MEDICAL SERVICES COMMISSION PAYMENT SCHEDULE: DENTAL SERVICES

(Schedules A-F)

Effective February 1, 2024

Ministry of Health

SCHEDULE A - DENTAL SURGERY (GENERAL DENTAL PRACTITIONERS)

Tariff of Fees Approved and/or Prescribed as the Payment Schedule
Effective February 1, 2024

Explanatory Notes:

(*i*) *Covered services generally include consultations, extractions, orthognathic surgery, trauma, etc. when performed in a hospital or other locations that meet the criteria outlined in Section 19(a.1) of the* Medical and Health Care Services Regulation*. Services not covered by the Medical Services Plan (MSP) include restorations, as well as radiographs and other diagnostic services, unless specifically listed in these Schedules. Please note that booking or admitting fees for covered services are not permitted under Section 17 of the* Medicare Protection Act*. Given the mix of private and public coverage, it is important that patients be clearly advised what portion of their services are covered by MSP and what is the patient's responsibility.*

(ii) The dentist's responsibility includes post-operative care of the operative site up to 8 weeks.

(iii) Should any surgical procedure require simple revision/reoperation within 6 weeks of the first surgery, then that procedure shall be billed using the corresponding surgical code and will be paid at 50% of that surgical fee.

(iv) When a dental/oral surgical procedure is a benefit listed in the Payment Schedule and therefore, payable by MSP, that payment at the rate listed in the Schedule is considered to be payment in full and there may be no additional charges to the patient or any other third-party for in-hospital surgical procedures, associated in-hospital care, or for the professional component of associated out-of-hospital services (e.g.: assessments, planning, patient counselling, post-operative follow-up within 8 weeks of surgery).

(v) When two or more procedures are performed under the same anesthetic, the procedure with the greater listed fee may be claimed in full and the fees for the additional procedure are reduced to 50% unless otherwise indicated in the Schedule.

Examinations:

Includes history and physical examination and interpretation of diagnostic data, (i.e. laboratory findings, radiographs, and pathology reports) where appropriate.

CONSULTATIONS / VISITS

***Explanatory Notes**:*

(i) *Emergency consultation fee (27000) is payable for admitted patients in the emergency or out-patient department of a hospital when the dentist is requested to see the patient in consultation on referral from a physician/dentist/oral and maxillofacial specialist on an urgent or emergency basis.*

(ii) *Consultations are not payable if the referral is for routine dental treatment (defined as fillings, prosthetic or periodontal reasons). This includes registered long-term care residents in facilities attached to an acute care facility.*

(iii) *Consultations are not insured services for patients seen in a private dental office, even if the office is located in a hospital, unless the consultation is associated with and followed by an in-hospital surgical procedure insured by the Plan.*

(iv) *Payment for non-emergent consultations (27005) will be honoured if the patient is booked in good faith with a hospital for a procedure and the patient cancels at a later date. Also, the non-emergent consultation fee may be billed a second time after six months from the initial consultation if the surgery has been delayed by the hospital and the patient requires an update to their condition because of this delay.*

Emergency Consultation

27000	Consultation in a hospital (including emergency room) by a dentist on referral from a physician, or dentist, or another oral and maxillofacial specialist on an urgent or emergency basis for immediate patient management (to include interpretation of x-rays).	96.59
27001	Emergency Consultation Surcharge – Emergency consultation service rendered between 1800 hours and 0800 hours or emergency consultation service rendered on a Saturday, Sunday or Statutory Holiday	21.72

Non-Emergent Consultation/Exam

27005	Initial consultations by request of physician or nurse practitioner or dentist, presenting a distinct diagnostic problem requiring diagnostic tests and/or telephone time and written report, and associated with and followed by an in-hospital oral surgical procedure covered by the Plan management (to include interpretation of x-rays).	96.59
27006	In-hospital consultation on the referral of a physician or nurse practitioner regarding a distinct medical diagnostic problem. Requires diagnostic tests and follow-up by the consulting dentist ***Note:*** *Call-out fee not payable in addition.*	131.63

Hospital Visits

27008 Hospital visit for medical management of oral disease for a patient in hospital when surgical intervention may-not be required (e.g.: infection) 19.69

Notes:

(i) Not payable on day of initial consultation.

