-D5899 PROSTHODONTICS (REMOVABLE)

(a) Complete dentures (including six months post delivery care):

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
°	D5110		Complete Denture—Maxillary	334.00		302.00

NOTE: Including denture I.D.

°	D5120	Complete Denture—Mandibular	342.00	311.00
---	-------	-----------------------------	--------	--------

NOTE: Including denture I.D.

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

1. Reimbursement also includes necessary rebases and/or relines for the six months following insertion.

2. In order to qualify for immediate denture reimbursement, the denture must involve the immediate replacement of anterior teeth which may include first premolars (teeth numbers 5 through 12 and 21 through 28 only). Second premolars 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.

°	D5130	Immediate Denture—Maxillary	365.00	332.00
---	-------	-----------------------------	--------	--------

NOTE 1: Replacing 1 through 4 teeth

°	D5130	22 Immediate Denture—Maxillary	392.00	353.00
---	-------	--------------------------------	--------	--------

NOTE 1: Replacing 5 through 8 teeth

°	D5140	Immediate Denture—Mandibular	372.00	338.00
---	-------	------------------------------	--------	--------

NOTE 1: Replacing 1 through 4 teeth

°	D5140	22 Immediate Denture—Mandibular	400.00	363.00
---	-------	---------------------------------	--------	--------

NOTE 1: Replacing 5 through 8 teeth

(c) Partial dentures (including six month post delivery care):

°	D5211	Maxillary Partial Denture—Resin Base (Including any conventional clasps, rests and teeth)	275.00	250.00
°	D5211	52 Maxillary Partial Denture—Resin Base (Including teeth—no clasps)	186.00	173.00
°	D5212	Mandibular Partial Denture—Resin Base (Including any conventional clasps, rests and teeth)	275.00	250.00
°	D5212	52 Mandibular Partial Denture—Resin Base (Including teeth—no clasps)	186.00	173.00
°	D5213	Maxillary Partial Denture—Cast Metal Framework with Resin Denture Bases (Including any conventional clasps, rests and teeth)	361.00	328.00
°	D5214	Mandibular Partial Denture—Cast Metal Framework with Resin Denture Bases (Including any conventional clasps, rests and teeth)	342.00	311.00

(d) Immediate replacement of anterior teeth in conjunction with partial dentures (codes D5211 through D5214 only) in addition to denture, maximum six teeth (Teeth numbers 6 through 11 and 22 through 27 only).

1. Immediate partial dentures—Reimbursement also includes necessary rebases and/or relines for the six months following insertion.

°	Y2505	Immediate Replacement of Anterior Teeth—Per Tooth	11.00	10.00
---	-------	---	-------	-------

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

(e) Adjustments to dentures—other than dentist providing denture or after the required period of post delivery care.

	D5410	Adjust Complete Denture—Maxillary	10.00	9.00
	D5411	Adjust Complete Denture—Mandibular	10.00	9.00

D5421		Adjust Partial Denture—Maxillary	10.00	9.00
D5422		Adjust Partial Denture—Mandibular	10.00	9.00

(f) Repairs to complete dentures:

1. Repair Broken Complete Denture Base:

i. Includes replacing teeth on denture

D5510	YU	Repair Broken Complete Denture Base	49.50	45.00
-------	----	-------------------------------------	-------	-------

NOTE: Maxillary—Upper

D5510	YL	Repair Broken Complete Denture Base	49.50	45.00
-------	----	-------------------------------------	-------	-------

NOTE: Mandibular—Lower.

D5520		Replace Missing or Broken Teeth—Complete Denture (Each Tooth)	15.00	15.00
-------	--	---	-------	-------

NOTE 1: Code may be used in addition to codes D5510 YU or YL above.

NOTE 2: List tooth codes of teeth being replaced.

(g) Repairs to partial denture:

D5610	YU	Repair Resin Denture Base	49.50	45.00
-------	----	---------------------------	-------	-------

NOTE: Maxillary.

D5610	YL	Repair Resin Denture Base	49.50	45.00
-------	----	---------------------------	-------	-------

NOTE: Mandibular.

D5620		Repair Cast Framework	33.00	30.00
-------	--	-----------------------	-------	-------

NOTE 1: Welding in addition to repair procedure(s), limit two welds per denture.

