Memorandum of Agreement
Surgical Dental Program

HER MAJESTY IN RIGHT OF NEWFOUNDLAND AND LABRADOR,
as represented by the Minister of Health and Community Services

And

The Newfoundland and Labrador Dental Association

(collectively referred to as the "Parties")

WHEREAS: The NLDA represents NLDA member dentists of the province of Newfoundland and Labrador;

AND WHEREAS: The Minister is desirous of providing insured Surgical/Dental services to MCP beneficiaries of Newfoundland and Labrador for the period of April 1, 2022 to March 31, 2026.

THEREFORE, the Parties agree to the conditions and provisions stipulated in the following Memorandum of Agreement.

This Agreement covers the fees for insured Surgical/Dental services provided to MCP beneficiaries of Newfoundland and Labrador for the period of April 1, 2022 to March 31, 2026.

Payments for these services are as per the MCP Surgical Dental Schedule, attached hereto.

1.0 Duration

(a) Both parties agree that this Agreement will be effective April 1, 2022 and will expire March 31, 2026. The first year of the Agreement will commence April 1, 2022 and will expire March 31, 2023.

(b) The second year of the Agreement will commence April 1, 2023 and will expire March 31, 2024.

(c) The third year of the Agreement will commence on April 1, 2024 and will expire March 31, 2025.

(d) The fourth year of the Agreement will commence on April 1, 2025 and will expire on March 31, 2026.

(e) The NLDA will inform the Department of Health and Community Services (DOHCS) in writing no sooner than 6 months prior to the expiry date of this Agreement of its intention to negotiate a new Agreement.

2.0 Fees

(a) For this Agreement the fee schedule will use the MCP Surgical Dental Schedule of Benefits as a base and apply increases as per the table in 2(b).

(b) Payments for insured services are as per the MCP Surgical Dental Schedule, attached hereto, and will be increased in accordance with the following schedule.

Year 1	Year 2	Year 3	Year 4
16.2%	0%	0%	0%

(c) Effective April 1, 2018 the following six procedures will continue to be paid as per attached schedule if performed in the office of the Oral Surgeon.

- Extractions (erupted and impacted)
- Biopsies (oral soft tissue) exempt from hospital treatment
- Removal of cysts
- Oro antral fistula closure
- Haemorrhage control
- Panorex

In an effort to ensure fiscal responsibility and the ability to provide insured services within the Surgical Dental Program, it is understood by all parties that the Department of Health and Community Services will monitor the volume of work and costs.

(d) Dental Health Program statistics will be shared with the NLDA. These statistics will include fee codes by capacity as well as other statistics as agreed upon by the NLDA and government. Statistics will be cleaned of any personal /private information.

IN **WITNESS WHEREOF** the parties have executed this agreement on the 4th day of May, 2022.

SIGNED on behalf of Her Majesty the Queen in Right of Newfoundland and Labrador by the Honourable John Haggie, Minister of Health and Community Services, in the presence of the witness hereto subscribing:

Witness

Hon. John Haggie

SIGNED on behalf of the Newfoundland & Labrador Dental Association by its proper officers in the presence of the witness hereto subscribing:

Witness

Dr. Michelle Zwicker
President

Witness

Amanda Squires
Executive Director

MCP SURGICAL DENTAL PROGRAM

SCHEDULE A

PREAMBLE

This Payment Schedule identifies the amounts prescribed as payable and rules and conditions of payment under the Physicians and Fee Regulations, adopted under the *Medical Care and Hospital Insurance Act* for insured services rendered by licensed General Dentists (hereafter referred to as Dentists) and Specialists. The fees listed apply to services rendered on or after the "effective date" at the top of each page of the payment schedule.

Additions, deletions and changes made to the Payment schedule require approval by the Minister of Heath and Community Services based on recommendations from MCP, in consultation with the Newfoundland and Labrador Dental Association.

Any changes made during the effective life of the Payment Schedule are published in MCP Newsletters. It is the responsibility of claiming Dentists and Specialists to ensure these changes are reflected in their billings.

1. INTRODUCTION

The Payment Schedule is divided into a number of sections:

- General Preamble
- Appendices
- Surgical Procedures

1.1 General Preamble

This section sets out the general definitions and constituent elements common to all insured services, as well as the specific elements for these services.

1.2 Appendices

This section gives details on specific policies referred to within the Preamble. These include:

- Dental Monitoring Committee
- Extraction of Erupted Teeth
- Extraction of Impacted Teeth

1.3 Surgical Procedures

Fees for Dentists and Specialists may be listed for each procedure. Dentist's bill for procedures using rates listed in the Dentist Column. Specialist's bill for procedures using rates listed in the Specialist Column. Where no fee is listed in the Dentist Column, 83.3% of the amount listed in the Specialist Column will apply.

2. INSURED/NON-INSURED SERVICES

2.1 Insured Services

An insured service is defined as one that is:

(a) listed in Section 3(b) of the *Medical Care Insurance Insured Services Regulations under the Medical Care Insurance Act*, 1999; and

(b) Medically necessary. The clinical need of the provision and claim of an insured service may be evaluated by the Dental Monitoring Committee of MCP;

Policies on pre-existing conditions necessary to define "medical necessity" exist for the specific services to qualify as MCP insured services. These are listed as appendices to this Preamble or may be published in MCP Newsletters.

2.2 Non-Insured Services

The following situations/conditions qualify as non-insured services:

(a) Specific services as listed in Section 4 of the *Medical Care Insurance Insured Services Regulations*. Queries as to the insurability of a specific service should be directed to the office of the Dental Consultant.

(b) Any dental services provided at the request of a third party, or which are covered by other agencies.

(c) Dental services provided to patients not insured by MCP or any other provincial Health Care Plan.

(d) Services provided as a result of dental research and experimentation.

Payment for dental and professional services which are research-related or experimental are not the financial responsibility of MCP. Only those related to routine, accepted care of a patient's problem and that are not in support

of the research related or experimental services are considered to be an insured service.

3. CLAIM SUBMISSION AND DOCUMENTATION REQUIREMENTS

3.1 General Information

3.1.1 All service items billed to MCP are the sole responsibility of the Dentist or Specialist rendering the service with respect to the appropriate documentation and billing.

