MCCSS Schedule of Dental Services and Fees
January 2019

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MCCSS Schedule of Dental Services and Fees

SOCIAL ASSISTANCE LEGISLATION

Dental benefits under this schedule are available under the following two programs:

- Ontario Disability Support Program (ODSP)
- Ontario Works (solely for children 17 years of age or younger residing in a First Nation community)*****

*** Please refer to page 5 of this Schedule for more information.**

THE SCHEDULE EXPLAINED

This schedule lists services for both the **Mandatory Basic Dental Care Plan** and the **Dental Special Care Plan (DSCP).** The Mandatory Basic Dental Care Plan covers ODSP recipients and their adult spouses as well as children 17 years of age or younger on Ontario Works, residing in a First Nation community.

The Dental Special Care Plan is intended to augment the Mandatory Basic Dental Care Plan for ODSP recipients and adult spouses, whose:

- Disability, prescribed medications or prescribed medical treatment directly impacts their oral health

DSCP services are highlighted in the schedule as follows:

Dental Special Care Plan	**EXAMINATION AND DIAGNOSIS, LIMITED ORAL** Additional frequency/units of time beyond the limits listed above are available through the DSCP for those patients under ODSP who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP				
	01202	Examination and Diagnosis, Limited Oral, Previous Patient (Recall) Examination of hard and soft tissues, including checking of occlusion and appliances, but not including specific tests/analysis as for Complete Oral Examination	19.00	22.81	**DSCP Limit:** maximum, 4 per 12 months, per patient, per dentist, per address (MB and DSCP combined). Pre-determination required for additional coverage beyond the MB limit.

All DSCP services require predetermination. Instructions for pre-determining DSCP services are available in the section “Pre-determination of Benefits” starting on page 7.

The services covered under DSCP are:

- Additional Recall Examinations (01202)
- Additional Polishing (11107)
- Additional Scaling / Root Planing (11111 – 11119, 43421 – 43429)
- Additional Fluoride Treatments (12111,12112,12113)
- Custom Fluoride Appliances (12601 – 12602)
- Bruxism Appliances (14611 – 14612)
- Crowns (27211, 27215, 27301)
- Periodontal Surgery, Grafts, Soft Tissue (42511, 42521, 42531, 42551, 42561)

Specific limits for dental services under the Mandatory Basic Dental Care Plan and DSCP are noted in the 'Limit' column where applicable. Some services require a note or specific criteria on the dental claim form to be considered for payment. These requirements are listed in the 'Limit' column beside the associated procedure codes.

ELIGIBILITY INFORMATION

Who is eligible?

Those eligible for Mandatory Basic Dental Care under this schedule are:

ODSP

- ODSP recipients
- The spouse of an ODSP recipient if the spouse is 18 years of age or older

Ontario Works

- Ontario Works children 17 years of age or younger, **whose families are residing in a First Nation community**
- Ontario Works children 17 years of age or younger **residing in a First Nation community** whose guardian receives Temporary Care Assistance on their behalf under Ontario Works

- Ontario Works recipients 17 years of age or younger and spouses 17 years of age or younger **who are residing in a First Nation community**

Dental Special Care Plan

Those eligible for the Dental Special Care Plan (DSCP) under this schedule are:

- ODSP recipients and their spouse (if the spouse is 18 years of age or older) whose disability, prescribed medications or prescribed medical treatment directly impacts their oral health

Who is not eligible for benefits under this schedule?

- Members of an ODSP benefit unit who are 17 years of age and younger
- Dependents (18 years of age or older) of ODSP recipients who are not the recipient's spouse
- Children on whose behalf Assistance for Children with Severe Disabilities (ACSD) is provided
- Members of an Ontario Works benefit unit 17 years of age and younger **(except for children aged 17 and younger residing in a First Nation community,)**
- Children whose guardian receives Temporary Care Assistance under Ontario Works **(except for children aged 17 or younger residing in a First Nation community)**
- Adult Ontario Works participants

Dental coverage for those not eligible for benefits under this schedule:

Members of a benefit unit 17 years of age and younger

- Healthy Smiles Ontario provides dental coverage for:
  - Members of an Ontario Works and ODSP benefit unit 17 years of age and younger
  - Children on whose behalf Temporary Care Assistance is provided under Ontario Works
  - Children on whose behalf ACSD is provided

Adult Ontario Works participants

- Municipalities may provide dental coverage for adult Ontario Works participants as a discretionary benefit (usually emergency and/or denture benefits).

ODSP dependent adults (i.e. dependents 18 years of age and older, other than a spouse)

- Municipalities may provide dental coverage for ODSP dependent adults18 years of age and older, as a discretionary benefit (usually emergency and/or denture benefits).

How does the dental office verify eligibility for patients?

Eligible adults under ODSP receive a dental card that indicates the program name and the valid benefit month. Ensure you ask for this card and keep a copy in the patient's file.

See page 5 for further information about eligible Ontario Works children residing in a First Nation community.

ONTARIO WORKS CLIENTS IN FIRST NATION COMMUNITIES

ELIGIBILITY INFORMATION

Who is eligible?

Children aged 17 years and under whose families are in receipt of Ontario Works AND are residing in a First Nation community are eligible for Mandatory Basic Dental Care under this schedule**.**

Dentists should continue their current procedures to bill for Ontario Works dental benefits for these clients.

Please note that if an Ontario Works family residing in a First Nation community enrolls in the Healthy Smiles Ontario (HSO) Program through the Ministry of Health and Long-Term Care, dental claims should be billed to the HSO Program.

How does the dental office verify eligibility for Ontario Works clients residing in a First Nation community?

Children who are 17 years of age and under may receive a dental card that indicates the program name, eligibility for 'basic' dental care and the valid benefit month. Ensure you ask for this card and keep a copy in the patient's file.

For children who are 17 years of age and under and not in receipt of a dental card, municipal documentation will indicate:

- the program name
- eligibility for basic dental care
- valid benefit month

For more information on how to verify eligibility for Ontario Works clients residing in First Nation communities, please contact the local Ontario Works office or Ontario Works dental plan administrator.

ONTARIO WORKS CLIENTS IN FIRST NATION COMMUNITIES cont'd

SUBMISSION OF DENTAL CLAIMS FOR ONTARIO WORKS CLIENTS IN FIRST NATION COMMUNITIES

Where do I send my claims?

For members of a benefit unit 17 and under in receipt of Ontario Works (including Temporary Care Assistance) AND who are residing in a First Nation community, claim forms should be sent to the local Ontario Works dental plan administrator. Please contact the local Ontario Works office if this information is not available.

PRE-DETERMINATION OF BENEFITS

With the exception of the Dental Special Care Plan, there is no pre-determination requirement.

When to pre-determine services?