(ii) Limit of one per day

(iii) Applicable only to patients in acute care facilities

(iv) Repeat visits to monitor condition may be billed when done in dental office if this is more convenient for the patient and the dentist

OUT-OF-OFFICE HOURS PREMIUMS

Explanatory Notes:

(i) *The call-out charge 27012 (27013, 27014, 27015 for surgical assistants) is **in addition to fee item 27000 and emergency surgery.** It applies only to those consultations/surgeries initiated and rendered within the designated time limits*

(ii) *Call-out charges apply only when the dentist is specially called to render emergency or non-elective services and only when the dentist must travel to the hospital to attend the patient(s).*

(iii) *For these fee items the claim must state both the time called and the time service is rendered*.

(iv) *The continuing care surcharge applies to surgical assistant fees also.*

(v) *Continuing care surcharge are payable to dentists only when the primary service to which the continuing care surcharges apply are payable by MSP on a fee-for-service basis*.

Call-Out Charges:

27012 Call out when dentist is called by a health authority to attend a patient in hospital – per call 229.60

Notes:

(i) Response time based on patient's clinical circumstances, but dentist must attend within 24 hours of receiving call.

(ii) Not applicable to surgical assistants.

(iii) Time call placed and service rendered must be indicated in time fields.

(iv) Not payable where existing paid call arrangements are in place.

(v) The call-out charge applies only to the first patient examined or treated on any one special visit. A call-out charge is applicable to each special call-out whether or not a previous call-out charge has been billed for the same patient on the same day.

(vi) For a second or subsequent call-out on the same day, supporting documentation must be submitted identifying why an additional visit was required.

Call-out Charges for Surgical Assistants:

27013	Evening (call placed between 1800 hours and 2300 hours and service rendered between 1800 hours and 0800 hours)	54.56
27014	Night (call placed and service rendered between 2300 hours and 0800 hours)	76.59
27015	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours)	54.56

Continuing Care Operative Surcharges

Applicable only to emergency surgery or non-emergency surgery which, because of intervening emergency surgery, commences within the designated times.

Applicable only to surgical procedure(s) requiring general anesthesia or neuroleptic anesthesia and/or requiring at least 45 minutes of surgical time.

27023	Evening (1800 hours to 2300 hours) - 32.77% of surgical (or assistant) fee	
	- minimum charge	54.56
	- maximum charge	376.24
27024	Night (2300 hours to 0800 hours) - 52.54% of surgical (or assistant)	
	- minimum charge	76.59
	- maximum charge	528.34
27025	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours) - 32.77% of surgical (or assistant) fee	
	- minimum charge	54.56
	- maximum charge	376.24

Notes:

(i) When surgery commences within evening time period (1800 – 2300 hrs) and continues into night time period (2300 – 0800 hrs), the appropriate item for billing is determined by the period in which the major portion of the surgical time is spent.

(ii) When emergency surgery commences prior to 1800, even if the major portion of surgical time is after 1800, surgical surcharges are not applicable.

(iii) If emergency surgery commences prior to 0800 and continues after 0800, surcharges are applicable to the entire surgical time.

(iv) Claim must state time surgery commenced.

DENTOALVEOLAR SURGERY REMOVAL OF TEETH

A. Impacted Third Molar

"The tooth is completely or partially unerupted and positioned against another tooth, bone or soft tissue, so that further eruption is unlikely."

Surgical removal of am impacted third molar, is an MSP insured service when performed by an enrolled dentist/oral maxillofacial specialist only when hospitalization is medically required for the proper performance of the procedure and criteria (i) or (ii) or (iii) are met, or if the patient has a pre-existing medical condition that requires hospital monitoring during the peri-operative period (*See Appendix 1, paragraph 2).*

(i) there is or has been a recent history of associated pathology, or

(ii) growth and development disturbances of the third molar impedes the eruption of another tooth, or

(iii) the impacted molar impedes the imminent placement of a prosthesis.

Without limiting the application of the foregoing, examples of pathology related to the extraction of an impacted third molar are:

- Infection
- A non-restorable carious lesion
- Non- treatable pulpal and/or periapical pathology
- Cellulitis
- Abscess and osteomyelitis
- Internal/external resorption of the tooth or adjacent tooth
- Fracture of tooth
- Disease of follicle including cyst/tumour
- Impeding surgery or reconstructive jaw surgery
- Involved in or within the field of tumour resection

B. Other Teeth

All other extractions are MSP insured services when, in the opinion of the dentist/oral maxillofacial specialist or attending medical practitioner, hospitalization is required for the proper performance of the procedure and:

(a) Where such treatment is an integral part of the management or treatment of a systemic condition or trauma, or,

(b) the surgical extraction is significantly complex or invasive in nature, such that it requires general anesthesia, or,

(c) the patient is a hospital in-patient and the performance of the procedure is medically necessary to the patient's care, or,

