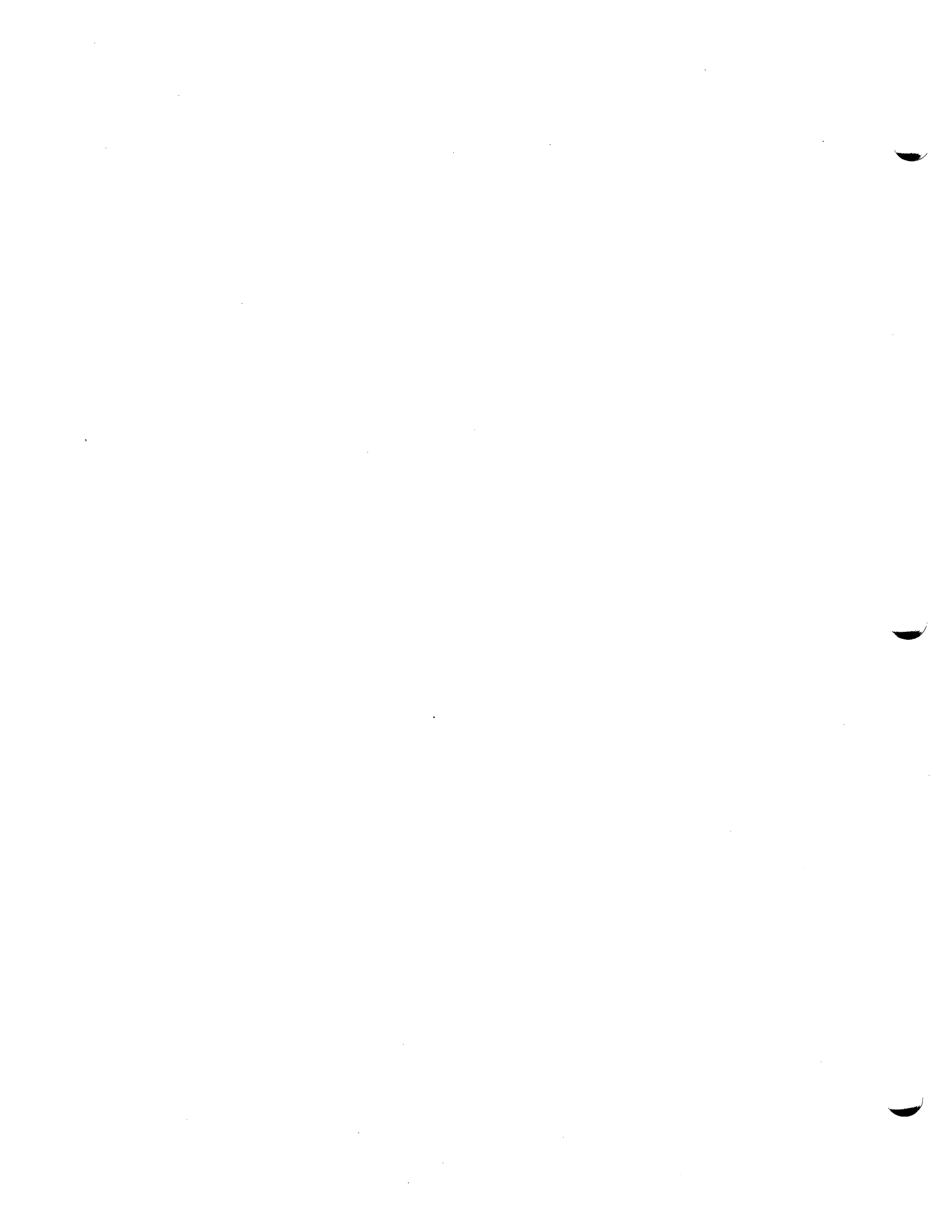


Former N.J.A.C. 10:56-1.2, "Dental treatment plan", recodified to 10:56-2.1.



10:56-1.3 Provisions for provider participation

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

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

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

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

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

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

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

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

10:56-1.4 Prior authorization

(a) All Dental Service Prior Authorization Forms (MC-10A) 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 \$35.00;

2. Emergency treatment with required radiography;

3. Adjustments to, or repair of, dentures when the Medicaid reimbursement does not exceed \$115.00, specialist fee, or \$100.00, nonspecialist fee effective for repairs made on or before September 16, 1996.

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

i. Oral prophylaxis;

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

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

iv. Impactions, fractures, and most surgical procedures;

v. Pulpotomy for permanent and primary teeth;

vi. All extractions of non-restorable teeth;

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

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

(c) Supplemental or amended prior authorization requirements include:

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

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

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

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

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

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

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

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

Section substantially amended.

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

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

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

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.

10:56-1.5 Basis for reimbursement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10:56-1.6 Reimbursement based on specialist designation

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

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

2. In those states not requiring specialty certification:

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

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

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

UNISYS

Provider Enrollment Unit

PO Box 4801

Trenton, New Jersey 08650-4801

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

1. Oral and Maxillofacial Surgery;

2. Endodontics;

3. Pedodontics—Pediatric Dentistry;

4. Orthodontics;

5. Periodontics; and/or

6. Prosthodontics.

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

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

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

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

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

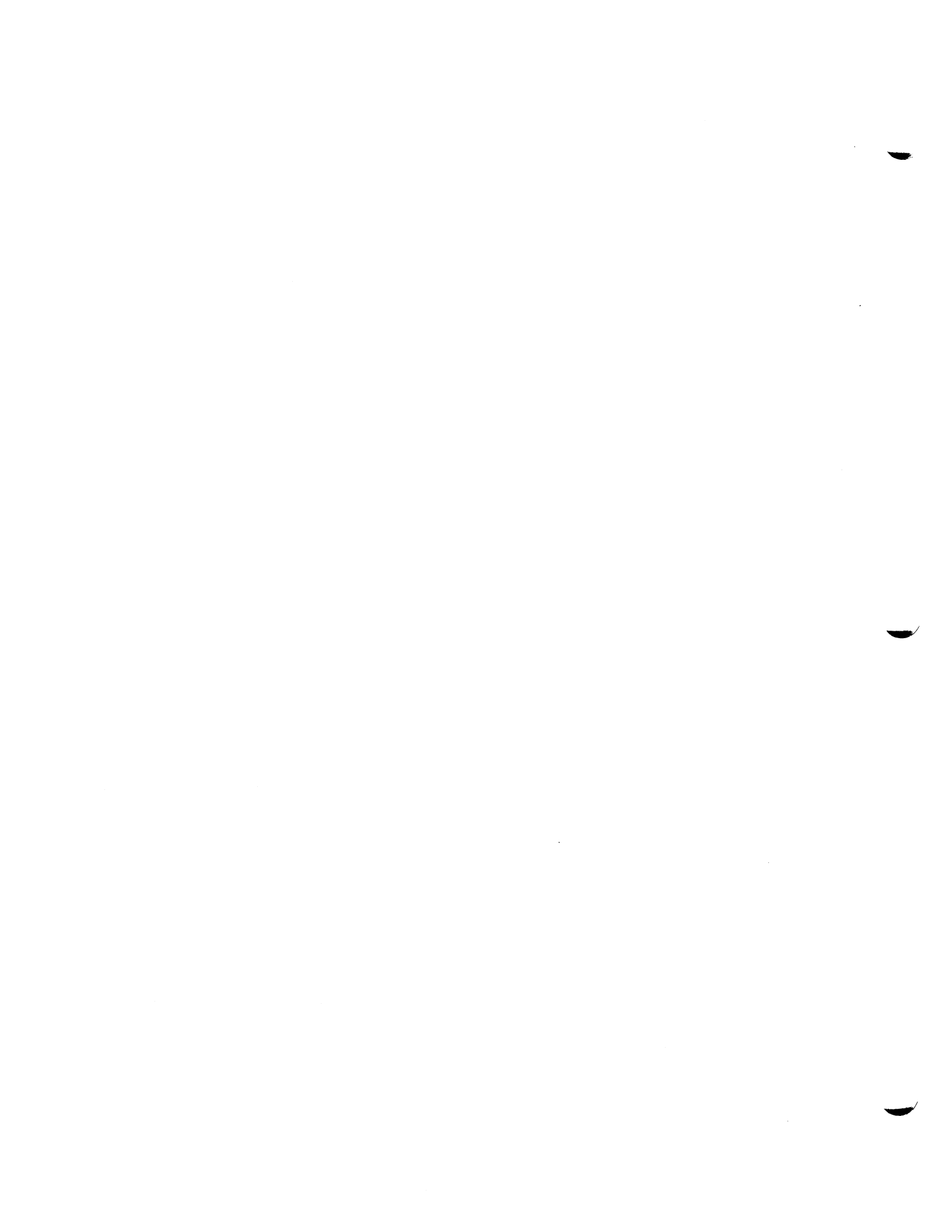
ii. Pertinent dental/medical history; and

iii. Detailed clinical examination data to include where applicable;

(1) Recipient's chief complaint;

(2) Diagnosis;

(3) Cavities;



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

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

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

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

Section substantially amended.