NOTE 2: May be used in conjunction with other repair procedures or as a separate repair procedure.

D5630	YU	Repair or Replace Broken Clasp	76.50	72.00
-------	----	--------------------------------	-------	-------

NOTE 1: Maxillary.

NOTE 2: Maximum two.

D5630	YL	Repair or Replace Broken Clasp	76.50	72.00
-------	----	--------------------------------	-------	-------

NOTE 1: Mandibular.

NOTE 2: Maximum two.

D5640		Replace Broken Teeth—Per Tooth	15.00	15.00
-------	--	--------------------------------	-------	-------

NOTE 1: Code D5640 may be used in addition to partial denture repair procedure(s), D5610 YU or YL above.

D5650		Add Tooth to Existing Partial Denture	66.00	60.00
-------	--	---------------------------------------	-------	-------

NOTE 1: To replace extracted tooth. (List tooth code being replaced).

NOTE 2: For additional replacements beyond the first tooth, use code D5640. List tooth (teeth) being replaced.

D5660	YU	Add Clasp to Existing Partial Denture	76.50	72.00
-------	----	---------------------------------------	-------	-------

NOTE 1: Maxillary—First Clasp.

NOTE 2: List tooth code being clasped.

NOTE 3: Maximum two.

D5660	YL	Add Clasp to Existing Partial Denture	76.50	72.00
-------	----	---------------------------------------	-------	-------

NOTE 1: Mandibular—First Clasp.

NOTE 2: List tooth being clasped.

NOTE 3: Maximum two.

(h) Denture rebase procedures:

D5710		Rebase Complete Maxillary Denture	132.00	120.00
D5711		Rebase Complete Mandibular Denture	132.00	120.00
D5720		Rebase Maxillary Partial Denture	124.00	113.00
D5721		Rebase Mandibular Partial Denture	124.00	113.00

(i) Denture relining procedures:

D5730		Reline Complete Maxillary Denture (Chairside)	29.00	26.00
D5731		Reline Complete Mandibular Denture (Chairside)	29.00	26.00
D5740		Reline Maxillary Partial Denture (Chairside)	29.00	26.00
D5741		Reline Mandibular Partial Denture (Chairside)	29.00	26.00
D5750		Reline Complete Maxillary Denture (Laboratory)	99.00	90.00
D5751		Reline Complete Mandibular Denture (Laboratory)	99.00	90.00
D5760		Reline Maxillary Partial Denture (Laboratory)	91.00	83.00
D5761		Reline Mandibular Partial Denture (Laboratory)	91.00	83.00

(j) Other removable prosthetic services:

D5860		Overdenture—complete	342.00	311.00
D5862		Precision attachment	150.00	150.00
D5867		Replacement of replaceable part of semi-precision or precision attachment (male or female component)	75.00	75.00
D5899		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".

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

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2000 d.426, effective October 16, 2000.
 See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
 Changed Maximum Fee Allowances throughout.
 Amended by R.2003 d.16, effective January 6, 2002.
 See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).
 Rewrote the section.

10:56-3.8 D5900-D5999 MAXILLOFACIAL PROSTHETICS

(a) Treatment prosthesis:

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				\$	\$	NS
	D5931		Obturator prosthesis, surgical	250.00		250.00
	D5936		Obturator prosthesis, interim	200.00		200.00
	D5937		Trismus appliance (not for TMD treatment)	125.00		125.00
	D5951		Feeding aid	500.00		500.00
	D5952		Speech aid prosthesis, pediatric	450.00		450.00
	D5953		Speech aid prosthesis, adult	450.00		450.00
	D5982		Surgical Stent	50.00		43.00
	D5986		Fluoride gel carrier	30.00		30.00
	D5988		Surgical splint	250.00		250.00
*	D5999		Unspecified Maxillofacial Prosthesis, by report	BR		BR

Amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2003 d.16, effective January 6, 2002.
 See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).
 Rewrote the section.

10:56-3.9 D6000-D6999 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 Weight %	High Noble Alloy	Noble Alloy	Predominantly Base Alloy
	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.