(d) there is difficult access to the airway or surgical site so as to cause significant anesthesia risk in a non-hospital environment, or,

(e) the emergent nature of the dental condition requires immediate surgical attention under general anesthesia, or,

(f) a demonstrated medical contra-indication (e.g. allergy) to local anesthesia precluding the performance of the extraction under local anesthesia, or,

(g) when indicated to safely complete another MSP insured surgical procedure such as fracture or osteotomy, or,

(h) the patient's age or physical and/or mental disability makes treatment impossible or unsafe outside a hospital setting

Notes:

(i) If another surgical procedure is being completed at the same time as removal of multiple teeth, the higher gross fee item shall be paid at 100% and the extractions in that quadrant shall be paid as per "each additional tooth per quadrant".

(ii) When cysts, tumours, or other pathological lesions are intimately related to the teeth, and when extraction of these teeth are necessitated by this pathology, then only one surgical fee is applicable. This fee would be the major fee, either for the extractions or for the surgery to eradicate this pathology. In no instance would two fees be paid for these procedures completed concurrently. Other teeth removed in the same quadrant would be paid as per "each additional tooth per quadrant". On these occasions, a note record is required to confirm additional teeth removed in same segment are not associated with cyst/tumour/lesion.

(iii) When extractions are completed with osteotomies or fractures, the extractions will be billed as per "each additional tooth per quadrant" regardless of the quadrant or numbers of quadrants involved.

(iv) Prior approval may be sought for those cases not fulfilling the criteria listed above when the dentist/oral maxillofacial surgeon is of the opinion that the hospitalization is medically required and essential for the safe and efficient performance of the extraction(s). Requests for prior approval should be forwarded in writing (with appropriate documentation to make a decision) to the Adjudication Supervisor, Medical Services Plan Operations, Health Insurance BC.

Pre-existing Medical Conditions

Pre-existing medical conditions refers to serious and/or complex medical problems (usually under active treatment) which have a significant potential of increasing the risk of the dental procedure.

For patients with a pre-existing medical condition as listed below whose dental treatment plan involves the extraction of at least one impacted third molar, meeting the above extraction criteria the MSP will pay for the anesthesia and extraction fee for the removal of additional impacted third molars at the same time if the dentist/oral maxillofacial specialist determines that it is in the best interest of the patient's health – e.g.: where a second general anesthetic has a significant potential of increasing the risk to the patient.

These pre-existing medical conditions include but are not limited to:

(a) Central Nervous System Disorders

(i) significant disability due to cerebrovascular accident,

(ii) epilepsy or seizures that are difficult to control,

(iii) significant cerebral palsy, myasthenia gravis, muscular dystrophy,

(iv) significant dementia such as Alzheimer's Disease,

(v) other forms of active central nervous disorders where there is loss of sensory, motor, or autonomic function under medical treatment;

(b) Cardiovascular Disorders

(i) significant disability due to myocardial infarction,

(ii) unstable angina on active treatment,

(iii) unstable, significantly elevated blood pressure on active treatment,

(iv) significant congestive heart failure,

(v) other forms of unstable cardiac disease under active treatment,

(vi) other cardiovascular disorders under treatment, including situations requiring extractions prior to cardiovascular surgery;

(c) Respiratory Disorders

(i) unstable pulmonary disease under active management;

(d) Renal Disorders

(i) unstable renal disease under active management;

(e) Hematologic Disorders

(i) leukemias under chemotherapy,

(ii) hemophilias or other bleeding diathesis,

(iii) anemia with hemoglobin less than 10 grams %,

(iv) other

(v) unstable hematologic disorders under active management;

(f) Hepatic Disorders

(i) hepatitis A, hepatitis B, hepatitis C under active management,

(ii) other significant hepatic diseases under active management;

(g) Endocrine Disorders

(i) hypothalmic and pituitary disorders requiring steroid therapy,

(ii) (those patients with) insulin dependent diabetes mellitus requiring monitoring of blood glucose,

(iii) other unstable endocrine disorders under active management;

(h) Neoplastic Disorders

(i) (those patients with) active cancer treatment and/or chemotherapy and/or radiotherapy,

(ii) other unstable neoplastic disorders under active management;

(i) Viral, Non Viral, Bacterial, Infectious or Immune Deficiency

(i) active herpes simplex,

(ii) acquired immune deficiency syndrome,

(iii) other unstable infectious disorders under active treatment;

(j) Metabolic Disorders

(i) malignant hyperthermia,

(ii) other significant metabolic disorders under active treatment;

(k) Other Disorders or Conditions

(i) medically proven contra-indication (e.g. allergy) to local anesthesia,

(ii) pre-radiation of the head and neck including situations involving extractions prior to radiation treatment,

(iii) post radiation necrosis or sepsis,

(iv) significant mental illness or incompetence,

(v) significant disability due to age or infirmity;

Other conditions for which hospitalization may be necessary will be given independent consideration.

