

CHAPTER 56

MANUAL FOR DENTAL SERVICES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

Subchapter 3, Procedure Codes and Descriptions, was readopted effective March 24, 1986 pursuant to Executive Order No. 66(1978) as R.1986 d.128. See: 18 N.J.R. 154(a), 18 N.J.R. 847(b). Pursuant to Executive Order No. 66(1978), Chapter 56 was readopted as R.1986 d.385, effective August 26, 1986. See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).

Subchapter 3, Procedure Codes and Descriptions, was repealed and replaced with a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), as R.1987 d.166 effective April 6, 1987.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

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

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

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of R.1996 d.428, Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was repealed and a new Subchapter 2, Provisions for Services, was adopted.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

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SUBCHAPTER 1. DENTAL SERVICES; GENERAL PROVISIONS

10:56-1.1 Purpose and scope

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

New Rule, R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former N.J.A.C. 10:56-1.1, "Definitions", recodified to 10:56-1.2.

10:56-1.2 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

“Program” means the New Jersey Medicaid program.

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

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

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

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

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

Amended by R.1984 d.270, effective July 2, 1984.

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

Section substantially amended.

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

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

Specialist amended.

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

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

Added definition of “bundled drug service.”

Recodified from 10:56-1.1 and amended by R.1996 d.428, effective September 16, 1996.

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

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

10:56-1.3 Provisions for provider participation

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

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

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

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

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

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

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

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

10:56-1.4 Prior authorization

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

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

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

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

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

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

i. A single asterisk (*); or

ii. A double asterisk (**); and/or

iii. A crosshatch (#).

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

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

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

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

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

2. Emergency treatment with required radiography;

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

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

i. Oral prophylaxis;

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

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

iv. Impactions, fractures, and most surgical procedures;

v. Pulpotomy for permanent and primary teeth;

vi. All extractions of non-restorable teeth;

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

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

(c) Supplemental or amended prior authorization requirements include:

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

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

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

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

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

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

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

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

Section substantially amended.

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

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

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

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

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

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

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

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

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

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 beneficiary eligibility.

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

i. Prostheses (to include, for example, dentures, crowns, space maintainers, and appliances, but not comprehensive orthodontic appliances or services) actually in process of fabrication;

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

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

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

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

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

3. For immediate dentures, similar to provisions for dentures inserted subsequent to the healing period, prior authorization must have been obtained during the 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.

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

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

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

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;

- (4) Missing teeth; and
- (5) Abnormalities;

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

v. Treatment plan with description of treatment rendered to include:

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

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

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

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

i. If a current examination is required within six months of a previous examination performed by the same provider and billed to Medicaid, the results of the

original examination shall be entered into the clinical record as the current dental status.

2. A time frame, established on an individual basis, for the next periodic examination of the recipient. The time frame shall be documented either at the time of examination, or at the completion of treatment. For example, it may be entered on the clinical record for six months, one year, two years, three years, or any other time period that the attending dentist has established per his knowledge of the recipient and the recipient's dental status.

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

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

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

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

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

(b) and (c) added.

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

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

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

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

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

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

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

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

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.

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

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

(b) Utilization refers to that service, procedure or item provided to a recipient by a qualified provider, in a setting, at a time, and in an amount which is appropriate and acceptable to the standards of the profession, at a cost described at N.J.A.C. 10:56-3.

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

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

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

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

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

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

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

SUBCHAPTER 2. PROVISIONS FOR SERVICES

10:56-2.1 Dental treatment plan

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

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

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

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

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

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

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

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

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

10:56-2.2 Standards of service

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

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

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

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

Recodified from 10:56-1.5 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former section, "Timeliness of claim submission and claim inquiry", repealed.

10:56-2.3 Special dental services

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

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

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

Substantially amended.

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

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

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

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

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

Updated the address.

10:56-2.4 Place of service

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

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

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 the 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 the facility regardless of the number of patients examined or treated.
3. For a provider to be reimbursed for an initial hospital call or same day surgery, the hospital record must include, at a minimum:
 - i. The chief complaint(s);
 - ii. A complete history of the present illness and related systematic review including recording of pertinent negative findings;
 - iii. A complete pertinent past medical history;
 - iv. Pertinent family history;
 - v. A description of a full examination pertaining to the history of the present condition including the recording of pertinent negative findings, and;
 - vi. A record of a working diagnosis and treatment plan, and preparation of an "order sheet."
4. If a history and examination required for reimbursement for procedure code 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).
 Amended by R.2000 d.426, effective October 16, 2000.
 See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(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.

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

(d) The originals of all radiographic films shall be available to authorized representatives of the New Jersey Medicaid program or other agencies of the State of New Jersey as approved by the New Jersey Medicaid program. Radiographs shall be forwarded to the Division of Medical Assistance and Health Services in the following situations:

1. When prior authorization is requested; or

2. Upon request by the Medicaid program for utilization review or adjudication purposes.

(e) All radiographic films shall be suitable for interpretation and when submitted to the New Jersey Medicaid program or its agents shall be properly mounted, marked "Right" and "Left" and identified with the recipient's name, the date, and the name of the dentist. Films that are technically unacceptable for proper interpretation will be returned to the provider for replacement at no additional cost to the Medicaid program. No reimbursement shall be made for the new set of radiographs that the dentist is required to provide. When already reimbursed, recoupment will be made, unless a replacement set of radiographs is sent to the Division for review.

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

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

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

ii. Age seven up to and including age 14: 12 films (10 periapical films, plus two bitewing films);

iii. For those recipients 15 years of age or older: 16 radiographs (at least 14 periapical plus two posterior bitewing films).

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

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

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

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

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

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

vii. If the provider requires additional films, he or she shall first secure prior authorization by a Medicaid dental consultant.

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

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

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

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

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

10:56-2.8 Diagnostic services: Clinical laboratory services

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

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

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

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

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

As amended, R.1982 d.403, effective November 15, 1982. (Operative date: February 1, 1983.)

See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).

Section substantially amended.

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

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

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

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

Section renumbered and (b)4 new.

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

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

10:56-2.9 Preventive dental care

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

1. Prophylaxis, as follows:

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

ii. For reimbursement purposes, dental prophylaxis shall be limited to once every six months for those recipients through age 17 and once every 12 months for those recipients 18 years of age or older, except as otherwise prior authorized by a dental consultant of the Medicaid Program, and except as provided in (a)1ii(1) below.

