

[N.J.A.C. 10:56](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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Title 10, Chapter 56 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

[N.J.S.A. 30:4D-1](#) et seq. and [30:4J-8](#) et seq.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: July 6, 2021.

See: [53 N.J.R. 1278\(a\)](#).

CHAPTER HISTORICAL NOTE:

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

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

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

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

Subchapter 3, Procedure Codes and Descriptions, was repealed and a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1987 d.166, effective April 6, 1987.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

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

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of R.1996 d.428, Subchapter 2, Provider Instructions for Requesting Authorization and Payment for Dental Services, was repealed and a new Subchapter 2, Provisions for Services, was adopted, effective September 16, 1996.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

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Chapter 56, Manual for Dental Services, was readopted as R.2001 d.268, effective July 10, 2001. See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

Chapter 56, Manual for Dental Services, was readopted as R.2007 d.36, effective December 27, 2006. See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 56, Manual for Dental Services, was scheduled to expire on December 27, 2013. See: [43 N.J.R. 1203\(a\)](#).

Chapter 56, Manual for Dental Services, was readopted, effective November 18, 2013. See: [45 N.J.R. 2602\(b\)](#).

In accordance with [N.J.S.A. 52:14B-5.1](#), Chapter 56, Manual for Dental Services, was scheduled to expire on November 18, 2020. Pursuant to Executive Order Nos. 127 (2020) and 244 (2021) and P.L. 2021, c. 104, any chapter of the New Jersey Administrative Code that would otherwise have expired during the Public Health Emergency originally declared in Executive Order No. 103 (2020) is extended through January 1, 2022. Chapter 56, Manual for Dental Services, was readopted, effective July 6, 2021. See: Source and Effective Date.

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 56, Manual for Dental Services, expires on July 6, 2028.

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[N.J.A.C. 10:56-1.1](#)

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§ 10:56-1.1 Purpose and scope

This chapter describes the requirements of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs pertaining to the provision of, and reimbursement for, medically-necessary dental services to eligible beneficiaries. In addition to the provider's private office, dental services may be provided in the home, hospital, ambulatory surgical center, approved independent clinic, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), residential treatment center, or elsewhere.

History

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

Former [N.J.A.C. 10:56-1.1](#), "Definitions", recodified to 10:56-1.2.

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Deleted "[\(N.J.A.C. 10:56\)](#)" following "chapter", substituted "requirements" for "policies and procedures" and "beneficiaries" for "individuals", and inserted "provider's" and "ambulatory surgical center".

Annotations

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[N.J.A.C. 10:56-1.2](#)

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§ 10:56-1.2 Definitions

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

"Ambulatory Surgical Center (ASC)" means any distinct entity that: operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization; has an agreement with the Centers for Medicare & Medicaid Services (CMS) as a Medicare participating provider for ambulatory surgical services; is licensed, if required, by the New Jersey State Department of Health and Senior Services, or is similarly licensed by a comparable agency of the state in which the facility is located; and meets the enrollment and participation requirements of the New Jersey Medicaid/NJ FamilyCare programs as indicated at [N.J.A.C. 10:49-3.2](#), and [10:66-1.3](#).

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

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

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

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

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

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

"Division" means the Division of Medical Assistance and Health Services.

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

1. Pain or acute infection from a restorable or a non-restorable tooth;

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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/NJ FamilyCare dental consultant in order to be reimbursed by the New Jersey Medicaid/NJ FamilyCare 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/NJ FamilyCare program.

"Prior authorization" means approval by a dental consultant to the New Jersey Medicaid/NJ FamilyCare program before a service is rendered.

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

"Routine dental service" means any dental service that is reimbursable by the New Jersey Medicaid/NJ FamilyCare program without authorization by a Medicaid/NJ FamilyCare dental consultant.

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

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

History

HISTORY:

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

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

Section substantially amended.

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

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

Specialist amended.

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

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

Added definition of "bundled drug service."

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

Former [N.J.A.C. 10:56-1.2](#), "Dental treatment plan", recodified to 10:56-2.1.

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

§ 10:56-1.2 Definitions

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

Substituted "beneficiary" for "recipient" throughout.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Inserted references to NJ FamilyCare throughout.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In the introductory paragraph, substituted "chapter" for "subchapter"; and added definition "Ambulatory Surgical Center (ASC)".

Annotations

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§ 10:56-1.3 Provisions for provider participation

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

1. Any out-of-State dentist may provide dental and surgical services under this program if he or she meets the documentation and licensing requirements in the State which he or she is practicing, and is a New Jersey Medicaid/NJ FamilyCare 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/NJ FamilyCare program as a dentist, a dental practitioner shall apply to, and be approved by the New Jersey Medicaid/NJ FamilyCare 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 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/NJ FamilyCare Provider Application, the Provider Agreement and other enrollment documents to the fiscal agent for the New Jersey Medicaid/NJ FamilyCare program, the dentist will receive written notification of approval or disapproval. If approved, the dentist will be assigned a Medicaid/NJ FamilyCare Provider Billing Number, a Medicaid/NJ FamilyCare Provider Service Number, and will be provided with an initial supply of pre-printed claim forms.

History

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

Former [N.J.A.C. 10:56-1.3](#), "Prior authorization", recodified to 10:56-1.4.

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

§ 10:56-1.3 Provisions for provider participation

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Inserted references to NJ FamilyCare throughout.

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§ 10:56-1.4 Prior authorization

(a) For dental services that require prior authorization, a Prior Authorization Form, (MC-10A), and the Dental Claim Form (MC-10), shall be submitted to:

Division of Medical Assistance and Health Services

Office of Utilization Management

Bureau of Dental Services, Mail Code 21

PO Box 713

Trenton, New Jersey 08625-0713

Telephone: (609) 588-7136

1. Requests for prior authorization should include recent diagnostic radiographs. When appropriate for the service requested, documentation to substantiate or demonstrate the need for the requested dental services shall also be included.

(b) Oral hygiene devices require prior authorization, regardless of cost.

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

(d) Dental 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:

1. A single asterisk (*); or
2. A double asterisk (**); and/or
3. A crosshatch (#).

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

4. Those services which do not require prior authorization have no asterisk or crosshatch indicators and are those basic services defined by Medicaid/NJ FamilyCare as "routine services."

(e) Prior authorization requests cannot be transferred from one dentist to another.

(f) Situations which require prior authorization for services which would otherwise be considered routine services include:

1. Services involving more than one supernumerary tooth;
2. The extraction of restorable teeth or teeth with no carious lesions;
3. Extractions in conjunction with orthodontic treatment not being reimbursed by the Medicaid/NJ FamilyCare program; and

§ 10:56-1.4 Prior authorization

4. Services to teeth that were denied as having been previously extracted.

(g) Prior authorization for additional and/or amended services that are found to be necessary after the original dental treatment plan has been prior authorized may be requested by recording such need on the Dental Prior Authorization Form (MC-10A). Providers shall submit a copy of the Dental Claim Form (MC-10) for the approved services and a second prior authorization request for the new services, indicating that a change in treatment plan has occurred. Providers shall include recent radiographs and any pertinent documentation to assist in consideration of the new services.

(h) Providers shall complete all dental procedures in both arches before impressions are taken for dentures. Payment for prior authorized dentures will be denied unless all dental procedures are completed in both arches before impressions are taken.

(i) Prior authorizations shall be effective for one year from the date of authorization and for the three months immediately preceding the date of authorization. Prior authorized ("non-routine") services shall be completed within one year of the date of the original authorization by the Division dental consultant.

1. If providers are unable to complete the services within the prior authorized period, providers may contact the Division dental consultant and request an extension of the authorized effective period, in accordance with (g) 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. Dental providers shall direct all questions regarding the status of a prior authorization request and denials of prior authorization requests to the Bureau of Dental Services, Mail Code 21, PO Box 713, Trenton, New Jersey 08625-0713, Telephone: (609) 588-7136.

History

HISTORY:

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.

§ 10:56-1.4 Prior authorization

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a), inserted ", with the Dental Claim Form (MC-10) attached," preceding "shall be submitted to:" in the introductory paragraph, amended the address, and inserted a reference to NJ FamilyCare in 3; in (d), inserted references to NJ FamilyCare in the introductory paragraph and 1.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Rewrote the section.

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[N.J.A.C. 10:56-1.5](#)

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§ 10:56-1.5 Basis for reimbursement

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

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

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

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

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

1. The stage of completion of the service shall be detailed on the Dental 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 Division dental consultant. The case will be returned to the provider and shall be retained for at least one year pending possible return of the beneficiary.

i. Requests for prorated reimbursement shall be submitted with all appropriate dental forms (either the dental claim for previously approved services or both the dental claim and the prior authorization form), a copy of the treatment plan and pertinent treatment records, any lab work to stage of completion and a written explanation of why the services were not completed. Payment will be delayed when requests for prorated reimbursement are incomplete.

ii. Should a patient return and completion of the prorated case occurs, the balance can be reimbursed. Prior authorization for the additional fee shall be submitted for review by a Division dental consultant. The provider shall include in the request documentation that the patient has returned and that the prorated work has been completed.

§ 10:56-1.5 Basis for reimbursement

- (d)** Partial reimbursement for an appliance completed but not delivered to the beneficiary because of circumstances beyond the control of the provider will be authorized by the New Jersey Medicaid/NJ FamilyCare 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 beneficiary returns and the service is completed, the provider may request reimbursement for the deducted amount. Procedures as outlined in (c) above will apply.
- (e)** Reimbursement is not made for, and beneficiaries shall not be asked to pay for, broken appointments.
- (f)** Reimbursement will be made only for dental treatment provided during the period of beneficiary eligibility, except that the treatment listed in paragraphs 1 through 5 below, if 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.
1. Prosthesis (to include, for example, dentures, crowns, space maintainers, and appliances, but not comprehensive orthodontic appliances or services) actually in process of fabrication;
 2. 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;
 3. 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.
 4. Notwithstanding any rule in this chapter 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) shall 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 rules are applicable.
 5. For immediate dentures, similar to provisions for dentures inserted subsequent to the healing period, prior authorization shall have been obtained during the eligibility period and all preliminary extractions completed during that same period. Authorized immediate complete dentures shall 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) shall be initiated within 120 days and the denture inserted 180 days after the last preliminary extraction. Prior authorization procedures set forth in this chapter shall apply as described at [N.J.A.C. 10:56-1.4](#).
- (g)** When other health or liability insurance is available, the Medicaid/NJ FamilyCare program requires that such benefits be utilized first and to the fullest extent. See [N.J.A.C. 10:49-7.3](#), Third party liability (TPL) benefits, for further information. Supplemental payment shall be made by the Medicaid/NJ FamilyCare program up to the provider's customary and usual fee, if the combined total does not exceed the amount payable under the Medicaid/NJ FamilyCare 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.

§ 10:56-1.5 Basis for reimbursement

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

(h) Failure to comply with documentation requirements will result in denial of claims, delays in payment and recovery of any payments made prior to determinations of non-compliance.

(i) Authorization of dental treatment or services shall not guarantee payment by the Medicaid/NJ FamilyCare fee-for-service programs. The provider shall assure, at the time of each visit, that the beneficiary being treated is eligible for the Medicaid/NJ FamilyCare programs, and for the dental services to be rendered, by using the beneficiary's health benefits identification card with one of the eligibility verification systems available to the provider. See N.J.A.C. 10:49-2 for beneficiary eligibility information.

History

HISTORY:

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

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

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

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

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

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

Former [N.J.A.C. 10:56-1.5](#), "Standards of service", recodified to 10:56-2.2.

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

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

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Inserted references to NJ FamilyCare throughout.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (c)1, deleted "Services" preceding "Claim", and substituted "Division dental consultant" for "Chief, Bureau of Dental Services"; added new (c)1i and (c)1ii; in (d), substituted "beneficiary" for "recipient" two times; in (e), substituted "shall" for "may", rewrote (f); and added new (h) and (i).

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[N.J.A.C. 10:56-1.6](#)

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§ 10:56-1.6 Reimbursement based on specialist designation

- (a) To obtain reimbursement as a specialist in the Medicaid/NJ FamilyCare programs, a specialist shall:
1. Obtain a specialty certification from the licensing agency of the State of New Jersey or of the state where dental services are to be rendered; or
 2. In those states not requiring specialty certification:
 - i. The specialist shall be a diplomate of a specialty board recognized by the American Dental Association or shall meet 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 shall submit proof of specialist certification as described above to:
- Unisys
Provider Enrollment Unit
PO Box 4801
Trenton, New Jersey 08650-4801
- (c) Specialist reimbursement shall 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.

History

HISTORY:

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.

§ 10:56-1.6 Reimbursement based on specialist designation

See: [30 N.J.R. 514\(a\)](#), [30 N.J.R. 2654\(a\)](#).

In (b), updated the address.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Rewrote (a); in (b), substituted "shall" for "is required to" and substituted "Unisys" for "UNISYS"; and in the introductory paragraph of (c), substituted "shall" for "will".

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[N.J.A.C. 10:56-1.7](#)

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§ 10:56-1.7 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

- (a) General policies regarding the collection of personal contribution to care for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D are set forth at N.J.A.C. 10:49-9.
- (b) Personal contribution to care for NJ FamilyCare-Plan C services shall be \$ 5.00 per 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 evaluations.
- (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 FamilyCare-Plan D including oral evaluations, oral prophylaxis and fluoride treatments.

History

HISTORY:

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\(b\)](#).

§ 10:56-1.7 Personal contribution to care requirements for NJ FamilyCare-Plan C and copayments for NJ FamilyCare-Plan D

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

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Personal contribution to care requirements for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D". Substituted "FamilyCare" for "KidCare" throughout; in the introductory paragraph of (b), substituted "shall be" for "is" preceding "\$ 5.00" and "per" for "a" preceding "visit"; and in (c) and (d), substituted "evaluations" for "examinations".

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[N.J.A.C. 10:56-1.8](#)

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§ 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/NJ FamilyCare dental consultant as specified in this chapter.

(b) Medical/dental supplies and equipment and other devices that are essential for the beneficiary's medical/dental condition shall be allowable unless such services are 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 shall not be covered by the Medicaid/NJ FamilyCare fee-for-service program.

History

HISTORY:

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.

Amended by R.2004 d.25, effective January 20, 2004.

§ 10:56-1.8 Non-covered services

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a), inserted reference to NJ FamilyCare.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (b), substituted "beneficiary's" for "recipient's" and "shall be" for "are" preceding "allowable", and inserted "such services are"; and in (c), substituted "shall not be" for "are not" and "Medicaid/NJ FamilyCare fee-for-service program" for "Program".

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[N.J.A.C. 10:56-1.9](#)

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§ 10:56-1.9 Recordkeeping requirements

(a) Dentists shall maintain individual records which fully disclose the type and extent of services provided to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs beneficiary, including detailing all services rendered for each encounter date. These records shall also fulfill the requirements of the New Jersey State Board of Dentistry as outlined in [N.J.A.C. 13:30-8.7](#). The Medicaid/NJ FamilyCare Dental Claim Form (MC-10) shall not be an acceptable substitute. Such beneficiary records shall be maintained in the provider's office regardless of the actual place of service (dental office, long-term care facility, or hospital). These records shall be available for a minimum of seven years following the last date of service. The dentist shall also document services in facility records as required in (b) and (c) below. Such information shall be readily available to representatives of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs or their agents as required.