Recodified from 10:56-1.2 and amended by R.1996 d.428, effective September 16, 1996.

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

Former section, "General billing procedures", repealed.

10:56-2.2 Standards of service

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

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

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

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

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

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

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

10:56-2.3 Special dental services

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

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

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

Substantially amended.

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

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

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

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

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

Updated the address.

10:56-2.4 Place of service

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

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

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 must be documented on the hospital records.

i. Dental services are also reimbursable if the recipient 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 recipient'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 recipient must provide the treatment necessary unless the examination indicates that a specialist is needed.

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

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

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

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

(c)3 added.

Amended by R.1986 d.236, effective June 16, 1986 (operative July 1, 1986).

See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

Added text in (a) "However, for recipients ... to N.J.A.C. 10:49-1.2."

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

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

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.

10:56-2.5 Visit policies

(a) A provider may be reimbursed for a house call (procedure code 09410) in addition to any other services provided on that day.

(b) The following apply to reimbursement for nursing facility visits (Y3005):

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 facility, regardless of the number of patients examined or treated.

(c) Reimbursement for hospital calls (09420 52, 09420 22, and 09420) 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 09420 52 is not reimbursable if billed in conjunction with a consultation or other hospital calls on the same day.

2. Procedure code 09420 52 is limited to once per trip to 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 09420 22 is not personally performed by the billing practitioner, the provider should bill for procedure code 09420 52 (hospital call), provided the criteria for that code are met.

5. An initial hospital call or same day surgery call (09420 22) 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 (09420 22) will not be reimbursed in conjunction with a consultation (09310) 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 (09420), 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).

10:56-2.6 Diagnostic services; general

(a) A complete examination of the oral cavity must 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. For reimbursement purposes, a comprehensive dental examination 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 prior authorized by a Dental Consultant of the Medicaid program.

(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 recipient must 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, reimbursement 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).

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.

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 when prior authorization by a Medicaid 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 recipient'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 program.

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 recipients up to and including age 20. Prior authorization is necessary for recipients 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).

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 dental consultant and will be influenced by the age and general health of the recipient; 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 recipients age 21 and older. When the recipient 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 recipients 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 program 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).

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 recipient, the amount of bone loss, the condition of the remaining dentition, the desire, ability, and motivation of the recipient 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 the Medicaid 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).

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 recipient. 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 recipient (for example, provision of dentures will enhance vocational placement);

ii. Medical status of recipient (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 recipient'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 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 include adjustments for three months. Prior authorization shall be required when the repair exceeds \$115.00 for a specialist or \$100.00 for a non-specialist.

(d) Denture relining, rebasing (jumping) or repairing (other than as noted in this section) shall be 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 recipient'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).

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 recipients 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.

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).

10:56-2.15 Orthodontic treatment

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

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

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

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

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

i. The assessment system is a modification of the work of Dr. J. A. Salzmann who has consented to allow the New Jersey Medicaid program to modify and utilize it.

ii. The difference from Dr. Salzmann's original work is that the New Jersey Medicaid program does not allow the eight additional points to denote aesthetic handicap for the anterior segment.

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

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

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

vi. The practitioner should be aware of the following:

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

(c) The New Jersey Medicaid Program Handicapping Malocclusion Assessment System shall be utilized to determine if the case fulfills the requirements for a diagnostic 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
Trenton, New Jersey 08650

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

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

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

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

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

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

UNISYS
PO Box 4811
Trenton, New Jersey 08650

identifying, by procedure code Y2975, the service that has been rendered. A copy of the Handicapping Malocclusion Assessment Record Form (FD-10) shall accompany this submission (Limitation—see N.J.A.C. 10:56-2.6).

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

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

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

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

i. The Dental Services Claim Form (MC-10) utilizing the proper code number(s) with requested fees for:

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

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

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

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

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

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

(2) A cephalometric radiograph with a detailed tracing;

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

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

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

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

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

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

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

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

(g) If the recipient eligibility continues through completion of treatment, final records similar to diagnostic aids described in (e)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

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

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

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

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

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

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

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

1. Orthodontic cases below 24 points on the Salzmann Assessment;
2. All limited orthodontic treatment cases;
3. All transfer orthodontic cases; and
4. All orthodontic cases in which the recipient has discontinued treatment for a period of six months or more and then returns for treatment.

As amended, R.1983 d.584, eff. January 1, 1984.
See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).

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

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

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

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

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

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

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.

10:56-2.16 Pedodontia; pediatric dentistry

(a) In recognition of the unique needs of providing dental care for children, and in conformance with the Federally mandated Early Periodic Screening Diagnosis and Treatment program for providing services for children, a special HCPCS code has been defined, "00110 WT," to be used by dental providers when billing for comprehensive clinical oral examinations of children.

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

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

(c) The HCPCS code 00110 WT is reimbursed at an enhanced rate of \$18.00 for a specialist and \$14.00 for a non-specialist. Reimbursement for a comprehensive clinical oral examination of a child, through age 20 years, is limited to once every six months, except as authorized by a Dental Consultant of the New Jersey Medicaid program. As a minimum, the examination must include:

1. Thorough observation of all conditions present in the oral cavity and contiguous structures including an oral cancer screening;

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

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

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

10:56-2.17 Adjunctive general services: anesthesia

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

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.

- iii. When the dentist performing the dental service (attending dentist) also administers the general anesthesia, then procedure code 09220 only is used and reimbursement will be limited to one general anesthesia charge per visit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) substantially amended.

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

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

10:56-2.18 Adjunctive general services: prescriptions

(a) This section is intended to describe the practitioner's responsibility in the writing of prescriptions in order to maintain the traditional recipient-prescriber-provider relationship, and to insure the recipient free choice of provider. Practitioners are urged to familiarize themselves with all aspects of this section in order to effect economies consistent with good medical/dental practices and to facilitate prompt payment to the provider.

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

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.

(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 recipient'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 (h)8 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 shall be considered to be a sustaining drug or

maintenance medication and should be prescribed in sufficient quantities to treat the recipient 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.

(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 so forth).

5. Medications prescribed for use by hospital inpatients.

6. Prescribed non-legend over-the-counter drugs for recipients 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 recipient 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 prep-

arations, 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 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).

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 recipient's records and must be available, upon request, to the New Jersey Medicaid program or any of its authorized representatives.

i. When the practitioner rendering the consultation services assumes the continuing care of the recipient, any subsequent services rendered by him 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 recipient is being referred. The consulting practitioner must note the diagnosis under Remarks (Item 20), the name and the Medicaid 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 recipient makes an appointment on his/her own.

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

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

vi. If a consultation is billed in an inpatient setting and the recipient 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 09420-22, 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 a Hospital Day—Subsequent—and be considered as concurrent care if concurrent 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).

