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Subchapter 3, Procedure Codes and Descriptions, was repealed and replaced with a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), as R.1987 d.166 effective April 6, 1987.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of R.1996 d.428, Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was repealed and a new Subchapter 2, Provisions for Services, was adopted.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

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

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

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

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

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

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

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

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

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

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

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

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

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

Amended by R.1985 d.7, effective February 4, 1985.
See: 16 N.J.R. 1933(a), 17 N.J.R. 309(a).
(g) text added: "and to the ... further information."
Amended by R.1986 d.385, effective September 22, 1986.
See: 18 N.J.R. 1337(a), 18 N.J.R. 1958(a).
Recodified from 10:56–1.11 and amended by R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former N.J.A.C. 10:56–1.5, "Standards of service", recodified to 10:56–2.2.

10:56–1.6 Reimbursement based on specialist designation

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

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

2. In those states not requiring specialty certification:

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

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

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

UNISYS
Provider Enrollment Unit
PO Box 4801
Trenton, New Jersey 08650–4801

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

1. Oral and Maxillofacial Surgery;

2. Endodontics;

3. Pedodontics—Pediatric Dentistry;

4. Orthodontics;

5. Periodontics; and/or

6. Prosthodontics.

New Rule, R.1996 d.428, effective September 16, 1996.
See: 28 N.J.R. 3069(a), 28 N.J.R. 4243(a).
Former N.J.A.C. 10:56–1.6, "Special dental services", recodified to 10:56–2.3.
Amended by R.1998 d.353, effective July 20, 1998.
See: 30 N.J.R. 514(a), 30 N.J.R. 2654(a).
In (b), updated the address.

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

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

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

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

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

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

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

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Former N.J.A.C. 10:56–1.7, Non-covered services, recodified to N.J.A.C. 10:56–1.8.
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.

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;