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

- i. The name, address, and telephone number of the beneficiary, the beneficiary's date of birth and HSP (health services program) number, and, if a minor, name of parent(s) or guardian.
- ii. Pertinent dental/medical history; and
- iii. Detailed clinical evaluation data to include where applicable:
 - (1) Beneficiary's chief complaint;
 - (2) Diagnosis;
 - (3) Cavities;
 - (4) Missing teeth; and
 - (5) Abnormalities;
- iv. Preoperative, progress, and postoperative radiographs, which shall be retained for a minimum of seven years following the last date of service. Professional liability insurance companies should be contacted for possible retention for longer periods. The number and type of radiographs shall be entered on the beneficiary's record. Postoperative radiographs shall be taken only when dentally necessary and only when such radiographs 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);

§ 10:56-1.9 Recordkeeping requirements

- (6) Description of treatment or services rendered at each visit to include the name of the dentist or hygienist rendering it.
- (7) All medications;
- (8) Diagnostic laboratory and/or radiographic procedure(s) ordered, including the result(s);
- (9) Copy of the dental prosthetic work authorization(s) (prescription(s)), and dental prosthetic laboratory receipt(s);
- (10) Explanation for any duplication of services within one year (prosthetic services within seven and one-half years);
- (11) Reasons for discontinuation of services (including attempts to complete treatment); and
- (12) Referral and consultation reports.

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

(c) A dentist who provides services for a nursing facility beneficiary (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 beneficiary's clinical record that includes the following:

1. The results of an evaluation which will establish an admission record of the beneficiary's dental status.
 - i. If a current examination is required within six months of a previous examination performed by the same provider and billed to Medicaid/NJ FamilyCare, 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 evaluation of the beneficiary. The time frame shall be documented either at the time of evaluation or at the completion of treatment. For example, it may be entered on the clinical record for six months, one year, two years, three years, or any other time period that the attending dentist has established per his or her knowledge of the beneficiary and the beneficiary's dental status.
3. A record of dental treatment provided at each encounter.
 - i. A photocopy of the completed and signed Medicaid/NJ FamilyCare Dental Claim Form (MC-10) for evaluation 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/NJ FamilyCare Dental Claim Form (MC-10) are listed separately on the beneficiary's clinical record in addition to the recordkeeping requirements described in this section.

History

HISTORY:

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.

§ 10:56-1.9 Recordkeeping requirements

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [30 N.J.R. 1060\(a\)](#).

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

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

See: [30 N.J.R. 1060\(a\)](#), [30 N.J.R. 3519\(a\)](#).

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

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

Rewrote the section.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (c)1i, inserted reference to NJ FamilyCare.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In the introductory paragraph of (a), substituted "shall" for "are required to" and deleted "Services" following "Dental"; in (a)1iii, substituted "evaluation" for "examination"; in (a)1iv, inserted ", which shall be", substituted "shall" for "should" two times and substituted "only when such radiographs" for "must"; in (b), substituted "shall" for "must"; in the introductory paragraph of (c), substituted "beneficiary" for "recipient" and "beneficiary's" for "recipient's"; in (c)1 and (c)2, substituted "evaluation" for "examination" throughout; and in (c)3i, substituted "Medicaid/NJ FamilyCare Dental" for "Medicaid Dental Services" two times, substituted "evaluation" for "examination" and substituted "beneficiary's" for "recipient's".

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[N.J.A.C. 10:56-1.10](#)

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

- (a) For the purposes of the New Jersey Medicaid/NJ FamilyCare fee-for-service program, utilization review, quality control and peer review are considered to be ongoing components in regard to the dental services provided to eligible beneficiaries.
- (b) Utilization refers to that service, procedure or item provided to a beneficiary by a qualified provider, in a setting, at a time, and in an amount which is appropriate and acceptable to the standards of the profession, at a cost described at N.J.A.C. 10:56-3.
- (c) Utilization review is the retrospective analysis of the performance of a dental provider with respect to the efficient provision for the use of services noted in (b) above, from the viewpoint of fiscal accountability.
- (d) Quality is that standard of dental care or degree of excellence generally prevailing throughout the profession by those who provide similar service which is not related to any geographical area or population group as judged by competent practitioners who are qualified to perform those procedures.
- (e) Dental review is the current ongoing review of the degree of quality in the delivery of continuing dental services and health care which is constantly monitored and maintained by the provision of direction, coordination and regulation through the cooperative efforts between representatives of the New Jersey Medicaid/NJ FamilyCare 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 shall 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.

History

HISTORY:

Recodified from 10:56-1.7 and amended by R.1996 d.428, effective September 16, 1996.

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

Recodified from [N.J.A.C. 10:56-1.9](#) by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: [30 N.J.R. 1060\(a\)](#).

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

See: [30 N.J.R. 1060\(a\)](#), [30 N.J.R. 3519\(a\)](#).

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

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (e), inserted reference to NJ FamilyCare.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In introductory paragraph of (f), inserted commas preceding "but" and "the following"; and in (f)3, inserted a comma following "records", and substituted "shall" for "must".

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[N.J.A.C. 10:56-2.1](#)

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§ 10:56-2.1 Dental treatment or services plan

- (a) In accordance with good dental practice, a plan of treatment or services shall be developed and described for each Medicaid/NJ FamilyCare patient on the Dental Claim Form (MC-10) following a comprehensive evaluation. If no treatment is necessary, this fact shall be entered on the Dental 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/NJ FamilyCare program.
- (c) In those instances where prior authorization is necessary, the two page prior authorization documents, that is, the Dental Prior Authorization Form MC-10(A) and the Dental Claim Form MC-10, shall be submitted along with the treatment plan and any additional documentation or radiographs appropriate to the request. A Division dental consultant may modify or deny the provider's treatment plan in accordance with the requirements of the New Jersey Medicaid/NJ FamilyCare fee-for-service programs, as specified in this chapter. Such modifications or denials are designed to provide dental treatment to the beneficiary that is adequate for the correction of the problem, that can be expected to last for the longest period of time, and represents, in the opinion of the dental consultant(s), the most judicious application of Medicaid/NJ FamilyCare fee-for-service reimbursement. If in the professional judgment of the provider such modification is not appropriate, the dentist may request another review by the Division dental consultant. A further review in the Bureau of Dental Services may be requested through the Division dental consultant.
- (d) In any dental treatment or services plan, the dentist shall discuss the proposed treatment plan and receive approval from the beneficiary and/or family member/guardian before submission for authorization and again after authorization is received and prior to initiation of treatment. It is suggested that the provider have the beneficiary sign the office records or a separate statement that the treatment plan meets with their approval, since no alteration of the treatment plan will be reimbursed based on the subsequent rejection of all or part of that treatment plan by the beneficiary or family member/guardian.
- (e) Consideration for development of a dental treatment plan shall be based upon the least costly treatment fulfilling the requirements of the specific situation. On the basis of post-utilization review, any dental treatment plan, including those not requiring prior authorization, may be reviewed by Division dental consultants to determine appropriateness of treatment. If the treatment is not appropriate, the payment shall be recovered.
- (f) If, in the opinion of a dentist, the beneficiary requires the services of a specialist, the dentist shall note the name of the practitioner to whom the beneficiary is being referred on the Dental Claim Form (MC-10) under remarks (Item 20). The specialist shall note the name and Medicaid/NJ FamilyCare Provider Service Number of the referring dentist on the Dental Claim Form (MC-10) in section 14, which is designated as Referring Practitioner.

History

§ 10:56-2.1 Dental treatment or services plan

HISTORY:

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

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

Section substantially amended.

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

Former section, "General billing procedures", repealed.

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a) and (b), inserted references to NJ FamilyCare.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Dental treatment plan". In (a), inserted "or services", deleted "Services" following "Dental" two times and substituted "evaluation" for "examination" and "shall" for "must"; rewrote (c); in (d), inserted "or services", substituted "shall" for "must" and inserted a comma following "their approval"; in (e), inserted "Division" and deleted "of the New Jersey Medicaid program" following "consultants"; deleted former (f); recodified former (g) as new (f); and in (f), deleted "Services" following "Dental" two times.

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[N.J.A.C. 10:56-2.2](#)

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§ 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/NJ FamilyCare 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

History

HISTORY:

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.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (c), inserted reference to NJ FamilyCare.

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§ 10:56-2.3 Special dental services

(a) Dental services for which no specific procedure code and description are noted, or which are limited or prohibited by this chapter, may be considered on a case-by-case basis, upon request. Such a request shall be submitted on the two part Dental Prior Authorization Form (MC-10A), and the Dental Claim Form (MC-10) and forwarded to the Bureau of Dental Services, Mail Code 21, PO Box 713, Trenton, New Jersey 08625-0713. An unspecified procedure code appropriate for the requested service shall be used when submitting the prior authorization request for these dental services. The request shall be accompanied by all supporting documentation.

1. If such unspecified services are associated with a temporomandibular joint dysfunction diagnosis or therapy, the requesting provider shall comply with the New Jersey Board of Dentistry protocol for diagnosis and treatment planning as set forth in [N.J.A.C. 13:30-8.22](#).

(b) If reimbursement for the dental service is "By Report," the requesting provider shall forward, in addition to all documentation required for any prior authorization request, a detailed written report, treatment plan and other documentation, such as charting, records, or radiographs, relevant to the requested dental service.

History

HISTORY:

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.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Rewrote the introductory paragraph of (a); and added new (a)1 and new (b).

Annotations

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[N.J.A.C. 10:56-2.4](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:56-2.4 Place of service

- (a) In addition to the private office, dental services may be provided in the home, a hospital, ambulatory surgical center, approved independent clinic, nursing facility, residential treatment center and elsewhere.
- (b) Services should be provided in any appropriate setting, governed by medical/dental necessity and not by the convenience or desires of the beneficiary or the providers of services.
1. Specific additional requirements 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 10:66, respectively.
 - i. Hospital outpatient dental clinics are subject to the same New Jersey Medicaid/NJ FamilyCare program requirements and reimbursement schedule, as specified in this chapter, that apply to the dentist in "private" practice (see [N.J.A.C. 10:52-2.3](#), 10:66 and 13:30.)
 2. Dental services performed on an inpatient basis in approved licensed hospitals are reimbursable, provided that such services require a hospital level of care, which level of care requirement shall be documented on the hospital records.
 - i. Dental services are also reimbursable if the beneficiary is admitted for an eligible non-dental condition and the dental services are rendered as part of the prescribed treatment for such condition, or to alleviate the beneficiary's discomfort during the period of hospitalization.
 - (1) Admission may be by the dentist or by a physician, depending on the by-laws of the individual hospital.
 - (2) When inpatient services are performed by a dentist who is reimbursed by the hospital under contractual or other arrangements, the services are considered a hospital cost, and shall be billed by the hospital and not by the dentist.
 - (3) Authorization by a Division dental consultant shall be 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 requirements of this chapter 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.

§ 10:56-2.4 Place of service

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

History

HISTORY:

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

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

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

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

(c)3 added.

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

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

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

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

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

Recodified from 10:56-1.12 and amended by R.1996 d.428, effective September 16, 1996.

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

Former section, "Patient eligibility", repealed.

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

Substituted references to beneficiaries for references to recipients throughout.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (b), inserted references to NJ FamilyCare throughout.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (a), inserted "ambulatory surgical center,"; in (b)1, substituted "Specific additional requirements" for "Policies specific"; in (b)1i, substituted "requirements" for "policies, procedures", "specified in this chapter" for "outlined in this manual" and ", 10:66 and 13:30" for "(a)"; in (b)2, inserted commas following "reimbursable" and the first occurrence of "care", substituted "such services require a hospital" for "they require that" and inserted "level of care requirement"; in (b)2i(1), inserted a comma following "physician"; in (b)2i(2), deleted "(s)" following "dentist"; in (b)2i(3), inserted "Division" and substituted "shall be" for "of the Medicaid/NJ FamilyCare program is"; and in (c)1, substituted "requirements of this chapter" for "policies and procedures as detailed in this manual".

Annotations

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§ 10:56-2.4 Place of service

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[N.J.A.C. 10:56-2.5](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:56-2.5 House calls and visits to beneficiary residences

- (a) A provider may be reimbursed for a house call/visit (procedure code D9410) in addition to any other services provided on that day. Procedure code D9410 shall include house calls/visits to nursing homes, long-term care facilities, hospice sites, institutions, and other types of extended care facilities.
- (b) The following apply to reimbursement for house calls/visits to the facilities identified in (a) above:
1. House calls/visits can be billed in addition to any other services provided to a specific patient on that day; and
 2. Billing for house calls/visits using code D9410 shall be limited to once per trip to the facility, regardless of the number of patients examined or treated.
- (c) Procedure code D9420, hospital calls, may be reported when providing treatment in the hospital or for operating room cases in the hospital or an ambulatory surgical center, and can be billed in addition to any dental services performed on that day; however, procedure code D9420 shall not be reimbursable if billed in conjunction with a consultation or other hospital calls on the same day. This use of code D9420 requires prior authorization. Prior authorization may be provided when the submitted evidence indicates a hospital, hospital operating room or ambulatory surgical center as the place of service or that the patient has special health needs that require the dental services to be provided in the hospital operating room or ambulatory surgical center. Requests for prior authorization of D9420 shall be submitted to the Division and shall include:
1. A complete pertinent medical history and medical diagnosis;
 2. The chief dental complaint;
 3. A description of the oral findings pertaining to the present condition, or, if not possible, an explanation as to why no such description is possible;
 4. The history of the present dental condition, including all findings; and
 5. A record of the working dental diagnosis and the treatment planned for the operating room visit.
- (d) Any subsequent hospital calls also require prior authorization. A request for authorization of such subsequent hospital calls may be submitted after the fact, with dates of service noted. The prior authorization for subsequent hospital calls shall include the following information:
1. The diagnosis associated with the need for hospitalization;
 2. Any subsequent dental care provided or needed, identified by procedure code;
 3. Any changes in the dental diagnosis or treatment plan; and
 4. The total number of visits.

History

§ 10:56-2.5 House calls and visits to beneficiary residences

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Visit policies". Rewrote the section.

Annotations

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[N.J.A.C. 10:56-2.6](#)

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§ 10:56-2.6 Diagnostic services: general

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

1. This dental evaluation is reimbursable only when part of a total treatment plan, unless the evaluation 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 Claim Form (MC-10).

2. Except as provided in [N.J.A.C. 10:78-7.1](#), for reimbursement purposes, a comprehensive dental evaluation shall be limited to once every six months for those beneficiaries through age 20 and once every 12 months for those beneficiaries 21 years of age or older except as prior authorized by a Division dental consultant.

(b) An emergency oral evaluation is distinguished from a complete evaluation of the oral cavity in that it is applicable only for diagnosis and/or observation of a specific complaint in an emergency situation.

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

(d) A Handicapping Malocclusion Assessment Examination (refer to [N.J.A.C. 10:56-2.15](#)) shall not be reimbursed for individuals age 21 or older.

1. For reimbursement purposes, a Handicapping Malocclusion Assessment Examination shall be limited to once every 12 months unless authorized. In addition, 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. Orthodontic evaluation, including the Handicapping Malocclusion Assessment Examination, shall be conducted before a child reaches age 18 to ensure that all orthodontic treatment proposed can be completed prior to the child's reaching age 21. Unless extenuating circumstances exist and the Division dental consultant has previously reviewed and approved the treatment, any and all orthodontic treatment not completed prior to the child's reaching age 21 shall be the sole responsibility of the provider.

History

HISTORY:

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.

§ 10:56-2.6 Diagnostic services: general

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

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

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

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

Section renumbered and (b)4 new.

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Substituted "evaluation" for "examination" throughout; in the introductory paragraph of (a), substituted "Division dental consultant" for "Dental Consultant"; in (a)1, deleted "Services" following "Dental"; in (a)2, substituted "20" for "17", "21" for "18" and "Division dental consultant" for "Dental Consultant of the Medicaid/NJ Family Care fee-for-service programs"; rewrote the introductory paragraph of (d); deleted (d)1; recodified former (d)2 as (d)1; in (d)1, substituted "shall be" for "is" two times; and added new (d)2.