Implant services:

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				\$	\$	NS
*	D6010		Surgical placement of implant body: endosteal implant	500.00		500.00
*	D6056		Prefabricated abutment	76.00		70.00
*	D6059		Abutment supported porcelain fused to metal crown (high noble metal)	279.00		253.00
*	D6060		Abutment supported porcelain fused to metal crown (predominantly base metal)	279.00		253.00
*	D6061		Abutment supported porcelain fused to metal crown (noble metal)	279.00		253.00
*	D6062		Abutment supported cast metal crown (high noble metal)	161.00		140.00

*	D6063		Abutment supported cast metal crown (predominantly base metal)	161.00		140.00
*	D6064		Abutment supported cast metal crown (noble metal)	161.00		140.00
*	D6066		Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	279.00		253.00
*	D6067		Implant supported metal crown (titanium, titanium alloy, high noble metal)	161.00		140.00
*	D6069		Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	279.00		253.00
*	D6070		Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	279.00		256.00
*	D6071		Abutment supported retainer for porcelain fused to metal FPD (noble metal)	279.00		256.00
*	D6072		Abutment supported retainer for cast metal FPD (high noble metal)	161.00		140.00
*	D6073		Abutment supported retainer for cast metal FPD (predominantly base metal)	161.00		140.00
*	D6074		Abutment supported retainer for cast metal FPD (noble metal)	161.00		140.00
*	D6199		Unspecified implant procedure, by report	BR		BR

(b) Bridge pontics:

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				\$	\$	NS
*	D6210		Pontic—Cast High Noble Metal	76.00		66.00
*	D6211		Pontic—Cast Predominantly Base Metal	76.00		66.00
*	D6212		Pontic—Cast Noble Metal	76.00		66.00
*	D6240		Pontic—Porcelain Fused to High Noble Metal	170.00		165.00
*	D6241		Pontic—Porcelain Fused to Predominantly Base Metal	170.00		165.00
*	D6242		Pontic—Porcelain Fused to Noble Metal	170.00		165.00
*	D6250		Pontic—Resin with High Noble Metal	90.00		80.00
*	D6251		Pontic Resin with Predominantly Base Metal	90.00		80.00
*	D6252		Pontic—Resin with Noble Metal	90.00		80.00
*	D6545		Retainer—cast metal for resin bonded fixed prosthesis	75.00		75.00

NOTE: Per tooth.

(c) Bridge retainers—crowns:

*	D6720		Crown—Resin with High Noble Metal	161.00		140.00
*	D6721		Crown—Resin with Predominantly Base Metal	161.00		140.00
*	D6722		Crown—Resin with Noble Metal	161.00		140.00
*	D6750		Crown—Porcelain Fused to High Noble Metal	279.00		253.00
*	D6751		Crown—Porcelain Fused to Predominantly Base Metal	279.00		253.00
*	D6752		Crown—Porcelain Fused to Noble Metal	279.00		253.00
*	D6790		Crown—Full Cast High Noble Metal	161.00		140.00
*	D6791		Crown—Full Cast Predominantly Base Metal	161.00		140.00
*	D6792		Crown—Full Cast Noble Metal	161.00		140.00

(d) Other fixed prosthetic services:

D6930	Recent Bridge	8.00	7.00
-------	---------------	------	------

NOTE 1: One abutment.

NOTE 2: Code may be used when recementing facing.

D6930	22	Recement Bridge	14.00	12.00
-------	----	-----------------	-------	-------

NOTE: Two or more abutments.

* D6970		Cast Post and Core in Addition to Bridge Retainer	75.00	68.00
---------	--	---	-------	-------

NOTE 1: Post and core fabricated (cast) and cemented as a separate unit from crown.

NOTE 2: Not in conjunction with Procedure Codes D3950 and D3950 22.

* D6972		Prefabricated Post and Core in Addition to Bridge Retainer	49.00	45.00
---------	--	--	-------	-------

NOTE: Not in conjunction with Procedure Codes D3950 and D3950 22.

D6973		Core build up for retainer, including any pins	49.00	45.00
* D6975		Coping—metal	161.00	140.00

NOTE: Cast crown.

* D6980		Bridge Repair, By Report	BR	BR
* D6999		Unspecified Fixed Prosthodontic Procedure, By Report	BR	BR

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

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

Amended by R.2000 d.426, effective October 16, 2000.

See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

Changed Maximum Fee Allowances throughout.

Amended by R.2003 d.16, effective January 6, 2002.

See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).

Rewrote the section.