3.1.2 If a specific fee code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution.

3.1.3 Claims for services rendered in hospitals must include the hospital/facility number of the institution where the service was rendered. For services rendered in the office of an Oral Maxillofacial Surgeon the institute number 0132 is to be used.

3.1.4 For claiming purposes, date of the service is the date of the patient contact.

3.1.5 Documentation of services which are to be billed to MCP must be completed before claims for these services are submitted to MCP.

3.1.6 All claims submitted must be verifiable from the Dentist's and Specialist's records with regard to the examination and/or procedure claimed. Where specific elements of record requirement are listed in this Preamble, but do not appear in the patient record of that service, that element of the service is deemed not to have been rendered and the fee component represented by that element is not payable.

3.1.7 Referrals to a Dentist or Specialist that meet the conditions of eligibility for i) extraction of impacted teeth, or ii) extraction of erupted teeth, should be accompanied by a Referral Form which clearly states the medical/dental history that necessitates the extraction.

3.1.8 A Dentist or Specialist shall, upon request by MCP, make available to MCP copies of patient records as may be required to clarify or verify services for which fees have been claimed.

3.1.9 For MCP Audit purposes, it is required that Dentists and Specialists maintain records supporting services billed to MCP for a period of six years.

Audits will be conducted in accordance with the *Medical Care Hospital Insurance Act*. Government agrees to have the audit process available on the Government website under the provider information section.

3.2 Procedures

When a procedural fee is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the fee(s) claimed.

For additional documentation requirements, refer to the specific codes being claimed.

3.3 Independent Consideration (I.C.)

3.3.1 Specific services in this Schedule are designated as billable on an I.C. basis only. Dentists and Specialists are required to identify claims for these services as I.C. and to provide additional applicable information.

3.3.2 Medically necessary services not listed in this Schedule, or for which a set fee is not listed, must be billed I.C. For these services an I.C. claim must include:

(a) The time involved performing the procedure claimed,

(b) A list of all procedures performed which are represented by the claim,

(c) The actual size of lesions removed or laceration repaired or the area of any defect which was repaired, if applicable,

(d) Comparison in scope and difficulty of the procedure with other procedures listed in the Payment Schedule, and

(e) A copy of the operative report along with the actual operating time for complex surgical procedures.

3.4 Use of Provider Number

3.4.1 Claims must be submitted using the Provider Number of the Dentist or Specialist who actually rendered the service.

3.4.2 Dentists and Specialists are required to request prior approval from MCP

for all arrangements where payment is to be directed to a designated payee. The claim must indicate a designated payee in the Payee number section.

3.5 Time Limitations on Claim Submission

3.5.1 All claims must be submitted within **90** days of the date of service. In exceptional circumstances this time period may be extended. A letter giving a full explanation for lateness must be submitted to the Manager of Claims Processing for special consideration.

3.5.2 All queries from MCP must be answered within the times specified on the queries. If no time is specified, a reply must be received within 90 days of the date of query.

3.5.3 All requests for changes to claims and queries regarding claims must be submitted within 90 days after the date of payment for the claims concerned.

4. DEFINITIONS OF TERMS/CONDITIONS

4.1 Specialty Designation

Registration and designation as a Dentist or within a specialty field are as determined by the Newfoundland and Labrador Dental Board for MCP billing purposes.

4.2 Age (unless otherwise specified)

(a) Newborn (neonate) - up to and including 28 days of age,
(b) Infant - 29 days up to but less than 2 years,
(c) Child - 2 years up to and including 15 years,
(d) Adolescent - 16 years up to and including 17 years, and
(e) Adult - 18 years and over.

4.3 Transferal

A transferal, as distinguished from a referral, takes place where the responsibility for the care of an in-patient is completely transferred permanently or temporarily, from one Dentist or Specialist to another (e.g. where the first Dentist or Specialist is leaving temporarily on holidays and is unable to continue to care for the patient). Subject to the requirements of Article 6(a) through to and inclusive of 6(e) of this MOA, a transferal of an in-patient to a Dentist or Specialist should be considered as continuing care and the Dentist or Specialist to whom the patient is transferred is not entitled to claim for a consultation but may be entitled to claim for a new patient examination.

5. DEFINITIONS/REQUIREMENTS OF A NEW PATIENT EXAMINATION

5.1 A new patient examination refers to a situation wherein a patient is referred by another practitioner to an Oral Surgeon for treatment or guidance.

(a) A new patient examination would require a direct physical encounter with the new patient in order to decide upon appropriate treatment and/or guidance.

(b) A new patient examination can be claimed under the appropriate fee code only when performed in conjunction with insured services.

(c) Not more than one new patient examination may be claimed by the same Oral Surgeon for the same patient.

(d) If a referral is made, and upon examination treatment is deferred or felt to be unnecessary, then the new patient exam can be billed and a note attached to claim indicating that patient was seen and returned to referring dentist with instructions.

6. DEFINITIONS/REQUIREMENT OF A SPECIFIC EXAMINATION

6.1 Such an examination may be claimed by a Dentist or Specialist for the evaluation or management or a separate oral issue which is not related to the provision of routine post-operative care for the primary surgery. Payment will require I.C. documentation.

6.2 A limit of three such examinations will apply per patient admission. Or 42 day period following surgery.

7. SURGICIAL PROCEDURES

7.1 Surgical fee codes are "bundled" and not divisible. Unless otherwise stated, the fee listed for a surgical procedure includes the following:

(a) investigation and preparation of the patient at the site of surgery,
(b) the operative procedure, and
(c) total post-operative care of the patient within a period of 42 days including:

(i) all hospital visits except for insured examinations (subsequent),
(ii) two office visits subsequent to discharge from hospital, if necessary.

The normal post-operative period is deemed to be 42 days for all surgical procedures.

7.2 Unless otherwise stated:

(a) When more than one operative procedure is performed by the same surgeon at the same time under the same anesthetic, the fee shall be the full fee for the major procedure: all other procedures shall be paid at the rate of eighty-five (85) percent of the listed fee for each procedure (exception Independent Operative Procedures (IOP's).