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:

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

(d) Specific elements of the HCPCS 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:

<u>Column</u>	<u>Title</u>
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:

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 below 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 program's recognized modifier codes are listed with appropriate procedure codes in this Subchapter 3. The modifiers "22", "52" and "76" are designated for use in the New Jersey Medicaid Dental Manual 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 program to distinguish between services rendered in the mandibular arch as opposed to the maxillary arch and the basic codes do not make 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:
- 04210—Gingivectomy or Gingivoplasty
 - 04220—Gingival Curettage
 - 04260—Osseous Surgery
 - 04341—Periodontal Scaling and Root Planing
 - 04272—Apically repositioning Flap Procedure
 - 07310—Alveoloplasty in Conjunction with Extraction
 - 07320—Alveoloplasty not in Conjunction with Extraction
 - 07340—Vestibuloplasty—Ridge Extension—Secondary Epithelialization
 - 07350—Vestibuloplasty—Ridge Extension
 - 09951 22—Occlusal Adjustment
 - 07470—Removal of Exostosis
5. Description Lists the code narrative.
6. Maximum Fee Allowance Lists the New Jersey Medicaid program's maximum reimbursement schedule for Specialist and Non-Specialist.
- i. S— Denotes Specialist fee.
 - ii. NS— Denotes Non-Specialist fee.
 - iii. BR—Denotes By Report (Individual Consideration of Procedure and Fee).
- (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 Claim form (MC-10).
- (e) Alphabetic and numeric symbols under "IND" & "MOD" and notes under "DESCRIPTION"
- 1. These symbols and notes when listed under the "IND", "MOD" and "DESCRIPTION" columns are elements of the HCPCS coding system. They assist the dentist in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.
 - 2. These symbols and/or letters and/or notes must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the HCPCS code. **THE PROVIDER WILL THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE HCPCS CODE NARRATIVE.** These requirements must be fulfilled in order to receive reimbursement.
 - 3. If there is no identifying symbol or note listed, the HCPCS code narrative prevails.
- (f) Listed throughout subchapter 3 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 modifi-

ers, 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 program 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 15B) 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.

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 program's maximum reimbursement for the given procedure.

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

Description	HCPCS Procedure Codes (Dental)
Alveoloplasty	07310-07320
Amalgam Restoration	
Permanent Teeth	02140-02161
Primary Teeth	02110-02131
Analgesia	09230
Anesthesia	
General	09220
Intravenous Sedation	09240
Local (not in conjunction with operative or surgical procedure)	09210
Special General	09220 22, 09220 52
Apexification	03350
Apically Repositioning Flap Procedure	04272
Apicoectomy	03410-03411
With Root Canal	03410 22-03411 22
Appliance, Orthodontic	
Comprehensive	Y2910-Y2950
Harmful Habit	08210-08220
Tooth Guidance	08110-08120
Arthrocentesis	07870
Arthrotomy	07860
Behavior Management	09920
Biopsy	
Hard Tissue	07285
Soft Tissue	07286
Bleaching, Discolored Tooth	03960
Bridge, Fixed	
Abutments	06720-06792
Pontics	06210-06252
Post + Core Cast	06970
Prefabricated	06972
Recementation	06930, 06930 22
Repairs	06980
Canal, Preparation and Fitting of Preformed	
Post	03950-03950 22
Casts, Diagnostic	00470
Cephalometric Film	00340
Including Tracing	00340 22
Complications, Post Surgical	09930
Composite Restorations	02330-02335 02385-02387
Condylectomy	07840
Consultation, Professional	09310
Crowns	
Bridge Abutments	06720-06792
Bridge Pontics	06210-06252
Buildup, Including Pins	02950
Individual	02710-02792, 02932
Recement	02920
Stainless Steel	02930-02931
Temporary (fractured tooth)	02970
Curettage	
Apical	03440
Gingival	04220
Cysts, Removal	07430-07461 22
Dentures	
Complete	05110-05120
Complete, Immediate	05130-05140 22
Partial, Removable	05211-05214
Partial, Removable, Immediate Tooth Replacement	Y2505

Description	HCPCS Procedure Codes (Dental)
Denture Adjustments	
Complete Dentures	05410-05411
Partial Dentures	05421-05422
Denture Identification	Y2515 YU-Y2515 YL
Denture Rebasing	
Complete Dentures	05710-05711
Partial Dentures	05720-05721
Denture Relining	
Complete Dentures	05730-05731, 05750-05751
Partial Dentures	05740-05741, 05760-05761
Denture Repair (Complete and Partial)	05510 YU-Y2510
Desensitizing Medicaments	09910
Destruction of Lesions by Physical Methods	07465
Diagnostic Services	
Biopsy Hard Tissue	07285
Soft Tissue	07286
Casts, Diagnostic	00470
Examination Emergency Oral	00130
Histopathologic	00501
Initial Oral	00110
Orthodontic Assessment	Y2975
Comprehensive	Y2965
Photographs Diagnostic	00471
Slides, Diagnostic	00471
Unspecified Diagnostic Procedure	00999
Dislocation-Reduction	07810-07830
Drugs or Medicaments	09630
Drug Injection, Therapeutic	09610
Emergency Procedures (Palliative)	09110
Endodontic Services	
Apexification	03350
Apicoectomy	03410-03411
With Root Canal	03410 22-03411 22
Bleaching, Discolored Tooth	03960
Canal Preparation and fitting of preformed dowel or post	03950-03950 22
Curettage, Apical	03440
Emergency (palliative)	03220
Hemisection	03920
Pulpectomy	Y2310
Pulpotomy, Therapeutic	03220
Retrograde Filling	03430
Root Amputation	03450
Root Canal Therapy	03310-03330
Unspecified Endodontic Procedure	03999
Examination	
Emergency Oral	00130
Histopathologic	00501
Initial Oral	00110
Initial Oral-Handicapped	00110 76
Orthodontic Assessment	Y2975
Comprehensive	Y2965
Excisions, Surgical	07410-07420 22
Exostosis, Removal	07470
Exposure, Surgical, of Tooth	07280-07281
Extractions	
Uncomplicated Root Removal	07130-07130 52
Tooth, Single	07110
Surgical Roots, Residual (Completely covered by bone)	07250
Tooth, Single	07210
Impactions:	
Complete Bony	07240
Partial Bony	07230
Soft Tissue	07220
Extraoral Radiographs	00250-00260
Fluoride-Topical	01201-01202 52
Fluoride-Topical-Handicapped	01201 76-01202 76
Foreign Body, Removal	07530-07540
Fractures	

Description	HCPCS Procedure Codes (Dental)
Compound	07710-07780
Simple	07610-07680
Frenulectomy	07960
Gingivectomy	04210-04211
Gingivoplasty	04210-04210
Gold Foil	02410-02430
Grafts	
Free Soft Tissue	04271
Osseous, Multiple Site	04262
Osseous, Single Site	04261
Pedicle Soft Tissue	04270
Habit Appliances, Orthodontic	08210-08220
Hemisection	03920
Histopathologic Examination	00501
Hospital Visits	09420 52-09420
Incision and Drainage	
Extraoral	07520
Intraoral	07510
Injection	
Therapeutic Drug	09610
TMJ	09610 22
Inlay, Gold	02510-02530
Intraoral Radiographs	00210 52-00210 00220-00230
Maxillofacial Tissue Defect, Repair	07954
Medications	09630
Meniscectomy	07850
Occlusal Adjustment	09951
Occlusal Guards, Periodontal	09940-09940 22
Occlusal Radiograph	00240
Onlay	02540
Oral Surgery Services	
Alveoloplasty	07320
Antro-Oral Fistula Closure	07260
Arthrocentesis	07870
Arthrotomy	07860
Biopsy Hard Tissue	07285
Soft Tissue	07286
Condylectomy	07840
Cysts, Tumors and Neoplasms, Removal	07430-07461 22
Destruction of Lesions, by physical methods	07465
Dislocation—Reduction	07810-07830
Excision, Surgical	07410-07420 22
Exostosis, Removal	07470
Exposure, Surgical, of Tooth	07280-07281
Extractions Uncomplicated Root Removal	07130-07130 52
Tooth, Single	07110
Surgical Roots, Residual (Completely covered by bone)	07250
Tooth, Single	07210
Impactions:	
Complete Bony	07240
Partial Bony	07230
Soft Tissue	07220
Foreign Body, Removal	07530-07540
Fracture:	
Compound	07710-07780
Simple	07610-07680
Frenulectomy	07960
Incision and Drainage:	
Extraoral	07520
Intraoral	07510
Manipulation of TMJ, Under Anesthesia	07830
Maxillofacial Tissue Defect, Repair	07955
Meniscectomy	07850
Operculectomy	07410
Antro-oral Fistula Closure	07260
Ostectomy, Partial	07480
Osteomyelitis, Sequestrectomy	07550-07550 22
Osteoplasty, Orthognathic Deformities	07940
Re-implantation, Tooth	07270-07270 22
Resection, Radical of Mandible	07490

