Saskatchewan
Ministry of
Health

SUPPLEMENTARY HEALTH

and

FAMILY HEALTH BENEFITS PROGRAMS

DENTAL BENEFITS FEE SCHEDULE

October 1, 2015

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SUPPLEMENTARY HEALTH and FAMILY HEALTH BENEFITS PROGRAMS
DENTAL BENEFITS FEE SCHEDULE

REFERENCE NOTES

The Saskatchewan Ministry of Health applies this fee schedule to dental services provided to eligible beneficiaries of the Saskatchewan Ministry of Health's Supplementary Health and Family Health Benefits Programs. The objective of coverage under these programs is to provide the basic dental care necessary for the maintenance of good oral health.

1. ELIGIBILITY

SUPPLEMENTARY HEALTH PROGRAM

It is the practitioner's responsibility to verify that a patient is eligible for coverage.

Eligibility for the Supplementary Health Program can be confirmed on the Provider Coverage Viewer using the nine-digit Health Services Number on the patient's plastic Health Services Card.

In rare circumstances, the Ministry of Social Services will issue documentation showing eligibility for temporary health coverage. A copy of this documentation should be attached to the claim form. Beneficiaries are eligible for Emergency Coverage only.

FAMILY HEALTH BENEFITS PROGRAM

Children under the age of 18 of families who are recipients of the Family Health Benefits Program are eligible for full Supplementary Health dental benefits as outlined in this fee schedule. Adults do not have coverage for dental services. Coverage can be confirmed on the Provider Coverage Viewer using the nine-digit Health Services Number on the patient's plastic Health Services Card.

Access to the Provider Coverage Viewer can be arranged by contacting eHealth's Service Desk at 1-888-316-7446 (Regina: (306) 337-0600).

Eligibility for either program can be confirmed by calling (306) 787-3124 (in Regina) or 1-800-266-0695.

2. EMERGENCY COVERAGE

Some adult Supplementary Health Program beneficiaries are not eligible for full dental coverage. Those eligible for Emergency Benefits Only will be identified on the Provider Coverage Viewer.

Services eligible under emergency coverage are listed under *Emergency Dental Benefits* on page 9 of this fee schedule.

3. PRIOR APPROVALS

Service code numbers prefixed with "**PA**" require prior approval before payment is guaranteed. Written *Approval for Payment* forms with a prior approval number will be issued in response to written or telephone requests for prior approval. It is recommended that the form be received before commencing treatment. The prior approval number must be quoted on the claim form when invoicing for the service.

Please ensure that radiographs submitted with applications for prior approval are properly mounted and dated.

4. SERVICE LIMITATIONS

Please note that many services are limited within specific time periods. These limitations are noted under the section headings or within the service descriptions. Dental service history can be obtained by calling (306) 787-3124 (in Regina) or 1-800-266-0695.

5. CONSIDERATION ON AN EXCEPTION BASIS

Applications for services beyond the limitations noted in this schedule, or for services not covered in this schedule, will be considered in exceptional circumstances on a case-by-case basis. Requests for consideration on an exception basis must include a detailed explanation of the beneficiary's case (including properly mounted radiographs when relevant). If the need is created by a medical problem, a physician's report should be provided in support of the application.

Requests for polishing and scaling procedures every 6 months may be considered for patients with a disability that prevents them from adequately cleaning their teeth. **An explanation of how the disability limits the patient's ability to properly clean his/her teeth is required on the claim form**.

Endodontic treatment (restricted to **anterior** teeth) will only be considered when there is an excellent prognosis for the affected tooth and the surrounding dentition. To assess long term prognosis of the affected tooth and surrounding dentition, please submit all of the following with the request for prior approval:

- Mounted periapical radiograph of the affected tooth;
- Mounted bitewing radiographs;
- Identification of missing teeth in the upper and lower quadrants; and
- Description of general oral health.

Please note: Posterior endodontics will **not** be considered.

For services approved on an exception basis where there is no equivalent service code and fee in this schedule, reimbursement will be at a rate of 90 percent of the College of Dental Surgeons of Saskatchewan's *Suggested Fee Guide* for the current year.