A pre-determination of benefits is only required for services listed under the Dental Special Care Plan (DSCP). The purpose of pre-determining benefits is to allow dentists to confirm that services covered under the DSCP are eligible. Pre-determination cannot be used to question a dentist's clinical findings or judgment. The DSCP provides coverage for additional services for ODSP patients whose disabilities, prescribed medication or medical treatment directly impacts their oral health necessitating one or more of the services listed in the DSCP. The DSCP also provides coverage for scaling and/or root planning (11111 – 11119, 43421 – 43429) once only prior to major cardiac, transplant or other surgery where dental cleaning is requested by the patient's medical/dental practitioner; AND for crowns (27211, 27215, 27301) where the patients are dependent on their dentition to operate a device that is mouth operated (e.g. wheelchair). The dentist must indicate the specific condition being treated (for additional information, refer to the 'DSCP Limit:' in the 'Limit' column of this schedule).

A pre-determination for services beyond the schedule may be submitted for approval by the plan administrator for persons with severe disabilities.

Do topical fluorides, panoramic radiographs, general anaesthesia, deep sedation and the facility fee have to be pre-determined?

No.

However, the eligibility requirements remain in place. Many services in this schedule are covered only under specific circumstances (e.g. fluoride, panoramic radiographs, gingivectomy). This schedule lists the criteria or limits that apply to each service in the 'Limit' column. In order for the plan administrator to determine eligibility for these services, the dentist must indicate the specific eligibility criteria that is/are applicable to the claim. This information must be provided in the 'For dentist use only' box on the Standard Dental Claim Form.

The services that require additional information are:

Procedure Code	Description	Requirement	Page Number
02601	Radiographs, Panoramic, Single film	List one criteria on dental claim form	16
1211x	Fluoride Treatment, Whole Mouth In Office - Rinse, Gel or Foam, and Varnish	List two criteria on dental claim form	18
42311	Gingivectomy – Uncomplicated, per sextant	Indicate medication or hereditary condition	23
425xx	Grafts, Soft Tissue	Indicate surgical site	23
7xxxx	Removals – Extractions Removals – Impactions	The removal of more than one bicuspid or the removal of more than one 3rd molar at one time requires confirmation that the extractions are not for Orthodontic purposes and/or the tooth is symptomatic on the dental claim form.	25

How long is the pre-determination of benefits valid?

The pre-determination of benefits for DSCP services, issued by the dental plan administrator, is valid for five years from the date of issue. Note: the client must be eligible for coverage in the month that treatment is rendered.

Can pre-determination of benefits be appealed?

Yes. Dentists may appeal the plan administrator's decision respecting the pre-determination of benefits. Appeals are to be made to the plan administrator. Details about the appeal process will be available from the dental plan administrator at the request of the dentist.

How to determine when to submit a pre-treatment form?

A pre-treatment form must be submitted for those DSCP services indicated in the schedule.

Example:

Dental Special Care Plan	**EXAMINATION AND DIAGNOSIS, LIMITED ORAL** Additional frequency/units of time beyond the limits listed above are available through the DSCP for those patients under ODSP who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP				
	01202	Examination and Diagnosis, Limited Oral, Previous Patient (Recall) Examination of hard and soft tissues, including checking of occlusion and appliances, but not including specific tests/analysis as for Complete Oral Examination	19.00	22.81	**DSCP Limit:** maximum, 4 per 12 months, per patient, per dentist, per address (MB and DSCP combined). Pre-determination required for additional coverage beyond the MB limit.

What pre-treatment form can be submitted?

The Standard Dental Pre-treatment form may be used for all patients.

What vital information is required on a pre-treatment form?

- Client/patient name and identification number
- Dentist signature
- Dentist name, address and unique identification number
- Client/patient signature to authorize the release of personal information to the plan administrator for pre-determination purposes
- Cardholder name and case identification number
- The DSCP services that are recommended
- Confirmation that disability, medical condition or medication will have a direct impact on their oral health
- For DSCP requests place DSCP on the Pre-treatment form
- The specific applicable criteria as listed in the schedule

Will X-rays and/or study models be required?

No. There is no requirement for a dentist to provide radiographs, study models or any other diagnostic material for dental treatment (planned or performed) under this schedule.

Where should pre-treatment forms be mailed?

Pre-treatment forms for adults under ODSP are to be submitted to AccertaClaim Servicorp Inc. (Accerta).

When should a reply to a pre-treatment form be expected?

The dental plan administrator is expected to reply within 5 working days from the date it received the pre-treatment form request.

SUBMISSION OF DENTAL CLAIMS

Where do I send my claims?

For adults under ODSP dental claims should be sent to:

Accerta

Toronto “P”

P.O. Box 310

Toronto, ON M5S 2S8

Which forms are required when submitting to Accerta?

Accerta can accept ODA/CDA approved dental claim forms only. This includes pre-printed or computer generated claim forms. The provincial/municipal dental claim form can be used for the ODSP and Ontario Works plans administered by Accerta. **Provincial/municipal claim forms can be printed or downloaded from Accerta’s website at** www.accerta.ca.

Can I use EDI to submit claims?

Accerta accepts EDI transmissions for ODSP dental claims. Transmission types include:

- Dental Claims Submission
- Dental Claim Reversal

EDI responses include:

- Explanation of Benefits (EOB)
    - Results of adjudication
    - Partial or full reimbursement notices
- Acknowledgement (ACK)
    - Response status message indicates the reason for the response
        - Claim is rejected because of errors (please call Accerta for assistance)
        - Claim is received successfully by the carrier and is held for further processing

The Primary Policy/Plan Number for ODSP is MCS.

Please use Accerta's carrier code (BIN 311140) by adding it under instream.

When should claims be submitted?

Claims are to be sent in as treatment occurs, except for multiple appointment procedures, such as root canals, which should be submitted on completion of the treatment.

Deadline for claims submissions

Claims must be received by Accerta for initial processing within 12 months of the date the services were provided.

CLAIMS PROCESSING AND ADJUDICATION

What happens when a patient visits more than one dentist?

Dentists will be reimbursed for treatment provided when a client exceeds frequency limitations by attending more than one dentist in a different office.

Is Extra or Balance Billing acceptable?

No. Extra billing or balance billing is not permitted for services covered and paid for under this schedule for adults on ODSP. A dentist may bill the patient for services not covered and not paid for under this schedule.

How to claim Specialists fees?

Where a general dental practitioner has referred a client to a specialist, the specialist will be reimbursed at the specialist rate provided that the proper procedure has been followed. Specialists must submit the name of the referring dentist on their claim form(s). In the case of person with disabilities, a referral from the client's medical practitioner will be acceptable. In this situation, the physician's name and practice address should be submitted on the specialist's claim form(s).