Description	HCPCS Procedure Codes (Dental)
Salivary Gland Excision	07981
Fistula Closure	07983
Sialodochoplasty	07982
Sialolithotomy	07980
Sinusotomy	07560
Stabilization, Tooth	07270-07270 22
Stent, Surgical	05982
Stomatoplasty	07340-07350
Suturing	07910 52-07912
Torus Palatinus, Removal	07470 22
Tracheotomy	07990
Tumors Benign, Excision	07430-07431 22
Malignant, Excision	07440-07441 22
Unspecified Oral Surgery Procedure	07999
Vestibuloplasty	07340-07350
Orthodontic Services	
Appliances, Orthodontic Comprehensive	Y2910-Y2950
Harmful Habit	08210-08220
Retention	08110-08120
Tooth Guidance	08110-08120
Comprehensive Treatment Adjustments	Y2920-Y2950
Appliances	Y2910
Examination Assessment System (Using Handicapping Malocclusion)	Y2975
Comprehensive	Y2965
Unspecified Orthodontic Treatment	08999
Osseous Surgery, Periodontal	04260
Ostectomy, Partial	07480
Osteomyelitis, Sequestrectomy	07550-07550 22
Osteoplasty, Orthognathic Deformities	07940
Palliative Treatment, Emergency	09110
Panoramic Radiograph	00330
Periodontal Appliances—Special	09940-09940 22
Periodontal Services	
Apically Repositioning Flap Procedure	04272
Curettage, Gingival	04220
Gingivectomy	04210-04211
Gingivoplasty	04210-04211
Grafts Free Soft Tissue	04271
Osseous, Single Site	04261
Osseous, Multiple Sites	04262
Pedicle Soft Tissue	04270
Occlusal Adjustment	09951-09952
Occlusal Guards	09940-09940 22
Osseous Surgery	04260
Periodontal Appliance—Special	09940-09940 22
Scaling and Root Planing	04341
Splinting, Provisional	04320-04321
Unspecified Periodontal Services	04999
Photographs, Diagnostic	00471
Pin Retention	02951
Plastic Crowns	
Laboratory Processed	02710
Prefabricated	02932
Post and Core	
Bridge Retainer: Cast	06970
Prefabricated	06972
Single Unit Cast	02952
Prefabricated	02954
Prefabricated Resin crown (Polycarbonate)	02932
Preventive Services	
Fluoride Topical	01201-01202 52
Prophylaxis	01110-01120
Sealants	01351
Prophylaxis	01110-01120
Prophylaxis-Handicapped Recipient	01110 76-01120 76
Prosthodontics	
Fixed	
Abutments (Bridge Retainers)	06720-06792
Crowns, Individual	02710-02792, 02932
Pontics	06210-06252
Post and Core	

Description	HCPCS Procedure Codes (Dental)
Bridge Retainer (Abutment) Cast	06970
Prefabricated	06972
Single Unit Cast	02952
Prefabricated	02954
Recementation Crowns, Individual	02920
Bridges	06930-06930 22
Repairs	06980
Unspecified	06999
Removable Adjustments	
Complete Denture	05410-05411
Partial Denture	05421-05422
Complete	05110-05120
Complete Immediate	05130-05140 22
Identification	Y2515 YU-Y2515 YL
Partial Removable	05211-05214
Partial, Immediate Tooth Replacement	Y2505
Rebasing Complete Denture	05710-05711
Partial Denture	05720-05721
Relining Complete Denture	05730-05731, 05750-05751
Partial Denture	05740-05741, 05760-05761
Repairs	05510 YU-Y2510
Stent, Surgical	05982
Unspecified Removable Prosthodontic Procedure	05899
Pulpectomy	Y2310
Pulpotomy, Therapeutic	03220
Radiographic Services	
Cephalometric Film	00340
Including tracing	00340 22
Radiographics Complete Series	00210 52-00210 22
Extraoral	00250-00260
Intraoral	00220-00230
Occlusal	00240
Panoramic	00330
Sialography	00310
Including Contrast Material	00310 22
Rebasing	
Complete Dentures	05710-05711
Partial Dentures	05720-05721
Recent	
Bridge, Fixed	06930-06930 22
Crown	02920
Inlay	02910
Space Maintainer	01550
Relining	
Complete Dentures	05730-05731, 05750-05751
Partial Dentures	05740-05741, 05760-05761
Repairs	
Fixed Bridge	06980
Removable Prosthetics	05510 YU-Y2510
Resection, Radical, of Mandible	07490
Restorative Services	
Amalgam	
Permanent Teeth	02140-02161
Primary Teeth	02110-02131
Composite Resin	02330-02335, 02385-02387, 02410-02430
Gold Foil	02510-02530
Inlay, Gold	02540
Onlay, Gold	02951
Pin Retention	02999
Unspecified Restorative Procedure	03430
Retrograde Filling	03310-03330
Root Canal Therapy	04340-04341
Root Planing and Scaling	03450
Root Amputation	
Salivary Gland	
Excisions	07981

Description	HCPCS Procedure Codes (Dental)
Fistula Closure	07983
Scaling (Additional to Prophy)	Y2105-Y2105 52
Scaling (Additional to Prophy) Handicapped	Y2105 76
Scaling and Root Planing	04340-04341
Sealants	01351
Sedation, Intravenous	09240
Sequestrectomy for Osteomyelitis	07550-07550 22
Sialodochoplasty	07982
Sialography	00310
Including Contrast Material	00310 22
Sialolithotomy	07980
Sinusotomy	07560
Slides, Diagnostic Photographs	00471
Space Maintainers	01510-01525
Splinting, Provisional	04320-04321
Stabilization, Tooth	04320-04321
Stainless Steel Crown (Prefabricated)	02930-02931
Stent, Surgical	05982
Stomatoplasty	07340-07350
Study Models—See Diagnostic Casts	
Suturing	07910 52-07912
Temporary Crown (Fractured Tooth)	02970
Temporo-Mandibular Joint	
Injection of muscles of mastication	09610 22
Manipulation under anesthesia	07830
Tooth Guidance Appliances	08110-08120
Tooth Processed to Arch Bar (Wire)	Y2115
Torus Palatinus, Removal	07470 22
Tracheotomy	07990
Tumors	
Benign, Excision	07430-07431 22
Malignant, Excision	07440-07441 22
Unspecified Procedures	
Adjunctive Procedure	09999
Bridge Repair, Fixed	06980
Diagnostic Procedure	00999
Endodontic Procedure	03999
Maxillofacial Prosthesis	05999
Oral Surgery Procedure	07999
Orthodontic Procedure	08999
Periodontal Services	04999
Preventive Procedure	Y2125
Prosthodontic, Fixed, Procedure	06999
Restorative Procedure	02999
Service, Unspecified	09999
Vestibuloplasty	07340-07350
Visits, Professional	09410-09420
Wounds, Traumatic, Repair	07919 52-07910 22
X-Rays (See Radiographs)	

Administrative Correction to (f)iv.
 See: 22 N.J.R. 1375(a).
 Amended by R.1990 d.456, effective September 4, 1990.
 See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
 In (d): added new (d)iv.
 Amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

10:56-3.2 00100-00999 DIAGNOSTIC

(a) Clinical Oral Examination:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fcc Allowance		
				S	\$	NS
	00110		Initial Oral Examination	7.00		6.00

NOTE 1: This is the code to be used for a Comprehensive Clinical Oral Examination of Medicaid recipients, both Initial and Periodic.

00260		Extraoral—Each Additional Film NOTE 1: Indicate number of views in item 17D and 17H of the Dental Services Claim form (MC-10). NOTE 2: Maximum reimbursable—2 additional views.	5.00	5.00
00310		Sialography	15.00	15.00
00310	22	Sialography NOTE: Includes injection of contrast material (filling and/or emptying phases).	30.00	30.00
00330		Panoramic Film	10.00	10.00
00340		Cephalometric Film	10.00	10.00
00340	22	Cephalometric Film NOTE: Includes tracing.	15.00	15.00

(c) Test and laboratory examinations:

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

10:56-3.3 01000-01999 PREVENTIVE

(a) Dental prophylaxis:

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

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

#	Y2105		Additional Scaling Maxillary and mandibular arches.	11.00		10.00
#	Y2105	52	Additional Scaling, One Arch NOTE 1: Maxillary or mandibular arch.	5.50		5.00

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

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

01110	76	Prophylaxis—Adult NOTE: Patients 16 years of age or older, maxillary and mandibular arches.	11.00	10.00
01120	76	Prophylaxis—Child NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.	8.00	7.00
Y2105	76	Additional Scaling	11.00	10.00

(b) Topical fluoride treatment (office procedure):