(1) Recipients with developmental disabilities, neurological impairments, or other disabilities, regardless of age, shall be eligible for examination, radiographs as appropriate, prophylaxis, extra-scaling and topical application of fluoride including prophylaxis, as often as every three months. Claims may be submitted directly to the fiscal agent for payment, without prior authorization. The nature of the recipient's disability must be recorded under Remarks (Item 20) on the Dental Services Claim Form. Special procedure codes with the modifier "76" must be submitted, for reimbursement, for example, 00110 76 (examination), 01110 76 (prophylaxis—adult), 01120 76 (prophylaxis—child), Y2105 76 (additional scaling) and 01201 76 and 01202 76 (fluoride including prophylaxis). See N.J.A.C. 10:56-3.2(a) and 3.3(a). In the event any of these services is required more often than every three months, prior authorization by the Medicaid dental consultant is required.

2. Fluoride treatment, as follows:

i. Topical fluoride treatment should be administered in accordance with appropriate standards. This consists of topical application of stannous fluoride or acid fluoride phosphate as a liquid or gel.

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

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

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

v. Oral fluoride medication may be prescribed (see: N.J.A.C. 10:56-2.17).

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

3. To encourage the maintenance of dental health, the same type of recall procedure as used in dental practice in the community shall be extended to eligible Medicaid recipients.

4. Recipient education for Medicaid recipients should consist of dental health orientation identical to that given all patients.

5. Sealants shall be a covered service of the Medicaid program subject to the following limitations:

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

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

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

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

As amended, R.1982 d.403, eff. November 16, 1982. (Operative date: February 1, 1983.)

See: 13 N.J.R. 875(a), 14 N.J.R. 1301(a).

Section substantially amended.

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

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

Old (a)1i deleted and new text substituted.

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

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

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 includes adjustments for three months. Prior authorization shall be required when the repair exceeds \$165.00 for a specialist or \$150.00 for a non-specialist.

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

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

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

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

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 work-up:

- i. The assessment system is a modification of the work of Dr. J. A. Salzmann who has consented to allow the New Jersey Medicaid program to modify and utilize it.
- ii. The difference from Dr. Salzmann's original work is that the New Jersey Medicaid program does not allow the eight additional points to denote aesthetic handicap for the anterior segment.
- iii. Referrals for orthodontics and initiation of orthodontic treatment should be delayed until the 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 08650-4811

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

1. The practitioner, considering the factors in this section, shall perform a visual/oral examination of the 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 08650-4811

identifying, by procedure code Y2975, the service that has been rendered. A copy of the Handicapping Malocclusion Assessment Record Form (FD-10) shall ac-

company this submission (Limitation—see N.J.A.C. 10:56-2.6).

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

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

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

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

i. The Dental Services 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 Services. It is suggested that models, radiographs, and photographs be duplicated before submission to enable the practitioner to retain a set in the office should there be breakage or loss in mailing.

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

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

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

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

(g) If the 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 Salzman 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.

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

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

10:56-2.16 Pedodontia: pediatric dentistry

(a) In recognition of the unique needs of providing dental care for children, and in conformance with the Federally mandated Early and 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 \$25.00 for a specialist and \$21.00 for a non-specialist. Reimbursement for a comprehensive clinical oral examination of a child, through age 20 years, is limited to once every six months, except as authorized by a Dental Consultant of the New Jersey Medicaid program. As a minimum, the examination must include:

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

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

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

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

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

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

10:56-2.17 Adjunctive general services: anesthesia

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

1. The administration of local anesthesia is considered part of the operative or surgical procedure and no additional fee will be paid.
2. In any setting exclusive of a hospital, when general anesthesia is provided by the dentist, such may be reimbursed subject to the following:
 - i. Necessity for same is demonstrated.
 - ii. Reimbursement can only be made to a dentist who satisfies all the established rules and regulations and has such written certification (permit) as may be required by the State of New Jersey or the state in which the service is being rendered.

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

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

iii. When the dentist performing the dental service (attending dentist) also administers the general anesthesia, then procedure code 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 the sole purpose of an injection shall be reimbursable for the injection only. If other dental procedures are performed that are reimbursable, an injection may, if medically indicated, be reimbursed in addition to the other procedures. The drug administered shall be consistent with the diagnosis and shall conform to accepted medical and pharmacological principles in respect to dosage, frequency, and route of administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

See: 6 N.J.R. 141(b), 6 N.J.R. 246(a).
 As amended, R.1975 d.262, eff. September 1, 1975.
 See: 7 N.J.R. 318(a), 7 N.J.R. 466(a).
 As amended, R.1975 d.339, eff. November 10, 1975.
 See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
 As amended, R.1976 d.215, eff. July 12, 1976.
 See: 8 N.J.R. 283(b), 8 N.J.R. 385(b).
 As amended, R.1977 d.302, eff. October 1, 1977.
 See: 9 N.J.R. 333(a), 9 N.J.R. 435(a).
 Amended by R.1986 d.385, effective September 22, 1986.
 See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
 (a) substantially amended.
 Recodified from 10:56-1.22 and amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2000 d.426, effective October 16, 2000.
 See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
 Amended by R.2001 d.10, effective January 2, 2001.
 See: 32 N.J.R. 3377(a), 33 N.J.R. 65(a).
 In (a), added 2ii(1).

10:56-2.18 Adjunctive general services: prescriptions

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

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

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

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

(b) The practitioner's individual Medicaid Provider Service Number shall appear on all prescriptions, and shall be given to the pharmacist with all telephone orders. The

appearance of this number in addition to the practitioner's name serves to expedite the mechanical aspects of processing the prescription claim. This requirement is a necessary and efficient step in computing each claim.

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

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

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

1. The practitioner should give preference to:

- i. Drugs listed in the latest edition of the United States Pharmacopoeia (U.S.P.), National Formulary (N.F.), A.M.A. Drug Evaluation, and Accepted Dental Therapeutics;
- ii. Oral medication, when as effective as injectable preparations.

(f) The quantity of medication prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 34-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 beneficiary for up to 34 days or provide 100 dosage units, whichever is greater.

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

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

4. For claims with service dates on or after July 1, 1999, the quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or, if required, an amount sufficient to provide medication during intervals between

prescriber visits. The amount of medication dispensed shall not exceed a 34-day supply for initial prescriptions and a 34-day supply or 100 unit doses, whichever is greater, for refill prescriptions.

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

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

2. Experimental drugs;

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

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

5. Medications prescribed for use by hospital inpatients.

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

7. Prescriptions written and dispensed with nonspecific directions.

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

9. Prescribed non-legend drugs unless listed below:

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

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

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

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

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

(i) Prescription refill requirements are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) substantially amended.

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

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

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

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

Amended by R.2001 d.124, effective April 16, 2001.