How to avoid reimbursement delays?

In order to ensure that the correct practitioner is reimbursed and that the reimbursement is sent to the correct practice address, the following information is required on all claim forms:

- The treating dentist's name
- The treating dentist's unique identification number (UIN), and
- The treating dentist's address

How is the frequency of services calculated?

Frequency and annual maximums will be calculated based on a 12 month rolling period.

How will radiographs be reimbursed?

Periapical films are paid cumulatively up to the maximum payable per patient, per dentist, per 12 month period. For example:

If 02112 is claimed, the amount payable is $16.33 for general practitioners and $19.60 for specialists.

If 02111 is subsequently claimed, the amount payable is $3.79 for general practitioners and $4.54 for specialists.

The represents the difference between the amount previously paid ($16.33 for general practitioners and $19.60 for specialists) and the maximum for 3 periapical films which is $20.12 for general practitioners and $24.14 for specialists.

Co-ordination of Benefits

Claims for services performed for clients who have dental benefits under a private dental plan contract or insurance policy, must be submitted through the private plan first. If the private insurance pays less than the full amount of the dentist's fee, benefits may be coordinated through this plan. This plan will top up the payment to the amount billed by the dentist, as long as the top up is equal to or less than, the fee shown in this schedule:

If 02142 is claimed, the amount billed by the provider, e.g. $34.00.

According to this schedule, the amount payable is $16.33.

If the private insurance covers 80% of the amount billed, the private insurance would pay $27.20 (80% of $34.00) leaving a balance of $6.80. This plan would pay the balance of $6.80 as the balance is less than the fee in MCCSS schedule ($16.33), so the provider's fee would be paid in full.

Please complete a duplicate dental claim form and attach the Explanation of Benefits from the first payer.

Please note, First Nations Inuit Health Branch (FNIHB) staffs have advised that where a client is eligible for coverage under the Non-Insured Health Benefits (NIHB) program and Ontario Works or ODSP, the NIHB program is second payer.

Please contact Accerta if you require further details.

OTHER INFORMATION

For questions about completing pre-treatment forms and/or claim forms, or questions about claims processing or payments please contact Accerta:

In Toronto call: 416-922-6565

Outside Toronto call: 1-800-505-7430

Or email: info@accerta.ca

Copies of this schedule are available on AccertaWorX or visit Accerta's website at www.accerta.ca.

Code	Description		GP	Specialist	Limit

DIAGNOSTIC SERVICES

EXAMINATION AND DIAGNOSIS, CLINICAL ORAL				All clients are covered for any **TWO examinations, from the list below, in any 12 month period** provided these examinations are within the frequency limitations described below. Please note that while all emergency exams are covered, they count toward the two exam limitation in any 12 month period. Consequently, if a patient has two or more emergency exams in a 12 month period, they would not be covered for any routine or non-emergency exams in that period. A recall exam or a complete oral exam is payable when 9 months have elapsed between these services.
Examination and Diagnosis, Complete Oral, to include: a) History, Medical and Dental b) Clinical Examination and Diagnosis of Hard and Soft tissues, including carious lesions, missing teeth, determination of pocket depth and location of periodontal pockets, gingival contours, mobility of teeth, interproximal tooth contact relationships, occlusion of teeth, TMJ, pulp vitality tests/analysis, where necessary and any other pertinent factors. c) Radiographs extra, as required.				1 per 60 months, per patient, per dentist, per address.
01101	Examination and Diagnosis, Complete, Primary Dentition, to include: (a) Extended examination and diagnosis on primary dentition, recording history, charting, treatment planning and case presentation, including above description	38.01	45.61	
01102	Examination and Diagnosis, Complete, Mixed Dentition to include: (a) Extended examination and diagnosis on mixed dentition, recording history, charting, treatment planning and case presentation, including above description b) Eruption sequence, tooth size - jaw size assessment	57.01	68.42	
01103	Examination and Diagnosis, Complete, Permanent Dentition to include: (a) Extended examination and diagnosis on permanent dentition, recording history, charting, treatment planning and case presentation, including above description	76.02	91.22	

EXAMINATION AND DIAGNOSIS, LIMITED ORAL				A recall exam or a complete oral exam is payable when 9 months have elapsed between these services. 1 per 9 months, per patient, per dentist, per address.
01202	Examination and Diagnosis, Limited Oral, Previous Patient (Recall) Examination of hard and soft tissues, including checking of occlusion and appliances, but not including specific tests/analysis as for Complete Oral Examination	19.00	22.81	

Dental Special Care Plan (DSCP)

EXAMINATION AND DIAGNOSIS, LIMITED ORAL Additional coverage beyond the limits listed above is available through the Dental Special Care Plan (DSCP) for those patients under ODSP/ACSD who are eligible for DSCP. A predetermination is required for approval of any additional coverage under DSCP.				
01202	Examination and Diagnosis, Limited Oral, Previous Patient (Recall) Examination with mirror and explorer of hard and soft tissues, including checking of occlusion and appliances, but not including specific tests/analysis as for Complete Oral Examination	19.00	22.81	**DSCP Limit**: Maximum, 4 per 12 months, per patient, per dentist, per address (MCCSS and DSCP combined). Pre-determination required for additional coverage beyond the MCCSS limit.

Code	Description		GP	Specialist	Limit
EXAMINATION AND DIAGNOSIS, LIMITED ORAL					
01204	Examination and Diagnosis, Specific Examination and evaluation of a specific situation		19.00	22.81	1 per 12 months, per patient, per dentist, per address.
01205	Examination and Diagnosis, Emergency Examination and diagnosis for the investigation of discomfort and/or infection in a localized area		19.00	22.81	All emergency exams will be covered and are counted towards the TWO examinations in any 12 month period limit. There is no limit on the number of emergency exams that will be covered.
RADIOGRAPHS (Including Radiographic Examination and Diagnosis and Interpretation) Radiographs, Intraoral, Periapical					Maximum of 8 periapical films per 12 months, per patient, per dentist, per address (except when required in an emergency situation) are paid cumulatively. Maximum payable for periapical and occlusal films combined is $27.02 for general practitioners and $32.42 for specialists.
02111	Single film		13.35	16.02	
02112	Two films		16.33	19.60	
02113	Three films		20.12	24.14	
02114	Four films		22.52	27.03	
02115	Five films		27.02	32.42	
02116	Six Films		27.02	32.42	
02117	Seven Films		27.02	32.42	
02118	Eight Films		27.02	32.42	
Radiographs, Intraoral, Occlusal					A single occlusal film is counted as 2 periapical films. Maximum payable is $19.80 for general practitioners and $23.75 for specialists.
02131	Single film		15.76	18.90	
02132	Two films		19.80	23.75	
Radiographs, Intraoral, Bitewing					Maximum payable for 2 bitewing films, per patient, per dentist, per 9 months is $16.33 for general practitioners and $19.60 for specialists.
02141	Single film		13.35	16.02	
02142	Two films		16.33	19.60	