(b) When a subsequent operation becomes necessary for the same condition because of a complication during the same hospitalization, the full fee will apply for each procedure.

(c) When a subsequent operation becomes necessary for a new condition developing during the same hospitalization, the full fee will apply for each procedure.

(d) When a surgical procedure must be repeated for the same condition during the same hospitalization or within normal convalescence, the tariff shall be the full fee for the initial procedure and half the usual fee for repeat procedure(s). This will not apply in cases where the subsequent operations are done by another surgeon.

(e) When different operative procedures are done by two different surgeons under the same anesthetic for different conditions, the fee will be 100% of the listed fee for each condition.

(f) Where a Specialist requires the expertise of another Certified Specialist, or a General Surgeon, the fee for the procedures performed shall be 150% of the listed fee and shall be divided equally between the two surgeons.

7.3 Soft Tissue Grafts

For the purpose of this Schedule, cranial bone grafts are deemed not to be from intraoral but rather extra oral sites.

Bone shavings or alloplasts placed simultaneously around dental implants as the sole grafting procedure are not insured services.

7.4 Reconstruction

For the purpose of this Schedule, bone or alloplastic reconstruction do not include surgical resection or tissue harvest.

Nasal reconstruction done for cosmetic purposes is not an insured service.

7.5 Orthognathic Surgery

For the purpose of this Schedule rigid fixation includes bone plates, bi-cortical screws and K-wires. The fee payable for rigid fixation is for one application per side per arch. **See code 84867 in the Surgical Dental Payment Schedule.**

7.6 Temporomandibular Joint

For the purposes of this Schedule, temporomandibular joint procedures are unilateral. If both joints are operated as the same surgery, the fee(s) for service(s) relating to the second joint is payable at 85% of the listed fee(s).

8. FRACTURES

8.1 Open reduction

Open reduction shall mean the reduction of a fracture by an operative procedure to include the exposure of the fracture, or internal skeletal wiring of the fracture, or placement of extra-skeletal pin fixation, such as the Roger Anderson type of apparatus.

8.2 Closed reduction

Closed reduction shall mean the reduction of a fracture by a simple application of arch bars and/or intermaxillary fixation such as used in a mandibular condylar fracture.

8.3 No reduction

No reduction shall mean the treatment of a fracture by any method other than that designated in 8.1 or 8.2 above.

8.4 The stated fee covers full treatment including necessary after care up to 42 days by the Dentist or Specialist of same specialty. This includes the removal of a wire or other device when used for traction or external fixation in the treatment of a fracture.

8.5 Multiple fractures or dislocations

In multiple fractures or dislocations, the fee for the major procedure shall be the full fee and the other fractures or dislocations shall be at eighty-five (85) percent of the listed fees.

8.6 Compound fractures

Compound fractures requiring extensive debridement should be billed I.C. at 150% of the listed fee for the closed reduction.

8.7 Open reduction of compound facial bone fractures requiring extensive debridement or reconstructive procedures to be assessed at double the operative fee. An I.C. form is required.

8.8 Where a patient is transferred to another surgeon for after-care of a fracture, the surgeon rendering the initial care shall receive 75% of the listed fee and the surgeon rendering the subsequent care 50% except where otherwise specified.

9. AFTER HOURS

9.1 Call Program (OMFS)

9.1.1 On-Call

(a) An Oral Surgeon will receive $174.00 per 24 hour call period.

(b) On-call Oral Surgeons will be available to respond to urgent and emergent requests for the purpose of examining, treating or providing diagnostic services to discharged or unattached patients:

i. Who present from the community to an emergency department; or
ii. Who are referred by physicians from other facilities; and/or
iii. Who are in-patients admitted by physicians in another specialty.

(c) Approved on-call rotations must follow a defined call schedule which provides coverage 24 hours per day 365 days per year.

(d) Implementation of an on-call rotation requires participation of more than one Oral Surgeon.

9.1.2 Call back

(a) If there is only one OMFS they may opt to receive call back but in no case will they receive both on-call and call-back compensation.

(b) An Oral Surgeon will receive $375.00 per call back.

9.2 Surgical Fees

9.2.1 Oral Surgeons who participate in procedures that are non-elective, unscheduled and which require the services of an Anesthesiologist are eligible for payment of a premium as follows:

(a) If a procedure commences between 6pm and midnight or on Sunday or a Statutory Holiday, then a 30% premium per procedure can be billed.

(b) If a procedure commences between 7am and 6pm on Saturday, then a 30% premium per procedure can be billed.

(c) If a procedure commences between 12am and 7am any day of the week, then a 50% premium per procedure can be billed.

(d) There shall be no pyramiding of the premiums outlined in 10.2.1(a), (b) and (c). For further clarity, an Oral Surgeon can only claim one premium per procedure.

9.3 Examinations after hours

(a) If an examination is rendered after hours (see fee code definition), an after-hours premium may be claimed.

(b) Where an after-hours premium is applicable based on the time the examination is rendered, a starting time indicator for that examination must appear in the patient's record.

(c) Statutory Holidays are as listed in the appropriate MCP Newsletter for that year and do not include additional Civic Holidays (e.g. Regatta Day). Premiums may be claimed for examinations provided on the ACTUAL Statutory Holiday but not on a day held in lieu of the holiday.

10. SEDATION

(a) Restricted to office of an Oral Surgeon,

(b) Can be claimed once per office visit,

(c) Can be claimed only when services being provided are insured under the Surgical Dental Program,

(d) Does not apply to services provided under the Provincial Dental Health Plan,

(e) Provider's remarks not required but a record of services performed must be maintained for audit purposes.

11. SURGICAL ASSISTANT'S SERVICES

11.1 Assistant's fees are payable by MCP only when the complexity of the procedure requires the presence of an assistant.

11.2 In surgical procedures requiring the presence of a Dentist as an assistant, the fee for the assistant shall be at 30% of the fee payable to the Oral Surgeon for the procedures performed.

11.3 Where the presence of a Specialist is required as an assistant because of the difficulty or complexity of a case, the fee payable will be 150% of the listed fee and shall be divided equally between the two providers.

