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Subchapter 3, Procedure Codes and Descriptions, was repealed and replaced with a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), as R.1987 d.166 effective April 6, 1987.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of R.1996 d.428, Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was repealed and a new Subchapter 2, Provisions for Services, was adopted.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.

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"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.

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

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

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

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

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

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

1. The practitioner should give preference to:

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

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

(f) The quantity of medication prescribed should provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between visits, but may not exceed a 60–day supply or 100 dosage units, whichever is greater.

1. Any drug used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more shall be considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the recipient for up to 60 days or provide 100 dosage units, whichever is greater.

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

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

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

2. Experimental drugs;

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

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

5. Medications prescribed for use by hospital inpatients.

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

7. Prescriptions written and dispensed with nonspecific directions.

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

9. Prescribed non-legend drugs unless listed below:

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

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

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).
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See: 5 N.J.R. 267(a), 5 N.J.R. 341(f).
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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).
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See: 7 N.J.R. 316(a), 7 N.J.R. 567(c).
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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).

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:56–3.1 Introduction

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

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

Section 3.2—Diagnostic

Section 3.3—Preventive

Section 3.4—Restorative

Section 3.5—Endodontics

Section 3.6—Periodontics

Section 3.7—Prosthodontics, Removable

Section 3.8—Maxillofacial Prosthetics

Section 3.9—Prosthodontics, Fixed

Section 3.10—Oral Surgery

Section 3.11—Orthodontics

Section 3.12—Adjunctive General Services

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

	Category of Service	HCPCS Codes
I.	Diagnostic	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	Lists the HCPCS procedure code numbers.
4.	MOD	(Modifier) Lists alphabetic or numeric characters. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes are listed with appropriate procedure codes in this Subchapter 3. The modifiers "22", "52" and "76" are designated for use in the New Jersey Medicaid Dental Manual as follows:

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

(1) This modifier may also be applied when a dental laboratory procedure is used in conjunction with specified chairside procedures or where an adjunctive service is rendered in addition to the basic service.

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

iii. 76— Repeat Procedure by Same Practitioner: The practitioner may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier "76" to the procedure code of the repeated service.

iv. YL Mandibular—Lower.

v. YU Maxillary—Upper.

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

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

UL—Upper Left
UR—Upper Right
LL—Lower Left
LR—Lower Right

The codes requiring the quadrant values are:

04210—Gingivectomy or Gingivoplasty
04220—Gingival Curettage
04260—Osseous Surgery
04341—Periodontal Scaling and Root Planing
04272—Apically repositioning Flap Procedure
07310—Alveoloplasty in Conjunction with Extraction
07320—Alveoloplasty not in Conjunction with Extraction
07340—Vestibuloplasty—Ridge Extension—Secondary Epithelialization
07350—Vestibuloplasty—Ridge Extension
09951 22—Occlusal Adjustment
07470—Removal of Exostosis

5. Description — Lists the code narrative.

6. Maximum Fee Allowance — Lists the New Jersey Medicaid program's maximum reimbursement schedule for Specialist and Non-Specialist.

i. S— Denotes Specialist fee.

ii. NS— Denotes Non-Specialist fee.

iii. BR—Denotes By Report (Individual Consideration of Procedure and Fee).

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

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

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

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

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

(f) Listed throughout subchapter 3 are some general and specific policies of New Jersey Medicaid Program relevant to HCPCS. For complete and specific policies in addition to those outlined herein, the practitioner must consult subchapter 1 and/or 2.

1. When requesting prior authorization or filing a claim, the HCPCS codes, including the referenced 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).