Code	Description		GP	Specialist	Limit
Radiographs, Panoramic					1 per 24 months, per patient, per dentist. **Except in an emergency when criteria 1, 2, 5 or 6 applies**. Maximum payable is $31.54 for general practitioners and $37.85 for specialists. These radiographs are covered when required due to: 1. facial trauma with symptoms of possible jaw fracture; 2. facial swelling of unknown etiology, 3. significant delayed eruption pattern; 4. severe gag reflex with multiple carious lesions; 5. diagnosis cannot be made using periapical film; 6. and special circumstances clearly substantiated by the practitioner. One of the above criteria **(listing the number is acceptable)** must appear on the dental claim form for consideration of payment.
02601	Single film		31.54	37.85	
TEST/ANALYSIS HISTOPATHOLOGICAL (technical procedure only)					
Test/Analysis, Histological, Soft Tissue (technical procedure only)					
04311	Biopsy, Soft Oral Tissue – by Puncture + L		38.01	45.61	
04312	Biopsy, Soft Oral Tissue – by Incision + L		38.01	45.61	
Test/Analysis, Histological, Hard Tissue (technical procedure only)					
04321	Biopsy, Hard Oral Tissue - by Puncture + L		88.69	106.42	
04322	Biopsy, Hard Oral Tissue - by Incision + L		88.69	106.42	

Code	Description		GP	Specialist	Limit

PREVENTIVE SERVICES

MAINTENANCE CARE SERVICES (RECALL)

POLISHING				1 per 9 months when performed in conjunction with a recall exam and scaling.
11107	One half unit		12.67	

Dental Special Care Plan (DSCP)

POLISHING Additional frequency/units of time beyond the limits listed above are available through the Dental Special Care Plan (DSCP) for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP.				**DSCP Limit**: Maximum, 4 occurrences per 12 months, per patient, per dentist, per address (MCCSS and DSCP combined) when performed in conjunction with a recall exam and scaling. Pre-determination required for additional coverage beyond the MCCSS limit.
11107	One half unit		12.67	

SCALING				A combined maximum (Scaling/Root Planing) 4 units per 12 months, per patient, per dentist.
11111	One unit of time		38.01	45.61
11112	Two units		76.02	91.22
11113	Three units		114.03	136.83
11114	Four units		152.03	182.44
11117	One half unit		19.00	22.80

Dental Special Care Plan (DSCP)

SCALING Additional frequency/units of time beyond the limits listed above are available through the Dental Special Care Plan (DSCP) for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP.				**DSCP Limit:** Coverage is available for an additional 8 units of scaling and/or root planing per 12 months, per patient, per dentist. (Maximum of 12 units of scaling and/or root planing under MCCSS and DSCP combined, per 12 months, per patient, per dentist). Pre-determination is required for the additional 8 units of scaling and/or root planing only. Covered on a periodic or ongoing basis as a result of increased susceptibility to periodontal disease as a result of the disability, prescribed medication or prescribed medical treatment **OR** once only prior to major cardiac, transplant or other surgery where dental cleaning is requested by the patient's medical/dental practitioner.
11111	One unit of time		38.01	45.61
11112	Two units		76.02	91.22
11113	Three units		114.03	136.83
11114	Four units		152.03	182.44
11115	Five units		189.63	227.55
11116	Six units		228.05	273.66
11117	One half unit		19.00	22.80
11119	Each additional unit		38.01	45.61

Code	Description		GP	Specialist	Limit
	FLUORIDE TREATMENTS, WHOLE MOUTH IN OFFICE				Coverage is limited to situations where **two or more** of the following criteria apply: 1. Water fluoride content is less than0.3 ppm, 2. Past history of smooth surface decay in the last three years 3. Present smooth surface decay 4. Evidence of long standing poor oral hygiene 5. A severe medically compromised patient 6. Xerostomia – radiation or drug induced **Two** of the above criteria (listing numbers are acceptable) must appear on the dental claim form for consideration of payment.
12111	Rinse		15.20		
12112	Gel or Foam		15.20		
12113	Varnish		15.20		

Dental Special Care Plan (DSCP)

	FLUORIDE TREATMENTS, WHOLE MOUTH IN OFFICE				**DSCP Limit:** As required, to address high risk of caries for patients who are at high risk as a direct result of their disability, prescribed medication or prescribed medical treatment.
12111	Rinse		15.20		
12112	Gel or Foam		15.20		
12113	Varnish		15.20		

Dental Special Care Plan (DSCP)

	FLUORIDE CUSTOM APPLIANCES				**DSCP Limit***:* Lifetime maximum of one maxillary and one mandibular appliance per patient. Covered when required to address reduced salivary flow due to head and neck irradiation or to address patients with chronic dry mouth as a result of their disability, prescribed medication or prescribed medical treatment.
	Fluoride, Custom Appliances (home application) The following procedure codes are covered under the DSCP only for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of coverage under DSCP.				
12601	Fluoride Custom Appliance - Maxillary Arch + L		38.01		
12602	Fluoride Custom Appliance – Mandibular Arch + L		38.01		
12603	Fluoride Custom Appliance - Maxillary plus Mandibular Combined + L		50.68		

PREVENTIVE SERVICES, MISCELLANEOUS

	Sealants, Pit and Fissure Sealants (Mechanical and/or chemical preparation included)				Restricted to first permanent molar up to the 8th birthday only and to the second permanent molar up to the 14th birthday only.
13401	First tooth		15.97		

	Mouthguards (Protective Appliance)				Ages 0 - 17 - 1 per 12 months, per patient, per dentist, per address. Age 18 and over - 1 per 60 months, per patient, per dentist, per address.
14502	Mouth Guards, Processed + L		63.35		

Code	Description		GP	Specialist	Limit
Dental Special Care Plan (DSCP)	**APPLIANCES, PERIODONTAL**				
	Appliances, Periodontal (including bruxism appliance); Includes Impression, Insertion and Insertion Adjustment (no post insertion adjustment) The following procedure codes are covered under the DSCP only for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of coverage under DSCP.				**DSCP Limit**: Maximum of 1 per 60 months, per patient, where patient is developmentally handicapped, or an accidental brain injury occurred.
	14611	Maxillary Appliance + L	152.03	182.44	
	14612	Mandibular Appliance + L	152.03	182.44	

Code	Description		GP	Specialist	Limit

RESTORATIVE SERVICES

Where at the same sitting in order to conserve tooth structure, separate amalgam/tooth coloured restorations are performed on the same tooth, the fee should be determined by counting the total number of surfaces restored. Maximum allowable for amalgam/tooth coloured restorations is five surfaces per tooth.