10:56-3.10 D7000-D7999 ORAL SURGERY

(a) Extractions—includes local anesthesia and routine post-operative care:

IND	HCPCS Code	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	D7110		Single Tooth	32.00		30.00
	D7120		Extraction—each additional tooth	32.00		30.00
	D7130		Root Removal—Exposed Roots	19.50		18.00

NOTE 1: Per tooth.

(b) Surgical extractions—includes local anesthesia and routine post-operative care:

1. Prior authorization for the removal of impacted teeth is necessary for those beneficiaries up to and including 17 years of age as denoted by those codes with the “#” (cross-hatch) indicator.

# D7210		Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	33.00	31.00
# D7220		Removal of Impacted Tooth—Soft Tissue	43.00	40.00
# D7230		Removal of Impacted Tooth—Partially Bony	114.00	106.00

# D7240		Removal of Impacted Tooth—Completely Bony	114.00	106.00
# D7250		Surgical Removal of Residual Tooth Roots (Cutting Procedure)	43.00	39.00

NOTE: Includes cutting of soft tissue and bone, removal of tooth structure and closure.

(c) Other surgical procedures:

D7260		Oroantral Fistula Closure	108.00	99.00
-------	--	---------------------------	--------	-------

NOTE 1: Code may also be used for antral root recovery.

NOTE 2: Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.

D7270		Tooth Re-implantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth and/or Alveolus	93.00	85.00
D7280		Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reason (Including Orthodontic Attachments)	101.00	94.00
D7281		Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	45.00	41.00
d D7285		Biopsy of Oral Tissue—Hard	30.00	26.00

NOTE: Independent procedure (laboratory must bill separately).

d D7286		Biopsy of Oral Tissue—Soft	18.00	16.00
---------	--	----------------------------	-------	-------

NOTE: Independent procedure (laboratory must bill separately).

(d) Alveoloplasty surgical preparation of ridge for dentures:

1. Reimbursement will be based upon quadrants.

D7310		Alveoloplasty in Conjunction with Extractions—Per Quadrant	62.50	56.50
-------	--	--	-------	-------

NOTE 1: In conjunction with extractions of at least three teeth or the roots of at least three teeth in the same quadrant.

NOTE 2: Specify quadrant.

D7320		Alveoloplasty Not In Conjunction with extraction—Per Quadrant	62.50	56.50
-------	--	---	-------	-------

(e) Vestibuloplasty—including revision of soft tissues on ridges, muscle reattachment, tongue, palate, and other oral soft tissues (complete description including size and position must be submitted). Reimbursement will be based upon quadrants.

D7340		Vestibuloplasty—Ridge Extension (Secondary Epithelialization)	65.00	59.00
-------	--	---	-------	-------

NOTE: Including management of hypertrophied and hyperplastic tissue, per quadrant.

D7350		Vestibuloplasty—Ridge Extension (Including Soft Tissue Grafts, Muscle Re-attachments, Revision of Soft Tissue Attachment, and Man-	169.00	153.00
-------	--	--	--------	--------

agement of Hypertrophied and Hyperplastic Tissue)

D7465	Destruction of Lesion(s) by Physical Methods: Electrosurgery, Chemotherapy, Cryotherapy or Laser	18.00	15.00
-------	--	-------	-------

NOTE: Per Quadrant.

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

NOTE: Biopsy report must be available upon request for review by the Division's dental consultants.

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

D7410	Radical Excision—Lesion Diameter Up to 1.25 cm.	30.00	26.00
D7420	Radical Excision—Lesion Diameter Over 1.25 cm.	42.00	37.00

NOTE: Up to and including three cm.

D7420	22	Radical Excision—Lesion Diameter Over 3 cm.	100.00	86.00
-------	----	---	--------	-------

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

1. In the excision and management of this type of lesion, a biopsy report must be available for review by the Medicaid dental consultants.

D7430	Excision of Benign Tumor—Lesion Diameter Up to 1.25 cm.	30.00	26.00
D7431	Excision of Benign Tumor—Lesion Diameter Over 1.25 cm.	42.00	37.00

NOTE: Up to and including three cm.