Note: *For removal of multiple teeth and/or roots, the higher fee item shall be paid at 100% per quadrant and other teeth and/or roots in the same quadrant shall be paid as per "each additional tooth and/or root per quadrant"*

Uncomplicated

27030	First tooth per quadrant – single tooth - uncomplicated	69.26
27031	Each additional tooth, same quadrant, same appointment	45.65

Complicated

	Erupted tooth, surgical approach, requiring surgical flap and/or sectioning of tooth	
27033	Each tooth	135.35
27034	Each additional tooth, same quadrant	95.97

Impacted Teeth

	Soft Tissue Coverage	
	Requiring incision of overlying soft tissue and removal of tooth	
27040	Single tooth	135.35
27041	Each additional tooth same quadrant	89.34
	Tissue and/or Bone Coverage	
	Requiring incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of tooth	
27045	Partial bony – single tooth	156.04
27046	Each additional – partial bony, same quadrant	73.79
27050	Full bony	218.07
27051	- each additional “full bony” impaction per quadrant	109.29
27054	Full bony impaction of extreme difficulty re: morphology or position	232.51
	***Note**: Radiographs must be supplied*	
27055	- each additional “full bony of extreme difficulty” per quadrant	160.98
27058	Removal of a tooth follicle (enucleation)	128.94
27059	- each additional “removal of a tooth follicle (enucleation)” per quadrant	103.11

Residual Roots

27060	Soft tissue coverage first per quadrant	82.91
27061	- each additional “soft tissue coverage root” per quadrant	36.70
27063	Bone coverage first per quadrant	156.11
27064	- each additional “bone coverage root” per quadrant	58.29
27070	Tooth transplantation (including splinting, donor removal and recipient bed preparation)	268.28
27071	Tooth transplantation - each additional per quadrant	134.14
27073	Surgical uprighting/repositioning/uncovering of a tooth	189.71
27074	Surgical uprighting/repositioning /uncovering of a tooth - each additional per quadrant	94.94
27076	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device	228.14
27077	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device - each additional per quadrant	114.07

SURGICAL ENDODONTICS

Apicoectomy

27082	Bicuspids and buccal roots of maxillary molars	313.01
27084	Palatal roots of maxillary molars and roots of mandibular molars	299.16
27086	Per root end fill, add	29.87
27088	Hemisection	111.45
27089	Open and drain when done in hospital as a last resort modality to bring relief for a patient with acute abscess causing excessive pain and swelling **Note:** *May be done as adjunct to soft tissue drainage.*	73.46

Root Amputations (includes tooth and furca recontouring)

27090	One root per tooth	222.94
27092	Two roots per tooth	267.45

OSSEOUS RECONTOURING

Alveoloplasty (Full fee per sextant)

27100	Per edentulous sextant	90.38
27102	In conjunction with multiple extractions	67.97
27105	Tuberosity reduction with bone removal (as a separate procedure and not in conjunction with removal of an impacted tooth)	187.80

Removal of torus/exostosis

27107	Per quadrant	147.75
27108	Palatal torus	233.03

SOFT TISSUE RECONTOURING (Full fee per sextant)

27120	Uncomplicated excision of hyperplastic tissue with primary closure, e.g., soft tissue tuberosities and epuli	82.91
27122	Operculectomy (as an isolated procedure - not to be billed as part of a routine extraction procedure)	38.76
27124	Gingivoplasty - per sextant ***Note**: Not in conjunction with tooth removal unless with systemic etiology - e.g. - drug induced hyperplasia*	89.80
27128	Frenectomy	187.18
27129	Frenectomy - second at same surgery	93.62

Vestibuloplasty

A surgical procedure involving the mucosa, musculature, and periosteum of the jaws which establishes a new vestibular depth.