Payment for restorations on primary teeth shall not exceed the cost of stainless steel/polycarbonate crowns. In amalgam/tooth coloured restorative situations where this limitation applies, an alternate benefit equivalent to stainless steel/polycarbonate crowns (codes 22201, 22211, 22401 and 22501) shall be provided for settlement purposes. These figures are reflected in the MCCSS Schedule of Dental Services and Fees.

No repeat surface (or pins) will be paid more than once in any 12 month period when the subsequent restoration is placed by the same dentist. The amount paid for the previous restoration will be deducted from the amount claimed for the new restoration if performed by the same dentist for the same patient.

CARIES,TRAUMA AND PAIN CONTROL				The final restoration is payable after 7 days have elapsed.
Caries/Trauma/Pain Control (removal of carious lesions or existing restorations or gingivally attached tooth fragment and placement of sedative/protective dressings, includes pulp caps when necessary, as a separate procedure)				
20111	First tooth	31.68	38.01	
20119	Each additional tooth same quadrant	31.68	38.01	
Caries/Trauma/Pain Control (removal of carious lesions or existing restorations or gingivally attached tooth fragment and placement of sedative/protective dressings, includes pulp caps when necessary and the use of a band for retention and support, as a separate procedure)				
20121	First tooth	31.68	38.01	
20129	Each additional tooth same quadrant	31.68	38.01	

RESTORATIONS, AMALGAM				
Restorations, Amalgam, Non-Bonded, Primary Teeth				
21111	One surface	25.34	30.41	
21112	Two surfaces	55.49	66.59	
21113	Three surfaces	63.35	76.02	
21114	Four surfaces	76.02	91.22	
21115	Five surfaces or maximum surfaces per tooth	76.02	91.22	
Restorations, Amalgam, Bonded, Primary Teeth				
21121	One surface	25.34	30.41	
21122	Two surfaces	55.49	66.59	
21123	Three surfaces	63.35	76.02	
21124	Four surfaces	76.02	91.22	
21125	Five surfaces or maximum surfaces per tooth	76.02	91.22	
Restorations, Amalgam, Non-Bonded, Permanent Bicuspid and Anteriors				
21211	One surface	25.34	30.41	
21212	Two surfaces	55.49	66.59	
21213	Three surfaces	63.35	76.02	
21214	Four surfaces	76.02	91.22	
21215	Five surfaces or maximum surfaces per tooth	76.02	91.22	

Code	Description		GP	Specialist	Limit
Restorations, Amalgam, Non-Bonded, Permanent Molars					
21221	One surface		31.68	38.01	
21222	Two surfaces		63.35	76.02	
21223	Three surfaces		79.32	95.17	
21224	Four surfaces		79.32	95.17	
21225	Five surfaces or maximum surfaces per tooth		79.32	95.17	
Restorations, Amalgam, Bonded, Permanent Bicuspid and Anteriors					
21231	One surface		25.34	30.41	
21232	Two surfaces		55.49	66.59	
21233	Three surfaces		63.35	76.02	
21234	Four surfaces		76.02	91.22	
21235	Five surfaces or maximum surfaces per tooth		76.02	91.22	
Restorations, Amalgam, Bonded, Permanent Molars					
21241	One surface		31.68	38.01	
21242	Two surfaces		63.35	76.02	
21243	Three surfaces		79.32	95.17	
21244	Four surfaces		79.32	95.17	
21245	Five surfaces or maximum surfaces per tooth		79.32	95.17	
Pins, Retentive per restoration (for amalgams and tooth coloured restorations)					Maximum 3 pins per permanent tooth, per patient, per dentist, per address.
21401	One pin		10.91	13.08	
21402	Two pins		18.20	21.83	
21403	Three pins		24.27	29.11	
21404	Four pins		24.27	29.11	
21405	Five pins or more		24.27	29.11	
RESTORATIONS PREFABRICATED/FULL COVERAGE					
Restorations, Prefabricated, Metal, Primary Teeth					
22201	Primary Anterior		95.02	114.03	
22211	Primary Posterior		95.02	114.03	
Restorations, Prefabricated, Metal, Permanent Teeth					
22301	Permanent Anterior		95.02	114.03	
22311	Permanent Posterior		95.02	114.03	
Restorations, Prefabricated, Plastic, Primary Teeth					
22401	Primary Anterior		95.02	114.03	
Restorations, Prefabricated, Plastic, Permanent Teeth					
22501	Permanent Anterior		95.02	114.03	

Code	Description		GP	Specialist	Limit
RESTORATIONS, TOOTH COLOURED/PLASTIC WITH/WITHOUT SILVER FILINGS					
Restorations, Tooth Coloured Permanent Anteriors Non Bonded Technique					
23101	One surface		44.34	53.22	
23102	Two surfaces (continuous)		57.01	68.42	
23103	Three surfaces (continuous)		87.17	104.59	
23104	Four surfaces (continuous)		87.17	104.59	
23105	Five surfaces or maximum surfaces per tooth		97.56	117.07	
Restorations, Permanent Anteriors, Bonded Technique (not to be used for Veneer Applications or Diastema Closure)					
23111	One surface		50.68	60.81	
23112	Two surfaces (continuous)		63.35	76.02	
23113	Three surfaces (continuous)		95.02	114.03	
23114	Four surfaces (continuous)		95.02	114.03	
23115	Five surfaces or maximum surfaces per tooth		106.42	127.71	
Restorations, Tooth Coloured/Plastic with/without Silver Filings, Permanent Posteriors, Non Bonded - Permanent Bicuspids					
23211	One surface		44.34	53.22	
23212	Two surfaces		79.32	95.17	
23213	Three surfaces		87.17	104.59	
23214	Four surfaces		104.66	125.58	
23215	Five surfaces or maximum surfaces per tooth		104.66	125.58	
Restorations, Tooth Coloured/Plastic with/without Silver Filings, Permanent Posteriors, Non Bonded – Permanent Molars					
23221	One surface		50.68	60.81	
23222	Two surfaces		87.17	104.59	
23223	Three surfaces		95.02	114.03	
23224	Four surfaces		114.03	136.83	
23225	Five surfaces or maximum surfaces per tooth		114.03	136.83	
Restorations, Tooth Coloured, Permanent Posteriors - Bonded Permanent Bicuspids					
23311	One surface		50.68	60.81	
23312	Two surfaces		87.17	104.59	
23313	Three surfaces		95.02	114.03	
23314	Four surfaces		114.03	136.83	
23315	Five surfaces or maximum surfaces per tooth		114.03	136.83	
Restorations, Tooth Coloured, Permanent Posteriors - Bonded Permanent Molars					
23321	One surface		57.01	68.42	
23322	Two surfaces		95.02	114.03	
23323	Three surfaces		102.88	123.46	
23324	Four surfaces		123.66	148.39	
23325	Five surfaces or maximum surfaces per tooth		123.66	148.39	
Restorations, Tooth Coloured, Primary Anterior Non Bonded					
23401	One surface		44.34	53.22	
23402	Two surfaces (continuous)		57.01	68.42	
23403	Three surfaces (continuous)		79.32	95.17	