Annotations

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[N.J.A.C. 10:56-2.7](#)

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§ 10:56-2.7 Diagnostic services: radiography

- (a) Radiological procedures shall be limited to those normally required to make a diagnosis and shall show all areas where treatment is anticipated with the exception of soft tissue lesions.
- (b) All radiographs should be examined carefully by the provider to assure quality care and to make certain that all necessary treatment has been diagnosed, planned for and/or completed.
- (c) Radiographs may be reviewed by dental consultants of the Medicaid/NJ Family Care fee-for-service programs and/or a dentist in private practice not employed by New Jersey Medicaid/NJ Family Care fee-for-service programs, if appropriate. It is recommended that the two film packet be used or a copy may be made by those dentists who wish to retain a set of radiographs in their office at all times.
- (d) The originals of all radiographic films shall be available to authorized representatives of the New Jersey Medicaid/NJ Family Care fee-for-service programs. Radiographs shall be forwarded to the Division of Medical Assistance and Health Services in the following situations:
1. When prior authorization is requested; or
 2. Upon request by the Medicaid/NJ Family Care fee-for-service programs for utilization review or adjudication purposes.
- (e) All radiographic films shall be suitable for interpretation and when submitted to the New Jersey Medicaid/NJ Family Care fee-for-service programs or their agents shall be properly mounted, marked "Right" and "Left" and identified with the beneficiary's name, the date, and the name of the dentist. Films that are technically unacceptable for proper interpretation will be returned to the provider for replacement at no additional cost to the Medicaid/NJ Family Care fee-for-service programs. No reimbursement shall be made for the new set of radiographs that the dentist is required to provide. When already reimbursed, recoupment will be made, unless a replacement set of radiographs is sent to the Division for review.
- (f) Reimbursement for dental radiographs shall be limited according to the following standards:
1. A complete series radiographic study is defined and limited by age. The maximum number of diagnostic radiographs that may be reimbursed as a single radiographic study every three years without prior authorization shall be as follows:
 - i. Up to and including age six: eight films (six periapical plus two bitewing films);
 - ii. Age seven, up to and including age 14: 12 films (10 periapical films, plus two bitewing films) or a panorex and two posterior bite wing films;
 - iii. For those beneficiaries 15 years of age or older: 16 radiographs (at least 14 periapical plus two posterior bitewing films) or a panorex plus four posterior bite wing films;
 - iv. A complete series radiographic study, which may include two or more bitewing radiographs with a panorex radiograph. 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,

§ 10:56-2.7 Diagnostic services: radiography

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 Division dental consultant;

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

vi. The maximum amount reimbursable for radiographs billed individually or in groups in conjunction with an initial evaluation, 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; and
- (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 from the Division dental consultant;

viii. If a beneficiary patient transfers to a new dental provider's office, that new dental provider's office shall request a copy of the beneficiary's radiographs from the previous dental provider, in accordance with [N.J.A.C. 13:30-8.7](#). The previous dental provider may request approval through the prior authorization process for duplication of the films. That prior authorization request shall be directed to the Division dental consultant and shall indicate the type and number of films to be duplicated; or

ix. If the films or their copies cannot be provided by the previous dental provider, the new dental provider shall document this fact in the beneficiary's patient record and proceed to take the needed films that are required to diagnose, develop a treatment plan and provide treatment. It is not the intention of the Medicaid/NJ FamilyCare program to impede timely treatment while waiting for the previous dentist to provide the requested radiographs and records.

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

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

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

1. Services provided by another dentist, physician, or hospital facility shall be billed directly to the Medicaid/NJ Family Care fee-for-service programs by that provider and not by the referring dentist.

History

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

§ 10:56-2.7 Diagnostic services: radiography

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (f)1iv, inserted reference to NJ FamilyCare.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (a), substituted "shall" for "must"; in (f)1, substituted "The" for "It represents the" and "that may be reimbursed" for "reimbursable", and inserted "shall be"; in (f)1iv, inserted ", which" and "with a panorex radiograph", substituted "or more bitewing" for "bitewing or more", "Division" for "Medicaid/NJ FamilyCare" and a semicolon for a period at the end; in (f)1vi, substituted "evaluation" for "examination"; in (f)1vi(2), inserted "and" at the end; in (f)1vi(3), substituted a semicolon for a period at the end; rewrote (f)1vii; added new (f)1viii and (f)1ix; and in (g), deleted "Services" following "Dental".

Annotations

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[N.J.A.C. 10:56-2.8](#)

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§ 10:56-2.8 Diagnostic services: Clinical laboratory services

- (a) "Clinical laboratory services" includes services provided by:
1. Independent clinical laboratories, including physician/dentist operated, out of hospital laboratories which perform primarily diagnostic work referred by other practitioners; and
 2. Hospital laboratories and laboratories of educational institutions which provide laboratory services to ambulatory beneficiaries as requested by a licensed practitioner.
- (b) Services provided by any of the above laboratories shall be billed directly to the Medicaid/NJ FamilyCare program by the laboratory, and not by the dentist.
- (c) All facilities or entities that perform clinical laboratory testing shall have certification for the services they are performing (see [N.J.A.C. 10:61](#)). Reimbursement for laboratory testing performed shall not be made to any facility without such CLIA certification. It shall be the initiating entity's responsibility to refer tests to laboratories which are New Jersey Medicaid/NJ Family Care fee-for-service providers and have a valid CLIA identification number.

History

HISTORY:

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

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

Section substantially amended.

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

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

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

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

Section renumbered and (b)4 new.

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

§ 10:56-2.8 Diagnostic services: Clinical laboratory services

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (b), inserted reference to NJ FamilyCare.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (b), substituted "shall" for "must".

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[N.J.A.C. 10:56-2.9](#)

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§ 10:56-2.9 Preventive dental care

(a) In addition to an oral evaluation every six months for beneficiaries through age 20 and once every 12 months for beneficiaries 21 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 beneficiaries through age 20 and once every 12 months for beneficiaries 21 years of age or older, except as otherwise prior authorized by a Division dental consultant, and except as provided (a)1ii(1) below.

(1) Beneficiaries with developmental disabilities, neurological impairments, or other disabilities, regardless of age, shall be eligible for evaluation, 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. In the event that any of the services listed in (A) below are required more often than every three months, a prior authorization request shall be submitted to the Division dental consultant. The nature of the beneficiary's disability shall be recorded under Remarks (Item 20) on the Dental Claim Form.

(A) The following procedure codes shall be used only if a beneficiary is developmentally disabled, neurologically impaired or medically compromised:

Comprehensive Oral Evaluation	D0150-76
Prophylaxis-Adult	D1110-76
Prophylaxis-Child	D1120-76
Topical Application of Fluoride with prophylaxis, Child	D1201-76
Topical Application of Fluoride with prophylaxis, Adult	D1205-76
Full Mouth Debridement	D4355-76
Non-intravenous Conscious Sedation	D9248-76

NOTE: Non-Intravenous Conscious Sedation shall be prior authorized after four times in a 12-month period.

2. Fluoride Treatment, as follows:

- i. Topical fluoride treatment should be administered in accordance with appropriate standards. This consists of topical application of stannous fluoride or acid fluoride phosphate as a liquid or gel.
- ii. A complete prophylaxis shall be performed prior to and in conjunction with the topical fluoride treatment.
- iii. Reimbursement for topical fluoride treatment shall be limited to once every six months without need for prior authorization for those beneficiaries through age 20.

§ 10:56-2.9 Preventive dental care

- iv. This is not a covered service for persons 21 years of age and over, except as noted in (a)1ii(1) above.
 - v. Oral fluoride medication may be prescribed (see: [N.J.A.C. 10:56-2.17](#)).
 - vi. Use of a prophylaxis paste containing fluoride shall not be billed as "topical fluoride treatment." For reimbursement purposes, this is considered to be only a prophylaxis.
3. To encourage the maintenance of dental health, the same type of recall procedure as used in dental practice in the community shall be extended to eligible Medicaid/NJ Family Care fee-for-service beneficiaries.
 4. Beneficiary education for Medicaid/NJ Family Care fee-for-service beneficiaries should consist of dental health orientation identical to that given all patients.
 5. Sealants shall be a covered service of the Medicaid/NJ Family Care fee-for-service programs, subject to the following limitations:
 - i. Application of sealants shall be limited to a one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars.
 - ii. Application of sealants shall be limited to beneficiaries up to and including 16 years of age.
 - iii. Sealants applied, other than as outlined above, are not reimbursable unless authorized by a Division dental consultant. A complete explanation of the request shall 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.

History

HISTORY:

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\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

Rewrote the section.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2007 d.36, effective February 5, 2007.

§ 10:56-2.9 Preventive dental care

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Rewrote the introductory paragraph of (a) and (a)1ii, (a)1ii(1) and (a)2iii; added (a)1ii(1)(A); in (a)2iv, inserted ", except as noted in (a)1ii(1) above"; and in (a)5iii, substituted "Division" for "Medicaid/NJ Family Care" and "shall" for "must".

Annotations

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[N.J.A.C. 10:56-2.10](#)

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§ 10:56-2.10 Restorative services

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

1. Filling restorations shall be reimbursed as follows:

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

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

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

iv. Plastic, acrylic, or unfilled resin restorative material shall be reimbursable.

v. 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.

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

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

viii. 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 considered for reimbursement as follows:

i. Prior authorization is required for all crowns and shall be based on substantial loss of tooth structure and the condition of the remaining teeth and supporting tissue to justify this treatment. The Dental Prior Authorization Form (MC-10A) and the Dental Claim Form (MC-10) shall be submitted with recent radiographs for review by a Division dental consultant.

ii. Generally, temporary acrylic or plastic 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. If extenuating circumstances exist that require the use of stainless steel crowns for permanent teeth

§ 10:56-2.10 Restorative services

on beneficiaries beyond the age of 17, a request for prior authorization with documentation shall be submitted for review by a Division dental consultant.

iii. Porcelain jackets will not be reimbursed.

3. Post and core shall be reimbursable under the following conditions:

i. A post and core is reimbursable on an endodontically treated tooth only in conjunction with a crown as the final restoration.

ii. A post and core on an endodontically treated tooth shall extend into at least one-half, and preferably two-thirds, of the length of the endodontically treated canal. Failure of a 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.

History

HISTORY:

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

See: [7 N.J.R. 318\(a\)](#), [7 N.J.R. 466\(a\)](#).

Recodified from 10:56-1.16 and amended by R.1996 d.428, effective September 16, 1996.

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

In (a)1i, inserted "/NJ Family Care" preceding "dental"; (a)1ii, substituted "beneficiary's" for "recipient's"; in (a)1v, inserted "fee-for-service" preceding "programs"; in (a)2i, substituted "beneficiaries" for "recipients".

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a)2, rewrote i and substituted "reimbursed" for "authorized" in iv.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (a)1i, substituted "Division" for "Medicaid/NJ Family Care"; in (a)2ii, substituted "Amalgam" for "Silver amalgam"; in (a)1iv, deleted "only when utilized for the six anterior teeth in each arch" following "reimbursable"; deleted former (a)1v; recodified former (a)1vi through (a)1ix as (a)1v through (a)1viii; in the introductory paragraph of (a)2, substituted "considered for reimbursement" for "reimbursed"; rewrote (a)2i and (a)2ii; deleted former (a)2iii; recodified former (a)2iv as (a)2iii; in (a)3, deleted "post and" preceding "core"; deleted former (a)3i; recodified former (a)3ii and (a)3iii as (a)3i and (a)3ii; and in (a)3ii, deleted "or post" preceding "and core" two times and substituted "shall" for "must".

Annotations

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Case Notes

ALJ ruled against a patient who sought certain dental services on findings that the services would not prolong the lifespan of the two teeth at issue. That was because the patient's medical records showed that she had more than 50% bone loss and that the condition of the two teeth was such that those services would not only not prolong the lifespan thereof but might actually shorten it. [A.A. v. Horizon NJ Health, OAL DKT. NO. HMA 08481-16, 2016 N.J. AGEN LEXIS 800](#), Initial Decision (September 21, 2016).

Applicant who was seeking authorization for certain dental services, including a "fill" of tooth number 31 preparatory to the insertion of a crown, was properly denied those services because she did not meet the regulatory criteria for the services, which included that the services were necessary to adequately restore and maintaining the integrity and contours of a natural tooth. [E.W. v. Amerigroup, OAL DKT. NO. HMA 05456-16, 2016 N.J. AGEN LEXIS 797](#), Initial Decision (September 21, 2016).

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[N.J.A.C. 10:56-2.11](#)

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§ 10:56-2.11 Endodontic services

(a) 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. Silver points shall not be reimbursed when used as the "permanent material" for filling the root canal.
2. Complete filling of the root canal is defined as filling of the canal to within 0.5 millimeters of the apex.

(b) Root canal treatment for beneficiaries with permanent teeth will not be reimbursed without prior authorization by a Division dental consultant. When the beneficiary is in pain, the dentist should institute emergency measures to extirpate the pulp and/or relieve the pain only until authorization is requested and received. The Dental Prior Authorization Form (MC-10A), and the Dental Claim Form (MC-10) shall be submitted with diagnostic periapical radiograph(s) of the involved teeth.

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

(c) 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 shall be available for review by Division staff.

(d) 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.

(e) 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.

(f) 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.

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(g) 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.

(h) Reimbursement includes those post-treatment radiographs determined necessary by the practitioner. Such radiographs shall be available to the Medicaid/NJ FamilyCare fee-for-service programs upon request.

History

HISTORY:

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

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

Note is renumbered to (a)5ii.

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Deleted former (a); recodified former (b) as (a), deleted former (b)1 and recodified former (b)2 and (b)3 as (a)1 and (a)2; recodified existing (c) through (i) as (b) through (h).

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Endodontia". In (a)1, substituted "shall not be reimbursed when used" for "are not acceptable"; rewrote introductory paragraph of (b); in (c), substituted "shall" for "must; and in (h), substituted ". Such radiographs shall" for "and must".

Annotations

Notes

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Case Notes

Applicant who was seeking authorization for certain dental services, including a "fill" of tooth number 31 preparatory to the insertion of a crown, was properly denied those services because she did not meet the regulatory criteria for the services, which included that the services were necessary to adequately restore and maintaining the

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integrity and contours of a natural tooth. [E.W. v. Amerigroup, OAL DKT. NO. HMA 05456-16, 2016 N.J. AGEN LEXIS 797](#), Initial Decision (September 21, 2016).

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[N.J.A.C. 10:56-2.12](#)

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§ 10:56-2.12 Periodontal services

- (a) Reimbursement shall be provided for periodontal scaling and root planing for four quadrants annually without prior authorization. Prior authorization shall be obtained for additional quadrants of periodontal scaling and root planing, and all other periodontal services. Such requests for prior authorization shall be submitted using the Dental Prior Authorization Form (MC-10A) and the Dental Claim Form (MC-10).
- (b) Additional periodontal services 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 periodontal charting, radiographs, and photographs where appropriate, shall be submitted to the Division dental consultant. Photographs are an excellent means of presenting the condition of the oral tissues to the consultant and shall be reimbursable.
- (c) When requesting periodontal surgery, consideration should be given to the age and health of the beneficiary, the amount of bone loss, the condition of the remaining dentition, the desire, ability, and motivation of the beneficiary to follow through with necessary home and follow-up care, and the prognosis for the remaining teeth.
- (d) When requesting prior authorization for periodontal services, the provider should submit, in addition to radiographs and photographs, a narrative, to include periodontal charting, indicating pocket depth for each tooth in the quadrant requested.
- (e) Reimbursement will be based upon quadrants, a site in a quadrant or the equivalent thereof, as determined by the Division dental consultant in accordance with [N.J.A.C. 10:56-3.1\(d\)](#)6vi.

History

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Added a new (a); recodified former (a) as (b) and substituted "Additional periodontal" for "Periodontal"; recodified former (b) through (d) as (c) through (e).

§ 10:56-2.12 Periodontal services

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Periodontal treatment". In (a), substituted "scaling and root planing" for "services" and "four" for "up to eight", and added last two sentences; in (b), substituted "services" for "treatment", inserted "periodontal charting," and "Division", and deleted "or slides" following "Photographs"; in (c), substituted "surgery" for "treatment"; in (d), deleted "of the code" following "authorization" and "(s)" following "quadrant", substituted "services" for "scaling and root planing" and inserted "charting, indicating"; and in (e), substituted "a site in a quadrant" for "a portion thereof," and "the Division" for "Medicaid/NJ Family Care".