- this does not include tissue harvest
- each fee paid at full on a sextant basis

27131	Each sextant	343.01
27132	Mucous membrane graft - add per sextant	67.07

SURGICAL EXCISION

Incisional Biopsies

27180	Soft tissue	99.55
27182	Hard tissue	178.85

LESIONS

INTRAORAL SOFT TISSUE LESIONS

Primary Closure

27220	Lesion base ≤ 1cm	202.35
27221	- each additional lesion ≤ 1cm	101.18
27225	Lesion base > 1cm	398.77
27226	- each additional lesion > 1cm	199.38

OSSEOUS LESIONS

Surface Osseous Lesions (other than tori and alveoloplasties)

27240	Lesion base ≤ 1cm	161.86
27241	- each additional lesion base ≤ 1cm	80.93
27245	Lesion base > l cm	306.21
27246	- each additional lesion base > l cm	153.10

Intraosseous Lesions

a) Treatment by Simple Excision, Enucleation, or Curettage

27250	≤ 1 cm in greatest diameter	202.35
27252	1cm to 5cm	398.77
27260	Each additional lesion same jaw is paid at 50%	
27265	Each additional lesion second jaw is paid at 75%	

MANAGEMENT OF INFLAMMATORY PROCESSES

Soft Tissue Incision and Drainage

27350	Vestibular or subperiosteal abscess	49.09
27355	Intraoral superficial (buccal, subcutaneous, infraorbital, and infratemporal spaces)	76.05
27365	Extraoral superficial (submental, subcutaneous and buccal spaces)	112.52
27375	Sequestrectomy for osteomyelitis	229.43

TREATMENT OF TRAUMATIC INJURIES

I) Dentoalveolar Trauma

27381	Management of a non-avulsed tooth with wire, composite, ribbon, or splint to stabilize displacement due to a traumatic event. Fee includes removal of splint after completion of stabilization. Removal can be done in a dentist's office	66.15

27382	Onetime fee for all additional teeth treated at same time for management of non-avulsed teeth with wire, composite, ribbon, or splint to stabilize displaced teeth due to a traumatic event. Fee includes removal of splint after completion of stabilization. Removal can be done in a dentist's office	33.08
27383	Removal of splint after stabilization if done by another dentist	50.44
27384	Management of a fractured tooth with a deep Class 2 fracture involving the dentin and or Class 3 fracture exposing the pulp, whereby the patient is in pain and requires a composite bonded and/or glass ionomer restoration.	115.50
27385	One time free for all additional teeth treated at the same time for the management of a fractured tooth with a deep Class 2 fracture involving the dentin and or Class 3 fracture exposing the pulp, whereby the patient is in pain and requires a composite bonded and/or glass ionomer restoration	60.61
27400	Implantation and splinting of an avulsed tooth (not including root canal therapy	286.59
27402	Reduction of alveolar fracture including debridement and necessary extractions	446.12

II) Facial Trauma

Soft Tissue Injuries

27405	Single layer suture of laceration	108.94

Hard Tissue Injuries

a) Midface Fractures

Closed Reductions

27440	Closed reduction of maxilla with arch bars or other tooth anchored fixation	396.55

b) Mandibular Fractures

Closed Reduction

27470	Closed reduction of mandible with arch bars or other tooth anchored fixation	449.59

Open Reduction - Intraoral

27475	Simple fracture of mandible (includes immobilization with tooth anchored fixation)	583.02

TEMPOROMANDIBULAR JOINT

27500	Reduction of dislocation	111.80
27502	Manipulation under anesthesia (as an isolated procedure only)	111.80

REMOVAL FOREIGN BODIES

	Removal of foreign body from bone (as a separate procedure only and not to include dental implants)	
27695	Surgical removal	268.28

ANTRAL SURGERY

27711	Immediate recovery of a tooth or foreign body from the maxillary antrum	84.95
27712	Secondary recovery of a tooth or foreign body from the maxillary antrum	268.28
27720	Closure of an oral antral fistula - immediate closure – sliding advancement buccal flap with periosteal release (not to be billed with code 27711)	185.43

SALIVARY GLANDS

27740	Dilation of salivary duct	36.11
27742	Sialodochoplasty	111.80

Intraductal sialolithotomy

27747	- submandibular	111.80

DENTOALVEOLAR COMPLICATIONS

27770	Post-operative complications	40.24

SURGICAL ASSISTANT

27801	G.P. surgical assistant	447.14
27802	After three hours continuous surgical assistance for one patient, for each additional 15 minutes, or fraction thereof, add	22.36

Note: *Claims for a surgical assist will only be paid with major surgical procedures such as osteotomies, reconstructive surgery, etc. Assistants at the following procedures will not be paid unless substantiated by an explanation of the medical necessity supporting the need of an assistant:*

- *Odontectomy (all)*
- *Exposure and repositioning of teeth (all)*
- *Osseous recontouring (all)*
- *Soft tissue recontouring (all)*
- *Biopsies (all)*
- *Lip surgery - wedge resection of lip and vermilionectomy*
- *Soft tissue lesions (fee codes 27220 and 27221)*
- *Surface Osseous lesions (fee codes 27240 and 27241)*