Code	Description		GP	Specialist	Limit
23404	Four surfaces (continuous)		79.32	95.17	
23405	Five surfaces or maximum surfaces per tooth		79.32	95.17	
Restorations, Tooth Coloured, Primary Anterior, Bonded Technique					
23411	One surface		50.68	60.81	
23412	Two surfaces (continuous)		63.35	76.02	
23413	Three surfaces (continuous)		87.17	104.59	
23414	Four surfaces (continuous)		87.17	104.59	
23415	Five surfaces or maximum surfaces per tooth		87.17	104.59	
Restorations, Tooth Coloured/Plastic with/without Silver Filings, Primary Posterior, Non Bonded					
23501	One surface		44.34	53.22	
23502	Two surfaces		79.32	95.17	
23503	Three surfaces		87.17	104.59	
23504	Four surfaces		95.02	114.03	
23505	Five surfaces or maximum surfaces per tooth		95.02	114.03	
Restorations, Tooth Coloured/Plastic, Primary Posterior, Bonded Technique					
23511	One surface		50.68	60.81	
23512	Two surfaces		87.17	104.59	
23513	Three surfaces		95.02	114.03	
23514	Four surfaces		95.02	114.03	
23515	Five surfaces or maximum surfaces per tooth		95.02	114.03	

Dental Special Care Plan (DSCP)

CROWNS, SINGLE UNITS (ONLY) The following procedure codes are covered under the DSCP only for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of coverage under DSCP.					**DSCP Limit**: Maximum 1 crown, per tooth, per lifetime, where the patient is dependent on their dentition to operate a device that is mouth operated (e.g. wheelchair). Reimbursement for crowns on posterior teeth will be limited to cost of cast metal crown.
CROWNS, PORCELAIN/CERAMIC/POLYMER GLASS FUSED TO METAL					
27211	Crown, Porcelain/Ceramic Fused to Metal Base + L		443.43	532.12	
27215	Crown, Porcelain/Ceramic/Polymer Glass Fused to Metal Base, Implant-Supported + L + E		354.74	425.69	
CROWNS, FULL, CAST METAL					
27301	Full, Cast Metal + L		364.88	437.86	

Code	Description		GP	Specialist	Limit

ENDODONTIC SERVICES

PULPOTOMY				Maximum payable equals root canal therapy minus pulpectomy/pulpotomy, if completed within three months by the same dentist.
Pulpotomy, Permanent Teeth (as a separate emergency procedure)				
32221	Anterior and Bicuspid Teeth	63.35	76.02	
32222	Molar Teeth	114.03	136.83	
Pulpotomy, Primary Teeth				
32231	Primary Dentition, as a Separate Procedure	63.35	76.02	
32232	Primary Dentition, Concurrent with Restorations (but excluding final restoration)	31.68	38.01	

PULPECTOMY (An emergency procedure and/or as a pre-emptive phase to the preparation of the root canal system for obturation)				Maximum payable equals root canal therapy minus pulpectomy/pulpotomy, if completed within three months by the same dentist.
Pulpectomy, Permanent Teeth/Retained Primary Teeth				
32311	One canal	63.35	76.02	
32312	Two canals	76.02	91.22	
32313	Three canals	114.03	136.83	
Pulpectomy, Primary Teeth				
32321	Anterior Tooth	63.35	76.02	
32322	Posterior Tooth	63.35	76.02	

ROOT CANAL THERAPY **To include: treatment plan, clinical procedures (ie: pulpectomy, biomechanical preparation, chemotherapeutic treatment and obturation), with appropriate radiographs, excluding final restoration**				Maximum payable equals root canal therapy minus pulpectomy/pulpotomy, if completed within three months by the same dentist.
Root Canals, Permanent Teeth/Retained Primary Teeth One Canal				
33111	One canal	253.39	304.06	
Root Canals, Permanent Teeth/Retained Primary Teeth, Two Canals				
33121	Two canals	316.74	380.08	
Root Canals, Permanent Teeth/Retained Primary Teeth, Three Canals				
33131	Three canals	494.11	592.92	
Root Canals, Permanent Teeth/Retained Primary Teeth, Four or More Canals				
33141	Four or more canals	570.13	684.14	

Apexification/Apexogenesis/Induction of Hard Tissue Repair (to include biomechanical preparation and placement of dentogenic media)				Coverage is limited to dependent children 0-17 years of age. Only one apexification procedure and one root canal procedure is payable per tooth, per patient, per dentist.
33601	One canal	228.05	273.66	
33602	Two canals	304.06	364.88	
33603	Three canals	380.08	456.10	

Code	Description		GP	Specialist	Limit
APICOECTOMY/APICAL CURETTAGE					The following teeth are covered: 13,12,11,21,22,23,33,32,31,41,42,43
Maxillary Anterior					
34111	One root		221.71	266.06	
Mandibular Anterior					
34141	One root		221.71	266.06	

RETROFILLING					The following teeth are covered: 13,12,11,21,22,23,33,32,31,41,42,43
Maxillary Anterior					
34211	One canal		44.34	53.22	
Mandibular Anterior					
34241	One canal		44.34	53.22	

Code	Description		GP	Specialist	Limit

PERIODONTAL SERVICES

PERIODONTAL SERVICES, NON-SURGICAL ORAL DISEASE, MANAGEMENT OF				
Oral Manifestations, Oral Mucosal Disorders Mucocutaneous disorders and diseases of localized mucosal conditions, e.g. lichen planus, aphthous stomatitis, benign mucous membrane pemphigoid, pemphigus, salivary gland tumors, leukoplakia with and without dysplasia, neoplasms, hairy leukoplakia, polyps, verrucae, fibroma, etc.				
41211	One unit of time	38.01	45.61	
Oral Manifestations of Systemic Disease or complications of medical therapy, e.g. complications of chemotherapy, radiation therapy, post operative neuropathics, post surgical or radiation therapy, dysfunction, oral manifestation of lupus erythematoses and systemic disease including leukaemia, diabetes and bleeding disorders (e.g. haemophilia).				
41231	One unit of time	38.01	45.61	
41232	Two units	76.02	91.22	
41233	Three units	114.03	136.83	