Annotations

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[N.J.A.C. 10:56-2.13](#)

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§ 10:56-2.13 Prosthodontic services

(a) Removable prosthodontic services shall be provided as follows:

1. Dentures, both partial and complete, may be prior authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the beneficiary. Prefabricated dentures or dentures that are temporary in nature shall not be reimbursable. When submitting a Dental Claim Form (MC-10) for reimbursement of approved complete or partial dentures, the date of service used shall be the date of insertion of the denture(s).
2. The following factors should also be considered when requesting prior authorization for dentures (including immediate dentures);
 - i. Age, school status, employment status and rehabilitative potential of the beneficiary (for example, provision of dentures will enhance vocational placement);
 - ii. Medical status of beneficiary (nature and severity of disease or impairment) and psychological predisposition;
 - iii. Condition of the oral cavity, including abnormal soft tissue or osseous conditions;
 - iv. Condition of present dentures, if applicable.
3. Generally, prior authorization for partial dentures to replace posterior teeth will not be granted if there are at least eight posterior teeth which in the opinion of a dental consultant are in reasonably good periodontal condition, occlusion and position, or where a prosthesis in one arch will produce equivalent dentition.
4. With the exception of immediate complete dentures, there shall be a three month wait for healing between the date of the last extraction and the initiation of the denture(s), partial or complete.
 - 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, denture(s) and any other dental services shall be submitted and will be reviewed for prior authorization 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. A minimum of two clasps and rests shall be provided.

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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 shall include the necessary adjustments and relines for a six month period following insertion.
7. Partial dentures shall be described on the Prior Authorization Form (MC-10A), 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 or recovered unless all dental procedures are completed in both arches before impressions are taken.
9. Dentures shall not be prior authorized when:
- i. Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remedial because of physiological or psychological reasons; or
 - ii. Dental history reveals that a denture was provided through any New Jersey State, county, or municipal agency in the seven and one-half year period prior to the date of the current request; or
 - iii. Repair, relining, or rebasing (jumping) of the beneficiary's present denture will make it serviceable.
10. Reimbursement for repairs to complete or partial dentures shall include 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.
11. Denture relining, rebasing (jumping) or repairing services, except as noted in this section, are reimbursable.
- i. 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.
 - ii. Relining is the process of resurfacing the tissue side of a denture with new base material to make it fit more accurately.
 - iii. The fee for relining and rebasing shall include all necessary adjustments for a six month period following insertion.
 - iv. 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.
 - iv. 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.
 - vi. The beneficiary's name (first and last names or, where space is a limiting factor, first initial and last name) must be processed into all dentures during the original fabrication or where possible during any subsequent processing, such as repair, relining and rebasing. 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.) and [N.J.A.C. 13:30-8.11](#).
- (b) Fixed prosthodontic services shall be provided as follows:
1. Fixed bridges will not normally be reimbursed. If extenuating circumstances exist, a prior authorization request shall be submitted to the Division dental consultant with recent diagnostic full mouth radiographs and written documentation of the circumstances.
 2. In extenuating circumstances, if a patient is mentally or physically compromised to the extent that a removable prosthesis cannot be tolerated, a request accompanied by documentation from the physician should be submitted.

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3. Replacement of an existing defective fixed bridge will only be considered for reimbursement if there are no other missing teeth in that arch, there is no radiographic evidence of a periodontal pathology present on recent radiographs and the abutment teeth have a favorable long term prognosis.

4. If there are fewer than eight posterior teeth in reasonably good occlusion and periodontal condition, a partial denture will be recommended by the Division dental consultant.

(c) Implant services shall be provided as follows:

1. Implants will not normally be considered for reimbursement. Prior authorization for implants will be limited to requests that demonstrate that a beneficiary has a facial anomaly, deformity or has been unable to function with a complete denture for at least two years and other oral surgical corrections have been unsuccessful in improving the retention of the denture.

2. If extenuating circumstances exist, a prior authorization request shall be submitted to a Division dental consultant with all supporting documentation and a complete restorative treatment plan, including denture services.

3. If other dentists are or will be involved in providing the needed comprehensive dental services, a team approach between the providers should be used to develop a treatment plan. The restorative dentist shall take the lead, collect the prior authorization requests from all involved providers and submit the requests to the Division dental consultant for review.

4. The Division dental consultant may forward an evaluation form requesting additional information.

5. The Dental Claim Form (MC-10) and diagnostics will be returned to the lead dentist by the Division dental consultant for forwarding to the appropriate team member.

History

HISTORY:

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

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

Section substantially amended.

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

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

(b)9 "Denture" substituted for "Dental".

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

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

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2007 d.36, effective February 5, 2007.

§ 10:56-2.13 Prosthodontic services

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Prosthodontic treatment". Rewrote (a), (b) and (c); and deleted (d).

Annotations

Notes

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Case Notes

Medicaid recipient prevailed on her claim that she was entitled to a lower denture and upper partial denture. Though the recipient had been provided with an upper denture in September 2016 and a lower denture in January 2017, the recipient had refused to accept them on the basis of poor fit, so the recipient remained eligible for the same. [E.R. v. Amerigroup, OAL DKT. NO. HMA 18586-2017, 2018 N.J. AGEN LEXIS 1145](#), Final Agency Determination (May 17, 2018).

Director accepted an ALJ's determination that an insurer had acted properly when it denied a Medicaid recipient's request for authorization for dental treatment including the placement of fixed bridgework because the recipient did not establish medical necessity such that the recipient was unable to eat or otherwise function without the treatment. [W.F. v. Horizon NJ Health, OAL DKT. NO. HMA 02924-16, 2016 N.J. AGEN LEXIS 1149](#), Final Administrative Determination (July 12, 2016).

Dental patient was not entitled to a ruling requiring a dental insurer to approve services involving the placement of two posterior 3-tooth bridges because the policy did not provide coverage for posterior bridges and the patient did not establish the existence of "medical necessity" for such treatment. [W.F. v. Horizon N.J. Health, OAL DKT. NO. HMA 2924-16, 2016 N.J. AGEN LEXIS 526](#), Initial Decision (June 13, 2016).

Medicaid recipient was properly denied dental benefits because dental records showed that she had more than eight points of contact in her teeth meaning that she did not meet the criteria for the benefits which were requested, which were maxillary and mandibular partial dentures. [C.C. v. Horizon NJ Health, OAL DKT. NO. HMA 18562-15, 2016 N.J. AGEN LEXIS 177](#), Initial Decision (April 7, 2016).

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[N.J.A.C. 10:56-2.14](#)

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§ 10:56-2.14 Oral and maxillofacial surgical services

(a) Dental extraction services shall be provided as follows:

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

i. If a provider is considering any extraction which will necessitate the insertion of a dental prosthesis, the provider shall request prior authorization. Reimbursement for such an extraction rendered without prior authorization will be denied, or if already paid, reimbursement will be recovered. Due to the rule limiting the authorization of dentures, [N.J.A.C. 10:56-2.13](#), it may be impossible to replace a denture 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/NJ FamilyCare Program or has been prior authorized by a Division dental consultant.

(2) That such extraction 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 performed:

(A) In conjunction with orthodontic care, if such orthodontic treatment has not met the New Jersey Medicaid/NJ FamilyCare guidelines or has not been prior authorized by the Division dental consultant; 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 Division dental consultant.

2. Reimbursement for dental extraction(s) includes local anesthesia, required suturing and routine post-operative care, including removal of the sutures. Alveoloplasty is reimbursable in conjunction with the extraction of teeth or the roots of teeth in the same quadrant during the same treatment visit. The alveoloplasty and the extractions shall be submitted on the same Dental Claim Form (MC-10) and have the same date of service.

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

(b) Prior authorization shall not be required for the extraction of impacted teeth for beneficiaries age 18 and older. Prior authorization shall be required for such an extraction for beneficiaries under the age of 18. 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

§ 10:56-2.14 Oral and maxillofacial surgical services

necessity cannot be demonstrated will not be accepted for reimbursement and shall be subject to recovery if payment has already been made.

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.

(c) Other oral and maxillofacial surgery services shall be provided as follows:

1. Requests for prior authorization of oral surgical procedures, when such authorization is necessary, shall 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 Division dental consultant with the Dental Claim Form (MC-10). The dentist shall also make 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 Prior Authorization Form (MC-10A) and the Dental Claim Form (MC-10) with all necessary information as mentioned in paragraph (c)1 above should be forwarded to the Division 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 the diagnostic service.
- ii. The dentist will be reimbursed when the biopsy is performed as an independent procedure separate and apart, and on a different date from, the excision of the total lesion.

(d) Extractions to be performed for orthodontic purposes only shall be submitted to the Division dental consultant for prior authorization. Referrals for prior authorization shall be noted in section 14 of the Dental Claim Form, MC-10.

History

HISTORY:

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

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

Substantially amended.

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

§ 10:56-2.14 Oral and maxillofacial surgical services

In (a), inserted references to NJ FamilyCare throughout.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Exodontia and oral surgery". Rewrote (a); in the introductory paragraph of (b), inserted new second sentence and "and shall be subject to recovery if payment has already been made"; deleted (b)2; rewrote (c); and in (d), inserted "dental consultant" and substituted "Dental Claim Form," for "Medicaid/NJ Family Care Dental Services Claim form".

Annotations

Notes

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[N.J.A.C. 10:56-2.15](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 56. MANUAL FOR DENTAL SERVICES > SUBCHAPTER 2. PROVISIONS FOR SERVICES

§ 10:56-2.15 Orthodontic services

- (a) The procedures in this section shall be followed for orthodontic referral, evaluation, and treatment.
- (b) Comprehensive orthodontic treatment shall be 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. Prior authorization shall be obtained in accordance with (e) below before any orthodontic treatment is initiated.
1. Orthodontic treatment shall not be reimbursed for the following:
 - i. For cosmetic purposes only;
 - ii. For individuals age 21 or older; and
 - iii. Except as specified at (d) below, for individuals with less than 24 points on the New Jersey Handicapping Malocclusion Assessment System (see (c) below).
 2. The following factors shall be considered by a dentist before making any referral and also by the practitioner who may render orthodontic treatment before assessing the beneficiary and performing the diagnostic work-up:
 - i. The assessment system is a modification of the work of Dr. J.A. Salzman who has consented to allow the New Jersey Medicaid/NJ FamilyCare program to modify and utilize it.
 - ii. The difference from Dr. Salzman's original work is that the New Jersey Medicaid/NJ FamilyCare program does not allow the eight additional points to denote aesthetic handicap for the anterior segment.
 - iii. Referrals for orthodontics and initiation of orthodontic treatment should be delayed until the beneficiary has all permanent teeth, unless prior authorized by a Division dental consultant.
 - iv. The beneficiary, together with the parent or guardian, should have the desire and ability to complete an extended treatment plan.
 - v. The rehabilitative potential of the beneficiary should be considered.
 - vi. The practitioner should be aware of the following:
 - (1) The Medicaid/NJ FamilyCare Eligibility Identification card should be examined on the first visit of each month. Make certain that the beneficiary being treated is listed as eligible and that the Medicaid/NJ FamilyCare number has not changed. If possible, a photocopy should be retained as part of the beneficiary's records on a monthly basis.
- (c) The New Jersey Medicaid/NJ FamilyCare 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

§ 10:56-2.15 Orthodontic services

Handicapping Malocclusion Assessment Record Form (FD-10). A copy of the reprint can be ordered from the Medicaid/NJ FamilyCare fiscal agent:

Unisys

PO Box 4752

Trenton, New Jersey 08650-4752

(d) The practitioner shall evaluate the beneficiary as follows:

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

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

i. Exception: If the malocclusion does not meet the minimum number of Assessment points (24), but there are other extenuating circumstances that should be considered, the practitioner should proceed with the diagnostic workup; however, the extenuating factors shall be recorded and substantiated and submitted with the diagnostic workup and treatment plan to the 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 Claim Form (MC-10) directly to the Medicaid/NJ FamilyCare fiscal agent, identifying, by procedure code D8660, the service that has been rendered. A copy of the Handicapping Malocclusion Assessment Record Form (FD-10) shall be retained in the provider's record for the patient. The provider shall submit the claim to:

Unisys

PO Box 4811

Trenton, New Jersey 08650-4811

iii. Requests for treatment which are submitted with assessments below the minimum number of points required (see (d)2 above) shall be denied for reimbursement for the diagnostic materials submitted, or shall be subject to 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.

(e) Prior authorization requirements for special orthodontic services are:

1. Upon completion of the diagnostic work-up, the provider shall 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 Prior Authorization Form (MC-10A) part 1 of 2 and the Dental Claim Form MC-10 part 2 of 2 utilizing the proper code number(s) with requested fees for:

- (1)** Assessment examination;

§ 10:56-2.15 Orthodontic services

- (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 of the diagnostic models with the correct inter-arch relationship indicated and/or photographs of the beneficiary which demonstrate the malocclusion and/or extenuating circumstance(s). The maximum number of photographs which is reimbursable is eight;
 - (A) The actual diagnostic models should only be submitted if it is impossible to demonstrate the orthodontic problem and extenuating circumstances by photographs, or if requested;
 - (2) A cephalometric radiograph with a detailed tracing;
 - (3) A series of intra-oral radiographs consistent with [N.J.A.C. 10:56-2.7](#) (or a diagnostic panoramic radiograph);
 - (4) Extra-oral lateral plate radiographs (but not if diagnostic panoramic radiograph has been submitted);
 - (5) Photographs (minimum size two inches by two inches)--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 Division dental consultant 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/NJ FamilyCare program of the action taken on the treatment request following review by the Division 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 periodic orthodontic treatment visits shall be based on the orthodontic treatment services provided. Reimbursement shall not be requested for any period in which there is no visit.
 - 2. Reimbursement for periodic orthodontic treatment visits shall be provided for a total of 36 visits per beneficiary; however, the provider shall request and obtain authorization for any visits needed in excess of 28 visits prior to such visits.
- (g) If the beneficiary's eligibility continues through completion of treatment, final records similar to the diagnostic aids described in (e)1iv above, shall be taken at termination of treatment and shall be submitted upon the Division's request, to:

Division of Medical Assistance and Health Services

Bureau of Dental Services

PO Box 713

Trenton, New Jersey 08625-0713

§ 10:56-2.15 Orthodontic services

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

(i) Reimbursement for comprehensive orthodontic evaluations and/or orthodontic assessment evaluations shall be made under the following conditions:

1. Reimbursement shall be limited to the provider or provider group who does such an evaluation with the intention of personally providing any orthodontic treatment necessary.
2. Reimbursement shall be limited to once every 12 months, unless prior authorized.
3. Comprehensive orthodontic evaluations shall not be reimbursable for beneficiaries age 21 or older.

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

(k) The following orthodontic cases shall undergo prepayment review by the Division before reimbursement will be remitted to the provider:

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

History

HISTORY:

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

See: [15 N.J.R. 1160\(a\)](#), [15 N.J.R. 2170\(a\)](#).

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

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

See: [18 N.J.R. 1337\(a\)](#), [18 N.J.R. 1958\(a\)](#).

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

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [30 N.J.R. 514\(a\)](#), [30 N.J.R. 2654\(a\)](#).

Updated addresses throughout the section.

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

§ 10:56-2.15 Orthodontic services

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

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Inserted references to NJ FamilyCare throughout.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Orthodontic treatment". Rewrote the section.