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

01201		Topical Application of Fluoride (Including Prophylaxis)—Child NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.	14.00	12.00
01202		Topical Application of Fluoride (Including Prophylaxis)—Adult NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.	17.00	15.00
01202	52	Topical Application of Fluoride (Including Prophylaxis)—Adult NOTE: Patients age 16 up to and including 20 years of age, maxillary or mandibular arch Code to be used if patient is edentulous in 1 arch.	8.50	7.50

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

01201	76	Topical Application of Fluoride (Including Prophylaxis)—Child NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.	14.00	12.00
01202	76	Topical Application of Fluoride (Including Prophylaxis)—Adult NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.	17.00	15.00

(c) Other Preventive Services:

01351		Sealant—Per Tooth	7.00	6.00
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(d) Space Maintenance (passive appliances):

01510		Space Maintainer—Fixed—Unilateral NOTE: Utilizing band(s).	40.00	35.00
01510	22	Space Maintainer—Fixed—Unilateral NOTE: Utilizing single stainless steel crown.	59.00	51.00
01515		Space Maintainer—Fixed—Bilateral NOTE: Lingual or palatal arch utilizing bands.	61.00	53.00

01515	22	Space Maintainer—Fixed—Bilateral	105.00	91.00
		NOTE: Lingual or palatal arch utilizing stainless steel crowns.		
Y2115		Tooth Processed to Arch Bar (Wire), Per Tooth	6.00	5.00
01525		Space Maintainer—Removable—Bilateral	69.00	60.00
01550		Recementation of Space Maintainer	7.00	6.00
* Y2125		Unspecified Preventive Procedure, By Report	BR	BR
		NOTE: The complete description of procedure(s) and the reason(s) the procedure was performed must be included in the report.		

Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).

In (a)2: added text regarding recipients up to and including 17 years of age. Deleting text regarding patients 16 years of age or older and increasing "Additional Scaling" fees. In "01202 52" changed "and" to "or" regarding mandibular arch.

In (c): Revised text in Note 1 and added new Note 2, recodifying Notes 2-3 as 3-4.

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

10:56-3.4 02000-02999 RESTORATIVE

(a) Amalgam restorations (including polishing):

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance	
				\$	NS
	02110		Amalgam—One Surface, Primary	17.00	15.00
	02120		Amalgam—Two Surfaces, Primary	23.00	20.50
	02130		Amalgam—Three Surfaces, Primary	29.00	26.00
	02131		Amalgam—Four or more Surfaces, Primary	36.00	31.50
	02140		Amalgam—One Surface, Permanent	17.00	15.00
	02150		Amalgam—Two Surfaces, Permanent	23.00	20.50
	02160		Amalgam—Three Surfaces, Permanent	29.00	26.00
	02161		Amalgam—Four or More Surfaces, Permanent	36.00	31.50

(b) Filled or unfilled resin restorations:

1. Proximal restorations in anterior teeth are normally considered to be single surface restorations. When access to a proximal cavity is gained by involvement of a second surface, reimbursement will be permitted for only one surface. A two or three surface proximal restoration will be reimbursed only when the facial and/or lingual margin(s) of the restoration extends beyond the proximal one-third of the facial and/or lingual surface(s).

2. Reimbursement will include acid etch where appropriate.

02330	Resin—One Surface	20.50	18.00
02331	Resin—Two Surfaces	27.50	24.00
02332	Resin—Three Surfaces	34.50	30.00
02335	Resin—Four or More Surfaces or Involving Incisal Angle	41.50	36.00
For permanent teeth only:			
02385	Resin—one surface, posterior permanent	20.50	18.00

02386	Resin—two surfaces, posterior permanent	27.50	24.00
02387	Resin—three surfaces, posterior permanent	34.50	30.00
	NOTE: Code to be used for three or more surfaces.		

(c) Gold Foil Restorations:

1. Primarily for use in Dental Colleges.

02410	Gold Foil—One Surface	9.00	8.00
02420	Gold Foil—Two Surfaces	18.00	16.00
02430	Gold Foil—Three Surfaces	27.00	24.00
	NOTE: Code to be used for three or more surfaces.		

(d) Inlay Restorations:

1. Primarily for use in dental colleges.

02510	Inlay—Metallic—One Surface	31.00	27.00
02520	Inlay—Metallic—Two Surfaces	56.00	49.00
02530	Inlay—Metallic—Three Surfaces	75.00	65.00
	NOTE: Code to be used for three or more surfaces.		
02540	Onlay—Metallic—Per Tooth (In Addition to Inlay)	23.00	20.00

(e) Crowns—single restoration only:

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

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

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

3. Prior authorization is not required for the codes listed below with the crosshatch (#) indicator when the recipient is 20 years of age or younger.

#	02710	Crown—Resin (Laboratory)	98.00	85.00
		NOTE: Laboratory processed.		
#	02720	Crown—Resin with High Noble Metal	161.00	140.00
		NOTE: Acrylic veneer.		
#	02721	Crown—Resin with Predominantly Base Metal	161.00	140.00
		NOTE: Acrylic Veneer.		
#	02722	Crown—Resin with Noble Metal	161.00	140.00
		NOTE: Acrylic Veneer.		
#	02750	Crown—Porcelain Fused to High Noble Metal	201.00	175.00
#	02751	Crown—Porcelain Fused to Predominantly Base Metal	201.00	175.00
#	02752	Crown—Porcelain Fused to Noble Metal	201.00	175.00
#	02790	Crown—Full Cast High Noble Metal	161.00	140.00
#	02791	Crown—Full Cast Predominantly Base Metal	161.00	140.00
#	02792	Crown—Full Cast Noble Metal	161.00	140.00

(f) Other restorative services:

02910	Recent Inlay	7.00	6.00
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02920	Recement Crown	7.00	6.00
02930	Prefabricated Stainless Steel Crown—Primary Tooth NOTE: Reimbursable only for deciduous teeth. EXCEPTION: Prior authorization by a Medicaid dental consultant.	41.00	35.00
02931	Prefabricated Stainless Steel Crown—Permanent Tooth NOTE: Reimbursable only for permanent posterior teeth up to and including 17 years of age. EXCEPTION: Prior authorized by a Medicaid dental consultant.	41.00	35.00
02932	Prefabricated Resin Crown NOTE: e.g., Polycarbonate—Reimbursable only for primary and permanent anterior teeth up to and including 15 years of age. EXCEPTION: Authorization by a Medicaid dental consultant.	40.00	35.00
# 02950	Crown Buildup Including Any Pins NOTE 1: And/or post. NOTE 2: Core of composite or amalgam.	34.00	30.00
02951	Pin Retention—Per Tooth, In Addition To Restoration NOTE 1: Per pin. NOTE 2: Maximum reimbursable—three pins. NOTE 3: Not in conjunction with Procedure Code 03950 and 03950-22.	4.00	3.00
# 02952	Cast Post And Core In Addition to Crown NOTE 1: Post and core fabricated (cast) and cemented as a separate unit from crown. NOTE 2: Preparatory to crown restoration only. NOTE 3: Not in conjunction with Procedure Code 03950 and 03950-22.	52.00	45.00
# 02954	Prefabricated Post And Core In Addition to Crown NOTE 1: Preparatory to crown restoration only. NOTE 2: Not in conjunction with Procedure Code 03950 and 03950-22.	34.00	30.00
02970	Temporary (Fractured Tooth) NOTE: Temporary crown—not reimbursable in conjunction with any other restorative procedure on same tooth.	29.00	25.00
* 02980	Crown Repair, By Report	BR	BR
* 02999	Unspecified Restorative Procedure, By Report	BR	BR

Public notice: Pursuant to N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowances increased in (b) and (d)8, effective August 1, 1988.
See: 20 N.J.R. 2101(a).
Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (h): added "02980—Crown Repair".
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

10:56-3.5 03000-03999 ENDODONTICS

(a) Therapeutic pulpotomy:

03220	Therapeutic Pulpotomy (Excluding Final Restoration)	15.00	13.00
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(b) Pulpectomy:

Y2310	Pulpectomy (Excluding Final Restoration)	17.00	15.00
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(c) Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care):

1. For emergency endodontic procedures, use code 03220.

2. Prior authorization is not required for the codes listed below with the crosshatch (#) indicator when the recipient is 20 years of age or younger. Check recipient's age carefully.