See: 32 N.J.R. 4392(a), 33 N.J.R. 1201(a).

In (a), added 2ii; in (e), substituted "(g)" for "(h)8"; in (f), substituted references to 34 days for references to 60 days and added 3 and 4; substituted references to beneficiaries for references to recipients throughout.

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:

Column Title
2. IND

(Indicator) Lists symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used. Explanation of indicators used in this column is given below:

- 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
4. MOD

Lists the HCPCS procedure code numbers. (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
6. Maximum Fee Allowance

Lists the code narrative. 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 modifiers, must be used in conjunction with the narratives in this subchapter.

2. The use of a procedure code will be interpreted by the New Jersey Medicaid 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
Denture Adjustments	
Complete Dentures	05410-05411
Partial Dentures	05421-05422
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	Onlay	02540
Drug Injection, Therapeutic	09610	Oral Surgery Services	
Emergency Procedures (Palliative)	09110	Alveoloplasty	07320
Endodontic Services		Antro-Oral Fistula Closure	07260
Apexification	03350	Arthrocentesis	07870
Apicoectomy	03410-03411	Arthrotomy	07860
With Root Canal	03410 22-03411 22	Biopsy Hard Tissue	07285
Bleaching, Discolored Tooth	03960	Soft Tissue	07286
Canal Preparation and fitting of preformed		Condylectomy	07840
dowel or post	03950-03950 22	Cysts, Tumors and Neoplasms, Removal	07430-07461 22
Curettage, Apical	03440	Destruction of Lesions, by physical methods	07465
Emergency (palliative)	03220	Dislocation—Reduction	07810-07830
Hemisection	03920	Excision, Surgical	07410-07420 22
Pulpectomy	Y2310	Exostosis, Removal	07470
Pulpotomy, Therapeutic	03220	Exposure, Surgical, of Tooth	07280-07281
Retrograde Filling	03430	Extractions Uncomplicated Root Removal	07130-07130 52
Root Amputation	03450	Tooth, Single	07110
Root Canal Therapy	03310-03330	Surgical Roots, Residual (Completely covered	
Unspecified Endodontic Procedure	03999	by bone)	07250
Examination		Tooth, Single	07210
Emergency Oral	00130	Impactions:	
Histopathologic	00501	Complete Bony	07240
Initial Oral	00110	Partial Bony	07230
Initial Oral—Handicapped	00110 76	Soft Tissue	07220
Orthodontic Assessment	Y2975	Foreign Body, Removal	07530-07540
Comprehensive	Y2965	Fracture:	
Excisions, Surgical	07410-07420 22	Compound	07710-07780
Exostosis, Removal	07470	Simple	07610-07680
Exposure, Surgical, of Tooth	07280-07281	Frenulectomy	07960
Extractions		Incision and Drainage:	
Uncomplicated Root Removal	07130-07130 52	Extraoral	07520
Tooth, Single	07110	Intraoral	07510
Surgical Roots, Residual	07250	Manipulation of TMJ, Under Anesthesia	07830
(Completely covered by bone)		Maxillofacial Tissue Defect, Repair	07955
Tooth, Single	07210	Meniscectomy	07850
Impactions:		Operculectomy	07410
Complete Bony	07240	Antro-oral Fistula Closure	07260
Partial Bony	07230	Osteotomy, Partial	07480
Soft Tissue	07220	Osteomyelitis, Sequestrectomy	07550-07550 22
Extraoral Radiographs	00250-00260	Osteoplasty, Orthognathic Deformities	07940
Fluoride—Topical	01201-01202 52	Re-implantation, Tooth	07270-07270 22
Fluoride—Topical—Handicapped	01201 76-01202 76	Resection, Radical of Mandible	07490
Foreign Body, Removal	07530-07540	Salivary Gland Excision	07981
Fractures		Fistula Closure	07983
Compound	07710-07780	Sialodochoplasty	07982
Simple	07610-07680	Sialolithotomy	07980
Frenulectomy	07960	Sinusotomy	07560
Gingivectomy	04210-04211	Stabilization, Tooth	07270-07270 22
Gingivoplasty	04210-04210	Stent, Surgical	05982
Gold Foil	02410-02430	Stomatoplasty	07340-07350
Grafts		Suturing	07910 52-07912
Free Soft Tissue	04271	Torus Palatinus, Removal	07470 22
Osseous, Multiple Site	04262	Tracheotomy	07990
Osseous, Single Site	04261	Tumors Benign, Excision	07430-07431 22
Pedicle Soft Tissue	04270	Malignant, Excision	07440-07441 22
Habit Appliances, Orthodontic	08210-08220	Unspecified Oral Surgery Procedure	07999
Hemisection	03920	Vestibuloplasty	07340-07350
Histopathologic Examination	00501	Orthodontic Services	
Hospital Visits	09420 52-09420	Appliances, Orthodontic Comprehensive	Y2910-Y2950
Incision and Drainage		Harmful Habit	08210-08220
Extraoral	07520	Retention	08110-08120
Intraoral	07510	Tooth Guidance	08110-08120
Injection		Comprehensive Treatment Adjustments	Y2920-Y2950
Therapeutic Drug	09610	Appliances	Y2910
TMJ	09610 22	Examination Assessment System	
Inlay, Gold	02510-02530	(Using Handicapping Malocclusion)	Y2975
Intraoral Radiographs	00210 52-00210	Comprehensive	Y2965
	00220-00230	Unspecified Orthodontic Treatment	08999
Maxillofacial Tissue Defect, Repair	07954	Osseous Surgery, Periodontal	04260
Medications	09630	Osteotomy, Partial	07480
Meniscectomy	07850	Osteomyelitis, Sequestrectomy	07550-07550 22
Occlusal Adjustment	09951	Osteoplasty, Orthognathic Deformities	07940
Occlusal Guards, Periodontal	09940-09940 22	Palliative Treatment, Emergency	09110
Occlusal Radiograph	00240	Panoramic Radiograph	00330