- *Intraosseous lesions (fee code 27250)*
- *Soft tissue incision and drainage (fee codes 27350, 27355, 27365)*
- *Osteomyelitis (fee code 27375)*
- *Foreign bodies (fee code 27692)*
- *Traumatic injuries of the teeth and skeleton (fee codes 27400, 27402, and 27440)*
- *Temporomandibular joint (fee codes 27500 and 27502)*
- *Antral Surgery (fee codes 27711 and 27720)*
- *Salivary glands (fee codes 27740, 27742 and 27747)*
- *Surgical endodontic procedures (all)*
- *Dentoalveolar complications (fee code 27770)*

MISCELLANEOUS FEE

27999 To be used for unusually complex procedures, for established but infrequently performed procedures which are not listed in this payment schedule, for unlisted “team” procedures or for any medically required service for which the practitioner desires independent consideration to be given by the Plan, a claim should be submitted using this code. When submitting claims using a miscellaneous fee code, you should include your estimate of an appropriate fee, details of the calculation of that fee and sufficient documentation of your services (such as an operative report) to substantiate the claim. Claims made under the miscellaneous code will be adjudicated in equity with services of similar responsibility, skill, and duration

SCHEDULE B - ORAL AND MAXILLOFACIAL SPECIALISTS

Tariff of Fees Approved and/or Prescribed as the Payment Schedule
Effective April 1, 2021

Explanatory Notes:

(i) *Covered services generally include consultations, extractions, orthognathic surgery, trauma, etc. when performed in a hospital or other locations that meet the criteria outlined in Section 19(a.1) of the* Medical and Health Care Services Regulation*. Services not covered by the Medical Services Plan (MSP) include restorations, as well as radiographs and other diagnostic services, unless specifically listed in these Schedules. Please note that booking or admitting fees for covered services are not permitted under Section 17 of the* Medicare Protection Act*. Given the mix of private and public coverage, it is important that patients be clearly advised what portion of their services are covered by MSP and what is the patient's responsibility.*

(ii) *Oral and Maxillofacial Specialists shall be entitled to charge the patient their customary consultation fee if no referral is made or if the referral does not lead to the provision of an MSP insured service. (See notes pertaining to Consultations/Visits got additional information).*

(iii) *The dentist's responsibility includes post-operative care of the operative site up to 8 weeks.*

iv) *Should any surgical procedure require simple revision/reoperation within 6 weeks of the first surgery, then that procedure shall be billed using the corresponding surgical code and will be paid at 50% of that surgical fee.*

(v) *When two or more procedures are performed under the same anesthetic, the procedure with the greater listed fee may be claimed in full and the fees for the additional procedure are reduced to 50% unless otherwise indicated in the Schedule.*

(vi) *When a dental/oral surgical procedure is a benefit listed in the Payment Schedule and therefore, payable by MSP, that payment at the rate listed in the Schedule is considered to be payment in full and there may be no additional charges to the patient <u>or any other third-party</u> for in-hospital surgical procedures, associated in-hospital care, or for the professional component of associated out-of-hospital services (e.g.: assessments, planning, patient counselling, post-operative follow-up within 8 weeks of surgery). It is understood that the technical component of associated out-of-hospital services (e.g.: x-ray, dental laboratory services, prostheses, etc.) may be billed directly to patients, except for those patient categories covered under Schedule E (page E1). No additional charges may be billed to patients in these categories.*

Examinations:

Includes history and physical examination and interpretation of diagnostic data, (i.e., laboratory findings, radiographs, and pathology reports) where appropriate.

CONSULTATIONS / VISITS

***Explanatory Notes**:*

(i) *Emergency consultation fee (35000) is payable for admitted patients in the emergency or out-patient department of a hospital when the dental/oral and maxillofacial specialist is requested to see the patient in consultation on referral from a physician/dentist/oral and maxillofacial specialist on an urgent or emergency basis.*

(ii) *Consultations are not payable if the referral is for routine dental treatment (defined as fillings, prosthetic or periodontal reasons). This includes registered long-term care residents in facilities attached to an acute care facility.*

(iii) *Consultations are not insured services for patients seen in a private dental office, even if the office is located in a hospital, unless the consultation is associated with and followed by an in-hospital surgical procedure insured by the Plan.*