11.4 When multiple or bilateral surgical procedures are done during the same anesthetic, the assistant's fee shall be based on the total fees payable for the procedures performed at which he/she assisted. When bilateral procedures or surgical revisions are carried out at separate times with separate anesthetic, the assistant shall be entitled to receive a full assistant's fee for each procedure.

11.5 In surgical procedures requiring more than one assistant, the second assistant shall compute his/her fees on the same basis as the first assistant.

Note: The time factor applicable to assistants in the Medical-Surgical Payment Schedule does not apply when fee code numbers in the Surgical-Dental Schedule are claimed.

12. MCP REGISTRATION

12.1 All Dentists and Specialists receiving funding from MCP for clinical services provided must be registered with MCP through completion of a Provider Registration Form.

12.2 Changes in practice (e.g. address, licensure status, banking information, method of remuneration, etc.) require notification to MCP prior to the changes being effective for billing purposes.

13. LOCUM COVERAGE

Written documentation of locum practice/services is required for all Dentists and Specialists. Contact MCP for current policy and forms.

Appendix "A"

DENTAL MONITORING COMMITTEE

TERMS OF REFERENCE

PURPOSE

- The Committee shall be assigned the responsibility of reviewing and making recommendations to the DOHCS Minister regarding complex dental claims which are referred to the Committee by the DOHCS Dental Consultant.

MEMBERSHIP

- The Dental Monitoring Committee shall consist of:
    - Five voting members, all of whom shall be dentists licensed to practice in Newfoundland and Labrador;
    - DOHCS's Dental Consultant shall be a permanent, non-voting committee members;
    - DOHCS's MCP Manager of Claims Processing shall be a permanent, non-voting committee member;
    - DOHCS may appoint one administrative support position as a permanent, non-voting committee member.
- The NLDA may recommend individuals as candidates for the position of voting members, and the Minister of DOHCS shall consider such recommendations.
- Voting members shall be appointed by the DOHCS Minister for a three year term.
- Whenever possible, to ensure continuity of committee experience, terms for voting members will be staggered.
- No voting members shall serve more than two consecutive terms. A voting member may serve subsequent terms, provided that there is a three year break in service after two consecutive terms.

COMMITTEE CHAIR

- The Dental Consultant will be Chairperson.

- Meetings shall not proceed in the absence of the Chairperson, unless he has appointed a DOHCS representative to act in his stead.

QUORUM

- Three voting members are necessary for a quorum.

MEETING TIMES AND DATES

- The Committee will meet quarterly.
- The dates of the meeting will be made available to the NLDA six months in advance of future DMC meetings.
- The NLDA will be informed of any rescheduling of meetings.
- Additional meetings may be called at the discretion of the Chairperson.

RECORDS OF DECISIONS

- A Record of Decisions shall be kept by the Chairperson for all meetings.
- All discussions will be held under executive privilege,
- A Record of Decisions shall be made available to the DOHCS Minister and NLDA Executive Committee following the meeting of the DMC.
- The format of the Record of Decisions will be agreed upon by NLDA Executive Committee and the Dental Consultant.

REMUNERATION

- Voting members will be remunerated in accordance with established Committee rates as per current Government policy.
- Out of town voting members will be reimbursed for travel expenses as per current Government policy.

VOTING

- All decisions of the Committee shall be made by majority vote.

Appendix B

EXTRACTION OF ERUPTED TEETH

The extraction of erupted teeth is not an insured benefit of the Surgical Dental Program of MCP except in the following situations:

1. Teeth in the line of an osseous fracture, removed at the time of treatment of the fracture(s).

2. Teeth involved in acute trauma, removed at the time of the initial presentation of the patient for treatment.

3. Teeth specifically associated with the treatment of tumors.

4. Teeth which are the direct or potential source of an infection which may compromise medical treatment for either of:
   (a) diabetes mellitus (uncontrolled)
   (b) bleeding dyscrasia
   (c) steroid therapy
   (d) immunosuppression
   (e) organ transplant
   (f) cardiac surgery (bypass, transplant, valves or septum)
   (g) chemotherapy/radiation therapy
   (h) psychiatric illness when the patient is hospitalized for treatment by a psychiatrist

   Numbers 1-4 above require a form to be signed by a medical or dental practitioner in which a request is made for the extraction of teeth and which clearly identifies the medical condition being treated.

5. Acute dental infection which places the patient in immediate medical distress involving uncontrolled septicemia or airway occlusion.

   This presupposes an emergency situation. Documentation by IC Form or hospital record may be required.

   The final decision of insurability in cases of managed medical conditions will rest with the Oral Maxillofacial Surgeon.

Appendix C

EXTRACTION OF IMPACTED TEETH

The extraction of impacted teeth is not an insured benefit of the Surgical Dental Program of MCP except in cases where such removal of partially erupted, or of completely bone covered, impacted teeth is associated with one or more of the following situations:

1. There is a history of persistent or recurring infection associated with the impacted tooth. Treatment would indicate two or more courses of antibiotics.

2. Extraction is requested by a physician to prevent complications in medically compromised patients who are being treated by the physician for either of:

    (a) Cardiac valvular disease
    (b) Renal disease
    (c) Hematological disorder
    (d) Immunosuppressive disease
    (e) Malignancies
    (f) Insulin dependent diabetes, or
    (g) Any other medical condition requiring in-hospital monitoring.
    (h) Cardiac valvular disease

3. Extraction is surgically indicated to treat a cystic and/or neoplastic process which is evident on radiographic examination

4. Extraction of the mandibular contralateral, partially erupted or completely bone covered, impacted tooth, is eligible for payment as described above, and as evidenced by clinical and radiographic data, is completed at the same appointment.

Copy of Hospital Operative Report of procedure is required.