Tempormandibular joint disorder ("TMJ" or "TMD") treatment is not covered and will not be considered on an exception basis.

6. PAYMENT OF CLAIMS

Dental accounts must be submitted within 12 months of the date of treatment.

Section 9(i) of Saskatchewan Regulation 65/66 states that "payments made to dentists pursuant to these regulations constitute payment in full for the services for which the payments were made, except:

(i) payments made pursuant to clause (c); and
(ii) payments made in accordance with provisions of the agreement mentioned in clause (g) that provide otherwise."

The intent of the legislation is:

- In providing professional services to a Supplementary Health Program beneficiary, the dentist agrees not to charge any fees or surcharges to the Government of Saskatchewan or to the beneficiary beyond the fees and surcharges set out in this fee schedule, except where permitted in this schedule.

- In providing professional services to a Family Health Benefits Program beneficiary, the dentist is permitted to charge the beneficiary the difference between the fee outlined in this fee schedule and the lesser of either his/her usual or customary fee for the service or the fee prescribed in the *Suggested Fee Guide* of the College of Dental Surgeons of Saskatchewan.

The additional costs permitted above must be fully disclosed to and accepted by the beneficiary or his or her legal guardian **prior** to the commencement of the service.

To expedite payment of claims, please ensure that claim forms are completely filled out and that appropriate additional information has been provided. All claim forms must include the following information:

- Claim number (up to 7 numeric characters-no dashes/slashes/punctuation)
- Payee code
- Dentist's name and address
- Date of service
- Saskatchewan Health Services Number
- Patient name and date of birth
- Dentist's signature
- Patient's signature (when required)
- Service code and fee
- Tooth number (if applicable)
- Prior Approval number (if one has been issued)
- Identify if there is third party coverage (see section 12).

7. PROSTHODONTICS

Prior Approval is required for all complete or partial denture and reline service codes (see reference note 3).

All fees for services provided three months post insertion are included in the initial fee for a denture.

COMPLETE DENTURES
Complete dentures will be replaced only on the basis of demonstrated need after a minimum period of 60 months.

PARTIAL DENTURES
Written application is required for all partial dentures. Ensure a **5-year prognosis** is evident before submitting a request for a partial denture. **If a partial denture is provided, the patient will not be considered for a partial or complete denture in the same arch within a period of 5 years.**

Applications for partial dentures require:

- Mounted radiographs of the supporting and surrounding teeth.
- A list of the teeth to be placed on the partial.
- A description of the state of the remaining teeth and periodontal condition.
- All restorative treatment **must be completed** and oral hygiene needs must be addressed prior to the submission of the request for prior approval. If the radiographs do not provide evidence of such, please advise of the date of completion.

Partial dentures may be approved when:

- One or more of the 1's, 2's or 3's are missing (under the age of 18, only claspless partials will be provided unless more than 2 anteriors are missing in one arch); or
- Five or more of the 4's to 7's are missing in one arch, including at least one of the 6's, and all of the teeth counted are to be placed on the partial denture.

RELINES
Relines are limited to one per service per 36-month period. The fee includes all adjustments and modifications.

Relines are not payable until 3 months post insertion.

REPAIRS
Denture repairs are limited to one per denture in a 12-month period. The addition of teeth to a partial denture provided by this program will not be paid within 24 months of the initial insertion (without prior approval).

8. PROSTHODONTICS PAYMENTS

CO-PAYMENT

Patients will make a co-payment, as required by Regulation, for complete and partial dentures (codes 51101, 51102, 52201, 52202, 52301 and 52302). The co-payment is a maximum of $15.00 per denture. The co-payment fee will be paid by the Supplementary Health Program for government wards and inmates of provincial correctional centres (this will be noted on the *Approval for Payment* form).

Claims for complete and partial dentures must be signed by the patient at the time of insertion.

INVOICING LAB COSTS FOR DENTURES

"+Lab" appended to the professional fee means that the dental laboratory will submit a claim directly to the Supplementary Health Program for its fee. A copy of the *Approval for Payment* form must accompany the order to the laboratory.