Periodontal Appliances-Special	09940-09940 22	Panoramic	00330
Periodontal Services		Sialography	00310
Apically Repositioning Flap Procedure	04272	Including Contrast Material	00310 22
Curettage, Gingival	04220	Rebasing	
Gingivectomy	04210-04211	Complete Dentures	05710-05711
Gingivoplasty	04210-04211	Partial Dentures	05720-05721
Grafts Free Soft Tissue	04271	Recement	
Osseous, Single Site	04261	Bridge, Fixed	06930-06930 22
Osseous, Multiple Sites	04262	Crown	02920
Pedicle Soft Tissue	04270	Inlay	02910
Occlusal Adjustment	09951-09952	Space Maintainer	01550
Occlusal Guards	09940-09940 22	Relining	
Osseous Surgery	04260	Complete Dentures	05730-05731,
Periodontal Appliance-Special	09940-09940 22	05750-05751	
Scaling and Root Planing	04341	Partial Dentures	05740-05741,
Splinting, Provisional	04320-04321	05760-05761	
Unspecified Periodontal Services	04999	Repairs	
Photographs, Diagnostic	00471	Fixed Bridge	06980
Pin Retention	02951	Removable Prosthetics	05510 YU-Y2510
Plastic Crowns		Resection, Radical, of Mandible	07490
Laboratory Processed	02710	Restorative Services	
Prefabricated	02932	Amalgam	
Post and Core		Permanent Teeth	02140-02161
Bridge Retainer: Cast	06970	Primary Teeth	02110-02131
Prefabricated	06972	Composite Resin	02330-02335
Single Unit Cast	02952	02385-02387	
Prefabricated	02954	Gold Foil	02410-02430
Prefabricated Resin crown (Polycarbonate)	02932	Inlay, Gold	02510-02530
Preventive Services		Onlay, Gold	02540
Fluoride Topical	01201-01202 52	Pin Retention	02951
Prophylaxis	01110-01120	Unspecified Restorative Procedure	02999
Sealants	01351	Retrograde Filling	013430
Prophylaxis	01110-01120	Root Canal Therapy	03310-03330
Prophylaxis-Handicapped Recipient	01110 76-01120 76	Root Planing and Scaling	04340-04341
Prosthodontics		Root Amputation	03450
Fixed		Salivary Gland	
Abutments (Bridge Retainers)	06720-06792	Excisions	07981
Crowns, Individual	02710-02792, 02932	Fistula Closure	07983
Pontics	06210-06252	Scaling (Additional to Propthy) Handicapped	Y2105 76
Post and Core		Scaling and Root Planing	04340-04341
Bridge Retainer (Abutment) Cast	06970	Sealants	01351
Prefabricated	06972	Sedation, Intravenous	09240
Single Unit Cast	02952	Sequestrectomy for Osteomyelitis	07550-07550 22
Prefabricated	02954	Sialodochoplasty	07982
Recementation Crowns, Individual	02920	Sialography	00310
Bridges	06930-06930 22	Including Contrast Material	00310 22
Repairs	06980	Sialolithotomy	07980
Unspecified	06999	Sinusotomy	07560
Removable Adjustments		Slides, Diagnostic Photographs	00471
Complete Denture	05410-05411	Space Maintainers	01510-01525
Partial Denture	05421-05422	Splinting, Provisional	04320-04321
Complete	05110-05120	Stabilization, Tooth	04320-04321
Complete Immediate	05130-05140 22	Stainless Steel Crown (Prefabricated)	02930-02931
Partial Removable	05211-05214	Stent, Surgical	05982
Partial, Immediate Tooth Replacement	Y2505	Stomatoplasty	07340-07350
Rebasing Complete Denture	05710-05711	Study Models—See Diagnostic Casts	
Partial Denture	05720-05721	Suturing	07910 52-07912
Relining Complete Denture	05730-05731,	Temporary Crown (Fractured Tooth)	02970
05750-05751		Temporo-Mandibular Joint	
Partial Denture	05740-05741,	Injection of muscles of mastication	09610 22
05760-05761		Manipulation under anesthesia	07830
Repairs	05510 YU-Y2510	Tooth Guidance Appliances	08110-08120
Stent, Surgical	05982	Tooth Processed to Arch Bar (Wire)	Y2115
Unspecified Removable Prosthodontic Proce- dure	05899	Torus Palatinus, Removal	07470 22
Pulpectomy	Y2310	Tracheotomy	07990
Pulpotomy, Therapeutic	03220	Tumors	
Radiographic Services		Benign, Excision	07430-07431 22
Cephalometric Film	00340	Malignant, Excision	07440-07441 22
Including tracing	00340 22	Unspecified Procedures	
Radiographics Complete Series	00210 52-00210 22	Adjunctive Procedure	09999
Extraoral	00250-00260	Bridge Repair, Fixed	06980
Intraoral	00220-00230	Diagnostic Procedure	00999
Occlusal	00240	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)1iv.
 See: 22 N.J.R. 1375(a).
 Amended by R.1990 d.456, effective September 4, 1990.
 See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
 In (d): added new (d)1iv.
 Amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2000 d.426, effective October 16, 2000.
 See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
 In (g), deleted references to Denture Identification, Identification and Scaling (Additional to Proply).

10:56-3.2 00100-00999 DIAGNOSTIC

(a) Clinical Oral Examination:

HCPCS Ind Codes	Mod	Procedure Description	Maximum Fec Allowance		
			S	\$	NS
00110		Initial Oral Examination	14.00		13.00

NOTE 1: This is the code to be used for a Comprehensive Clinical Oral Examination of Medicaid/NJ KidCare fee-for-service beneficiaries.

NOTE 2: All conditions present in the oral cavity and contiguous structures to include oral cancer screening:

- a. Charting of all abnormalities;
- b. Development of a complete treatment plan to be recorded in its entirety on the Dental Services Claim form (MC-10).

NOTE 3: for reimbursement of the examination:

- a. All items on the Dental Services Claim form (MC-10) must be completed;
- b. If No Other Treatment is Necessary, this fact must be noted on the Dental Services Claim form (MC-10) in the diagnosis box. The abbreviation "NOTN" may be used.

00110	76	Initial Oral Examination	14.00	13.00
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NOTE 1: This code is to be used only if a recipient is developmentally disabled or neurologically impaired, in which case an examination may be provided as often as every three months and may be submitted directly to the fiscal agent for payment without prior authorization. The nature of the recipient's disability must be recorded under "Remarks" on the Dental Services Claim form (MC-10).

NOTE 2: In the event an examination is required more often than every three months, prior authorization by a Medicaid dental consultant is required.

00110	WT	Comprehensive oral examination —child	25.00	21.00
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NOTE 1: This code is to be used for comprehensive clinical oral examination of a beneficiary through and including the age of 20.

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

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

NOTE 3: For reimbursement of the comprehensive oral examination with code 00110-WT:

- a. The examination is limited to once every six months except as authorized by a dental consultant of the New Jersey Medicaid Program;
- b. All items on the Dental Services Claim form (MC-10(A)) should be completed;
- c. If no other treatment is necessary, this fact must be noted on the Dental Services Claim form (MC-10(A)) in the diagnosis box (20). The abbreviation "NOTN" may be used to indicate no other treatment needed.