D7431	22	Excision of Benign Tumor—Lesion Diameter Over 3 cm.	100.00	86.00
D7440	Excision of Malignant Tumor—Lesion Diameter Up to 1.25 cm.	100.00	86.00	
D7441	Excision of Malignant Tumor—Lesion Diameter Over 1.25 cm.	274.00	256.00	

NOTE: Up to and including three cm.

D7441	22	Excision of Malignant Tumor—Lesion Diameter Over 3 cm.	473.00	413.00
D7450	Removal of Odontogenic Cyst or Tumor—Lesion Diameter Up to 1.25 cm.	50.00	43.00	
D7451	Removal of Odontogenic Cyst or Tumor—Lesion Diameter Over 1.25 cm.	100.00	87.00	

NOTE: Up to and including three cm.

D7451	22	Removal of Odontogenic Cyst or Tumor—Lesion Diameter Over 3 cm.	150.00	130.00
D7460	Removal of Non Odontogenic Cyst or Tumor—Lesion Diameter Up to 1.25 cm.	50.00	43.00	
D7461	Removal of Non Odontogenic Cyst or Tumor—Lesion Diameter Over 1.25 cm.	100.00	87.00	

NOTE: Up to and including three cm.

D7461	22	Removal of Non Odontogenic Cyst or Tumor—Lesion Diameter Over 3 cm.	150.00	130.00
-------	----	---	--------	--------

(h) Excision of bone tissue:

D7471	Removal of Exostosis—per site	62.50	56.50
-------	-------------------------------	-------	-------

1. Reimbursement will be based upon quadrants.

NOTE: Per quadrant.

D7471	22	Removal of Exostosis	109.00	98.00
-------	----	----------------------	--------	-------

NOTE: Torus palatinus.

D7480	Partial Osteotomy (Guttering or Saucerization)	211.00	184.00
D7490	Radical Resection of Mandible with Bone Graft	807.00	807.00

(i) Surgical incision:

D7510	Incision and Drainage of Abscess—Intraoral Soft Tissue	28.00	26.00
D7520	Incision and Drainage of Abscess—Extraoral Soft Tissue	42.00	37.00
D7530	Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue	18.00	16.00
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System	51.00	45.00
D7550	Sequestrectomy for Osteomyelitis	48.00	42.00

NOTE: Intraoral.

D7550	22	Sequestrectomy for Osteomyelitis	90.00	75.00
-------	----	----------------------------------	-------	-------

NOTE: Extraoral.

D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	242.00	210.00
-------	--	--------	--------

NOTE: Sinusotomy, maxillary (antrotomy, Caldwell Luc, unilateral).

(j) Treatment of fractures—simple:

1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.

D7610	Maxilla—Open Reduction (Teeth Immobilized if Present)	273.00	249.00	
D7620	Maxilla—Closed Reduction (Teeth Immobilized if Present)	182.00	166.00	
D7620	52	Maxilla—Closed Reduction	80.00	76.00

NOTE: No manipulation or fixation.

D7630	Mandible—Open Reduction (Teeth Immobilized if Present)	363.00	331.00	
D7630	22	Mandible—Open Reduction (Teeth Immobilized if Present)	454.00	414.00

NOTE: Complicated—multiple surgical approaches (three or more) including internal fixation, interdental fixation, skeletal pinning with extraoral fixation.

D7640	Mandible—Closed Reduction (Teeth Immobilized if Present)	182.00	166.00
-------	--	--------	--------

D7640	52	Mandible—Closed Reduction	80.00	76.00
-------	----	---------------------------	-------	-------

NOTE: No manipulation or fixation.

D7650		Malar and/or Zygomatic Arch— Open Reduction	182.00	166.00
D7660		Malar and/or Zygomatic Arch— Closed Reduction	63.00	58.00

NOTE: Including towel clip technique.

D7660	52	Malar and/or Zygomatic Arch— Closed Reduction	56.00	52.00
-------	----	--	-------	-------

NOTE: No manipulation or fixation.

D7670		Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00
-------	--	--	--------	--------

NOTE 1: Alveolar fracture.

NOTE 2: Reduction with wiring, application of arch bar or splint.

D7680		Facial Bones—Complicated Reduc- tion with Fixation and Multiple Sur- gical Approaches	363.00	331.00
-------	--	---	--------	--------

NOTE 1: Maxilla, malar and/or zygomatic arch.

NOTE 2: Multiple surgical approaches (three or more), fixation, traction, head frame, multiple internal and/or external fixation, and head cap.