Only dental laboratories located in Saskatchewan, which charge according to the *Supplementary Health and Family Health Benefits Programs Dental Laboratory Payment Schedule*, are eligible for payment by this program.

INVOICING LAB COSTS FOR DENTURE REPAIRS

"+L*" appended to the professional fee means that the dental office will submit claims for both its professional fee and the laboratory fee for denture repairs, as follows:

- Complete the *Dental Claim Form* for the professional fee(s)
- Add the "laboratory fee" (use code 99111)
- Total the claim
- Attach an original copy of the laboratory bill.

The dentist will be reimbursed for the total of the professional and laboratory fees for acrylic denture repairs. Payment to the laboratory is the dentist's responsibility.

UNCLAIMED DENTURES

Dentures that have not been picked up by the patient within 90 days of manufacture may be invoiced at 75% of the professional fee (please include an explanation).

9. SPACE MAINTAINERS

Space maintainers are indicated when the primary first molar is lost and:

- the permanent first molar has not yet erupted to the plane of occlusion, or
- in instances of mild or no crowding, the first molar has erupted but there is at least 1mm of bone overlying the unerupted first bicuspid.

Space maintainers are NOT indicated in severely crowded cases if the mixed dentition analysis reveals an arch length deficiency of four (4) or more millimeters per quadrant.

Current, dated mounted radiographs (bitewings and/or panorex) must be submitted at the time of request that adequately reveal the amount of bone overlying the unerupted first bicuspid.

Please provide the tooth number of the tooth that has been/will be removed.

***Please note*:** There is a limit of one unilateral per quadrant (15101 or 15201) **or** one lingual holding arch (15103) **per arch** every 5 years.

CODE 15101 AND 15201 GUIDELINES

- Procedure codes 15101 and 15201 are for the maintenance of space for missing primary first and/or second molars.

- The fees for codes 15101 and 15201 do not include laboratory charges. Attach a copy of the laboratory bill and invoice using code 99111 for the laboratory fee.

CODE 15103 GUIDELINES

- Procedure code 15103 is payable only in situations where there is a deep bite (greater than 50% overbite) and in conjunction with missing c's, d's or e's and/or those with hypertonic musculative (please submit a photograph of mentalis area for the hypertonic musculative).

- The fee for code 15103 does not include laboratory charges. Attach a copy of the laboratory bill and invoice using code 99111 for the laboratory fee.

10. TOOTH NUMBERS

Tooth numbers are required for all relevant services, such as: emergency exams, radiographs, extractions, restorations, partial dentures, etc.

Please use tooth #95 for supernumerary extractions (#96 for a second tooth).

11. AUDIT

Services are subject to audit.

12. BALANCE BILLING FOR FAMILY HEALTH BENEFITS BENEFICIARIES WITH PRIVATE INSURANCE

Dental providers are permitted to balance bill Family Health Benefits beneficiaries the difference between the fees outlined in this schedule and the lesser of their usual or customary fee for the service or the fee prescribed in the *Suggested Fee Guide* of the College of Dental Surgeons of Saskatchewan (CDSS).

Some of these beneficiaries may have additional dental insurance.

The current policy of the Saskatchewan Ministry of Health is that the Family Health Benefits Program **may be used as the payer of first or last resort**. The following is the Saskatchewan Ministry of Health billing process for claims involving private insurance.

To expedite the payment process please:

- Indicate 3rd party coverage on the claim form.
- Include the name of the private insurance carrier on the claim form.
- Indicate if the Family Health Benefits Program is the 1st Payer or 2nd Payer.
- Always bill using CDSS fees or usual/customary fees.

FAMILY HEALTH BENEFITS PROGRAM (Primary or 1st Payer) – PRIVATE INSURANCE CARRIER (Secondary or 2nd Payer)

- The claim will be paid at Supplementary Health Program Fee Schedule rates.
- A claim adjustment/error letter will be sent to the provider that provides a line-by-line breakdown of each procedure code and the amount paid.
- The claim adjustment/error letter can be used to balance bill the insurance carrier.