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
84000	New Patient Exam	72.69	87.21
84001	Specific Exam	45.75	57.50
	FOR GENERAL DENTISTS		
	Services listed with no corresponding fees will require prior approval		
	EXTRACTION OF ERUPTED TEETH (See Appendix A)		
84040	Removal of erupted tooth, uncomplicated procedure	50.61	60.73
84042	Multiple removal, additional teeth, per tooth	22.43	26.91
84044	Surgical removal of erupted tooth, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of tooth, includes routine post-op	108.53	130.24
84045	Each additional tooth removed, same appointment, same quadrant	78.26	93.91
84046	Removal of residual roots, covered by soft tissue, single	88.14	105.77
84048	- each additional tooth, same quadrant	44.07	52.89
84050	Removal residual roots, covered by bone, single	142.32	170.79
84052	- each additional tooth, same quadrant	66.12	79.34
	EXTRACTION OF IMPACTED TEETH (See Appendix B)		
84060	Impaction, requires incision of overlying soft tissue and removal of tooth, per tooth, IOP (I.C. form required)	108.54	130.25
84062	Impaction, requires incision of overlying soft tissue, elevation of flap and either removal of bone or sectioning and removal of tooth, per tooth IOP (I.C. form required)	173.27	207.92
84064	Impaction, requires incision of overlying soft tissue, elevation of flap and removal of completely bone covered tooth, per tooth, IOP, (I.C. form required)	218.30	261.97
84066	Impaction, requires incision of overlying soft tissue, elevation of flap, removal of bone and/or sectioning of tooth for removal and/or presents unusual circumstances or difficulties. Operative report is required. IOP (I.C. form required)	237.51	285.02
	NOTE: For all following services, claims will be reviewed prior to payment whenever, in a category, more than one service is provided per patient at the same operation. Operative reports or I.C. forms may be required for such reviews.		
	SURGICAL MOVEMENT OF TEETH		
84080	Repositioning, surgical, per tooth	185.49	222.59
84082	Transplantation, erupted tooth		342.45
84084	Transplantation, unerupted tooth		428.06
	REMODELING AND RECONTOURING ORAL TISSUES		
	ALVEOLOPLASTY: When teeth are extracted, trimming of bone and suturing are considered as part of the procedure. Should an Alveoloplasty be claimed together with fee codes for extractions, an OR report or I.C. form must accompany the claim.		
84100	Alveoloplasty, in conjunction with extractions, per sextant, OR report or I.C. form required	68.50	82.20
84102	Alveoloplasty, not in conjunction with extractions, per sextant	107.01	128.41
	Remodelling of Bone		
84104	Mylohyoid ridge, remodelling		313.91
84106	Genial tubercles, remodelling		214.02

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	Excision of Bone		
84108	Nasal bone		228.29
84110	Torus palatinus		328.18
84112	Torus mandibularis, per quadrant		214.02
	Removal of Bone Exostosis Multiple		
84114	Quadrant		357.91
	Reduction of Bone, Tuberosity		
84116	Unilateral	133.77	160.52
	Gingivoplasty and/or Stomatoplasty		
84120	Gingivoplasty, per sextant	107.01	128.41
84122	Gingivectomy, per sextant	156.96	188.36
84124	Excision of vestibular hyperplastic tissue, per sextant		133.76
84126	Surgical shaving of papillary hyperplasia of the palate		227.26
84128	Excision of pericoronal gingiva (for retained tooth/implant) per tooth/implant		49.93
	Remodelling Floor of Mouth		
84130	Full arch lowering of the floor of the mouth, (excludes splint and model)		891.80
	Vestibuloplasty		
84132	Submucosal, per arch, uncomplicated (includes splint)		297.10
84134	Secondary epithelialization, uncomplicated, per arch		392.31
84136	Vestibuloplasty, with labial inverted flap, (secondary epithelializaton, complicated)		785.52
84138	Vestibuloplasty, with skin graft		713.44
84140	Vestibuloplasty, with mucosal graft		785.52
	Alveolar Ridge Reconstruction		
84142	Alveolar ridge reconstruction, with autogenous bone/arch, per arch		1,065.95
84144	Ceramic grafting, per sextant		356.71
	TESTS, HISTOLOGICAL		
84150	Biopsy, soft oral tissue, by incision, IOP	107.02	128.42
84152	Biopsy, hard oral tissue, by incision, IOP		285.21
	SURGICAL EXCISIONS		
	Surgical Excision, Tumours, Benign		
84160	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, less than 2 cm.	174.82	209.79
84162	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, over 2 cm.	297.62	357.15
84164	Tumours, benign, bone tissue, less than 2 cm.	228.30	273.96
84166	Tumours, benign, bone tissue over 2 cm.	342.44	410.93
84168	Extra-large lesions over 3 cm. or complicated		850.34
	Surgical Excisions, Tumours, Malignant		
84170	Tumours, malignant, soft tissue, less than 2 cm.		249.70
84172	Tumours, malignant, soft tissue, over 2 cm.		428.06
84174	Tumours, malignant, bone tissue, less than 3 cm.		428.06
84176	Tumours, malignant, bone tissue, 3-6 cm.		713.44
84178	Large lesions over 6 cm. or complicated, (minimum value **$740.78**)		I.C.

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	Cheiloplasty (lip shave)		
84180	Cheiloplasty, partial		321.05
84182	Cheiloplasty, total		524.29
	Grafts, bone, to the jaw		
84190	Per graft		891.80
	Augmentations, Prosthetic, of the Jaw		
84200	Implantation of intraosseous prosthesis (continuity defect)		891.80
84202	Removal of intraosseous prosthesis		392.38
84204	Augmentation of the chin		445.91
	Surgical Excision of Cysts/Granulomas		
84210	Less than 2 cm.	200.20	240.24
84212	Over 2 cm.	627.10	752.52
84214	Cyst, complicated (over 6 cm.)		659.92
84216	Marsupialization		461.83
	SURGICAL INCISIONS		
	Surgical Incision and Drainage and/or Exploration, Intraoral		
84220	Intraoral surgical exploration, soft tissue, IOP	111.22	133.46
84222	Intraoral abscess, soft tissue, IOP	57.07	68.48
84224	Intraoral abscess in major anatomical area with drain	221.16	265.40
	Surgical Incision and Drainage and/or exploration, extraoral		
84230	Extraoral abscess, superficial, soft tissue	92.74	111.29
84232	Extraoral abscess, deep soft tissue, with drain	221.16	265.40
	Surgical Incision for Removal of Foreign Bodies		
84240	From skin or subcutaneous alveolar tissue	85.63	102.75
84242	Of reaction-producing foreign bodies		245.65
84244	Of needle from musculoskeletal system		245.65
	Sequestrectomy (for Osteomyelitis)		
84250	Sequestrectomy, for osteomyelitis		267.54
84252	Sequestrectomy, and saucerization		392.38
84254	Extraoral sequestrectomy (complicated) (minimum value $407.43)		I.C.
	Mandibulectomy		
84260	Partial (3-6 cm.)		781.57
84262	Hemi (6-12cm.)		1,172.62
84264	Total (more than 12 cm.) (minimum value $645.96)		I.C.
	Maxillectomy		
84270	Partial (3-6 cm.)		383.47
84272	Hemi (6-12 cm.)		490.48
84274	Total (more than 12 cm.) (minimum value $645.96)		I.C.
	Apicoectomy		
84280	Apicoectomy and/or apical curettage, one root	171.21	205.45
84282	Apicoectomy and/or apical curettage, two roots	263.98	316.78
84284	Apicoectomy and/or apical curettage, three roots or more	356.71	428.05