(k) Treatment of fractures—compound:

1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.

D7710		Maxilla—Open Reduction	273.00	249.00
-------	--	------------------------	--------	--------

NOTE: Teeth immobilized if present.

D7720		Maxilla—Closed Reduction	182.00	166.00
-------	--	--------------------------	--------	--------

NOTE: Teeth immobilized if present.

D7720	52	Maxilla—Closed Reduction	80.00	76.00
-------	----	--------------------------	-------	-------

NOTE: No manipulation or fixation.

D7730		Mandible—Open Reduction	363.00	331.00
-------	--	-------------------------	--------	--------

NOTE: Teeth immobilized if present.

D7730	22	Mandible—Open Reduction	454.00	414.00
-------	----	-------------------------	--------	--------

NOTE: Complicated—multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.

D7740		Mandible—Closed Reduction	182.00	166.00
-------	--	---------------------------	--------	--------

NOTE: Teeth immobilized if present.

D7740	52	Mandible—Closed Reduction	80.00	76.00
-------	----	---------------------------	-------	-------

NOTE: No manipulation or fixation.

D7750		Malar and/or Zygomatic Arch— Open Reduction	182.00	166.00
D7760		Malar and/or Zygomatic Arch— Closed Reduction	63.00	58.00

NOTE: Including towel clip technique.

D7760	52	Malar and/or Zygomatic Arch— Closed Reduction	56.00	52.00
-------	----	--	-------	-------

NOTE: No manipulation or fixation.

D7770		Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00
-------	--	--	--------	--------

NOTE 1: Alveolar fracture.

NOTE 2: Reduction with wiring, application of arch bar or splint.

D7780		Facial Bones—Complicated Reduc- tion with Fixation and Multiple Sur- gical Approaches	363.00	331.00
-------	--	---	--------	--------

NOTE 1: Maxilla, malar and/or zygomatic arch.

NOTE 2: Multiple surgical approaches (three or more), fixation, traction, head frame, multiple internal and/or external fixation, and head cap.

(l) Reduction of dislocation and management of other temporo-mandibular joint dysfunctions:

D7810		Open Reduction of Dislocation	273.00	249.00
D7820		Closed Reduction of Dislocation	27.00	25.00
d D7830		Manipulation under Anesthesia	27.00	25.00

NOTE: Anesthesia additional.

D7840		Condylectomy	362.00	315.00
D7850		Meniscectomy	362.00	315.00
D7852		Disc repair	362.00	308.00

NOTE: Unilateral.

D7854		Synovectomy	200.00	173.00
D7858		Joint reconstruction	623.00	623.00
D7860		Arthrotomy	182.00	155.00
D7865		Arthroplasty	362.00	308.00

NOTE: Unilateral.

d D7870		Arthrocentesis	18.00	16.00
---------	--	----------------	-------	-------

NOTE: Injection or aspiration (give complete details).

D7871		Non-arthroscopic lysis and lavage	190.00	190.00
D7872		Arthroscopy—diagnosis, with or without biopsy	75.00	65.00
D7873		Arthroscopy—surgical: lavage and lysis of adhesions	200.00	200.00
D7874		Arthroscopy—surgical: disc reposi- tioning and stabilization	500.00	425.00
D7875		Arthroscopy—surgical: synovectomy	264.00	224.00
D7877		Arthroscopy—surgical: debridement	160.00	136.00
* D7880		Occlusal orthotic device, by report	BR	BR
D7899		Unspecified TMD therapy, by re- port	BR	BR

(m) Repair of traumatic wounds:

1. Describe completely, giving size, site, and all pertinent information.
2. Fee includes suture removal.

D7910	Suture of Recent Small Wounds up to 5 cm.	35.00	32.00
-------	---	-------	-------

NOTE: 2.5 cm. up to five cm.

(n) Complicated suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure):

1. Also for irregularly shaped lacerations requiring extensive debridement.

D7911	Complicated suture—Up to 5 cm.	138.00	138.00
D7912	Complicated suture—greater than 5 cm.	242.00	242.00
D7920	Skin graft (identify defect covered, location and type of graft)	70.50	70.50

(o) Other repair procedures:

D7940	Osteoplasty—For Orthognathic Deformities	225.00	191.00
D7941	Osteotomy—Mandibular rami	726.00	726.00

NOTE: Unilateral.