PRIVATE INSURANCE CARRIER (Primary or 1st Payer) – FAMILY HEALTH BENEFITS PROGRAM (Secondary or 2nd Payer)

- Attach a copy of the insurance carrier explanation of benefits to the Supplementary Health Program claim form.
- For each eligible service, the Family Health Benefits Program will pay the difference in cost between what the insurance carrier paid and the lesser of either the dentist's usual/customary fee or the CDSS *Suggested Fee Guide* (not to exceed the Supplementary Health Program fee).

EXCEPTION

Eligible beneficiaries with third party coverage who have received posterior composite filling reimbursement that is equal to or higher than the non-bonded amalgam rate listed in the current College of Dental Surgeons of Saskatchewan *Suggested Fee Guide* are not entitled to additional payment through provincial programs.

EMERGENCY DENTAL BENEFITS

Adult Supplementary Health recipients with Emergency Benefits Only are limited to the emergency services listed on this page.

The tooth number must be provided on the claim form for all emergency procedure codes.

01205	Examination – emergency (includes prescription), limited to one per six month period o Beneficiaries with "Full Dental Benefits" are not eligible for this service.	$44.50
02111	Periapical radiograph, single film	$19.70
20111	Caries control – removal of carious lesions and placement of sedative dressing, limited to once per tooth	$83.70
71101	Extraction, first tooth in each quadrant	$115.70
71109	Extraction, each additional tooth in same quadrant	$76.50

***Please Note*: More than two extractions per quadrant requires prior approval.**

DIAGNOSTIC

Only one of procedure codes 01201 and 01202 will be funded in a 12-month period.

A maximum of four films or a panorex will be funded in a 12-month period.

01201	Examination – new patient	$38.30
01202	Examination – previous patient - recall exam	$29.40
01701	Examination – prosthodontic (edentulous patient), limited to once in a 60-month period	$56.10
02111	Periapical radiograph, single film	$19.70
02112	Periapical radiograph, two films	$26.70
02113	Periapical radiograph, three films	$33.80
02114	Periapical radiograph, four films	$41.80

02141	Bitewing radiograph, single film	$19.70
02142	Bitewing radiograph, two films	$26.70
02143	Bitewing radiograph, three films	$33.80
02144	Bitewing radiograph, four films	$41.80
02601	Panoramic radiograph (panorex), can be substituted in place of four films	$65.00

PREVENTIVE

Procedure codes 11101, 12101 and 13217 are limited to once each in a 12-month period.

Scaling procedure codes are limited to a total of two units in a 12-month period.

11101	Polishing – one half unit of time	$15.10
11111	Scaling – one unit of time (age 14 and older)	$32.90
11112	Scaling – two units of time (age 14 and older)	$65.90
11117	Scaling – one half unit of time (age 14 and older)	$16.90
12101	Topical fluoride (age 17 and under)	$18.80
13217	Oral hygiene instruction – one half unit of time (age 13 and under)	$13.50

Sealants

- Limited to once every three years.
- Limited to patients age 13 and under.

13401	Pit and fissure sealant – single tooth, permanent molar only	$24.30
13409	Pit and fissure sealant – additional permanent molar in the same quadrant	$16.20

Space Maintainers

- Limited to one unilateral per quadrant (15101 or 15201) **or** one lingual holding arch (15103) **per arch** every 5 years.
- Missing tooth number is required on claim form.
- Pre-treatment mounted radiographs must be attached to claim form.
- Fees do not include laboratory charges. Attach a copy of the laboratory bill and invoice using code 99111 for the laboratory fee.
- See page 7, reference note 9 for more information.