PERIODONTAL SERVICES, SURGICAL (Includes local anaesthetic, suturing and the placement and removal of initial surgical dressing. A surgical site is an area that lends itself to one or more procedures. It is considered to include a full quadrant, sextant or a group of teeth or in some cases a single tooth).				Maximum 6 different sextants per 12 months, per patient, per dentist, per address.
Gingivectomy, Uncomplicated				Coverage is limited to cases involving gingival hyperplasia that is directly related to a specific drug or hereditary syndrome. Note drug or syndrome on the dental claim.
42311	Per sextant	199.67	239.61	

Dental Special Care Plan (DSCP)

PERIODONTAL SURGERY, GRAFTS, SOFT TISSUE The following procedure codes are covered under the DSCP only for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of coverage under DSCP.				
Grafts, Soft Tissue, Pedicle (Including Apically or Lateral Sliding and Rotated Flaps)				Note: Identify surgical site(s) on the dental claim form. Where required to improve the prognosis of the dentition
42511	Per Site	266.06	319.27	
Grafts, Soft Tissue, Pedicle (Coronally Positioned)				
42521	Per Site	266.06	319.27	
Grafts, Free Soft Tissue				
42531	Per Site	266.06	319.27	
Grafts, Free Connective Tissue (For root coverage)				
42551	Per Site	380.08	456.10	
Grafts, Free Connective Tissue (For ridge augmentation)				
42561	Per Site	380.08	456.10	

Code	Description		GP	Specialist	Limit
PERIODONTAL SURGERY, MISCELLANEOUS PROCEDURES					
Periodontal Abscess or Pericoronitis, may include one or more of the following procedures: Lancing, Scaling, Curettage, Surgery or Medication					Maximum 2 units per 12 months, per patient, per dentist, per address.
42831	One unit of time		38.01	45.61	
42832	Two units		76.02	91.22	
ROOT PLANING, PERIODONTAL					
Root Planing					A combined maximum (Scaling/Root Planing) 4 units per 12 months, per patient, per dentist.
43421	One unit of time		38.01	45.61	
43422	Two units		76.02	91.22	.
43423	Three units		114.03	136.83	
43424	Four units		152.03	182.44	
43427	One half unit		19.00	22.81	
Dental Special Care Plan (DSCP)					
ROOT PLANING Additional frequency/units of time beyond the limits listed above are available through the Dental Special Care Plan (DSCP) for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP.					**DSCP Limit:** Coverage is available for an additional 8 units of scaling and/or root planing per 12 months, per patient, per dentist. (Maximum of 12 units of scaling and/or root planing under MCCSS and DSCP combined, per 12 months, per patient, per dentist). Pre-determination is required for the additional 8 units of scaling and/or root planing only. Covered on a periodic or ongoing basis as a result of increased susceptibility to periodontal disease as a result of the disability, prescribed medication or prescribed medical treatment **OR** once only prior to major cardiac, transplant or other surgery where dental cleaning is requested by the patient's medical/dental practitioner.
43421	One unit of time		38.01	45.61	
43422	Two units		76.02	91.22	
43423	Three units		114.03	136.83	
43424	Four units		152.03	182.44	
43425	Five units		189.63	227.55	
43426	Six units		228.05	273.66	
43427	One half unit		19.00	22.81	
43429	Each additional unit		38.01	45.61	
CHEMOTHERAPEUTIC AND/OR ANTIMICROBIAL AGENTS					
Chemotherapeutic and/or antimicrobial agents, topical application					
43511	One unit of time		38.01	45.61	One unit per visit, 2 visits per 12 months, per patient, per dentist, per address.
MISCELLANEOUS PERIODONTAL SERVICES					
Periodontal Re-evaluation/Evaluation This follow-up service applies to the evaluation of ongoing periodontal treatment or to a post-surgical re-evaluation performed more than one month after surgery or if performed by another practitioner					
49101	One unit of time		38.01	45.61	Payable one month after 42311, 42511, 42521, 42531, 42551 is claimed only or if performed by a different practitioner.

Code	Description		GP	Specialist	Limit

ORAL AND MAXILLOFACIAL SURGERY

For examination and radiographs refer to Diagnostic Services.

The removal of more than one bicuspid or the removal of more than one 3rd molar at one time, requires confirmation on the dental claim form that the extractions are not for Orthodontic purposes and/or the tooth is symptomatic.

REMOVALS, (EXTRACTIONS), ERUPTED TEETH				
Removals, Erupted Teeth, Uncomplicated				
71101	Single tooth, Uncomplicated		38.01	45.61
71109	Each additional tooth same quadrant, same appointment		19.00	22.81
Removals, Erupted Teeth, Complicated				
71201	Odontectomy, (extraction), Erupted Tooth, Surgical Approach, Requiring Surgical Flap and/or Sectioning of Tooth		88.69	106.42
71209	Each additional tooth, same quadrant		88.69	106.42

REMOVALS, IMPACTIONS, SOFT TISSUE COVERAGE				
Removals, Impaction, Requiring Incision of Overlaying Soft Tissue and Removal of the Tooth				
72111	Single tooth		88.69	106.42
72119	Each additional tooth, same quadrant		88.69	106.42

REMOVALS, IMPACTIONS, INVOLVING TISSUE AND/OR BONE COVERAGE				
Removals, Impactions, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap and EITHER Removal of Bone and Tooth OR Sectioning and Removal of Tooth				
72211	Single tooth		133.03	159.64
72219	Each additional tooth, same quadrant		133.03	159.64
Removals, Impaction, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap, Removal of Bone AND Sectioning of Tooth for Removal;				
72221	Single Tooth		177.37	212.84
72229	Each additional tooth, same quadrant		177.37	212.84
Removals, Impactions, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap, Removal of Bone, AND/OR Sectioning of the Tooth for Removal AND/OR presents Unusual Difficulties and Circumstances				
72231	Single tooth		202.71	243.25
72239	Each additional tooth, same quadrant		202.71	243.25

REMOVALS, (EXTRACTIONS), RESIDUAL ROOTS				
Removals, Residual Roots, Erupted				
72311	First tooth		38.01	45.61
72319	Each additional tooth, same quadrant		38.01	45.61

Removals, Residual Roots, Soft Tissue Coverage				
72321	First tooth		76.02	91.22
72329	Each additional tooth, same quadrant		76.02	91.22