(iv) *Payment for non-emergent consultations (35005) will be honoured if the patient is booked in good faith with a hospital for a procedure and the patient cancels at a later date. Also, the non-emergent consultation fee may be billed a second time after six months from the initial consultation if the surgery has been delayed by the hospital and the patient requires an update to their condition because of this delay.*

Emergency Consultation

35000	Consultation in a hospital (including emergency room) by an Oral and Maxillofacial specialist on referral from a physician, or dentist, or another Oral and Maxillofacial specialist on an urgent or emergency basis for immediate patient management (to include interpretation of x-rays).	118.93
35001	Emergency Consultation Surcharge – Emergency consultation service rendered between 1800 hours and 0800 hours or emergency consultation service rendered on a Saturday, Sunday or Statutory Holiday	27.14

Non-Emergent Consultation/Exam

35005	Initial consultations by request of physician or nurse practitioner or dentist, presenting a distinct diagnostic problem requiring diagnostic tests and/or telephone time and written report, and associated with and followed by an in-hospital oral and maxillofacial surgical procedure covered by the Plan (to include interpretation of x-rays).	118.93
35006	In-hospital consultation on the referral of a physician or nurse practitioner regarding a distinct medical diagnostic problem. Requires diagnostic tests and follow-up by the consulting oral and maxillofacial specialist. ***Note:*** *Call-out fee not payable in addition.*	183.70

Hospital Visits

35008 Hospital visit for medical management of oral disease for a patient in hospital when surgical intervention may-not be required (e.g.: infection) 24.60

Notes:

(i) Not payable on day of initial consultation.

(ii) Limit of one per day.

(iii) Applicable only to patients in acute care facilities.

(iv) Repeat visits to monitor condition may be billed when done in dental office if this is more convenient for the patient and the dentist.

OUT-OF-OFFICE HOURS PREMIUMS

Explanatory Notes:

(i) The call-out charge 35012 (35013, 35014, 35015 for surgical assistants) **is in addition to fee item 35000 and emergency surgery.** It applies only to those consultations/surgeries initiated and rendered within the designated time limits.

(ii) Call-out charges apply only when the dentist/oral and maxillofacial surgeon is specially called to render emergency or non-elective services and only when the dentist/oral and maxillofacial specialist must travel to the hospital to attend the patient(s).

(iii) For these fee items the claim must state both the time called and the time service is rendered.

(iv) The continuing care surcharge applies to surgical assistant fees also.

(v) Continuing care surcharges are payable to dentist/oral and maxillofacial specialists only when the primary service to which the continuing care surcharges apply are payable by MSP on a fee-for-service basis.

Call-out Charges:

35012 Call-out when oral and maxillofacial specialist is called by a health authority to attend a patient in hospital – per call 306.14

Notes:

(i) Response time based on patient's clinical circumstances, but oral surgeon must attend within 24 hours of receiving call.

(ii) Not applicable to surgical assistants.

(iii) Time call placed and service rendered must be indicated in time fields.

(iv) Not payable where existing paid call arrangements are in place.

(v) The call-out charge applies only to the first patient examined or treated on any one special visit. A call-out charge is applicable to each special call-out whether or not a previous call-out charge has been billed for the same patient on the same day.

(vi) For a second or subsequent call-out on the same day, supporting documentation must be submitted identifying why an additional visit was required.

Call-Out Charges for Surgical Assistants

35013	Evening (call placed between 1800 hours and 2300 hours and service rendered between 1800 hours and 0800 hours)	54.56
35014	Night (call placed and service rendered between 2300 hours and 0800 hours)	76.59
35015	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours)	54.56

Continuing Care Operative Surcharges

Applicable only to emergency surgery or non-emergency surgery which, because of intervening emergency surgery, commences within the designated times. Applicable only to surgical procedure(s) requiring general anesthesia or neuroleptic anesthesia and/or requiring at least 45 minutes of surgical time.

35023	Evening (1800 hours to 2300 hours) - 32.77% of surgical (or assistant) fee	
	- minimum charge	54.56
	- maximum charge	376.24
35024	Night (2300 hours to 0800 hours) - 52.54% of surgical (or assistant) fee	
	- minimum charge	76.59
	- maximum charge	528.34
35025	Saturday, Sunday or Statutory Holiday (call placed between 0800 hrs and 1800 hrs) - 32.77% of surgical (or assistant) fee	
	- minimum charge	54.56
	- maximum charge	376.24

Notes:

(i) When surgery commences within evening time period (1800 – 2300 hrs) and continues into night time period (2300 – 0800 hrs), the appropriate item for billing is determined by the period in which the major portion of the surgical time is spent.