# 03310	One Canal (Excluding Final Restoration) NOTE: Code to be used for incisors and cuspids (permanent).	103.00	90.00
# 03320	Two Canals (Excluding Final Restoration) NOTE: Code to be used for premolars and all primary teeth without permanent successors.	132.00	115.00
# 03330	Three Canals (Excluding Final Restoration) NOTE: Code to be used for molars (permanent).	172.00	150.00
03350	Apexification (Per Treatment Visit) NOTE 1: Treatment may extend over a period of 6 to 18 months. NOTE 2: Maximum—two (2) visits. Exception: Prior authorization by a Medicaid dental consultant.	31.00	27.00

(d) Periapical Services:

1. When more than one apical curettage and/or apicoectomy and/or other apical surgery is performed through the same operative site, the maximum amount reimbursable by the New Jersey Medicaid Program shall be the amount specified in this schedule with the greater allowance, plus one-half of the amounts specified for each of the other procedures.

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

(e) Apicoectomy performed in conjunction with endodontic procedure:

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

d* 03410	22	Apicoectomy/Endodontic Procedure (Per Tooth)—First Root	111.50	98.50
d* 03411	22	Apicoectomy/Endodontic Procedure (Per Tooth)—Each Additional Root NOTE: Maximum—two additional roots. Must be billed in conjunction with Code 03410 22.	44.00	36.00
03430		Retrograde Filling—Per Root NOTE 1: Reimbursable only in addition to apicoectomy. NOTE 2: Maximum per tooth—three roots.	9.00	7.50
03440		Apical Curettage NOTE: Per tooth.	49.00	42.00

03450	Root Amputation—Per Root NOTE 1: Surgical resection of entire root(s). NOTE 2: Per tooth.	55.00	48.00	*	04341	Periodontal Scaling and Root Planing—Per Quadrant	25.50	22.50
				*	04999	Unspecified Periodontal Service, By Report	BR	BR

(f) Other endodontic procedures:

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

03920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	55.00	48.00					
03950	Canal Preparation and Fitting of Preformed Dowel or Post NOTE: Without cementation.	16.00	14.00					
03950	22 Canal Preparation and Fitting of Preformed Dowel or Post NOTE 1: Can be used when the final restoration is an amalgam or composite resin. NOTE 2: With cementation.	23.00	20.00					
03960	Bleaching Discolored Tooth NOTE 1: Limited to non-vital teeth. NOTE 2: Per visit. NOTE 3: Reimbursement limited to two visits without prior authorization.	11.00	10.00					
d* 03999	Unspecified Endodontic Procedure, By Report	BR	BR					

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

(a) Complete Dentures (including routine post delivery care):

		Maximum Fee Allowance			
Ind	HCPCS Codes	Mod	Procedure Description	\$	\$ NS
*	05110		Complete Upper NOTE: Maxillary.	231.00	201.00
*	05120		Complete Lower NOTE: Mandibular.	238.00	207.00

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

10:56-3.6 04000-04999 PERIODONTICS

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

Ind	HCPCS Codes	Mod	Procedure Description	\$	\$ NS
*	04210		Gingivectomy or Gingivoplasty—Per Quadrant	43.60	37.50
	04211		Gingivectomy or Gingivoplasty—Per Tooth NOTE: Maximum number of teeth reimbursable—Three	6.00	5.50
*	04220		Gingival Curettage, By Report NOTE: Per Quadrant.	22.60	19.50
*	04260		Osseous Surgery (Including Flap Entry and Closure) Per Quadrant	75.00	64.50
*	04261		Osseous Graft—Single Site (Including Flap Entry, Closure, and Donor Sites)	BR	BR
*	04262		Osseous Graft—Multiple Sites (Including Flap Entry, Closure, and Donor Sites)	BR	BR
*	04270		Pedicle Soft Tissue Graft Procedure NOTE: Per site.	32.00	28.00
*	04271		Free Soft Tissue Graft Procedure (Including Donor Site) NOTE: Per site.	49.00	42.00
*	04272		Apically Repositioning Flap Procedure NOTE: Per quadrant.	36.00	31.50

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

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 nos. 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.

*	05130		Immediate Upper NOTE 1: Maxillary. NOTE 2: 1 through 4 teeth.	253.00	220.00
*	05130	22	Immediate Upper NOTE 1: Maxillary. NOTE 2: 5 through 8 teeth.	280.00	243.00
*	05140		Immediate Lower NOTE 1: Mandibular. NOTE 2: 1 through 4 teeth.	258.00	224.00
*	05140	22	Immediate Lower NOTE 1: Mandibular. NOTE 2: 5 through 8 teeth.	286.00	249.00

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

*	05211		Upper Partial—Acrylic Base (Including Any Conventional Clasps and Rests) NOTE: Includes a minimum of two cast chrome clasps with rests.	190.00	165.00
*	05211	52	Upper Partial—Acrylic Base—Without Clasps (Flipper)	101.00	88.00
*	05212		Lower Partial—Acrylic Base—(Including Any Conventional Clasps and Rests) NOTE: Includes a minimum of two cast chrome clasps with rests.	190.00	165.00
*	05212	52	Lower Partial—Acrylic Base—Without Clasps (Flipper)	101.00	88.00
*	05213		Upper Partial—Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests) NOTE: Includes a minimum of two cast chrome clasps with rests.	250.00	217.00

(b) Adjunctive periodontal services:

04320	Provisional Splinting—Intracoronaral NOTE: Per tooth.	18.00	16.00		
04321	Provisional Splinting—Extracoronaral NOTE 1: Per tooth. NOTE 2: This code may also be used for stabilization of traumatized teeth.	11.00	10.00		

*	05214	Lower Partial—Predominantly Base Cast Base with Acrylic Saddles (Including any Conventional Clasps and Rests) NOTE: Includes a minimum of two cast chrome clasps with rests.	237.00	206.00
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(d) Immediate replacement of anterior teeth in conjunction with partial dentures (codes 05211 through 05214 only) in addition to denture, maximum six (6) teeth (Teeth #s 6 through 11 and 22 through 27 only).

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

*	Y2505	Immediate Replacement of Anterior Teeth—Per Tooth NOTE: List tooth code(s) of tooth being replaced.	6.00	5.00
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(e) Adjustments to dentures—other than dentist providing denture or after the required period of post delivery care:

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

(f) Repairs to complete dentures:

1. Repair Broken Complete Denture Base:

i. Includes replacing teeth on denture.

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

(g) Repairs to partial denture:

05610	YU	Repair Acrylic Saddle or Base NOTE: Maxillary.	34.50	30.00
05610	YL	Repair Acrylic Saddle or Base NOTE: Mandibular.	34.50	30.00
05620		Repair Cast Framework NOTE 1: Welding in addition to repair procedure(s), limit two (2) welds per denture. NOTE 2: May be used in conjunction with other repair procedures or as a separate repair procedure.	23.00	20.00
05630	YU	Repair or Replace Broken Clasp NOTE: Maxillary.	52.50	48.00
05630	YL	Repair or Replace Broken Clasp NOTE: Mandibular.	52.50	48.00
05640		Replace Broken Teeth—Per Tooth NOTE: Code 05640 may be used in addition to partial denture re-	5.00	5.00

05650		pair procedure(s), 05610 YU or YL above. Add Tooth to Existing Partial Denture NOTE 1: To replace extracted tooth (List tooth code being replaced). NOTE 2: For additional replacements beyond the first tooth use code 05640. List tooth (teeth) being replaced.	46.00	40.00
05660	YU	Add Clasp to Existing Partial Denture NOTE 1: Maxillary—First Clasp. NOTE 2: List tooth being clasped. NOTE 3: For additional clasp(s), use code Y2510.	52.50	48.00
05660	YL	Add Clasp to Existing Partial Denture NOTE 1: Mandibular—First Clasp. NOTE 2: List tooth code being clasped. NOTE 3: For additional clasp(s) use code Y2510.	52.50	48.00
Y2510		Each additional Clasp—For Repair NOTE 1: List code of tooth being clasped. NOTE 2: Code Y2510 may be used in addition to repair procedure(s).	21.00	18.00

(h) Denture rebase procedures:

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

(i) Denture relining procedures:

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

(j) Other removable prosthetic services:

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

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowances increased at (i), (j) and (k) effective October 1, 1988, January 1, 1989 and April 1, 1989. See: 20 N.J.R. 2101(a).

Administrative Correction: In (k) 05212 effective April 1, 1989 corrected 140.00 to 165.00.

As amended by R.1989 d.135. See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).

(k1) 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).