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	TREATMENT OF FRACTURES		
84300	Intermaxillary fixation, per arch	221.16	265.40
84302	Intramaxillary suspension (wiring)	221.16	265.40
84304	Circumzygomatic wiring, unilateral	128.42	154.11
84306	Removal of wire, plate and screw		392.38
84308	Removal of intermaxillary fixation, IOP	128.42	154.11
84310	Occlusal equilibration per arch, IOP		89.18
	Fractures, Reduction, Mandible		
84330	Closed (simple)	479.39	575.27
84332	Open (simple)	636.85	764.21
84334	Open (multiple)	1,333.63	1,600.35
	Fractures, Reduction, Maxilla Horizontal, LeFort I		
84340	Closed (simple)	479.39	575.27
84342	Open (simple)	636.85	764.21
84344	Open (multiple)	1,333.63	1,600.35
84346	Compound fracture of maxilla (requiring reduction and soft tissue repair)	677.77	813.33
	Pyramidal, LeFort II		
84350	Closed (simple)	479.39	575.27
84352	Open (unilateral)	677.77	813.33
84354	Open (bilateral)	1,333.63	1,600.35
	Fractures, Reduction, Naso-orbital		
84360	Closed (simple)	428.06	513.67
84362	Open (single)	535.07	642.08
84364	Open (multiple)	677.77	813.33
	Fractures, Reduction, Malar Bone		
84370	Closed (simple)	539.50	647.41
84372	Open (simple)	543.54	652.24
84374	Open, complicated orbit involved	856.13	1,027.35
	Fractures, Reduction, Zygomatic Arch		
84380	Closed	269.61	323.53
84382	Open	539.50	647.41
	Fractures, Reduction, Craniofacial Dysfunction, LeFort III Transverse		
84390	Closed	535.07	642.08
84392	Open	1,277.04	1,532.45
	Fractures, Reduction, Alveolar		
84400	Fracture, alveolar, debride, teeth removed – no fixation	128.42	154.11
84402	Reduction, alveolar, closed, with teeth	545.94	655.13
84404	Reduction, alveolar, open, with teeth	221.16	265.40
84406	Replantation, avulsed tooth (including splinting), single	321.05	385.26
84408	Replantation, avulsed teeth (including splinting), each additional	154.10	184.93
84410	Repositioning of traumatically displaced teeth (including splinting)	221.16	265.40
84412	Repairs, lacerations, uncomplicated, 5 cm. or less	99.86	119.83
84414	Repairs, lacerations, complicated, up to 5 cm.	128.42	154.11
84416	Repairs, lacerations, complicated, over 5 cm. (minimum value $201.49)		I.C.

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	TREATMENT OF MAXILLOFACIAL DEFORMITIES		
	Osteotomy, Ostectomy, Ramus of Mandible		
84426	Osteotomy, unilateral		1,319.83
84428	Osteotomy, subcondylar, closed		1,596.30
84430	Osteotomy, subcondylar, open		1,677.42
84432	Osteotomy, ramus, oblique, extraoral		1,677.42
84434	Osteotomy, ramus, oblique, intraoral		1,677.42
84436	Osteotomy/ostectomy body of mandible		1,677.42
84438	Osteotomy, coronoidectomy		717.14
84440	Osteotomy, condylar neck		1,596.30
84442	Osteotomy, saggital split		1,677.42
	Osteotomy, Miscellaneous		
84444	Osteotomy, oblique with bone graft		2,050.40
84446	Osteotomy, inverted "L"		1,596.30
84448	Osteotomy, "C"		1,596.30
	Osteotomy, Maxilla		
84450	Osteotomy, maxilla, LeFort II		1,677.42
84452	Osteotomy, maxilla, LeFort III		2,056.41
84454	Osteotomy, maxilla, LeFort IIII		2,836.13
84456	Additional to above requiring two segments		356.27
84458	Additional to above requiring three segments		712.65
84460	Additional to above requiring four segments		712.65
84462	Additional to above requiring a cranial flap		596.15
84464	Closure of cleft fistula, alveolar		329.98
84466	Closure of cleft fistula, palatal		490.48
84468	Pharyngoplasty		490.48
84470	Submucous resection		322.28
	Osteotomy, Maxilla/Mandible, Segmental Maxilla		
84480	Osteotomy, segmental, anterior		1,496.62
84482	Osteotomy, segmental, posterior		1,677.42
84484	Osteotomy, midpalate split, anterior		1,596.30
84486	Osteotomy, midpalate split, complete		1,596.30
	Mandible		
84488	Osteotomy, segmental, anterior with transfer of mental eminence		1,319.83
84490	Osteotomy, segmental, anterior without transfer of mental eminence		1,319.83
84492	Osteotomy, segmental, posterior		1,649.82
84494	Osteotomy, lower border, mandible		1,649.82
84496	Osteotomy, total dento-alveolar		1,677.42
	Osteotomy, with "Interpositional Graft"		
84500	Using bone		2,050.40
84502	Using alloplast		2,050.40
84504	Using cartilage		2,050.40
	Genioplasty		
84510	Genioplasty, sliding		445.91
84512	Genioplasty, reduction		383.47
84514	Genioplasty, augmentation with graft		701.53
84516	Myotomy, suprahyoid		445.91