00120		Periodic Oral Examination	14.00	13.00
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NOTE: An examination performed on a patient of record to determine any changes in the patient's oral health status since a previous initial or periodic examination.

d	00130	Emergency Oral Examination	4.00	3.00
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NOTE: Make NOTE of diagnosis and/or observation(s) on the Dental Services Claim form (MC-10).

- (b) Radiographs:

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

i. Indicate number of films in items 13, 17D, and 17H of the Dental Services Claim form (MC-10);

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

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	00210	52	Intraoral—Complete Series (including bitewings)	18.00		18.00

NOTE 1: Limited to patients up to and including age 6.

NOTE 2: 8 films.

00210	Intraoral—Complete Series (including bitewings)	22.00	22.00
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NOTE 1: Limited to patients age 7 up to and including age 14.

NOTE 2: 12 films.

22	Intraoral—Complete Series (including bitewings)	26.00	26.00
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NOTE 1: Limited to patients age 15 or older.

NOTE 2: Minimum of 16 films.

00220	Intraoral—Periapical—First Film	3.75	3.75
00230	Intraoral—Periapical—Each Additional Film	2.75	2.75

NOTE 1: Indicate complete number of films (00220 Plus 00230) in items 12, 17D and 17H.

00240	Intraoral—Occlusal Film	5.00	5.00
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NOTE 1: Per film (maximum—two (2 films)).

NOTE 2: Indicate number of films in item 17D and 17H.

2. Extraoral Radiographs

00250	52	Extraoral, First Film	10.00	10.00
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NOTE: Code to be used for lateral, anteroposterior, temporomandibular radiographs, etc. (one view).

00260	Extraoral—Each Additional Film	5.00	5.00
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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.

00270	Bitewing—One Film	3.00	3.00
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00272	Bitewings—Two Films	5.00	5.00
00274	Bitewings—Four Films	9.00	9.00
00310	Sialography	15.00	15.00
00310	22 Sialography	30.00	30.00

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

00330	Panoramic Film	15.75	15.75
00340	Cephalometric Film	15.00	15.00
00340	22 Cephalometric Film	22.50	22.50

NOTE: Includes tracing.

(c) Test and laboratory examinations:

00470	Diagnostic Casts	11.50	10.00
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NOTE: Casts must have bases and be trimmed to permit articulation, per cast.

00471	Diagnostic Photographs	1.00	1.00
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NOTE: Or slides, per view.

d	00501	Histopathologic Examination	10.00
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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.

d*	00999	Unspecified Diagnostic Procedure, By Report	BR	BR
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NOTE: Complete description of procedure and the reason the procedure was performed.

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

10:56-3.3 01000-01999 PREVENTIVE

(a) Dental prophylaxis:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	01110		Prophylaxis—Adult	17.00		16.00

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

01110	52	Prophylaxis—Adult	8.50	8.00
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NOTE 1: Patients 16 years of age or older, maxillary or mandibular arch; includes additional scaling.

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

01120	Prophylaxis—Child	14.00	13.00
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NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches; includes additional scaling.

1. 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	16.00	15.00
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NOTE: Patients 16 years of age or older, maxillary and mandibular arches.

01120	76	Prophylaxis—Child	13.00	12.00
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NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

Y2105	76	Additional Scaling	16.00	15.00
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(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	24.00	22.00
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NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

01202		Topical Application of Fluoride (Including Prophylaxis)—Adult	27.00	25.00
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NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.

01202	52	Topical Application of Fluoride (Including Prophylaxis)—Adult	13.50	12.50
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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.

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	24.00	22.00
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NOTE: Patients up to and including 15 years of age, maxillary and mandibular arches.

01202	76	Topical Application of Fluoride (Including Prophylaxis)—Adult	27.00	25.00
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NOTE: Patients age 16 up to and including 20 years of age, maxillary and mandibular arches.

(c) Other Preventive Services:

01351		Sealant—Per Tooth	10.00	9.00
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(d) Space Maintenance (passive appliances):

01510		Space Maintainer—Fixed—Unilateral	85.00	80.00
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NOTE: Utilizing band(s) or stainless steel crowning.

01515		Space Maintainer—Fixed—Bilateral	123.00	115.00
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NOTE: Lingual or palatal arch utilizing bands or stainless steel crowning.

01525		Space Maintainer—Removable—Bilateral	69.00	60.00
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01550		Recementation of Space Maintainer	7.00	6.00
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* Y2125		Unspecified Preventive Procedure, By Report	BR	BR
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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).

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

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

Rewrote the section.

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	32.00		30.00
	02120		Amalgam—Two Surfaces, Primary	38.00		35.50
	02130		Amalgam—Three Surfaces, Primary	44.00		41.00
	02131		Amalgam—Four or more Surfaces, Primary	51.00		46.50
	02140		Amalgam—One Surface, Permanent	32.00		30.00
	02150		Amalgam—Two Surfaces, Permanent	38.00		35.50
	02160		Amalgam—Three Surfaces, Permanent	44.00		41.00
	02161		Amalgam—Four or More Surfaces, Permanent	51.00		46.50

(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 mar-

gin(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	35.50	33.00
02331	Resin—Two Surfaces	42.50	39.00
02332	Resin—Three Surfaces	49.50	45.00
02335	Resin—Four or More Surfaces or Involving Incisal Angle	59.50	54.00

For permanent teeth only:—

02385	Resin—one surface, posterior permanent	32.00	30.00
02386	Resin—two surfaces, posterior permanent	38.00	35.50
02387	Resin—three surfaces, posterior permanent	44.00	41.00

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

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
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NOTE: Laboratory processed.

# 02720	Crown—Resin with High Noble Metal	161.00	140.00
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NOTE: Acrylic veneer.

# 02721	Crown—Resin with Predominantly Base Metal	161.00	140.00
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NOTE: Acrylic Veneer.

# 02722	Crown—Resin with Noble Metal	161.00	140.00
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NOTE: Acrylic Veneer.

# 02750	Crown—Porcelain Fused to High Noble Metal	279.00	253.00
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# 02751	Crown—Porcelain Fused to Predominantly Base Metal	279.00	253.00
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# 02752	Crown—Porcelain Fused to Noble Metal	279.00	253.00
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# 02790	Crown—Full Cast High Noble Metal	161.00	140.00
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# 02791	Crown—Full Cast Predominantly Base Metal	161.00	140.00
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# 02792	Crown—Full Cast Noble Metal	161.00	140.00
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(f) Other restorative services:

02910	Recement Inlay	7.00	6.00
02920	Recement Crown	7.00	6.00
02930	Prefabricated Stainless Steel Crown—Primary Tooth	76.00	70.00

NOTE: Reimbursable only for deciduous teeth.