10:56-3.8 05900-05999 MAXILLOFACIAL PROSTHETICS

(a) Treatment prostheses:

	05982	Surgical Stent	50.00	43.00
*	05999	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).

10:56-3.9 06000-06999 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 Au., Pd. and/or Pt. > 60% (with at least 40% Au)	Noble Alloy Au., Pd. and/or Pt. > 25%	Predominantly Base Alloy Au., Pd. and/or Pt. < 25%
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2. There is only one fee for each type of pontic or crown. Use the type of alloy most appropriate for the patient's needs.

(b) Bridge pontics:

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

(c) Bridge retainers—crowns:

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

*	06790	Crown—Full Cast High Noble Metal	161.00	140.00
*	06791	Crown—Full Cast Predominantly Base Metal	161.00	140.00
*	06792	Crown—Full Cast Noble Metal	161.00	140.00

(d) Other fixed prosthetic services:

	06930	Recement Bridge	8.00	7.00
		NOTE 1: One abutment. NOTE 2: Code may be used when recementing facing.		
	06930	22 Recement Bridge	14.00	12.00
		NOTE: Two or more abutments. Cast Post and Core in Addition to Bridge Retainer		
*	06970	NOTE: Post and core fabricated (cast) and cemented as a separate unit from crown. Not in conjunction with Procedure Codes 03950 and 03950-22	52.00	45.00
*	06972	Prefabricated Post and Core in Addition to Bridge Retainer	34.00	30.00
		Not in conjunction with Procedure Codes 03950 and 03950-22		
*	06980	Bridge Repair, By Report	BR	BR
*	06999	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).

10:56-3.10 07000-07999 ORAL SURGERY

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

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

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

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

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

(c) Other surgical procedures:

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

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

1. Reimbursement will be based upon quadrants.

07310	Alveoloplasty in Conjunction with Extraction—Per Quadrant NOTE 1: In conjunction with extractions of at least three teeth or the roots of at least three teeth in the same quadrant. NOTE 2: Specify quadrant.	43.50	37.50
07320	Alveoloplasty Not In Conjunction With Extraction—Per Quadrant	43.50	37.50

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

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

(f) Surgical excision of reactive inflammatory lesions (scar tissue or localized congenital lesions): NOTE: Biopsy report must be available upon request for review by the Division's dental consultants.

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

07410	Radical Excision—Lesion Diameter Up to 1.25 cm.	30.00	26.00
07420	Radical Excision—Lesion Diameter Over 1.25 cm. NOTE: Up to and including 3 cm.	42.00	37.00

07420	22 Radical Excision—Lesion Diameter Over 3 cm.	100.00	86.00
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(g) Removal of tumors, cysts, and neoplasms:

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

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

(h) Excision of bone tissue:

07470	Removal of Exostosis—Maxilla or Mandible	43.50	37.50
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Reimbursement will be based upon quadrants.

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

(i) Surgical incision:

07510	Incision and Drainage of Abscess—Intraoral Soft Tissue	18.00	16.00
07520	Incision and Drainage of Abscess—Extraoral Soft Tissue	42.00	37.00
07530	Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue	18.00	16.00
07540	Removal of Reaction—Producing Foreign Bodies, Musculoskeletal System	51.00	45.00
07550	Sequestrectomy for Osteomyelitis	48.00	42.00

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

07720	52	NOTE: Teeth immobilized if present. Maxilla—Closed Reduction NOTE: No manipulation or fixation.	30.00	26.00
07730		Mandible—Open Reduction NOTE: Teeth immobilized if present	242.00	210.00
07730	22	Mandible—Open Reduction NOTE: Complicated-multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.	303.00	263.00

(j) Treatment of fractures—simple:

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

07610		Maxilla—Open Reduction (Teeth Immobilized if Present)	182.00	158.00
07620		Maxilla—Closed Reduction (Teeth Immobilized if Present)	121.00	105.00
07620	52	Maxilla—Closed Reduction NOTE: No manipulation or fixation.	30.00	26.00
07630		Mandible—Open Reduction (Teeth Immobilized if Present)	242.00	210.00
07630	22	Mandible—Open Reduction (Teeth Immobilized if Present) NOTE: Complicated-multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.	303.00	263.00
07640		Mandible—Closed Reduction (Teeth Immobilized if Present)	121.00	105.00
07640	52	Mandible—Closed Reduction NOTE: No manipulation or fixation.	30.00	26.00
07650		Malar and/or Zygomatic Arch—Open Reduction	121.00	105.00
07660		Malar and/or Zygomatic Arch—Closed Reduction NOTE: Including towel clip technique.	42.00	37.00
07660	52	Malar and/or Zygomatic Arch—Closed Reduction NOTE: No manipulation or fixation.	30.00	26.00
07670	YU	Alveolus—Stabilization of Teeth, Open Reduction Splinting NOTE 1: Maxillary alveolar fracture. NOTE 2: Reduction with wiring, and application of arch bar or splint.	92.00	80.00
07670	YL	Alveolus—Stabilization of Teeth, Open Reduction Splinting NOTE 1: Mandibular alveolar fracture. NOTE 2: Reduction with wiring, and application of arch bar or splint.	92.00	80.00
07680		Facial Bones—Complicated Reduction with Fixation and Multiple Surgical Approaches NOTE 1: Maxilla, malar and/or zygomatic arch. NOTE 2: Multiple surgical approaches (three or more), fixation, traction, headframe, multiple internal and/or external fixation, and head cap.	242.00	210.00

07740		Mandible—Closed Reduction NOTE: Teeth immobilized if present.	121.00	105.00
07740	52	Mandible—Closed Reduction NOTE: No manipulation or fixation.	30.00	26.00
07750		Malar and/or Zygomatic Arch—Open Reduction	121.00	105.00
07760		Malar and/or Zygomatic Arch—Closed Reduction NOTE: Including towel clip technique.	42.00	37.00
07760	52	Malar and/or Zygomatic Arch—Closed Reduction NOTE: No manipulation or fixation.	30.00	26.00
07770	YU	Alveolus—Stabilization of Teeth, Open Reduction Splinting NOTE 1: Maxillary alveolar fracture. NOTE 2: Reduction with wiring, and application of arch bar or splint.	92.00	80.00
07770	YL	Alveolus—Stabilization of Teeth, Open Reduction Splinting NOTE 1: Mandibular alveolar fracture. NOTE 2: Reduction with wiring, and application of arch bar or splint.	92.00	80.00
07780		Facial Bones—Complicated Reduction with Fixation and Multiple Surgical Approaches NOTE 1: Maxilla, malar and/or zygomatic arch. NOTE 2: Multiple surgical approaches (three or more), fixation, traction, headframe, multiple internal and/or external fixation, and head cap.	242.00	210.00

(l) Reduction of dislocation and management of other temporo-mandibular joint dysfunctions:

07810		Open Reduction of Dislocation	182.00	158.00
07820		Closed Reduction of Dislocation	18.00	16.00
d 07830		Manipulation under Anesthesia NOTE: Anesthesia additional.	18.00	16.00
07840		Condylectomy	362.00	315.00
07850		Meniscectomy	362.00	315.00
07860		Arthrotomy	362.00	315.00
d 07870		Arthrocentesis NOTE: Injection or aspiration (Give complete details).	18.00	16.00

(m) Repair of traumatic wounds:

1. Describe completely, giving size, site, and all pertinent information.

2. Fee includes suture removal.

(k) Treatment of fractures—compound:

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

07710		Maxilla—Open Reduction NOTE: Teeth immobilized if present.	182.00	158.00
07720		Maxilla—Closed Reduction	121.00	105.00

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

07910	22	NOTE: 2.5 cm. up to 5 cm. Suture of Recent Small Wounds NOTE: Over 5 cm. up to 7.5 cm.	30.00	26.00
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3. Laceration over 7.5 cm. use code 07999.

(n) Complicated suturing (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure):

1. Also for irregularly shaped lacerations requiring extensive debridement.

**	07911	Suture—Up to 5 cm.	BR	BR
**	07912	Suture—Over 5 cm.	BR	BR

(o) Other Repair Procedures:

*	07940	Osteoplasty—For Orthognathic Deformities	BR	BR
*	07955	Repair of Maxillofacial Soft and Hard Tissue Defects	BR	BR
	07960	Frenulectomy (Frenectomy or Frenotomy)—Separate Procedure	32.00	28.00
	07980	Sialolithotomy	48.00	42.00
	07981	Excision of Salivary Gland	182.00	158.00
	07982	Sialodochoplasty	151.00	131.00
	07983	Closure of Salivary Fistula 1	151.00	131.00
	07990	Emergency Tracheotomy	121.00	105.00
d**	07999	Unspecified Oral Surgery Procedure, By Report	BR	BR

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

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowance increased for (c) single tooth and (d) surgical removal of erupted tooth effective August 1, 1988.