Annotations

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Case Notes

Medicaid recipient was properly denied orthodontic care on a finding that the relevant assessment yielded a score of 24 while a score of 26 was required for eligibility. While [N.J.A.C. 10:56-2.15](#) reflected the lower 24-point assessment originally cited by the ALJ, the state in fact had adopted the New Jersey Orthodontic Evaluation HLD (NJ-Mod2) assessment tool, and the requirement of 26 points that was reflected therein was the relevant standard. [F.T. v. Horizon N.J. Health, OAL DKT. NO. HMA10207-16, 2016 N.J. AGEN LEXIS 957](#), Initial Decision (November 4, 2016).

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[N.J.A.C. 10:56-2.16](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 56. MANUAL FOR DENTAL SERVICES > SUBCHAPTER 2. PROVISIONS FOR SERVICES

§ 10:56-2.16 Pediatric dental services

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

(b) A dental provider shall bill using the HCPCS code for a comprehensive clinical oral evaluation provided to a child.

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

(c) The HCPCS code D0150 EP is reimbursed at an enhanced rate of \$ 26.00 for a specialist and \$ 22.00 for a non-specialist. Reimbursement for a comprehensive clinical oral evaluation of a child, through age 20 years, shall be limited to once every six months, except as authorized by a Division dental consultant. At a minimum, the evaluation shall 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.

History

HISTORY:

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\(a\)](#).

§ 10:56-2.16 Pediatric dental services

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

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

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

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (c), inserted a reference to NJ FamilyCare in the introductory paragraph.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Pedodontia: pediatric dentistry". In (a), substituted "evaluations" for "examinations"; in the introductory paragraph of (b), substituted "A" for "On or after January 15, 1995, a", "shall" for "may" and "evaluation" for "examination"; rewrote (b)1; and rewrote the introductory paragraph of (c).

Annotations

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[N.J.A.C. 10:56-2.17](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:56-2.17 Adjunctive general services

(a) General anesthesia, parenteral conscious sedation, enteral sedation and analgesia rules are as follows:

1. For general anesthesia, parenteral conscious sedation, enteral sedation and analgesia, dental providers shall comply with all applicable rules, including, but not limited to, the permit requirements of [N.J.A.C. 13:30-8.1A](#), [13:30-8.2](#), [13:30-8.3](#), [13:30-8.4](#) and [13:30-8.20](#) for the service, or similar requirements of the state in which the service is rendered. A valid copy of the permit issued by the New Jersey State Board of Dentistry or the state in which the service is rendered shall be on file with the Division's Provider Enrollment Unit in order for the Medicaid/NJ FamilyCare fee-for-service programs to reimburse a dentist for administering anesthesia, sedation or analgesia. Providers of dental services shall, within 30 days after receiving such original or renewal permit, forward a copy of the permit by certified mail, return receipt requested, to the following address:

Unisys

Provider Enrollment Unit

PO Box 4804

Trenton, New Jersey 08650-4804

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

iii. When general anesthesia is administered by a dentist, such service is reimbursable provided:

(1) Anesthetic management is necessary to perform the dental services.

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

(3) An anesthesia record is maintained and a copy is 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 parenteral conscious sedation shall be subject to the following conditions:

i. Such sedation is in effect continuously during the dental procedure.

History

HISTORY:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) substantially amended.

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

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

See: [32 N.J.R. 3377\(a\)](#), [33 N.J.R. 65\(a\)](#).

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

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

§ 10:56-2.17 Adjunctive general services

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

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Adjunctive general services: anesthesia". Rewrote (a); in the introductory paragraph of (b), inserted "and in accordance with all applicable rules, including, but not limited to, [N.J.A.C. 13:30-8.4](#),"; in (b)1, substituted "shall include" for "are all inclusive for", and rewrote (b)7.

Annotations

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[N.J.A.C. 10:56-2.18](#)

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§ 10:56-2.18 Adjunctive general services: prescriptions

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

1. The New Jersey Medicaid/NJ FamilyCare 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/NJ FamilyCare 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 shall write "brand medically necessary" on each written prescription. When prescribing a non-MAC brand named drug, the prescriber may initial 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/NJ FamilyCare 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.

§ 10:56-2.18 Adjunctive general services: prescriptions

(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 shall not exceed a 34-day supply for initial prescriptions or 34-day supply or 100 dosage units, whichever is greater, for refill prescriptions.

1. Any drug used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered to be a sustaining drug or maintenance medication and should be prescribed in sufficient quantities to treat the beneficiary for up to 34 days for initial prescriptions or provide a 34-day supply or 100 dosage units, whichever is greater, for refill prescriptions.
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. 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, or 34-day supply or 100 dosage units, 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).

§ 10:56-2.18 Adjunctive general services: prescriptions

(h) Prescriptions may be telephoned or faxed 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 that a brand is medically necessary, for a MAC listed drug product, the dentist shall fax or 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.

History

HISTORY:

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.

§ 10:56-2.18 Adjunctive general services: prescriptions

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

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

See: [32 N.J.R. 4392\(a\)](#), [33 N.J.R. 1201\(a\)](#).

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

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

Substituted references to beneficiaries for references to recipients throughout; in (h), inserted a reference to NJ FamilyCare.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a) and (b), inserted references to NJ FamilyCare throughout.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (a)2, substituted "shall" for "must indicate either substitution allowed or" and "initial" for "indicate" and inserted quotation marks throughout; rewrote (f); in the introductory paragraph of (h), inserted "or faxed"; and in (h)1, inserted "that a" and "is", and substituted "shall fax or" for "must".

Annotations

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[N.J.A.C. 10:56-2.19](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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§ 10:56-2.19 Adjunctive general services: medical supplies

Following receipt of a prescription from the dentist, prior authorization from the Medical Assistance Customer Center shall be obtained by the medical supplier for certain medical supplies; therefore, the practitioner shall be prepared to certify and document dental necessity to the Division dental consultant.

History

HISTORY:

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).

§ 10:56-2.19 Adjunctive general services: medical supplies

(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.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office".

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Section was "Adjunctive general services; medical/dental/supplies". Substituted "shall" for "must" two times and "supplier" for "supply dealer", deleted "provider (pharmacist or" preceding "medical", "/dental" preceding "supplies" and "medical/" following "document", and inserted "Division".

Annotations

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[N.J.A.C. 10:56-2.20](#)

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§ 10:56-2.20 Consultations

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

1. A written report which includes diagnosis and recommendations for future management shall be provided to the referring practitioner. A copy shall be retained with the beneficiary's records and must be available, upon request, to the New Jersey Medicaid/NJ FamilyCare fee-for-service programs or any of their authorized representatives.
 - i. When the practitioner rendering the consultation services assumes the continuing care of the beneficiary, any subsequent services rendered by him or her will no longer be considered as consultation.
 - ii. When consultation services are requested, the referring practitioner shall include on the clinical records the name of the consulting practitioner to whom the beneficiary is being referred. The consulting practitioner shall note the diagnosis under Remarks (Item 20) and the name and the Medicaid/NJ FamilyCare Provider Services number of the referring practitioner on the clinical records and on the Dental Claim Form (MC-10) under Referring Practitioner (Item 14).
 - iii. A consultation shall be disallowed if either or both diagnosis or referring practitioner is missing. However, an examination may be billed alone or in conjunction with other treatment if the beneficiary makes an appointment on his or her own.
 - iv. A consultation shall be disallowed if performed on the same beneficiary by the same practitioner, members of the same group, members of a shared health care facility, or practitioners sharing a common record within a 12 month span of a prior claim for the same or related disease, illness or condition.
 - v. A consultation shall be declined in any setting, if the consultation occurs between members of the same group, shared health care facility, or practitioners sharing common records.
 - vi. If a consultation is billed in an inpatient setting and the beneficiary is then transferred to the service of the consultant, the consultant shall not bill for a Hospital Call.

History

HISTORY:

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

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

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

§ 10:56-2.20 Consultations

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

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

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

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

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (a)1ii, substituted "shall" for "must" twice, inserted "and" following "(Item 20)", and deleted "services" following "Dental"; in (a)1iii, (a)1iv and (a)1v, substituted "shall" for "will"; in (a)1vi, substituted "consultant shall" for "consultation may", substituted "Call" For "Day Initial; however, Hospital Day Subsequent -- may be billed for visits on ensuing days"; and deleted (a)1vii.

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[N.J.A.C. 10:56-2.21](#)

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 56. MANUAL FOR DENTAL SERVICES > SUBCHAPTER 2. PROVISIONS FOR SERVICES

§ 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 Centers for Medicare & Medicaid Services 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

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

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/NJ FamilyCare. These services require prior authorization from the Medical Assistance Customer Center (MACC). (See Medical Supplier Services chapter, [N.J.A.C. 10:59.](#))

History

HISTORY:

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\(a\)](#).

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a)13, inserted a reference to NJ FamilyCare and substituted "Medical Assistance Customer Center (MACC)" for "Medicaid District Office (MDO)".

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In (a)11, substituted "Centers for Medicare & Medicaid Services" for "Health Care Financing Administration (HCFA)".

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[N.J.A.C. 10:56-2.22](#)

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§ 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).

History

HISTORY:

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\(a\)](#).

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[N.J.A.C. 10:56-3.1](#)

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§ 10:56-3.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare program utilizes the American Dental Association's Code on Dental Procedures and Nomenclature as published in the Current Dental Terminology (CDT) and incorporated herein by reference, as amended and supplemented, and designated by the Centers for Medicare & Medicaid Services (CMS) as the national standard for reporting dental services under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. The CDT is published by, and may be obtained from, the American Dental Association, 211 East Chicago Ave., Chicago, Illinois 60611, <http://www.ada.org/> and/or PMIC, 4727 Wilshire Blvd., Suite 300, Los Angeles, CA 90010, <http://www.medicalcodingbooks.com>. Revisions to the CDT (code additions, code deletions and replacement codes) will be reflected in this chapter through publication of a notice of administrative change in the New Jersey Register. Revisions to existing reimbursement amounts specified by the Department and specification of new reimbursement amounts for new codes will be made by rulemaking in accordance with the Administrative Procedure Act, [N.J.S.A. 52:14B-1](#) et seq.

(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:

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

1. The lists of HCPCS in the 11 separate sections of this subchapter are arranged in tabular form with specific information for a code given under columns with titles such as: "IND," "HCPCS CODES," "MOD," "DESCRIPTION," and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below in (d)2 through 6.

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§ 10:56-3.1 Introduction

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

1. These symbols and notes when listed under the "IND", "MOD" and "DESCRIPTION" columns are elements of the HCPCS coding system. They assist the dentist in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.
2. These symbols and/or letters and/or notes must not be ignored because in certain instances requirements are created in addition to the narrative which accompanies the HCPCS code. THE PROVIDER WILL THEN BE LIABLE FOR THE ADDITIONAL REQUIREMENTS AND NOT JUST THE HCPCS CODE NARRATIVE. These requirements must be fulfilled in order to receive reimbursement.
3. If there is no identifying symbol or note listed, the HCPCS code narrative prevails.

(f) Listed throughout this subchapter are some general and specific policies of New Jersey Medicaid/NJ FamilyCare program relevant to HCPCS. For complete and specific policies in addition to those outlined herein, the practitioner must consult N.J.A.C. 10:56-1 and/or 2.

1. When requesting prior authorization or filing a claim, the HCPCS codes, including the referenced modifiers, must be used in conjunction with the narratives in this subchapter.
2. The use of a procedure code will be interpreted by the New Jersey Medicaid/NJ FamilyCare programs as evidence that the dentist personally furnished, as a minimum, the service for which it stands.
3. For purposes of reimbursement, a dentist, dental group, shared health care facility or dentists sharing a common record shall be considered a single provider.
4. When billing, the provider shall enter into the procedure code column (Item 17B) of the Dental Services Claim Form (MC-10), a HCPCS code as listed in this subchapter. If an appropriate code cannot be found, the provider shall leave the procedure code column blank and shall submit a narrative description of the service for authorization and fee assignment on the Dental Prior Authorization Form MC-10A part 1 of 2 and the Dental Claim Form MC-10 part 2 of 2.
5. Date(s) of service(s) must be indicated on the Dental Services Claim form (MC-10).
6. When submitting a claim, the dentist shall always use her or his usual and customary fee. The fee designated for the HCPCS procedure codes represents the New Jersey Medicaid/NJ FamilyCare fee-for-service programs' maximum reimbursement for the given procedure.

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

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History

HISTORY

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.

§ 10:56-3.1 Introduction

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 Prophy).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

Rewrote (d)4 and (d)6; in (f), rewrote the introductory paragraph, inserted a reference to NJ FamilyCare in 2, and inserted a reference to NJ FamilyCare fee-for-service in 6.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a), inserted a reference to NJ FamilyCare and substituted "Centers for Medicare and Medicaid Services (CMS) Healthcare" for "Health Care Financing Administration's (HCFA)" in the first sentence; in (f), inserted a reference to NJ FamilyCare and substituted "N.J.A.C. 10:56-1 and/or 2" for "subchapter 1 and/or 2" in the introductory paragraph.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

Rewrote (a).

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[N.J.A.C. 10:56-3.2](#)

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§ 10:56-3.2 D0100-D0999 DIAGNOSTIC

(a) Clinical Oral Examination:

				Maximum Fee		
				Allowance		
IND	Code	Mod	Procedure Description	S	\$	NS
	D0150		Comprehensive oral evaluation	15.00		14.00

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

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

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

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

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

D0150	76	Comprehensive oral evaluation	14.00	13.00
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NOTE 1: This code is to be used only if a beneficiary is developmentally disabled or neurologically impaired (see [N.J.A.C. 10:56-2.9\(a\)1ii](#)), in which case an examination may be provided as often as every three months and may be submitted directly to the fiscal agent for payment without prior authorization. The nature of the beneficiary's disability must be recorded under "Remarks" on the Dental Services Claim form (MC-10).

D0150	EP	Comprehensive oral evaluation	25.00	21.00
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NOTE 1: a. This code is to be used for comprehensive oral evaluation of a Medicaid/NJ FamilyCare fee-for-service beneficiary through and including the age of 20.

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

§ 10:56-3.2 D0100-D0999 DIAGNOSTIC

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

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

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

- a. The examination is limited to once every six months for patients under 21 years of age, except as authorized by a dental consultant of the New Jersey Medicaid/NJ FamilyCare program;
- b. All items on the Dental Services Claim form (MC-10) should be completed;
- c. If no other treatment is necessary, this fact must be noted on the Dental Services Claim form (MC-10) in the diagnosis box (20). The abbreviation "NOTN" may be used to indicate no other treatment needed.

D0120	Periodic Oral Evaluation	15.00	14 .0 0
-------	--------------------------	-------	---------------

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

D0120	EP Periodic Oral Evaluation	15.00	14 .0 0
-------	-----------------------------	-------	---------------

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

d D0140	Limited oral evaluation	4.00	3. 00
---------	-------------------------	------	----------

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

D0160	Detailed and extensive oral	14.00	13 .0 0
-------	-----------------------------	-------	---------------

evaluation problem focused by report.

D0170	Re-evaluation--limited, problem	14.00	13 .0 0
-------	---------------------------------	-------	---------------

focused (Established patient; not post-operative visit)

(b) Radiographs:

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

- i. Indicate number of films in item 13 of the Dental Services Claim form (MC-10);

§ 10:56-3.2 D0100-D0999 DIAGNOSTIC

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.