EXCEPTION: Prior authorization by a Division dental consultant.

02931	Prefabricated Stainless Steel Crown—Permanent Tooth	76.00	70.00
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NOTE: Reimbursable only for permanent posterior teeth up to and including 17 years of age.

EXCEPTION: Prior authorized by a Division dental consultant.

02932	Prefabricated Resin Crown		
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NOTE: e.g., Polycarbonate—Reimbursable only for primary and permanent anterior teeth up to and including 15 years of age.

EXCEPTION: Authorization by a Division dental consultant.

# 02950	Crown Buildup Including Any Pins	49.00	45.00
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NOTE 1: And/or post.

NOTE 2: Core of composite or amalgam.

02951	Pin Retention—Per Tooth, In Addition to Restoration	6.00	5.00
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NOTE 1: Per pin.

NOTE 2: Maximum reimbursable—three pins.

NOTE 3: Not in conjunction with Procedure Code 03950 and 03950-22.

#	02952	Cast Post and Core In Addition to Crown	75.00	68.00
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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.

#	02954	Prefabricated Post and Core In Addition to Crown	49.00	45.00
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NOTE 1: Preparatory to crown restoration only.

NOTE 2: Not in conjunction with Procedure Code 03950 and 03950-22.

	02970	Temporary (Fractured Tooth)	29.00	25.00
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NOTE: Temporary crown—not reimbursable in conjunction with any other restorative procedure on same tooth.

*	02980	Crown Repair, By Report	BR	BR
*	02999	Unspecified Restorative Procedure, By Report	BR	BR

Public notice: Pursuant to N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriations Act (P.L. 1988, c.47), maximum fee allowances increased in (b) and (d)8, effective August 1, 1988.
 See: 20 N.J.R. 2101(a).
 Amended by R.1990 d.456, effective September 4, 1990.
 See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).
 In (h): added "02980—Crown Repair".
 Amended by R.1996 d.428, effective September 16, 1996.
 See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
 Amended by R.2000 d.426, effective October 16, 2000.
 See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
 Changed Maximum Fee Allowances throughout.

10:56-3.5 03000-03999 ENDODONTICS

(a) Therapeutic pulpotomy:

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance		
				S	\$	NS
	03220		Therapeutic Pulpotomy (Excluding Final Restoration)	28.00		26.00

(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):

- For emergency endodontic procedures, use code 03220.
- 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)	148.00	135.00
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NOTE: Code to be used for incisors and cuspids (permanent).

#	03320	Two Canals (Excluding Final Restoration)	190.00	173.00
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NOTE: Code to be used for premolars and all primary teeth without permanent successors.

#	03330	Three Canals (Excluding Final Restoration)	247.00	225.00
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NOTE: Code to be used for molars (permanent).

	03350	Apexification (Per Treatment Visit)	31.00	27.00
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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.

(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 and NJ Kid-Care fee-for-service programs 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	79.00	72.00
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NOTE: Maximum—two additional roots

(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	135.50	122.50
d*	03411	22	Apicoectomy/Endodontic Procedure (Per Tooth)—Each Additional Root	44.00	36.00

NOTE: Maximum—two additional roots. Must be billed in conjunction with Code 03410 22.

	03430	Retrograde Filling—Per Root	9.00	7.50
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NOTE 1: Reimbursable only in addition to apicoectomy.

NOTE 2: Maximum per tooth—three roots.
 03440 Apical Curettage 49.00 42.00

NOTE: Per tooth.

03450 Root Amputation—Per Root 55.00 48.00

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

NOTE 2: Per tooth.

(f) Other endodontic procedures:

03920 Hemisection (Including Any Root Removal), Not Including Root Canal Therapy 55.00 48.00
 03950 Canal Preparation and Fitting of Preformed Dowel or Post 16.00 14.00

NOTE: Without cementation.

03950 22 Canal Preparation and Fitting of Preformed Dowel or Post 23.00 20.00

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

NOTE 2: With cementation.

03960 Bleaching Discolored Tooth 11.00 10.00

NOTE 1: Limited to non-vital teeth.

NOTE 2: Per visit.

NOTE 3: Reimbursement limited to two visits without prior authorization.

d* 03999 Unspecified Endodontic Procedure, By Report BR BR

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

Changed Maximum Fee Allowances throughout; and in (d), inserted a reference to NJ KidCare fee-for-services programs.

10:56-3.6 04000-04999 PERIODONTICS

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

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance	
				\$	NS
*	04210		Gingivectomy or Gingivoplasty—Per Quadrant	43.60	37.50
	04211		Gingivectomy or Gingivoplasty—Per Tooth	6.00	5.50

NOTE: Maximum number of teeth reimbursable—Three

* 04220 Gingival Curettage, By Report 22.60 19.50

NOTE: Per Quadrant.

*	04260	Osseous Surgery (Including Flap Entry and Closure) Per Quadrant	75.00	64.50
*	04261	Osseous Graft—Single Site (Including Flap Entry, Closure, and Donor Sites)	BR	BR
*	04262	Osseous Graft—Multiple Sites (Including Flap Entry, Closure, and Donor Sites)	BR	BR
*	04270	Pedicle Soft Tissue Graft Procedure	32.00	28.00

NOTE: Per site.

* 04271 Free Soft Tissue Graft Procedure (Including Donor Site) 49.00 42.00

NOTE: Per site.

* 04272 Apically Repositioning Flap Procedure 36.00 31.50

NOTE: Per quadrant.

(b) Adjunctive periodontal services:

04320 Provisional Splinting—Intra-coral 18.00 16.00

NOTE: Per tooth.

04321 Provisional Splinting—Extra-coral 11.00 10.00

NOTE 1: Per tooth.

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

*	04341	Periodontal Scaling and Root Planing—Per Quadrant	37.50	34.50
*	04999	Unspecified Periodontal Service, By Report	BR	BR

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

In (b), changed Maximum Fee Allowances for Periodontal Scaling and Root Planing—Per Quadrant.

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

(a) Complete dentures (including routine post delivery care and placement of I D included in fee):

Ind	HCPCS Codes	Mod	Procedure Description	Maximum Fee Allowance		
				\$	\$	NS
*	05110		Complete Upper	334.00		302.00
	05120		Complete Lower	342.00		311.00

NOTE: Maxillary.

NOTE: Mandibular.