See: 20 N.J.R. 2101(a).
Amended by R.1989 d.135, effective March 20, 1989.
See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).
Qualifier added to 07130, in (c); prior authorization requirement removed from 07210, in (d).
Administrative Corrections to (c), (l)1 and (q).
See: 22 N.J.R. 1375(a).
Amended by R.1990 d.456, effective September 4, 1990.
See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
In (d): revised (d)1 to specify conditions for extraction, by incorporating text from old (d)2. Recodified (d)3 as (d)2 and added new (d)3. Deleted asterisks in List. In (f)1: added new "07310".
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

10:56-3.11 08000-08999 ORTHODONTICS

(a) Minor treatment for tooth guidance:

1. Includes all necessary adjustments.

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

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	08110		Removable Appliance Therapy	115.00		100.00
	08120		Fixed Appliance Therapy	115.00		100.00

(b) Minor treatment to control harmful habits:

1. Includes all necessary adjustments.

08210	Removable Appliance Therapy	115.00	100.00
08220	Fixed Appliance Therapy	115.00	100.00

(c) Comprehensive orthodontic treatment—Permanent Dentition:

1. Treatment of permanent dentition. Indicate anticipated time under treatment—maximum treatment reimbursable including retention—three years. Reimbursement for comprehensive orthodontic treatment will include retention as required at no additional charge.

Y2910	Appliances	178.00	155.00
Y2920	1st Through 12th Month of Treatment (To Start On Day Insertion of Appliances Is Completed), Per Month	40.00	35.00
Y2930	13th Through 24th Month of Treatment, Per Month	40.00	35.00
Y2940	25th Through 30th Month of Treatment Per Month	14.00	12.00
Y2950	31st Through 36th Month (Maximum Reimbursable Period of Treatment), Per Month	14.00	12.00

(d) Other orthodontic services:

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

Y2965	Orthodontic Examination (Comprehensive) and (Complete Orthodontic) Treatment Plan	6.00	5.00
Y2975	Orthodontic Assessment Examination, using the Handicapping Malocclusion Assessment System	6.00	5.00
* 08999	Unspecified Orthodontic Procedure, By Report	BR	BR

NOTE: Complete description, diagnosis and treatment plan must be submitted.

Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowance increased at (c), effective August 1, 1988.
See: 20 N.J.R. 2101(a).
Amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).

10:56-3.12 09000-09999 ADJUNCTIVE GENERAL SERVICES

(a) Unclassified treatment:

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

NOTE: Emergency treatment of dental pain or infection, palliative (flat fee for all services performed, when not covered by separately listed procedure). Diagnosis and description of treatment is required. Per tooth or per site.

(b) Anesthesia:

09210		Local Anesthesia Not in Conjunction with Operative or Surgical Procedures	13.00	11.00
		NOTE 1: Infiltration and/or nerve block for diagnostic purposes or purposes other than anesthesia.		
		NOTE 2: Complete report must be available in patient records.		
09220		General Anesthesia	25.00	25.00
		NOTE: This code applies when the dentist performing the services (attending dentist) also administers the general anesthesia or in conjunction with oral surgery services only.		

09430

NOTE 2: Consisting of care and treatment by the Practitioner subsequent to the date of "Hospital Day—Initial" and including those procedures ordinarily performed during a hospital visit dependent upon the practitioner's discipline.
 NOTE 3: Not reimbursable for those services that include follow-up days.
 Office Visit for Observation (During Regularly Scheduled Hours)—No Other Services Performed 9.00 7.00
 NOTE: Code may also be used when post-operative services are necessary following a major surgical procedure (e.g., bony impactions, fractures, etc.)

(c) Special general anesthesia:

1. Basic units—(See American College of Anesthesiologists Relative Value Guide—1967).

09220	22	Maximum 4 units	22.00	22.00
09220	52	Time units: Each additional 15 minute period or major portion thereof. (Limited to "table" or "chair" time only). Maximum reimbursable two hours.	5.50	5.50
		NOTE 1: The general anesthesia codes above are limited to use in restorative dentistry alone or restorative dentistry in conjunction with other dental services requiring anesthetic management. These codes are reimbursable only to the dentist whose sole function is to administer general anesthesia.		
		NOTE 2: An anesthesia record must be available which shows elapsed anesthesia time, and pin-points time and amounts of drugs administered, pulse rate and character, blood pressure, respiration, and so forth.		
09230		Analgesia	10.00	9.00
09240		Intravenous Sedation	10.00	9.00
		NOTE: Parenteral Conscious Sedation		

(f) Drugs:

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

(g) Miscellaneous services:

09910		Application of Desensitizing Medicaments	6.00	5.00
		NOTE 1: Application to a tooth, i.e., cervical sensitivity, erosions etc.		
# 09920		Behavior Management	15.00	13.00
		NOTE 1: Code to be used for those beneficiaries with developmental and other disabilities whose disorders necessitate an excessive amount of time to accomplish treatment (e.g., mental retardation, neurological disorders, etc.) For any use of this code, the dentist shall specify the beneficiary's disability which necessitates the use of this code on the MC-10A, Request for Prior Authorization, under Section 20, Remarks.		
		NOTE 2: Payment will be based on 15-minute time units or a major portion thereof. Maximum reimbursement is eight time units on a single date of service.		
		NOTE 3: The type of disorder and the number of time units requested must be entered on the Dental Services Claim form (MC-10).		
		NOTE 4: Prior authorization is required for all occurrences of this code.		
		NOTE 5: Code to be used in addition to other procedures performed.		
09930		Treatment of Complications (Post Surgical)—Unusual Circumstances, By Report	6.00	5.00
		NOTE: This code may also be used for post-operative treatment beyond that normally provided as part of the basic procedure or when provided by practitioner other than one who provided the original service or in excess of "follow-up days". (California Relative Value Study—1964), per visit.		

(d) Professional consultation (diagnostic service provided by a dentist other than practitioner providing treatment):

1. A complete report must be available.

d 09310		Consultation—Per Session	22.00	17.00
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(e) Professional visits:

09410		House Call	10.50	9.00
Y3005		Long Term Care Facility Visits	10.50	9.00
09420	52	Hospital Call	9.00	7.00
		NOTE: Code 09420 52 will not be reimbursable in conjunction with Code 09310 or Codes 09420 22 or 09420.		
09420	22	Hospital Call	22.00	17.00
		NOTE: Code to be used for Hospital Day—Initial—Inpatient or Same Day Surgery.		
09420		Hospital Call	9.00	7.00
		NOTE 1: Code to be used for Hospital Day—Subsequent.		

09940		Occlusal Guards NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards). NOTE 2: Office procedure.	35.00	30.00
09940	22	Occlusal Guards NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards). NOTE 2: Laboratory procedure.	50.00	43.00
09951		Occlusal Adjustment—Limited NOTE: 1 to 3 Teeth.	6.00	5.00
09951	22	Occlusal Adjustment NOTE: Per quadrant (minimum six teeth).	17.00	15.00
d** 09999		Unspecified Adjunctive Procedure, By Report NOTE: To be used only where no code number exists or existing code is not precisely applicable. Complete description of condition and proposed treatment must be submitted to the Medicaid dental consultants.	BR	BR

As amended, R.1981 d.331, effective September 10, 1981.
See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).

Delete text of (e)22 and substitute new text therefor.
As amended, R.1983 d.584, effective January 1, 1984.
See: 15 N.J.R. 1160(a), 15 N.J.R. 2170(a).

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

Substantially amended.
Public notice: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowance increased at (b) Adjunctive general services effective August 1, 1988.

See: 20 N.J.R. 2101(a).
Administrative Correction to (c).
See: 20 N.J.R. 1375(a).

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

See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Amended by R.1998 d.353, effective July 20, 1998.
See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).
In (g), rewrote NOTE 1 and NOTE 4.

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the fiscal agent billing supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

UNISYS
PO Box 4801
Trenton, New Jersey 08650

or contact:

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

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