Code	Description		GP	Specialist	Limit
Removals, Residual Roots, Bone Tissue Coverage					
72331	First tooth		88.69	106.42	
72339	Each additional tooth, same quadrant		88.69	106.42	
SURGICAL EXCISION, TUMORS, BENIGN					
Tumors, Benign, Scar Tissue, Inflammatory or Congenital Lesions of Soft Tissue of the Oral Cavity					
74111	1 cm and under		133.03	159.64	
74112	1 -2 cm		144.07	172.89	
74113	2 - 3 cm		155.11	186.13	
74114	3 - 4 cm		166.15	199.38	
74115	4 - 6 cm		177.19	212.63	
74116	6 - 9 cm		188.23	225.88	
74117	9 - 15 cm		199.28	239.13	
74118	15 cm and over		210.32	252.38	
SURGICAL EXCISION, CYSTS/GRANULOMAS (BASED ON CYST SIZE)					
Excision of Cyst					
74631	1 cm and under		133.03	159.64	
74632	1 - 2 cm		144.07	172.89	
74633	2 - 3 cm		155.11	186.13	
74634	3 -4 cm		166.15	199.38	
74635	4 - 6 cm		177.19	212.63	
74636	6 - 9 cm		188.23	225.88	
74637	9 - 15 cm		199.28	239.13	
74638	15 cm and over		210.32	252.38	
FRACTURES, REDUCTIONS, ALVEOLAR					
Replantation, Avulsed Tooth/Teeth (including splinting)					
76941	Replantation, first tooth		88.69	106.42	
76949	Each additional tooth		88.69	106.42	
Repositioning of Traumatically Displaced Teeth					
76951	One unit of time		31.68	38.01	
Repairs, Lacerations, Uncomplicated, Intraoral or Extraoral					
76961	2 cm or less		44.34	53.22	
76962	2 - 4 cm		44.34	53.22	

Code	Description		GP	Specialist	Limit

ADJUNCTIVE GENERAL SERVICES

This program allows for either an intravenous sedation OR an inhalation sedation, if performed on the same client on the same date of service. Claims received with both services performed on the same day will result in the payment of only one service.

General anaesthesia and sedation will be covered for all beneficiaries who are eligible for services under the MCCSS dental schedule. When the general anaesthesia is provided by a physician-anaesthetist, the claiming dentist should note the physician's name in the comments box on the claim form.

ANAESTHESIA, GENERAL

(includes pre-anaesthetic evaluation and post-anaesthetic evaluation and post-anaesthetic follow-up)

The elimination of all sensations, accompanied by the loss of consciousness. Also included is "dissociative" anaesthesia (Ketamine).

General Anaesthesia				Limit of 8 units per visit.
92212	Two units of time	112.04	134.45	
92213	Three units	142.71	171.27	
92214	Four units	173.40	208.08	
92215	Five units	204.09	244.90	
92216	Six units	234.76	281.71	
92217	Seven units	265.44	318.53	
92218	Eight units	296.11	355.34	

Note: The equipment, facilities and support services for general anaesthetic may be provided by the practitioner who provides the dental treatment or the practitioner who provides the general anaesthesia or by a practitioner who provides neither the treatment nor the general anaesthesia. A dentist who provides the dental treatment, the general anaesthetic and the facility cannot use the following codes.

Provision of facilities, equipment and support services, for general anaesthesia when provided by a separate practitioner.				Limit of 8 units per visit.
92222	Two units of time	38.84	46.60	
92223	Three units	58.25	69.90	
92224	Four units	77.66	93.20	
92225	Five units	97.07	116.49	
92226	Six units	116.48	139.78	
92227	Seven units	135.89	163.07	
92228	Eight units	155.31	186.37	

ANAESTHESIA, DEEP SEDATION				
Anaesthesia, Deep Sedation (a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including inability to respond purposefully to verbal command. These states apply to any technique that has depressed the patient beyond conscious sedation except general anaesthesia. Any intravenous technique leading to these conditions in a patient including neuroleptanalgesia/anaesthesia, would fall within this category of service. (includes pre-anaesthetic evaluation and post anaesthetic follow-up)				Limit of 8 units per visit.
92302	Two units of time	103.43	124.11	
92303	Three units	134.10	160.93	
92304	Four units	164.78	197.74	
92305	Five units	195.47	234.56	
92306	Six units	226.15	271.38	
92307	Seven units	256.82	308.19	
92308	Eight units	287.51	345.01	

Code	Description		GP	Specialist	Limit
ANAESTHESIA, CONSCIOUS SEDATION					
Anaesthesia, Conscious Sedation (A medically controlled state of depressed consciousness that allows protective reflexes to be maintained, retains the patient's ability to maintain a patent airway independently and continuously and permits appropriate response by the patient to physical stimulation or verbal command, e.g., "open your eyes" (includes pre-anaesthetic evaluation and post anaesthetic follow-up) Any technique leading to these conditions in a patient would fall within this category of service. Conscious sedation is a varied technique which can require different levels of monitoring, in accordance with the Regulatory Authority Guidelines for the Use of Sedation and General Anaesthesia in Dental Practice. The Guidelines should be consulted and observed.					
Nitrous Oxide Time is measured from the placement of the inhalation device and terminates with the removal of the Inhalation device					8 units per visit.
92411	One unit of time		16.98	20.38	
92412	Two units		29.66	35.58	
92413	Three units		42.34	50.81	
92414	Four units		55.01	66.00	
92415	Five units		67.69	81.24	
92416	Six units		80.37	96.44	
92417	Seven units		93.03	111.64	
92418	Eight units		105.72	126.85	
Parenteral Conscious Sedation (regardless of method – IM or IV)					8 units per visit.
92441	One unit of time		56.03	67.23	
92442	Two units		80.10	96.12	
92443	Three units		104.17	125.00	
92444	Four units		128.24	153.89	
92445	Five units		152.32	182.78	
92446	Six units		176.39	211.66	
92447	Seven units		200.47	240.56	
92448	Eight units		224.54	269.44	
LABORATORY PROCEDURES					
(This code is used in conjunction with the "+L" and "+E" designation following the specific codes in the guide. The addition of these codes are to facilitate computer or manual input for third party claims processing, personal records and statistics, providing one description for a specific procedure code) When filling out third party claim forms, these codes must follow immediately after the corresponding dental procedure code carried out by the dentist, so as to correlate the lab expenses with the correct procedures. The following services are only covered when claimed in conjunction with codes which carry the +L designation.					The amount listed on the invoice will be paid in full. For 99333, please submit in-office laboratory expenses. Laboratory fees must appear immediately below the procedure code(s) to which they apply. A copy of the Laboratory Invoice, or receipt of laboratory payment, must be submitted with the claim form for Commercial Laboratory Procedures (code 99111).
99111	"+L" Commercial Laboratory Procedures (A commercial laboratory is defined as an independent business which performs laboratory services and bills the dental practices for these services on a case by case basis)		I.C.	I.C.	
99222	Laboratory charges for oral pathology biopsy services when provided in conjunction with surgical services from the 30000, 40000 and 70000 code series		I.C.	I.C.	
99333	"+L" In-Office Laboratory Procedures (An in-office laboratory is defined as a laboratory service(s) performed within the same business entity)		I.C.	I.C.	