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

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	
				S	NS
*	06210		Pontic—Cast High Noble Metal	76.00	66.00
*	06211		Pontic—Cast Predominantly Base Metal	76.00	66.00
*	06212		Pontic—Cast Noble Metal	76.00	66.00
*	06240		Pontic—Porcelain Fused to High Noble Metal	170.00	165.00
*	06241		Pontic—Porcelain Fused to Predominantly Base Metal	170.00	165.00
*	06242		Pontic—Porcelain Fused to Noble Metal	170.00	165.00
*	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	279.00	253.00
*	06751		Crown—Porcelain Fused to Predominantly Base Metal	279.00	253.00
*	06752		Crown—Porcelain Fused to Noble Metal	279.00	253.00
*	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
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NOTE 1: One abutment.

NOTE 2: Code may be used when recementing facing.

06930	22	Recement Bridge	14.00	12.00
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NOTE: Two or more abutments.

*	06970		Cast Post and Core in Addition to Bridge Retainer	75.00	68.00
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NOTE: Post and core fabricated (cast) and cemented as a separate unit from crown.

Not in conjunction with Procedure Codes 03950 and 03950-22

*	06972		Prefabricated Post and Core in Addition to Bridge Retainer	49.00	45.00
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Not in conjunction with Procedure Codes 03950 and 03950-22

*	06980		Bridge Repair, By Report	BR	BR
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*	06999		Unspecified Fixed Prosthodontic Procedure, By Report	BR	BR
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Amended by R.1996 d.428, effective September 16, 1996.

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

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

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

Changed Maximum Fee Allowances throughout.

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	
				S	NS
	07110		Single Tooth	32.00	30.00
	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	19.50	18.00
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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 beneficiaries 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	33.00	31.00
#	07220	Removal of Impacted Tooth—Soft Tissue	43.00	40.00
#	07230	Removal of Impacted Tooth—Partially Bony	114.00	106.00
#	07240	Removal of Impacted Tooth—Completely Bony	114.00	106.00
#	07250	Surgical Removal of Residual Roots (Cutting Procedure)	43.00	39.00

NOTE: Completely covered by bone.

(c) Other surgical procedures:

07260		Oroantral Fistula Closure	108.00	99.00
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NOTE: Code may also be used for antral root recovery.

07270		Tooth Re-implantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth and/or Alveolus	93.00	85.00
07270	22	Tooth Re-implantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth and/or Alveolus	118.00	107.00

NOTE: Includes single stage nerve extirpation and canal filling.

	07280	Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reason (Including Orthodontic Attachments)	101.00	94.00
	07281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	45.00	41.00
d	07285	Biopsy of Oral Tissue—Hard	30.00	26.00

NOTE: Independent procedure (laboratory must bill separately).

d	07286	Biopsy of Oral Tissue—Soft	18.00	16.00
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NOTE: Independent procedure (laboratory must bill separately).

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

1. Reimbursement will be based upon quadrants.

	07310	Alveoloplasty in Conjunction with Extraction—Per Quadrant	62.50	56.50
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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.

	07320	Alveoloplasty Not in Conjunction with Extraction—Per Quadrant	62.50	56.50
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(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)	65.00	59.00
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NOTE: Including management of hypertrophied and hyperplastic tissue, Per Quadrant.

	07350	Vestibuloplasty—Ridge Extension (Including Soft Tissue Grafts, Muscle Re-attachments, Revision of Soft Tissue Attachment, and Management of Hypertrophied and Hyperplastic Tissue)	169.00	153.00
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NOTE: Per Quadrant.

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

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

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

	07410	Radical Excision—Lesion Diameter Up to 1.25 cm.	30.00	26.00
	07420	Radical Excision—Lesion Diameter Over 1.25 cm.	42.00	37.00

NOTE: Up to and including 3 cm.

	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.	42.00	37.00

NOTE: Up to and including 3 cm.

	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.	274.00	256.00

NOTE: Up to and including 3 cm.

	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.	100.00	87.00

NOTE: Up to and including 3 cm.

	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.	100.00	87.00

NOTE: Up to and including 3 cm.

	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	62.50	56.50
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Reimbursement will be based upon quadrants.

NOTE: Per quadrant.

	07470	22 Removal of Exostosis	109.00	98.00
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NOTE: Torus palatinus.

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	28.00	26.00
07520	Incision and Drainage of Abscess—Extraoral Soft Tissue	42.00	37.00
07530	Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue	18.00	16.00
07540	Removal of Reaction—Producing Foreign Bodies, Musculoskeletal System	51.00	45.00
07550	Sequestrectomy for Osteomyelitis	48.00	42.00

NOTE: Intraoral.

07550	22	Sequestrectomy for Osteomyelitis	90.00	75.00
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NOTE: Extraoral.

07560		Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign body	242.00	210.00
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NOTE: Sinusotomy, maxillary (antrotomy, Caldwell-Luc, unilateral).

(j) Treatment of fractures—simple:

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

07610		Maxilla—Open Reduction (Teeth Immobilized if Present)	273.00	249.00
07620		Maxilla—Closed Reduction (Teeth Immobilized if Present)	182.00	166.00
07620	52	Maxilla—Closed Reduction	80.00	76.00

NOTE: No manipulation or fixation.

07630		Mandible—Open Reduction (Teeth Immobilized if Present)	363.00	331.00
07630	22	Mandible—Open Reduction (Teeth Immobilized if Present)	454.00	414.00

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

07640		Mandible—Closed Reduction (Teeth Immobilized if Present)	182.00	166.00
07640	52	Mandible—Closed Reduction	80.00	76.00

NOTE: No manipulation or fixation.

07650		Malar and/or Zygomatic Arch—Open Reduction	182.00	166.00
07660		Malar and/or Zygomatic Arch—Closed Reduction	63.00	58.00

NOTE: Including towel clip technique.

07660	52	Malar and/or Zygomatic Arch—Closed Reduction	56.00	52.00
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NOTE: No manipulation or fixation.

07670	YU	Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00
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NOTE 1: Maxillary alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07670	YL	Alveolus—Stabilization of Teeth, Open Reduction Splinting	138.00	126.00
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NOTE 1: Mandibular alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07680		Facial Bones—Complicated Reduction with Fixation and Multiple Surgical Approaches	363.00	331.00
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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.

(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	273.00	249.00
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NOTE: Teeth immobilized if present.

07720		Maxilla—Closed Reduction	182.00	166.00
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NOTE: Teeth immobilized if present.

07720	52	Maxilla—Closed Reduction	80.00	76.00
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NOTE: No manipulation or fixation.