15101	Space maintainer – band type, fixed unilateral, payment is limited to once in each quadrant every five years (lab code 99111)	$101.50+ L*
15103	Space maintainer – band type, fixed bilateral, soldered lingual arch, payment limited to once per arch every five years (lab code 99111)	$181.80+ L*
15201	Space maintainer – stainless steel crown type, fixed, payment limited to once in each quadrant every five years (lab code 99111)	$129.90+ L*

RESTORATIVE SERVICES

Restorations – Amalgam, Primary and Permanent Posterior (including teeth 53, 63, 73, 83)

Restorations to tooth numbers 51, 52, 61, 62, 71, 72, 81 and 82 are not covered services.

Limit of one restoration per tooth per 12-month period.

Total surfaces whether continuous or not.

Tooth number must be identified.

21111	Primary dentition, one surface	$75.70
21112	Primary dentition, two surfaces	$101.50
21113	Primary dentition, three or more surfaces	$116.60
21211	Permanent bicuspids, one surface	$97.90
21212	Permanent bicuspids, two surfaces	$131.70

21213	Permanent bicuspids, three surfaces	$151.30
21214	Permanent bicuspids, four surfaces	$170.90
21215	Permanent bicuspids, five or maximum surfaces per tooth	$190.50
21221	Permanent molars, one surface	$109.50
21222	Permanent molars, two surfaces	$148.60
21223	Permanent molars, three surfaces	$170.00
21224	Permanent molars, four surfaces	$192.20
21225	Permanent molars, five or maximum surfaces per tooth	$214.50

Restorations – Tooth Coloured (Acid Etch/Bond Technique), Permanent Anteriors

Limit of one restoration per tooth per 12-month period.

Total surfaces whether continuous or not.

Tooth number must be identified.

23111	Permanent anteriors, one surface	$109.20
23112	Permanent anteriors, two surfaces	$149.50
23113	Permanent anteriors, three surfaces	$174.50
23114	Permanent anteriors, four surfaces	$199.60
23115	Permanent anteriors, five or maximum surfaces per tooth	$224.60

Restorations – Tooth Coloured (Acid Etch/Bond Technique), Primary and Permanent Posterior (including teeth 53, 63, 73, 83)

Restorations to tooth numbers 51, 52, 61, 62, 71, 72, 81 and 82 are not covered services.

Limit of one restoration per tooth per 12-month period.

Total surfaces whether continuous or not.

Tooth number must be identified.

Dentists are permitted to charge a fee to those clients choosing composite fillings in posterior teeth. This fee is to be the difference in cost between the fees outlined below and the lesser of either the dentist's usual/customary fee for the service or the fee prescribed in the *Suggested Fee Guide* of the College of Dental Surgeons of Saskatchewan.
The additional costs permitted above must be fully disclosed to and accepted by the beneficiary or his or her legal guardian **prior** to the commencement of the service.

23511	Primary dentition, one surface	$75.70
23512	Primary dentition, two surfaces	$101.50
23513	Primary dentition, three or more surfaces	$116.60
23311	Permanent bicuspids, one surface	$97.90
23312	Permanent bicuspids, two surfaces	$131.70
23313	Permanent bicuspids, three surfaces	$151.30
23314	Permanent bicuspids, four surfaces	$170.90
23315	Permanent bicuspids, five or maximum surfaces per tooth	$190.50

23321	Permanent molars, one surface	$109.50
23322	Permanent molars, two surfaces	$148.60
23323	Permanent molars, three surfaces	$170.00
23324	Permanent molars, four surfaces	$192.20
23325	Permanent molars, five or maximum surfaces per tooth	$214.50

Other Restorative Services

Tooth number must be identified.

20111	Caries control – removal of carious lesions and placement of sedative dressing. Other restorations are not payable within 3 months of a sedative dressing. Limited to once per tooth.	$83.70

The following codes are limited to one per tooth in a 60-month period.

22211	Crown – prefabricated, metal, primary posterior	$157.50
22311	Crown – prefabricated, metal, permanent posterior	$157.50
29101	Recementation (crowns or space maintainers must have been placed more than 3 months prior to service date)	$97.00

ENDODONTICS

32232	Pulpotomy – primary tooth, payment limited to once per tooth (tooth number must be identified)	$71.20

DENTURES

Prior Approval required if noted "PA".