D7943	Osteotomy—Mandibular rami with bone graft; includes obtaining the graft	1,058	1,058
-------	---	-------	-------

NOTE: Unilateral.

D7944	Osteotomy—Segmented or subapical—per sextant or quadrant	332.00	289.00
D7945	Osteotomy—body of mandible	332.00	289.00
D7946	LeFort I (maxilla—total)	546.00	546.00
* D7947	LeFort I (maxilla—segmented)	365.00	365.00
D7948	LeFort II or LeFort III (Osteoplasty of facial bones for midface Hypoplasia or retrusion)—without bone graft	1,095	1,095
D7949	LeFort II or LeFort III—with bone graft	1,427	1,427
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones—autogenous or nonautogenous, by report	575.00	489.00
D7955	Repair of Maxillofacial Soft and Hard Tissue Defects	203.00	176.00
D7960	Frenulectomy (Frenectomy or Frenotomy)—Separate Procedure	60.00	56.00
D7970	Excision of hyperplastic tissue—per arch	45.00	39.00
D7971	Excision of pericoronal gingiva	42.00	37.00
D7980	Sialolithotomy	48.00	42.00
D7981	Excision of Salivary Gland, by report	182.00	158.00
D7982	Sialodochoplasty	151.00	131.00
D7983	Closure of Salivary Fistula	151.00	131.00
D7990	Emergency Tracheotomy	121.00	105.00
D7991	Coronoidectomy	362.00	308.00
* D7995	Synthetic graft—mandible or facial bones, by report	BR	BR
D7996	Implant—mandible for augmentation purposes (excluding alveolar ridge), by report	BR	BR
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	151.00	151.00
** D7999	Unspecified Oral Surgery Procedure, By Report	BR	BR

NOTE: Complete description of procedure and the reason the procedure was performed.

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowance increased for (c) single tooth and (d) surgical removal of erupted tooth effective August 1, 1988.

See: 20 N.J.R. 2101(a).
 Amended by R.1989 d.135, effective March 20, 1989.
 See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).
 Qualifier added to 07130, in (c); prior authorization requirement removed from 07210, in (d).
 Administrative Corrections to (c), (l)1 and (q).
 See: 22 N.J.R. 1375(a).
 Amended by R.1990 d.456, effective September 4, 1990.
 See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
 In (d): revised (d)1 to specify conditions for extraction, by incorporating text from old (d)2. Recodified (d)3 as (d)2 and added new (d)3. Deleted asterisks in List. In (f)1: added new "07310".
 Amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2000 d.426, effective October 16, 2000.
 See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
 Changed Maximum Fee Allowances throughout.
 Amended by R.2001 d.268, effective August 6, 2001.
 See: 33 N.J.R. 1554(a), 33 N.J.R. 2666(b).
 In (g)1, inserted a reference to NJ FamilyCare.
 Amended by R.2003 d.16, effective January 6, 2002.
 See: 34 N.J.R. 2681(a), 35 N.J.R. 232(a).
 Rewrote the section.

10:56-3.11 D8000-D8999 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		
				\$	\$	NS
	D8010		Limited orthodontic treatment of the primary dentition	595.00		590.00
	D8020		Limited orthodontic treatment of the transitional dentition	595.00		590.00
	D8030		Limited orthodontic treatment of the adolescent dentition	595.00		590.00
	D8040		Limited orthodontic treatment of the adult dentition	595.00		590.00
	D8050		Interceptive orthodontic treatment of the primary dentition	595.00		590.00
	D8060		Interceptive orthodontic treatment of the transitional dentition	595.00		590.00

(b) Minor treatment to control harmful habits:

1. Includes all necessary adjustments.
- | | | | |
|-------|-----------------------------|--------|--------|
| D8210 | Removable Appliance Therapy | 595.00 | 590.00 |
| D8220 | Fixed Appliance Therapy | 595.00 | 590.00 |

(c) Comprehensive orthodontic treatment—adolescent dentition:

1. Treatment of permanent dentition. Indicate anticipated time under treatment—maximum treatment reimbursable including retention—three years. Reimbursement for comprehensive orthodontic treatment will include removal and retention as required at no additional charge.