				Maximum Fee		
HCPCS				Allowance		
IND	Code	Mod	Procedure Description	S	\$	NS
	D0210	52	Intraoral-Complete Series	18.00		18.00
						0
	NOTE 1: Limited to patients up to and including age six.					
	NOTE 2: Eight films.					
	D0210		Intraoral--Complete Series	22.00		22.00
			(including bitewings)			0
	NOTE 1: Limited to patients age seven up to and including age 14.					
	NOTE 2: Twelve films.					
	D0210	22	Intraoral--Complete Series	26.00		26.00
			(including bitewings)			0
	NOTE 1: Limited to patients age 15 or older.					
	NOTE 2: Minimum of 16 films.					
	D0220		Intraoral--Periapical--First Film	3.75		3.75
	D0230		Intraoral--Periapical--Each Additional Film	2.75		2.75
	NOTE 1: Indicate complete number of films (D0220 Plus D0230) in item 13.					
	D0240		Intraoral--Occlusal Film	5.00		5.00
	NOTE 1: Per film (maximum--two films).					
	NOTE 2: Indicate number of films in item 13.					
2.	Extraoral Radiographs					
	D0250		Extraoral, First Film	10.00		10.00
						0
	NOTE: Code to be used for lateral, anteroposterior, temporo-mandibular radiographs, etc. (one view).					
	D0260		Extraoral-- Each Additional Film	5.00		5.00
	NOTE 1: Indicate number of views in item 13.					
	NOTE 2: Maximum reimbursable--two additional views.					
	D0270		Bitewing--Single film	3.00		3.00
	D0272		Bitewings--Two films	5.00		5.00
	D0274		Bitewings--Four films	9.00		9.00
	D0290		Posterior--anterior or lateral skull and facial bone survey film	10.00		10.00
						0
	D0310		Sialography	15.00		15.00
						0
	D0310	22	Sialography	30.00		30.00
						0
	NOTE: Includes injection of contrast material (filling and/or emptying phases).					
	D0320		Temporomandibular joint anthrogram, including injection	30.00		30.00
						0

§ 10:56-3.2 D0100-D0999 DIAGNOSTIC

D0321		Other temporomandibular joint films, by report	BR	BR
D0322		Tomographic survey	125.00	90.0 0
D0330		Panoramic Film	15.75	15.7 5
D0340		Cephalometric Film	15.00	15.0 0
D0340	22	Cephalometric Film	22.50	22.5 0

NOTE: Includes tracing.

(c) Test and laboratory examinations:

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

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

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

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

NOTE: Or slides, per view.

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

NOTE 1: The gross and microscopic examination of oral tissues, both hard and soft.

NOTE 2: Limited to specialists in oral pathology, and Oral Diagnosis (Pathology) Departments of dental schools.

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

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

History

HISTORY:

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

§ 10:56-3.2 D0100-D0999 DIAGNOSTIC

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

Rewrote (a) and (b).

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

In (a) NOTE 1, substituted "NJ FamilyCare" for "NJ KidCare"; in (a)b NOTE 1, substituted "beneficiary" for "recipient" and "beneficiary's" for "recipient's".

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (a), raised the maximum fee allowance for HCPCS codes D0150 and D0120, and inserted references to NJ FamilyCare throughout.

Annotations

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[N.J.A.C. 10:56-3.3](#)

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§ 10:56-3.3. D1000-D1999 PREVENTIVE

(a) Dental prophylaxis:

Click here to view image.

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

Click here to view image.

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.

Click here to view image.

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

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

Click here to view image.

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

Click here to view image.

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

(b) Topical fluoride treatment (office procedure):

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

Click here to view image.

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

Click here to view image.

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

Click here to view image.

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

Click here to view image.

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

Click here to view image.

NOTE: Patients age 16 up to and including 20 years of age, maxillary or mandibular arch. Code to be used if patient is edentulous in one arch.

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

§ 10:56-3.3. D1000-D1999 PREVENTIVE

Click here to view image.

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

Click here to view image.

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

(c) Other Preventive Services

Click here to view image.

NOTE 1: Unfilled premolars and permanent molars.

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

(d) Space Maintenance (passive appliances)

Click here to view image.

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

Click here to view image.

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

Click here to view image.

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

History

HISTORY

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.

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

In (a)1, substituted "beneficiary" for "recipient" and increased the Maximum Fee Allowances for Adult and Child Prophylaxis; in (b)2, substituted "beneficiary" for "recipient".

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Annotations

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[N.J.A.C. 10:56-3.4](#)

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§ 10:56-3.4 D2000-D2999 RESTORATIVE

(a) Amalgam restorations (including polishing):

				Maximum Fee		
				Allowance		
IND	Code	Mod	Procedure Description	S	\$	NS
	D2110		Amalgam--One Surface, Primary	32.00		30.00
	D2120		Amalgam--Two Surfaces, Primary	38.00		35.50
	D2130		Amalgam--Three Surfaces, Primary	44.00		41.00
	D2131		Amalgam--Four or More Surfaces, Primary	51.00		46.50
	D2140		Amalgam--One Surface, Permanent	32.00		30.00
	D2150		Amalgam--Two Surfaces, Permanent	38.00		35.50
	D2160		Amalgam--Three Surfaces, Permanent	44.00		41.00
	D2161		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 margin(s) of the restoration extends beyond the proximal one-third of the facial and/or lingual surface(s).

2. Reimbursement will include acid etch where appropriate.

D2330	Resin-based composite--One Surface, anterior	35.50	33.00
D2331	Resin-based composite--Two Surfaces, anterior	42.50	39.00
D2332	Resin-based composite--Three Surfaces, anterior	49.50	45.00
D2335	Resin-based composite--Four or more Surfaces or involving incisal angle (anterior)	59.50	54.00
D2336	Resin-based composite crown, anterior--primary	40.00	35.00

§ 10:56-3.4 D2000-D2999 RESTORATIVE

D2337	Resin-based composite crown, anterior--permanent	40.00	35.0 0
D2380	Resin-based composite--One surface, posterior--primary	32.00	30.0 0
D2381	Resin-based--Two surfaces, posterior--primary	38.00	35.0 0
D2382	Resin-based composite--three or more surfaces, posterior--primary	44.00	41.0 0
For permanent teeth only:			
D2385	Resin-based composite--One surface, posterior--permanent	32.00	30.0 0
D2386	Resin-based composite--two surfaces, posterior--permanent	38.00	35.5 0
D2387	Resin-based composite--three surfaces, posterior--permanent	44.00	41.0 0
D2388	Resin-based composite--four or more surfaces, posterior--permanent	44.00	41.0 0

NOTE: Code to be used for three or more surfaces.

(c) Gold Foil Restorations:**1. Primarily for use in Dental Colleges.**

D2410	Gold Foil--One Surface	9.00	8.00
D2420	Gold Foil--Two Surfaces	18.00	16.0 0
D2430	Gold Foil--Three Surfaces	27.00	24.0 0

NOTE: Code to be used for three or more surfaces.

(d) Inlay Restorations:**1. Primarily for use in dental colleges.**

D2510	Inlay--Metallic--One Surface	31.00	27.0 0
D2520	Inlay--Metallic--Two Surfaces	56.00	49.0 0
D2530	Inlay--Metallic--Three or more Surfaces	75.00	65.0 0

NOTE: Code to be used for three or more surfaces.

D2542	Onlay--Metallic--Two Surfaces	79.00	69.0 0
D2543	Onlay--Metallic--Three Surfaces	98.00	85.0 0

(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.

§ 10:56-3.4 D2000-D2999 RESTORATIVE

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.

	High Noble	Noble	Predominantly Base
	<u>Classification</u>		
Weight %	Au., Pd. and/or Pt. >60% (with at least 40% Au)	Au., Pd. and/or Pt. >25%	Au., Pd. and/or Pt. </=25%
3. Codes to be used for crowns, single restoration only:			
D2710	Crown Resin (Laboratory)		98.00 85.00
			0
NOTE: Laboratory processed.			
D2720	Crown--Resin with High Noble Metal		161.00 140.00
			00
NOTE: Acrylic veneer.			
D2721	Crown--Resin with Predominantly Base Metal		161.00 140.00
			00
NOTE: Acrylic veneer.			
D2722	Crown--Resin with Noble Metal		161.00 140.00
			00
NOTE: Acrylic veneer.			
D2750	Crown--Porcelain Fused to High Noble Metal		279.00 253.00
			00
D2751	Crown--Porcelain Fused to Predominantly Base Metal		279.00 253.00
			00
D2752	Crown--Porcelain Fused to Noble Metal		279.00 253.00
			00
D2790	Crown--Full Cast High Noble Metal		161.00 140.00
			00
D2791	Crown--Full Cast Predominantly Base Metal		161.00 140.00
			00
D2792	Crown--Full Cast Noble Metal		161.00 140.00
			00
(f) Other restorative services:			
D2910	Recement Inlay		7.00 6.00
D2920	Recement Crown		7.00 6.00
D2930	Prefabricated Stainless Steel Crown--Primary Tooth		76.00 70.00
			00
NOTE: Reimbursable only for deciduous teeth.			
D2931	Prefabricated Stainless Steel Crown--Permanent Tooth		76.00 70.00
			00

§ 10:56-3.4 D2000-D2999 RESTORATIVE

NOTE: Reimbursable only for permanent posterior teeth up to and including 17 years of age.

D2932	Prefabricated Resin Crown	40.00	35.00
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NOTE: For example, Polycarbonate--Reimbursable only for primary and permanent anterior teeth up to and including 15 years of age.

D2933	Prefabricated Stainless Steel	135.50	124.00
-------	-------------------------------	--------	--------

	Crown with Resin window		0
D2940	Sedative Filling	10.00	9.00

D2950	Core Buildup including any Pins	49.00	45.00
-------	---------------------------------	-------	-------

NOTE 1: And/or post.

NOTE 2: Core of composite or amalgam.

D2951	Pin Retention--Per Tooth, In Addition to Restoration	6.00	5.00
-------	--	------	------

NOTE 1: Per pin.

NOTE 2: Maximum reimbursable--three pins.

NOTE 3: Not in conjunction with Procedure Code D3950 and D3950 22.

D2952	Cast Post and Core In Addition to Crown	75.00	68.00
-------	---	-------	-------

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 D3950 and D3950 22.

D2954	Prefabricated Post and Core In Addition to Crown	49.00	45.00
-------	--	-------	-------

NOTE 1: Preparatory to crown restoration only.

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

D2970	Temporary Crown (Fractured Tooth)	29.00	25.00
-------	-----------------------------------	-------	-------

NOTE: A preformed artificial crown which is fitted over a damaged tooth as an immediate protective device in tooth injury.

* D2980	Crown Repair, By Report	BR	BR
---------	-------------------------	----	----

* D2999	Unspecified Restorative Procedure, By Report	BR	BR
---------	--	----	----

History

HISTORY:

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.

§ 10:56-3.4 D2000-D2999 RESTORATIVE

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

Changed Maximum Fee Allowances throughout.

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

In (e)3, substituted "beneficiary" for "recipient".

Administrative correction.

See: [34 N.J.R. 4204\(a\)](#).

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Annotations

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§ 10:56-3.5 D3000-D3999 ENDODONTICS

(a) Therapeutic Pulpotomy:

				Maximum Fee		
				Allowance		
IND	HCPCS Code	Mod	Procedure Description	S	\$	NS
	D3220		Therapeutic Pulpotomy (Excluding Final Restoration)--removal of pulp coronal to the Dentinocemental junction and application of medicament	28.00		26.00
	D3221		Gross pulpal debridement, Primary and Permanent teeth	28.00		26.00
	D3230		Pulpal therapy (resorbable filling)--Anterior, Primary Tooth (excluding final restoration)	74.00		67.50
	D3240		Pulpal therapy (resorbable filling)--Posterior, Primary Tooth (excluding final restoration)	95.00		86.50

(b) Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care):

1. For emergency endodontic procedures, use code D3220.

D3310	Anterior (excluding final restoration)	148.00	135.00
-------	--	--------	--------

NOTE: Code to be used for incisors and cuspids (permanent).

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

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

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

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

D3346	Retreatment of previous root canal therapy--anterior	148.00	135.00
D3347	Retreatment of previous root canal therapy--bicuspid	190.00	173.00
D3348	Retreatment of previous root canal	247.00	225.00

§ 10:56-3.5 D3000-D3999 ENDODONTICS

		therapy--molar		00
D3351		Apexification/ recalcification--In	31.00	27.00
		itial visit (apical		0
		closure/calific repair of		
		perforations, root resorption,		
		etc.)		

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

NOTE 2: Maximum--two visits.

(c) Apicoectomy/periradicular Services:

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

D3410		Apicoectomy/periradicular	79.00	72.00
		surgery--anterior		0

(d) Apicoectomy performed in conjunction with endodontic procedure:

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

D3421		Apicoectomy/periradicular	79.00	72.00
		surgery--Bicuspid (first root)		0
D3425		Apicoectomy/periradicular	79.00	72.00
		surgery--Molar (first root)		0
D3426		Apicoectomy/periradicular	44.00	36.00
		surgery--(Each additional root)		0
D3430		Retrograde Filling--Per Root	9.00	7.50

NOTE 1: Reimbursable only in addition to apicoectomy.

NOTE 2: Maximum per tooth--three roots.

D3450		Root Amputation--Per Root	55.00	48.00
				0

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

NOTE 2: Maximum two roots.

(e) Other endodontic procedures:

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

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

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

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

NOTE 2: With cementation.

d*	D3999	Unspecified Endodontic Procedure,	BR	BR
		By Report		

History

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

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

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

In (c)2, substituted references to beneficiaries for references to recipients; in (d)1, substituted "NJ FamilyCare" for "NJ KidCare."

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Annotations

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§ 10:56-3.6 D4000 D4999 PERIODONTICS

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

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

NOTE 1: Maximum number of teeth reimbursable--Three.

NOTE 2: D4210 PA required only when exceeding four quadrants, twice annually.

#	D4220		Gingival Curettage, Surgical--Per Quadrant	22.50		19.50
#	D4260		Osseous Surgery (including Flap Entry and Closure)--Per Quadrant	75.00		64.50
*	D4261		Osseous, Single Site	56.25		48.40
*	D4263		Bone Replacement Graft First Site in Quadrant	261.00		261.00
*	D4264		Bone Replacement Graft--Each Additional Site in Quadrant (Use if Performed on Same Date of Service)	130.50		130.50
#	D4270		Pedicle Soft Tissue Graft Procedure	32.00		28.00

NOTE 1: Per site.

NOTE 2: D4220, D4260, D4261, D4270 PA required only for services exceeding four quadrants, twice annually.

#	D4271		Free Soft Tissue Graft Procedure (Including Donor Site)	49.00		42.00
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NOTE: Per site.

*	D4245		Apically Positioned Flap	36.00		31.50
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NOTE: Per quadrant.

*	D4249		Clinical Crown Lengthening--Hard Tissue	75.00		64.50
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NOTE: Per quadrant.

§ 10:56-3.6 D4000 D4999 PERIODONTICS

*	D4274	Distal or Proximal Wedge Procedure (When Not Performed in Conjunction with Surgical Procedures in the same Anatomical Area)	169.00	153.0 0
(b) Adjunctive periodontal services:				
	D4320	Provisional Splinting--Intracoronaral	18.00	16.00
	NOTE: Per tooth.			
	D4321	Provisional Splinting--Extracoronaral	11.00	10.00
	NOTE 1: Per tooth.			
	NOTE 2: This code may also be used for stabilization of traumatized teeth.			
#	D4341	Periodontal Scaling and Root Planing--Per Quadrant	37.50	34.50
	D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	11.00	10.00
	D4355	76 Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis	11.00	10.00
	NOTE 1: Code to replace Y2105-76--additional scaling.			
	NOTE 2: Code to be used when the beneficiary is developmentally disabled * [on]* *or* neurologically impaired (see N.J.A.C. 10:56-2.9(a)1ii).			
	NOTE 3: D4341 PA required for services exceeding four quadrants, twice annually.			
d*	D4999	Unspecified Periodontal Procedure, By Report	BR	BR

History

HISTORY:

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 Peridontal Scaling and Root Planing--Per Quadrant.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

Rewrote the section.

Annotations

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[N.J.A.C. 10:56-3.7](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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

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

				Maximum Fee		
				Allowance		
IND	Code	Mod	Procedure Description	S	\$	NS
*	D5110		Complete Denture--Maxillary	334.00		302.00
NOTE: Including denture I.D.						
*	D5120		Complete Denture--Mandibular	342.00		311.00

NOTE: Including denture I.D.