Adequate diagnosis must be undertaken to **ensure 5-year prognosis** of the denture. Conversion from a partial denture to a complete denture within a 5-year time period will not be considered.

Patient signature on the date of insertion is required on claim form for complete or partial dentures.

See pages 5-6 for more information.

Dentures – Complete, Standard
Patient co-payment of $15.00 per denture.

PA	51101	Maxillary	$809.10+ LAB
PA	51102	Mandibular	$882.50+ LAB

Dentures – Partial, Acrylic without Clasps
Patient co-payment of $15.00 per denture.

PA	52201	Maxillary	$290.10+ LAB
PA	52202	Mandibular	$290.10+ LAB

Dentures – Partial, Acrylic with Wrought Clasps
Patient co-payment of $15.00 per denture.

PA	52301	Maxillary	$469.90+ LAB
PA	52302	Mandibular	$469.90+ LAB

Acrylic Denture Adjustment

54201	Adjustment of acrylic partial or complete denture when done more than 3 months after initial placement. Limit of 1 per denture per 12-month period**. (Indicate upper or lower denture on claim form.)**	$73.90

Trays and Bite Blocks

99333	Model	$9.60
99334	Tray	$27.10
99335	Bite block	$31.80

Acrylic Denture Repairs

+L* – dentist to bill for lab work under code 99111.

Limited to one of each of the following service codes in a 12-month period.

Addition of teeth to a partial denture will not be paid within 24 months of the initial insertion.

55101	Repair – maxillary denture, no impression	$60.50+ L*
55102	Repair – mandibular denture, no impression	$60.50+ L*
55201	Repair – maxillary denture, impression required	$121.00+ L*
55202	Repair – mandibular denture, impression required	$121.00+ L*

Acrylic Denture Relines

+LAB – dental lab to invoice directly.

Limited to one of each of the following service codes in a 36-month period.

Not payable until 3 months post insertion.

PA	56211	Reline – self-curing, maxillary	$194.00
PA	56212	Reline – self-curing, mandibular	$194.00
PA	56231	Reline – processed, maxillary	$239.00+ LAB
PA	56232	Reline – processed, mandibular	$239.00+ LAB

Upgrade to Cast Metal Partials

Clients have the option of choosing a cast metal partial rather than an acrylic partial by paying the difference in cost between the fee outlined below and the lesser of either the dentist's usual/customary fee for the service or the fee prescribed in the *Suggested Fee Guide* of the College of Dental Surgeons of Saskatchewan.

Lab codes and fees for cast metal partial dentures and relines can be found on page 18.

PA 53101	Maxillary	$469.90
PA 53102	Mandibular	$469.90

Cast Metal Partial Lab Codes

The following codes are to be used when billing the lab component for cast metal partial dentures. The dentist must invoice the program directly for lab fees. The client is responsible for the difference between these fees and the actual laboratory costs.

59076	Maxillary partial (includes first tooth)	$160.60
59077	Mandibular partial (includes first tooth)	$160.60
59702	Each additional tooth	$11.20
59105	Model	$9.60
59025	Tray	$27.10
59097	Bite block	$31.80
59134	Reline – processed, maxillary (includes model)	$104.70
59135	Reline – processed, mandibular (includes model)	$104.70

Cast Metal Partial Denture Adjustment

54205	Adjustment of cast metal partial denture when done more than 3 months after initial placement. Limit of 1 per denture in a 12-month period. (Indicate upper or lower denture on claim form.)	$73.90

Cast Metal Partial Repairs

+L* – Dentist to bill for lab work as code 99112 at 50% of the lab cost (include copy of invoice). The patient is responsible for the remaining 50%.

Limited to one of each of the following service codes in a 12-month period.

Addition of teeth to a partial denture will not be paid within 24 months of the initial insertion.

55301	Repair – maxillary denture, no impression	$60.50+ L*
55302	Repair – mandibular denture, no impression	$60.50+ L*
55401	Repair – maxillary denture, impression required	$121.00+ L*
55402	Repair – mandibular denture, impression required	$121.00+ L*

Cast Metal Partial Relines

Limited to one of each of the following service codes in a 36-month period.