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	Miscellaneous Treatment of Maxillofacial Deformities		
84520	Corticotomy, per 9 cuts (maximum $1,325.99)		I.C.
84522	Interdental septotomy	156.96	188.36
84524	Surgical expansion of the palate		688.65
	Palatorraphy		
84530	Palatorraphy, anterior (closure of palatine fissure)		445.91
84532	Palatorraphy, posterior		445.91
84534	Palatorraphy, total		824.73
84536	Palotorraphy, with bone graft separate		994.13
84538	Palatorraphy, with bone graft to anterior alveolar ridge separate		771.30
	Frenectomy		
84540	Frenectomy	131.98	158.38
84542	Frenoplasty	131.98	158.38
	Glossectomy		
84550	Glossectomy, partial, anterior wedge		329.98
84552	Glossectomy, full postero-anterior wedge (minimum $484.47)		I.C.
	Cleft Surgery		
84560	Primary unilateral cleft lip repair (minimum $201.49)		I.C.
84562	Secondary unilateral cleft lip repair (minimum $201.49)		I.C.
84564	Primary bilateral cleft lip repair (minimum $201.49)		I.C.
84566	Secondary bilateral cleft lip repair (minimum $201.49)		I.C.
84568	Reconstruction of cleft lip with lip switch flap (minimum $201.49)		I.C.
84570	Complex reconstruction or revision of cleft lip (minimum $201.49)		I.C.
84572	Closure of alveolar cleft (see grafting codes)		552.91
	Oronasal Fistula		
84580	Primary closure at time of initial surgery	263.98	316.78
84582	Secondary closure with palatal flap		445.91
84584	Secondary closure with pharyngeal flap		445.91
84586	Secondary closure with tongue flap		445.91
84588	Secondary closure with buccal flap		994.13
	TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTIONS		
	TMJ, Dislocation, Management		
84600	TMJ, dislocation, open reduction, (exposure of joint)		713.44
84602	TMJ, dislocation, closed reduction, uncomplicated	107.01	128.41
84604	TMJ, dislocation, closed reduction, under G.A.	178.36	214.03
84606	TMJ, luxation reduction, without anaesthesia	107.01	128.41
84608	TMJ, luxation reduction, under G.A.	178.36	214.03
84610	TMJ, manipulation under anaesthesia	178.36	214.03
84612	TMJ, fixation (arch bars)		383.47
	TMJ, Capsule, Management of		
84616	Menisectomy		623.61
84618	Capsulorraphy		713.44
84620	Myotomy, lateral pterygoid muscle		713.44
84622	Plication, posterior attachment of the disk of the TMJ, in cases of internal derangement		1,282.87

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	TMJ, Condylar, Surgical		
84626	Condylectomy		623.61
84628	Condylotomy		606.41
84630	Osteotomy, oblique, with silastic interposition for ankylosis (graft)		1,596.30
	TMJ, Articular Eminence, management of		
84634	Reconstruction of the glenoid fossa zygomatic arch and temporal bone (Obwegeser technique)		1,983.42
84636	Articular eminence, arthroplasty		713.44
	TMJ, Arthrocentesis		
84640	Puncture and aspiration		89.18
	TMJ, Management by Injection		
84644	Anti-inflammatory drugs		89.18
84646	With sclerosing agent		I.C.
	TMJ, Appliance Splints for use ONLY in post-surgical cases		
84650	Maxillary, IOP	131.98	158.38
84652	Mandibular, IOP	131.98	158.38
84654	Occlusal adjustment, per arch, IOP		89.18
	Arthrography of TMJ		
84660	Performing the Arthrographic procedure		185.08
	TREATMENT OF SALIVA GLANDS		
84670	Salivary duct, dilation, IOP		94.26
84672	Salivary duct, insertion of polyethylene tube		94.26
84674	Salivary duct, sialodochoplasty		300.66
84676	Salivary duct, reconstruction		276.46
84678	Salivary duct, sialolithotomy anterior 1/3 of canal		276.46
84680	Salivary duct, sialolithotomy posterior 2/3 of canal		383.47
84682	Salivary duct, external approach (minimum $318.54)		I.C.
84684	Excision of submandibular gland		672.21
84686	Excision of sublingual gland		421.21
84688	Excision of mucocele		196.20
84690	Excision of ranula		321.05
84692	Marsupialization of ranula		150.39
84694	Salivary gland removal, parotid		1,568.22
	NEUROLOGICAL DISTURBANCES, TREATMENT OF		
	Neurological Disturbances, Trigeminal Nerve		
84700	Injection for destruction, IOP		193.50
84702	Avulsion at periphery		415.68
84704	Alcoholization of a branch, IOP		89.18
84706	Infiltration of a branch for diagnosis	35.66	42.79
	Neurological Disturbances, Mental Nerve		
84710	Transposition of		611.53
84712	Decompression of canal		497.95
	Neurological Disturbances, Inferior Dental Nerve		
84716	Complete avulsion		490.48