07730		Mandible—Open Reduction	363.00	331.00
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NOTE: Teeth immobilized if present

07730	22	Mandible—Open Reduction	454.00	414.00
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NOTE: Complicated-multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.

07740		Mandible—Closed Reduction	182.00	166.00
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NOTE: Teeth immobilized if present.

07740	52	Mandible—Closed Reduction	80.00	76.00
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NOTE: No manipulation or fixation.

07750		Malar and/or Zygomatic Arch—Open Reduction	182.00	166.00
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07760		Malar and/or Zygomatic Arch—Closed Reduction	63.00	58.00
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NOTE: Including towel clip technique.

07760-52 Malar and/or Zygomatic Arch— 56.00 52.00
Closed Reduction

NOTE: No manipulation or fixation.

07770 YU Alveolus—Stabilization of Teeth, 138.00 126.00
Open Reduction Splinting

NOTE 1: Maxillary alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07770 YL Alveolus—Stabilization of Teeth, 138.00 126.00
Open Reduction Splinting

NOTE 1: Mandibular alveolar fracture.

NOTE 2: Reduction with wiring, and application of arch bar or splint.

07780 Facial Bones—Complicated 363.00 331.00
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.

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

07810 Open Reduction of Dislocation 273.00 249.00
07820 Closed Reduction of Dislocation 27.00 25.00
d 07830 Manipulation under Anesthesia 27.00 25.00

NOTE: Anesthesia additional.

07840 Condylectomy 362.00 315.00
07850 Meniscectomy 362.00 315.00
07860 Arthroscopy 362.00 315.00
d 07870 Arthrocentesis 18.00 16.00

NOTE: Injection or aspiration (Give complete details).

(m) Repair of traumatic wounds:

1. Describe completely, giving size, site, and all pertinent information.
2. Fee includes suture removal.

07910 52 Suture of Recent Small Wounds 26.00 24.00

NOTE: Up to 2.5 cm.

07910 Suture of Recent Small Wounds 35.00 32.00
up to 5 cm.

NOTE: 2.5 cm. up to 5 cm.

07910 22 Suture of Recent Small Wounds 43.00 39.00

NOTE: Over 5 cm. up to 7.5 cm.

3. Laceration over 7.5 cm. use code 07999.

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

1. Also for irregularly shaped lacerations requiring extensive debridement.

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

(o) Other repair procedures:

* 07940 Osteoplasty—For Orthognathic Deformities BR BR
* 07955 Repair of Maxillofacial Soft and Hard Tissue Defects BR BR
07960 Frenulectomy (Frenectomy or Frenotomy)—Separate Procedure 60.00 56.00
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).
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
Changed Maximum Fee Allowances throughout.

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	493.00	370.00
Y2920	1st Through 12th Month of Treatment to Start on Day Insertion of Appliances is Completed), Per Month	80.00	75.00
Y2930	13th Through 24th Month of Treatment, Per Month	80.00	75.00
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	11.00	10.00
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).
 Amended by R.2000 d.426, effective October 16, 2000. See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).
 In (c) and (d), changed Maximum Fee Allowances.

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	10.00	9.00

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
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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	125.00	125.00
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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.

(c) Special general anesthesia:

1. (Basic units—See American Society of Anesthesiologists Relative Value Guide—2000).

09220	22	Maximum 4 units	44.00	44.00
09220	52	Time units: Each additional 15 minute period or major portion thereof. (Limited to "table" or "chair" time only). Maximum reimbursable: two hours.	11.00	11.00

NOTE 1: The general anesthesia codes above are limited to use in restorative dentistry alone or restorative dentistry in conjunction with other dental services requiring anesthetic management. These codes are reimbursable only to the dentist whose sole function is to administer general anesthesia.

NOTE 2: An anesthesia record must be available which shows elapsed anesthesia time, and pinpoints time and amounts of drugs administered, pulse rate and character, blood pressure, respiration and so forth.

09230	Analgesia	15.00	14.00
09240	Intravenous Sedation	50.00	49.00

NOTE: Parenteral Conscious Sedation

(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	20.50	19.00
Y3005	Long Term Care Facility Visits	20.50	19.00
09420	52 Hospital call	19.00	17.00

NOTE: Code 09420 52 will not be reimbursable in conjunction with Code 09310 or Codes 09420 22 or 09420.

09420	22	Hospital Call	32.00	27.00
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NOTE: Code to be used for Hospital Day—Initial—Inpatient or Same Day Surgery.

09420	Hospital Call	19.00	17.00
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NOTE 1: Code to be used for Hospital Day—Subsequent.

NOTE 2: Consisting of care and treatment by the Practitioner subsequent to the date of “Hospital Day—Initial” and including those procedures ordinarily performed during a hospital visit dependent upon the practitioner’s discipline.

NOTE 3: Not reimbursable for those services that include follow-up days.

09430	Office Visit for Observation (During Regularly Scheduled Hours)—No Other Services Performed	9.00	7.00
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NOTE: Code may also be used when post-operative services are necessary following a major surgical procedure (e.g., bony impactions, fractures, etc.)

(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
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(g) Miscellaneous services:

09910	Application of Desensitizing Medicaments	6.00	5.00
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NOTE 1: Application to a tooth, i.e., cervical sensitivity, erosions etc.

NOTE 2: Specify tooth code(s).

#	09920	Behavior Management	15.00	13.00
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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	9.00	8.00
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NOTE: This code may also be used for post-operative treatment beyond that normally provided as part of the basic procedure or when provided by practitioner other than one who provided the original service or in excess of “follow-up days”. (California Relative Value Study—1964), per visit.

09940	Occlusal Guards	50.00	45.00
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NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards).

NOTE 2: Office procedure.

09940	22	Occlusal Guards	65.00	58.00
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NOTE 1: Special periodontal appliances (including occlusal guards and athletic mouth guards).

NOTE 2: Laboratory procedure.

09951	Occlusal Adjustment—Limited	6.00	5.00
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NOTE: 1 to 3 Teeth.

09951	22	Occlusal Adjustment	17.00	15.00
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NOTE: Per quadrant (minimum six teeth).

d**	09999	Unspecified Adjunctive Procedure, By Report	BR	BR
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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.

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.
Amended by R.2000 d.426, effective October 16, 2000.
See: 32 N.J.R. 2411(a), 32 N.J.R. 3836(a).

Changed Maximum Fee Allowances throughout.
Amended by R.2001 d.10, effective January 2, 2001.
See: 32 N.J.R. 3377(a), 33 N.J.R. 65(a).

In (c)1, substituted "Society" for "College" following "American",
and substituted "2000" for "1967" following "Guide—".

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 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049

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.