Not payable until 3 months post insertion.

PA	56221	Reline – self-curing, maxillary	$194.00
PA	56222	Reline – self-curing, mandibular	$194.00
PA	56241	Reline – processed, maxillary	$239.00
PA	56242	Reline – processed, mandibular	$239.00

ORAL SURGERY

Tooth number required on claim form for the following codes.

EXTRACTION, UNCOMPLICATED

71101	First tooth in each quadrant	$115.70
71109	Each additional tooth in same quadrant	$76.50

EXTRACTION, COMPLICATED, SURGICAL APPROACH REQUIRING SURGICAL FLAP AND/OR SECTIONING OF TOOTH

- Claim to include mounted radiographs and a detailed explanation.
- Code 71101 not payable in same quadrant on the same day.

71201	First tooth in each quadrant	$199.40
71209	Each additional tooth in same quadrant	$131.70
76941	Reposition or replantation, avulsed tooth including splinting, first tooth in arch	$365.80
76949	Reposition or replantation, avulsed tooth including splinting, each additional tooth in arch	$130.80

ADJUNCTIVE GENERAL SERVICES

91231	Behavioural management of a child under 7 years of age, in office only (cannot be charged in conjunction with 94301 or 94302 or the anaesthesia codes on page 21).	**25%** of professional fee to a maximum of $97.00
94301	Institutional visit (hospital, special care home), during regular scheduled office hours; maximum one visit per day per institution.	$38.30
94302	Institutional visit (hospital, special care home), unscheduled, after regular scheduled office hours; maximum one visit per day per institution. **An explanation is required on the claim form.**	$53.40

CERTIFIED SPECIALIST SURCHARGE

00002	Surcharge on general practice fees for services provided by a dentist holding a specialist licence.	**15%** of general practitioner fee

ORAL AND MAXILLOFACIAL SURGERY

As provided by a dentist holding a specialist licence in oral surgery

01601	Examination – surgical, general o Payment is limited to once in a 12-month period. o Beneficiaries with "Emergency Coverage Only" are not eligible for this service.	$146.00
01602	Examination – surgical, specific o Payment is limited to once in a 12-month period. o Tooth number required. o Beneficiaries with "Emergency Coverage Only" are eligible for this service.	$73.00
02600	Radiograph – panoramic	$65.00

Oral Surgery

Tooth number required for all of the following codes.

Code 71100 cannot be billed in conjunction with codes 71200 through 72231 in the same quadrant on the same day.

71100	Removal of first tooth in each quadrant, uncomplicated	$135.30
71108	Removal of subsequent tooth in each quadrant	$78.30
71200	Complicated surgical approach to an erupted or fractured tooth requiring a surgical flap and/or sectioning of tooth	$268.80
72111	Soft tissue impaction	$281.20
72211	Semi-osseous unerupted impaction (bone removal)	$309.70
72231	Unerupted and impacted, full osseous, unusual difficulties and circumstances (may include supernumerary teeth)	$452.00
72321	Root removal – soft tissue coverage requiring flap	$210.00
72331	Root removal – totally covered by bone	$280.40

ADJUNCTIVE GENERAL SERVICES

ANAESTHESIA – CONSCIOUS SEDATION

Only one form of sedation may be charged per visit.

Sedation cannot be charged in conjunction with code 91231.

Unit of time defined as 15 minutes.

		General Practitioner	Specialist
	Nitrous oxide		
92411	One unit of time	$40.90	$86.30
92412	Two or more units of time	$67.60	$113.00
	Nitrous oxide with oral sedation		
92431	One unit of time	$73.00	$92.60
92432	Two or more units of time	$121.90	$124.60
	Parenteral conscious sedation (intravenous or intramuscular)		
92441	One unit of time	$49.80	$114.80
92442	Two or more units of time	$99.70	$166.40
	Combined techniques of inhalation plus intravenous and/or intramuscular injection		
92451	One unit of time	n/a	$105.00
92452	Two or more units of time	$176.20	$210.00