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

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

2. In order to qualify for immediate denture reimbursement, the denture must involve the immediate replacement of anterior teeth which may include first premolars (teeth numbers 5 through 12 and 21 through 28 only). Second premolars and molars must not be included among the qualifying teeth. The date of insertion of a denture and the extractions must carry an identical date of service. List tooth code(s) of teeth involved.

*	D5130		Immediate Denture--Maxillary	365.00		332.00
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NOTE 1: Replacing 1 through 4 teeth

*	D5130	22	Immediate Denture--Maxillary	392.00		353.00
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NOTE 1: Replacing 5 through 8 teeth

*	D5140		Immediate Denture--Mandibular	372.00		338.00
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NOTE 1: Replacing 1 through 4 teeth

*	D5140	22	Immediate Denture--Mandibular	400.00		363.00
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NOTE 1: Replacing 5 through 8 teeth

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

*	D5211		Maxillary Partial Denture--Resin	275.00		250.00
Base (Including any conventional clasps, rests and teeth)						
*	D5211	BD52	Maxillary Partial Denture--Resin	186.00		173.00

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		Base (Including teeth--no clasps)		
*	D5212	Mandibular Partial Denture--Resin	275.00	250.0 0
		Base (Including any conventional clasps, rests and teeth)		
*	D5212	BD52 Mandibular Partial Denture--Resin	186.00	173.0 0
		Base (Including teeth--no clasps)		
*	D5213	Maxillary Partial Denture--Cast	361.00	328.0 0
		Metal Framework with Resin Denture Bases (Including any conventional clasps, rests and teeth)		
*	D5214	Mandibular Partial Denture--Cast	342.00	311.0 0
		Metal Framework with Resin Denture Bases (Including any conventional clasps, rests and teeth)		

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

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

*	Y2505	Immediate Replacement of Anterior Teeth--Per Tooth	11.00	10.0 0
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NOTE: List tooth code(s) of tooth being replaced.

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

	D5410	Adjust Complete Denture--Maxillary	10.00	9.00
	D5411	Adjust Complete Denture--Mandibular	10.00	9.00
	D5421	Adjust Partial Denture--Maxillary	10.00	9.00
	D5422	Adjust Partial Denture--Mandibular	10.00	9.00

(f) Repairs to complete dentures:

1. Repair Broken Complete Denture Base:

i. Includes replacing teeth on denture

	D5510	YU Repair Broken Complete Denture Base	49.50	45.0 0
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NOTE: Maxillary--Upper

	D5510	YL Repair Broken Complete Denture Base	49.50	45.0 0
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NOTE: Mandibular--Lower.

	D5520	Replace Missing or Broken Teeth--Complete Denture (Each Tooth)	15.00	15.0 0
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NOTE 1: Code may be used in addition to codes D5510 YU or YL above.

NOTE 2: List tooth codes of teeth being replaced.

(g) Repairs to partial denture:

	D5610	YU Repair Resin Denture Base	49.50	45.00
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§ 10:56-3.7 D5000-D5899 PROSTHODONTICS (REMOVABLE)

NOTE: Maxillary.

D5610	YL	Repair Resin Denture Base	49.50	45.00
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NOTE: Mandibular.

D5620		Repair Cast Framework	33.00	30.00
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NOTE 1: Welding in addition to repair procedure(s), limit two welds per denture.

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

D5630	YU	Repair or Replace Broken Clasp	76.50	72.00
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NOTE 1: Maxillary.

NOTE 2: Maximum two.

D5630	YL	Repair or Replace Broken Clasp	76.50	72.00
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NOTE 1: Mandibular.

NOTE 2: Maximum two.

D5640		Replace Broken Teeth--Per Tooth	15.00	15.00
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NOTE 1: Code D5640 may be used in addition to partial denture repair procedure(s), D5610 YU or YL above.

D5650		Add Tooth to Existing Partial Denture	66.00	60.00
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NOTE 1: To replace extracted tooth. (List tooth code being replaced).

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

D5660	YU	Add Clasp to Existing Partial Denture	76.50	72.00
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NOTE 1: Maxillary--First Clasp.

NOTE 2: List tooth code being clasped.

NOTE 3: Maximum two.

D5660	YL	Add Clasp to Existing Partial Denture	76.50	72.00
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NOTE 1: Mandibular--First Clasp.

NOTE 2: List tooth being clasped.

NOTE 3: Maximum two.

(h) Denture rebase procedures:

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

(i) Denture relining procedures:

D5730		Reline Complete Maxillary Denture (Chairside)	29.00	26.00
D5731		Reline Complete Mandibular Denture (Chairside)	29.00	26.00
D5740		Reline Maxillary Partial Denture (Chairside)	29.00	26.00
D5741		Reline Mandibular Partial Denture (Chairside)	29.00	26.00
D5750		Reline Complete Maxillary Denture	99.00	90.00

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	(Laboratory)		
D5751	Reline Complete Mandibular Denture	99.00	90.00
	(Laboratory)		
D5760	Reline Maxillary Partial Denture	91.00	83.00
	(Laboratory)		
D5761	Reline Mandibular Partial Denture	91.00	83.00
	(Laboratory)		
(j) Other removable prosthetic services:			
D5860	Overdenture--complete	342.00	311.00
			0
D5862	Precision attachment	150.00	150.00
			0
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	75.00	75.00
*	D5899 Unspecified Removable Prosthodontic Procedure, By Report	BR	BR

History

HISTORY:

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

See: 20 N.J.R. 2101(a).

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

As amended by R.1989 d.135.

See: 20 N.J.R. 2558(a), 21 N.J.R. 760(a).

(k)1 deleted and NOTE changed to "a minimum of 2 cast chrome casts with rests".

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

Changed Maximum Fee Allowances throughout.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Annotations

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

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§ 10:56-3.8 D5900-D5999 MAXILLOFACIAL PROSTHETICS

(a) Treatment prosthesis:

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

History

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

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[N.J.A.C. 10:56-3.9](#)

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§ 10:56-3.9 D6000-D6999 PROSTHODONTICS, FIXED

(a) Each abutment and each pontic constitutes a unit in a bridge.

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

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

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

Implant services:

			Maximum Fee		
HCPCS			Allowance		
IND	Code	Mod	Procedure Description	S	\$ NS
*	D6010		Surgical placement of implant	500.00	500.00
			body: endosteal implant		
*	D6056		Prefabricated abutment	76.00	70.00
*	D6059		Abutment supported porcelain fused	279.00	253.00
			to metal crown (high noble metal)		
*	D6060		Abutment supported porcelain fused	279.00	253.00
			to metal crown (predominantly base metal)		
*	D6061		Abutment supported porcelain fused	279.00	253.00
			to metal crown (noble metal)		
*	D6062		Abutment supported cast metal	161.00	140.00
			crown (high noble metal)		
*	D6063		Abutment supported cast metal	161.00	140.00
			crown (predominantly base metal)		
*	D6064		Abutment supported cast metal	161.00	140.00

§ 10:56-3.9 D6000-D6999 PROSTHODONTICS, FIXED

					00
			crown (noble metal)		
*	D6066		Implant supported porcelain fused	279.00	253.00
			to metal crown (titanium, titanium alloy, high noble metal)		
*	D6067		Implant supported metal crown	161.00	140.00
			(titanium, titanium alloy, high noble metal)		
*	D6069		Abutment supported retainer for	279.00	253.00
			porcelain fused to metal FPD (high noble metal)		
*	D6070		Abutment supported retainer for	279.00	256.00
			porcelain fused to metal FPD (predominantly base metal)		
*	D6071		Abutment supported retainer for	279.00	256.00
			porcelain fused to metal FPD (noble metal)		
*	D6072		Abutment supported retainer for	161.00	140.00
			cast metal FPD (high noble metal)		
*	D6073		Abutment supported retainer for	161.00	140.00
			cast metal FPD (predominantly base metal)		
*	D6074		Abutment supported retainer for	161.00	140.00
			cast metal FPD (noble metal)		
*	D6199		Unspecified implant procedure, by report	BR	BR

(b) Bridge pontics:

			Maximum Fee		
HCPCS			Allowance		
IND	Code	Mod	Procedure Description	S	\$ NS
*	D6210		Pontic--Cast High Noble Metal	76.00	66.00
*	D6211		Pontic--Cast Predominantly Base Metal	76.00	66.00
*	D6212		Pontic--Cast Noble Metal	76.00	66.00
*	D6240		Pontic--Porcelain Fused to High Noble Metal	170.00	165.00
*	D6241		Pontic--Porcelain Fused to Predominantly Base Metal	170.00	165.00
*	D6242		Pontic--Porcelain Fused to Noble Metal	170.00	165.00
*	D6250		Pontic--Resin with High Noble Metal	90.00	80.00
*	D6251		Pontic Resin with Predominantly	90.00	80.00

§ 10:56-3.9 D6000-D6999 PROSTHODONTICS, FIXED

		Base Metal		
*	D6252	Pontic--Resin with Noble Metal	90.00	80.00
*	D6545	Retainer--cast metal for resin bonded fixed prosthesis	75.00	75.00

NOTE: Per tooth.

(c) Bridge retainers--crowns:

*	D6720	Crown--Resin with High Noble Metal	161.00	140.00
				0
*	D6721	Crown--Resin with Predominantly	161.00	140.00
				0
		Base Metal		
*	D6722	Crown--Resin with Noble Metal	161.00	140.00
				0
*	D6750	Crown--Porcelain Fused to High	279.00	253.00
				0
		Noble Metal		
*	D6751	Crown--Porcelain Fused to	279.00	253.00
				0
		Predominantly Base Metal		
*	D6752	Crown--Porcelain Fused to Noble	279.00	253.00
				0
		Metal		
*	D6790	Crown--Full Cast High Noble Metal	161.00	140.00
				0
*	D6791	Crown--Full Cast Predominantly	161.00	140.00
				0
		Base Metal		
*	D6792	Crown--Full Cast Noble Metal	161.00	140.00
				0

(d) Other fixed prosthetic services:

	D6930	Recement Bridge	8.00	7.00
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NOTE 1: One abutment.

NOTE 2: Code may be used when recementing facing.

	D6930	22 Recement Bridge	14.00	12.00
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NOTE: Two or more abutments.

*	D6970	Cast Post and Core in Addition to Bridge Retainer	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: Not in conjunction with Procedure Codes D3950 and D3950 22.

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

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

	D6973	Core build up for retainer, including any pins	49.00	45.00
*	D6975	Coping--metal	161.00	140.00
				0

NOTE: Cast crown.

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

History

HISTORY:

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

Changed Maximum Fee Allowances throughout.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Annotations

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[N.J.A.C. 10:56-3.10](#)

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§ 10:56-3.10 D7000-D7999 ORAL SURGERY

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

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

NOTE 1: Per tooth.

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

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

#	D7210		Surgical Removal of Erupted Tooth	33.00		31.00
			Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth			
#	D7220		Removal of Impacted Tooth--Soft Tissue	43.00		40.00
#	D7230		Removal of Impacted Tooth--Partially Bony	114.00		106.00
#	D7240		Removal of Impacted Tooth--Completely Bony	114.00		106.00
#	D7250		Surgical Removal of Residual Tooth Roots (Cutting Procedure)	43.00		39.00

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

(c) Other surgical procedures:

D7260		Oroantral Fistula Closure	108.00		99.00
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NOTE 1: Code may also be used for antral root recovery.

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

D7270		Tooth Re-implantation and/or Stabilization of Accidentally	93.00		85.00
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§ 10:56-3.10 D7000-D7999 ORAL SURGERY

		Avulsed or Displaced Tooth and/or Alveolus		
	D7280	Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reason (Including Orthodontic Attachments)	101.00	94.00
	D7281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption	45.00	41.00
d	D7285	Biopsy of Oral Tissue--Hard	30.00	26.00
		NOTE: Independent procedure (laboratory must bill separately).		
d	D7286	Biopsy of Oral Tissue-Soft	18.00	16.00

NOTE: Independent procedure (laboratory must bill separately).

(d) Alveoloplasty surgical preparation of ridge for dentures:**1. Reimbursement will be based upon quadrants.**

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

	D7320	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.

	D7340	Vestibuloplasty--Ridge Extension (Secondary Epithelialization)	65.00	59.00
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NOTE: Including management of hypertrophied and hyperplastic tissue, per quadrant.

	D7350	Vestibuloplasty--Ridge Extension (Including Soft Tissue Grafts, Muscle Re-attachments, Revision of Soft Tissue Attachment, and 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.

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

NOTE: Up to and including three cm.

	D7420	22 Radical Excision--Lesion Diameter	100.00	86.00
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§ 10:56-3.10 D7000-D7999 ORAL SURGERY

Over 3 cm.

(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/NJ FamilyCare dental consultants.

D7430		Excision of Benign Tumor--Lesion	30.00	26.0 0
		Diameter Up to 1.25 cm.		
D7431		Excision of Benign Tumor--Lesion	42.00	37.0 0
		Diameter Over 1.25 cm.		
D7431	22	Excision of Benign Tumor--Lesion	100.00	86.0 0
		Diameter Over 3 cm.		
D7440		Excision of Malignant	100.00	86.0 0
		Tumor--Lesion Diameter Up to 1.25 cm.		
D7441		Excision of Malignant	274.00	256. 00
		Tumor--Lesion Diameter Over 1.25 cm.		

NOTE: Up to and including three cm.

D7441	22	Excision of Malignant	473.00	413. 00
		Tumor--Lesion Diameter Over 3 cm.		
D7450		Removal of Odontogenic Cyst or	50.00	43.0 0
		Tumor--Lesion Diameter Up to 1.25 cm.		
D7451		Removal of Odontogenic Cyst or	100.00	87.0 0
		Tumor--Lesion Diameter Over 1.25 cm.		

NOTE: Up to and including three cm.

D7451	22	Removal of Odontogenic Cyst or	150.00	130. 00
		Tumor--Lesion Diameter Over 3 cm.		
D7460		Removal of Non Odontogenic Cyst or	50.00	43.0 0
		Tumor--Lesion Diameter Up to 1.25 cm.		
D7461		Removal of Non Odontogenic Cyst or	100.00	87.0 0
		Tumor--Lesion Diameter Over 1.25 cm.		

NOTE: Up to and including three cm.

D7461	22	Removal of Non Odontogenic Cyst or	150.00	130. 00
		Tumor--Lesion Diameter Over 3 cm.		
D7465		Destruction of Lesion(s) by	18.00	15.0 0
		Physical Methods: Electrosurgery, Chemotherapy, Cryotherapy or Laser		

§ 10:56-3.10 D7000-D7999 ORAL SURGERY

(h) Excision of bone tissue:

D7471		Removal of Exostosis--per site	62.50	56.50
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1. Reimbursement will be based upon quadrants.

NOTE: Per quadrant.

D7471	22	Removal of Exostosis	109.00	98.00
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NOTE: Torus palatinus.

D7480		Partial Osteotomy (Guttering or	211.00	184.00
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Saucerization)

D7490		Radical Resection of Mandible with	807.00	807.00
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Bone Graft

(i) Surgical incision:

D7510		Incision and Drainage of	28.00	26.00
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Abscess--Intraoral Soft Tissue

D7520		Incision and Drainage of	42.00	37.00
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Abscess--Extraoral Soft Tissue

D7530		Removal of Foreign Body, Skin, or	18.00	16.00
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Subcutaneous Areolar Tissue

D7540		Removal of Reaction Producing	51.00	45.00
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Foreign Bodies, Musculoskeletal

System

D7550		Sequestrectomy for Osteomyelitis	48.00	42.00
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NOTE: Intraoral.

D7550	22	Sequestrectomy for Osteomyelitis	90.00	75.00
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NOTE: Extraoral.

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

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

(j) Treatment of fractures--simple:**1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.**

D7610		Maxilla--Open Reduction (Teeth	273.00	249.00
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Immobilized if Present)

D7620		Maxilla--Closed Reduction (Teeth	182.00	166.00
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Immobilized if Present)

D7620	52	Maxilla--Closed Reduction	80.00	76.00
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NOTE: No manipulation or fixation.