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	Neurological Disturbances Surgery		
84720	Injured nerve repair, primary		398.67
84722	Injured nerve repair, secondary		938.45
84724	Neural transposition and decompression		563.72
84726	Implantation of electrode for peripheral nerve stimulation		365.26
84728	Excision of tumour or neuroma		329.98
84730	Add 40% to basic fee when using operating microscope		I.C.
84732	Nerve repair with graft		481.86
	ANTRAL SURGERY		
	Antral Surgery, Recovering Foreign Bodies		
84740	Immediate recovery of dental root or foreign body from the antrum	263.98	316.78
84742	Immediate closure of antrum by another dental surgeon	263.98	316.78
84744	Delayed recovery of a dental root with oral antrostomy		445.91
84746	Antral surgery with nasal antrostomy		445.91
	Antral Surgery, Lavage		
84750	Lavage, oral approach	69.28	83.13
84752	Lavage, nasal approach	69.28	83.13
	Antral Surgery, Oro-antral Fistula Closure (same session)		
84758	Closure with buccal flap	263.98	316.78
84760	Closure with gold plate	263.98	316.78
84762	Closure with palatal flap	263.98	316.78
	Antral surgery Oro-antral Fistula Closure (subsequent session)		
84766	Closure with buccal flap		994.13
84768	Closure with gold plate		445.91
84770	Closure with palatal flap		445.91
	HAEMORRHAGE CONTROL		
84780	Secondary haemorrhage control, IOP	85.63	102.75
84782	Haemorrhage control using compression and haemostatic agent, IOP	85.63	102.75
84784	Hamemorrhage control using haemostatic substances and sutures (includes removal of bony tissues if necessary), IOP (minimum $242.38)		I.C
	GRAFTS, SURGICAL		
	Harvesting of Intraoral Tissue for Grafting to Operative Site		
84800	Bone		285.38
84802	Cartilage		285.38
84804	Skin		108.19
84806	Mucosa		I.C.
84808	Muscle		I.C.
84810	Dermis		I.C.

SURGICAL DENTAL PROCEDURES

Code		Dentist	Oral Surg.
	Harvesting of Extraoral Tissue for Grafting to Operative Site (to include ilium, rib, etc.)		
84820	Bone		535.08
84822	Cartilage		535.08
84824	Costochondral		299.61
84826	Skin		108.19
84828	Mucosa		108.19
84830	Fascia		163.17
84832	Muscle		163.17
84834	Dermis		163.17
84836	Nerve		340.93
	Vascularized Tissue Flaps		
84840	Free		87.25
84842	Attached		87.25
	EMERGENCY PROCEDURES		
84850	Tracheotomy	263.98	316.78
84852	Crico-thyroidotomy	263.98	316.78
	APPLICATION OF SURGICAL SPLINTS		
84860	Study model, IOP	42.77	51.33
84862	Surgical template, IOP	71.35	85.62
84864	Surgical template with fixation clasp, IOP	178.36	214.03
84866	Surgical obturator, surgical or gunning splint, IOP	316.51	379.81
	RIGID FIXATION		
84867	Rigid fixation used for osteotomies or treatment of traumatic injuries		276.46
	RADIOGRAPHS		
87020	X-Rays (Panorex)	69.81	83.78

SURGICAL DENTAL PROCEDURES
Provided In Office by Oral Maxillofacial Surgeons

Code		Rate

The following payment schedule reflects fees that can be billed by oral surgeons for services provided in their office. The effective date will be April 1, **2022**.

It is understood by all parties that the Department of Health and Community Services will monitor the volume of work and costs relating to this new schedule. This payment schedule for office-based procedures expires March 31, **2026.**

84000	New Patient Exam	**87.21**
84001	Specific Exam	**57.50**
84038	In-Office Sedation	**366.24**
	EXTRACTION OF ERUPTED TEETH, IF COMPLETED IN OFFICE OF ORAL SURGEON (See Appendix A)	
84039	Removal of erupted tooth, uncomplicated procedure	**105.72**
84041	Multiple removal, additional teeth, per tooth	**56.87**
84043	Surgical removal of erupted tooth, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of tooth, includes routine post-op care **(*For each addition tooth, same quadrant see 84055)**	**254.08**
84047	Removal of residual roots, covered by soft tissue, single	**198.79**
84049	- each additional tooth, same quadrant	**154.48**
84051	Removal of residual roots, covered by bone, single	**298.05**
84053	- each additional tooth, same quadrant	**259.16**
84055	**Surgical removal of an additional erupted tooth same quadrant, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of tooth, includes routine post-op care (*For first tooth see 84043)**	**190.56**
	EXTRACTION OF IMPACTED TEETH (See Appendix B)	
84061	Impaction, requires incision of overlying soft tissue and removal of tooth, per tooth, IOP (I.C. form required)	**255.12**
84063	Impaction, requires incision of overlying soft tissue, elevation of flap and either removal of bone or sectioning and removal of tooth, per tooth IOP (I.C. form required)	**363.09**
84065	Impaction, requires incision of overlying soft tissue, elevation of flap and removal of completely bone covered tooth, per tooth, IOP (I.C. form required)	**476.22**
84067	Impaction, requires incision of overlying soft tissue, elevation of flap, removal of bone and/or sectioning of tooth for removal and/or presents unusual circumstances or difficulties. Operative report is required. IOP (I.C. form required)	**579.58**
	Note: For all following services, claims will be reviewed prior to payment whenever, in a category, more than one service is provided per patient at the same operation. Operative reports or I.C. forms may be required for such reviews.	
	TESTS, HISTOLOCIAL	
84151	Biopsy, soft oral tissue, by incision, IOP	**159.22**
84153	Biopsy, hard oral tissue, by incision, IOP	**271.48**
	SURGICAL EXCISIONS	
84161	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, less than 2 cm.	**437.63**
84163	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, over 2 cm.	**528.87**
84165	Tumours, benign, bone tissue, less than 2 cm.	**469.94**
84167	Tumours, benign, bone tissue over 2 cm.	**838.52**
	Surgical Excisions of Cysts/Granulomas	
84211	Less than 2 cm	**378.71**

SURGICAL DENTAL PROCEDURES
Provided In Office by Oral Maxillofacial Surgeons

Code		Rate
	ANTRAL SURGERY	
	Antral Surgery, Recovering Foreign Bodies	
84741	Immediate recovery of dental root or foreign body from the antrum	**554.98**
	Antral Surgery, Oro-antral Fistula Closure (same session)	
84759	Closure with buccal flap	**881.02**
	HAEMORRHAGE CONTROL	
84781	Secondary haemorrhage control, IOP	**177.84**
84783	Haemorrhage control using compression and haemostatic agent, IOP	**117.59**
84785	Haemorrhage control using haemostatic substances and sutures (includes removal of bony tissues if necessary), IOP (minimum **$242.38**)	**I.C.**
	RADIOGRAPHS	
87021	X-Rays (Panorex - In-Office for Insured Services)	**86.45**