D7630		Mandible--Open Reduction (Teeth	363.00	331.00
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Immobilized if Present)

D7630	22	Mandible--Open Reduction (Teeth	454.00	414.00
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Immobilized if Present)

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

D7640		Mandible--Closed Reduction (Teeth	182.00	166.00
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§ 10:56-3.10 D7000-D7999 ORAL SURGERY

		Immobilized if Present)		00
D7640	52	Mandible--Closed Reduction	80.00	76.00
NOTE: No manipulation or fixation.				
D7650		Malar and/or Zygomatic Arch--Open Reduction	182.00	166.00
D7660		Malar and/or Zygomatic Arch--Closed Reduction	63.00	58.00
NOTE: Including towel clip technique.				
D7660	52	Malar and/or Zygomatic Arch--Closed Reduction	56.00	52.00
NOTE: No manipulation or fixation.				
D7670		Alveolus--Stabilization of Teeth, Open Reduction Splinting	138.00	126.00
NOTE 1: Alveolar fracture.				
NOTE 2: Reduction with wiring, application of arch bar or splint.				
D7680		Facial Bones--Complicated Reduction with Fixation and Multiple Surgical Approaches	363.00	331.00
NOTE 1: Maxilla, malar and/or zygomatic arch.				
NOTE 2: Multiple surgical approaches (three or more), fixation, traction, head frame, multiple internal and/or external fixation, and head cap.				
(k) Treatment of fractures--compound:				
1. Open reduction involves the dissection of tissues and/or the visual inspection of the fracture site.				
D7710		Maxilla--Open Reduction	273.00	249.00
NOTE: Teeth immobilized if present.				
D7720		Maxilla--Closed Reduction	182.00	166.00
NOTE: Teeth immobilized if present.				
D7720	52	Maxilla--Closed Reduction	80.00	76.00
NOTE: No manipulation or fixation.				
D7730		Mandible--Open Reduction	363.00	331.00
NOTE: Teeth immobilized if present.				
D7730	22	Mandible--Open Reduction	454.00	414.00
NOTE: Complicated--multiple surgical approaches (three or more) including internal fixation, interdental fixation, and skeletal pinning with extraoral fixation.				
D7740		Mandible--Closed Reduction	182.00	166.00
NOTE: Teeth immobilized if present.				
D7740	52	Mandible--Closed Reduction	80.00	76.00
NOTE: No manipulation or fixation.				

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	D7750	Malar and/or Zygomatic Arch--Open	182.00	166.00
		Reduction		
	D7760	Malar and/or Zygomatic Arch--Closed Reduction	63.00	58.00
NOTE: Including towel clip technique.				
	D7760	52 Malar and/or Zygomatic Arch--Closed Reduction	56.00	52.00
NOTE: No manipulation or fixation.				
	D7770	Alveolus--Stabilization of Teeth, Open Reduction Splinting	138.00	126.00
NOTE 1: Alveolar fracture.				
NOTE 2: Reduction with wiring, application of arch bar or splint.				
	D7780	Facial Bones--Complicated Reduction with Fixation and Multiple Surgical Approaches	363.00	331.00
NOTE 1: Maxilla, malar and/or zygomatic arch.				
NOTE 2: Multiple surgical approaches (three or more), fixation, traction, head frame, multiple internal and/or external fixation, and head cap.				
(I) Reduction of dislocation and management of other temporo-mandibular joint dysfunctions:				
	D7810	Open Reduction of Dislocation	273.00	249.00
	D7820	Closed Reduction of Dislocation	27.00	25.00
d	D7830	Manipulation under Anesthesia	27.00	25.00
NOTE: Anesthesia additional.				
	D7840	Condylectomy	362.00	315.00
	D7850	Meniscectomy	362.00	315.00
	D7852	Disc repair	362.00	308.00
NOTE: Unilateral.				
	D7854	Synovectomy	200.00	173.00
	D7858	Joint reconstruction	623.00	623.00
	D7860	Arthrotomy	182.00	155.00
	D7865	Arthroplasty	362.00	308.00
NOTE: Unilateral.				
d	D7870	Arthrocentesis	18.00	16.00
NOTE: Injection or aspiration (give complete details).				
	D7871	Non-arthroscopic lysis and lavage	190.00	190.00
	D7872	Arthroscopy--diagnosis, with or without biopsy	75.00	65.00
	D7873	Arthroscopy--surgical: lavage and	200.00	200.00

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	lysis of adhesions		
D7874	Arthroscopy--surgical: disc	500.00	425.0 0
	repositioning and stabilization		
D7875	Arthroscopy--surgical: synovectomy	264.00	224.0 0
D7877	Arthroscopy--surgical: debridement	160.00	136.0 0
* D7880	Occlusal orthotic device, by report	BR	BR
D7899	Unspecified TMD therapy, by report	BR	BR

(m) Repair of traumatic wounds:

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

D7910	Suture of Recent Small Wounds up to 5 cm.	35.00	32.0 0
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NOTE: 2.5 cm. up to five cm.

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

1. Also for irregularly shaped lacerations requiring extensive debridement.

D7911	Complicated suture--Up to 5 cm.	138.00	138. 00
D7912	Complicated suture--greater than 5 cm.	242.00	242. 00
D7920	Skin graft (identify defect covered, location and type of graft)	70.50	70.5 0

(o) Other repair procedures:

D7940	Osteoplasty--For Orthognathic Deformities	225.00	191.0 0
D7941	Osteotomy--Mandibular rami	726.00	726.0 0

NOTE: Unilateral.

D7943	Osteotomy--Mandibular rami with bone graft; includes obtaining the graft	1,058	1,058
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NOTE: Unilateral.

D7944	Osteotomy--Segmented or subapical--per sextant or quadrant	332.00	289.0 0
D7945	Osteotomy--body of mandible	332.00	289.0 0
D7946	LeFort I (maxilla--total)	546.00	546.0 0
* D7947	LeFort I (maxilla--segmented)	365.00	365.0 0
D7948	LeFort II or LeFort III (Osteoplasty of facial bones for midface Hypoplasia or	1,095	1,095

§ 10:56-3.10 D7000-D7999 ORAL SURGERY

	retrusion)--without bone graft		
D7949	LeFort II or LeFort III--with bone graft	1,427	1,427
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones--autogenous or nonautogenous, by report	575.00	489.00
D7955	Repair of Maxillofacial Soft and Hard Tissue Defects	203.00	176.00
D7960	Frenulectomy (Frenectomy or Frenotomy)--Separate Procedure	60.00	56.00
D7970	Excision of hyperplastic tissue--per arch	45.00	39.00
D7971	Excision of pericoronary gingiva	42.00	37.00
D7980	Sialolithotomy	48.00	42.00
D7981	Excision of Salivary Gland, by report	182.00	158.00
D7982	Sialodochoplasty	151.00	131.00
D7983	Closure of Salivary Fistula	151.00	131.00
D7990	Emergency Tracheotomy	121.00	105.00
D7991	Coronoidectomy	362.00	308.00
* D7995	Synthetic graft--mandible or facial bones, by report	BR	BR
D7996	Implant--mandible for augmentation purposes (excluding alveolar ridge), by report	BR	BR
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	151.00	151.00
** D7999	Unspecified Oral Surgery Procedure, By Report	BR	BR

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

History

HISTORY:

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).

§ 10:56-3.10 D7000-D7999 ORAL SURGERY

Qualifier added to 07130, in (c); prior authorization requirement removed from 07210, in (d).

Administrative Corrections to (c), (d)1 and (q).

See: 22 N.J.R. 1375(a).

Amended by R.1990 d.456, effective September 4, 1990.

See: 22 N.J.R. 1660(b), 22 N.J.R. 2713(a).

In (d): revised (d)1 to specify conditions for extraction, by incorporating text from old (d)2. Recodified (d)3 as (d)2 and added new (d)3. Deleted asterisks in List. In (f)1: added new "07310".

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

See: [28 N.J.R. 3069\(a\)](#), [28 N.J.R. 4243\(a\)](#).

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

See: [32 N.J.R. 2411\(a\)](#), [32 N.J.R. 3836\(a\)](#).

Changed Maximum Fee Allowances throughout.

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

See: [33 N.J.R. 1554\(a\)](#), [33 N.J.R. 2666\(b\)](#).

In (g)1, inserted a reference to NJ FamilyCare.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2004 d.25, effective January 20, 2004.

See: [35 N.J.R. 4032\(a\)](#), [36 N.J.R. 568\(a\)](#).

In (g)1, inserted reference to NJ FamilyCare.

Annotations

Notes

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NEW JERSEY ADMINISTRATIVE CODE
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End of Document

[N.J.A.C. 10:56-3.11](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 56. MANUAL FOR DENTAL SERVICES > SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:56-3.11 D8000-D8999 ORTHODONTICS

(a) Minor treatment for tooth guidance:

1. Includes all necessary adjustments.
2. Code may also be used for Orthodontic Retention Appliances following comprehensive treatment by a previous dentist.

				Maximum Fee		
				Allowance		
IND	Code	Mod	Procedure Description	S	\$	NS
	D8010		Limited orthodontic treatment of the primary dentition	595.00		590. 00
	D8020		Limited orthodontic treatment of the transitional dentition	595.00		590. 00
	D8030		Limited orthodontic treatment of the adolescent dentition	595.00		590. 00
	D8040		Limited orthodontic treatment of the adult dentition	595.00		590. 00
	D8050		Interceptive orthodontic treatment of the primary dentition	595.00		590. 00
	D8060		Interceptive orthodontic treatment of the transitional dentition	595.00		590. 00

(b) Minor treatment to control harmful habits:

1. Includes all necessary adjustments.

D8210	Removable Appliance Therapy	595.00	590. 00
D8220	Fixed Appliance Therapy	595.00	590. 00

(c) Comprehensive orthodontic treatment--adolescent dentition:

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

D8080	Comprehensive orthodontic	2,581	2,58 1
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§ 10:56-3.11 D8000-D8999 ORTHODONTICS

treatment of the adolescent
dentition

(d) Other orthodontic services:

D8660	Pre-orthodontic treatment visit	11.00	10.00
NOTE 1: This code is to be used for comprehensive orthodontic evaluation and assessment.			
NOTE 2: Definition and Criteria for Assessing Handicapping Malocclusion Permanent Dentition form (FD-10) must be available in patient records.			
D8691	Repair of orthodontic appliance	49.50	45.00
D8692	Replacement of lost or broken	115.00	110.00
	retainer		0
* D8999	Unspecified Orthodontic Procedure, By Report	BR	BR

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

History

HISTORY:

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.

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Annotations

Notes

[Chapter Notes](#)

NEW JERSEY ADMINISTRATIVE CODE

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[N.J.A.C. 10:56-3.12](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 56. MANUAL FOR DENTAL SERVICES > SUBCHAPTER 3. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)

§ 10:56-3.12 D9000-D9999 ADJUNCTIVE GENERAL SERVICES

(a) Unclassified treatment:

				Maximum Fee		
				Allowance		
IND	Code	Mod	Procedure Description	S	\$	NS
d	D9110		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:

D9210		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.

D9211		Regional block anesthesia	13.00	11.00
D9212		Trigeminal division block anesthesia	18.00	16.00
D9220	D922	General Anesthesia	125.00	125.00

NOTE: This code applies when the dentist performing the services (attending dentist) also administers the general anesthesia or in conjunction with oral surgery services only.

(c) Special general anesthesia:

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

D9220		General anesthesia--first 30 minutes	22.00	22.00
D9221		General anesthesia--each additional 15 minutes	11.00	11.00

NOTE 1: Time units are for each additional 15 minute period or major portion thereof limited to "table" or "chair" time only. Maximum reimbursable is two hours.

NOTE 2: 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.

§ 10:56-3.12 D9000-D9999 ADJUNCTIVE GENERAL SERVICES

NOTE 3: 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.

D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	15.00	14.0 0
D9241	Intravenous sedation/ analgesia--first 30 minutes	50.00	49.0 0

NOTE: Parenteral Conscious Sedation.

D9242	Intravenous sedation/ analgesia--each additional 15 minutes	11.00	11.0 0
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NOTE: Maximum reimbursable is eight units.

D9248	Non-intravenous conscious sedation	40.00	40.0 0
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(d) Professional consultation (diagnostic service provided by a dentist other than practitioner providing treatment):

1. A complete report must be available.

d	D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	22.00	17.0 0
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(e) Professional visits

D9410	House/extended care facility call	20.50	19.00
D9420	Hospital Call	32.00	27.00

NOTE: Code to be used for Hospital Day--Initial--Inpatient or Same Day Surgery.

D9420	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 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.

D9430	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 (for example, bony impactions, fractures, etc.)

(f) Drugs:

D9610	Therapeutic Drug Injection	2.50	2.50
D9610	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*	D9630	Other Drugs and/or Medicaments, By Report	BR	BR
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(g) Miscellaneous services:

D9910	Application of Desensitizing Medicaments	6.00	5.00
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§ 10:56-3.12 D9000-D9999 ADJUNCTIVE GENERAL SERVICES

NOTE 1: Application to tooth/teeth for cervical sensitivity, erosions, etc.

NOTE 2: This code is not to be used for bases, liners or adhesives under restorations.

NOTE 3: Per visit.

D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	35.50	33.00
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NOTE 1: This code is not to be used for bases, liners or adhesives under restorations.

NOTE 2: Specify tooth code(s).

D9920	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 necessitated an excessive amount of time to accomplish treatment (for example, mental retardation, neurological disorders, etc.). For 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 where services exceed the thresholds listed in note 2 below.

NOTE 2: Payment will be based on place of service and utilization thresholds in units (one unit equals 15 minutes) as follows:

Place of Service	Utilization Threshold
Office or Clinic	2
Inpatient/Outpatient Hospital	4
Skilled Nursing Facility	2

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 that exceed the thresholds.

NOTE 5: Code to be used in addition to other procedures performed.

D9930	Treatment of Complications (Post Surgical)--Unusual Circumstances	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.

D9940	Occlusal Guards	50.00	45.00
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NOTE 1: Special periodontal appliance (including occlusal guards and athletic mouth guards).

NOTE 2: Office procedure.

D9940	22	Occlusal Guards	65.00	58.00
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NOTE 1: Special periodontal appliance (including occlusal guards and athletic mouth guards).

NOTE 2: Laboratory procedure.

D9951	Occlusal Adjustment--Limited	6.00	5.00
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NOTE: One to three teeth.

D9952	22	Occlusal Adjustment--Complete	68.00	60.00
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D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	6.00	5.00
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D9974	Internal bleaching--per tooth	33.00	33.00
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d**	D9999	Unspecified Adjunctive Procedure, By Report	BR	BR
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NOTE: To be used only when 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 consultant.

History

§ 10:56-3.12 D9000-D9999 ADJUNCTIVE GENERAL SERVICES

HISTORY:

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--".

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

See: [34 N.J.R. 2681\(a\)](#), [35 N.J.R. 232\(a\)](#).

Rewrote the section.

Amended by R.2003 d.132, effective March 17, 2003.

See: [34 N.J.R. 3921\(a\)](#), [35 N.J.R. 1424\(a\)](#).

Rewrote (g).

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[N.J.A.C. 10:56, Appx. A](#)

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 56 No. 3, February 5, 2024

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APPENDIX A FISCAL AGENT BILLING SUPPLEMENT

FISCAL AGENT BILLING SUPPLEMENT

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

History

HISTORY:

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.

Amended by R.2007 d.36, effective February 5, 2007.

See: [38 N.J.R. 3419\(a\)](#), [39 N.J.R. 479\(a\)](#).

In the introductory paragraph, deleted "/manual" following "chapter" and "replacement pages will be distributed to providers and" following "supplement," and inserted "and revisions will be made available to providers" and "access www.njmmis.com or"; and in the first address, substituted "Unisys" for "UNISYS".

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