(ii) When emergency surgery commences prior to 1800, even if the major portion of surgical time is after 1800, surgical surcharges are not applicable.

(iii) If emergency surgery commences prior to 0800 and continues after 0800, surcharges are applicable to the entire surgical time.

(iv) Claim must state time surgery commenced.

DENTOALVEOLAR SURGERY
REMOVAL OF TEETH

A. Impacted Third Molar

"The tooth is completely or partially unerupted and positioned against another tooth, bone or soft tissue, so that further eruption is unlikely."

Surgical removal of am impacted third molar, is an MSP insured service when performed by an enrolled dentist/oral maxillofacial specialist only when hospitalization is medically required for the proper performance of the procedure and criteria (i) or (ii) or (iii) are met, or if the patient has a pre-existing medical condition that requires hospital monitoring during the peri-operative period (See Appendix 1, paragraph 2).

(i) there is or has been a recent history of associated pathology, or

(ii) growth and development disturbances of the third molar impedes the eruption of another tooth, or

(iii) the impacted molar impedes the ***imminent*** placement of a prosthesis.

Without limiting the application of the foregoing, examples of pathology related to the extraction of an impacted third molar are:

- Infection
- A non-restorable carious lesion
- Non- treatable pulpal and/or periapical pathology
- Cellulitis
- Abscess and osteomyelitis
- Internal/external resorption of the tooth or adjacent tooth
- Fracture of tooth
- Disease of follicle including cyst/tumour
- Impeding surgery or reconstructive jaw surgery
- Involved in or within the field of tumour resection

B. Other Teeth

All other extractions are MSP insured services when, in the opinion of the dentist/oral maxillofacial specialist or attending medical practitioner, hospitalization is required for the proper performance of the procedure and:

(a) Where such treatment is an integral part of the management or treatment of a systemic condition or trauma, or,

(b) the surgical extraction is significantly complex or invasive in nature, such that it requires general anesthesia, or,

(c) the patient is a hospital in-patient and the performance of the procedure is medically necessary to the patient's care, or,

(d) there is difficult access to the airway or surgical site so as to cause significant anesthesia risk in a non-hospital environment, or,

(e) the emergent nature of the dental condition requires immediate surgical attention under general anesthesia, or,

(f) a demonstrated medical contra-indication (e.g. allergy) to local anesthesia precluding the performance of the extraction under local anesthesia, or,

(g) when indicated to safely complete another MSP insured surgical procedure such as fracture or osteotomy, or,

(h) the patient's age or physical and/or mental disability makes treatment impossible or unsafe outside a hospital setting

Explanatory Notes:

(i) *If another surgical procedure is being completed at the same time as removal of multiple teeth, the higher gross fee item shall be paid at 100% and the extractions in that quadrant shall be paid as per "each additional tooth per quadrant".*

(ii) *When cysts, tumours, or other pathological lesions are intimately related to the teeth, and when extraction of these teeth are necessitated by this pathology, then only one surgical fee is applicable. This fee would be the major fee, either for the extractions or for the surgery to eradicate this pathology. In no instance would two fees be paid for these procedures completed concurrently. Other teeth removed in the same quadrant would be paid as per "each additional tooth per quadrant". On these occasions, a note record is required to confirm additional teeth removed in same segment are not associated with cyst/tumour/lesion.*

(iii) *When extractions are completed with osteotomies or fractures, the extractions will be billed as per "each additional tooth per quadrant" regardless of the quadrant or numbers of quadrant involved.*

(iv) *Prior approval may be sought for those cases not fulfilling the criteria listed above when the dentist/oral maxillofacial specialist is of the opinion that the hospitalization is medically required and essential for the safe and efficient performance of the extraction(s). Requests for prior approval should be forwarded in writing (with appropriate documentation to make a decision) to the Adjudication Supervisor, Medical Services Plan Operations, Health Insurance BC.*

APPENDIX 1

Pre-existing Medical Conditions:

Pre-existing medical conditions refers to serious and/or complex medical problems (usually under active treatment) which have a significant potential of increasing the risk of the dental procedure.

Patients with a pre-existing medical condition as listed below whose dental treatment plan involves the extraction of at least one impacted third molar meeting the above extraction criteria, the MSP will pay for the anesthesia and extraction fee for the removal of additional impacted third molars at the same time if the dentist/oral maxillofacial specialist determines that it is in the best interest of the patient's health – e.g.: where a second general anesthetic has a significant potential of increasing the risk to the patient.

These pre-existing medical conditions include but are not limited to:

(a) Central Nervous System Disorders

(i) significant disability due to cerebrovascular accident,

(ii) epilepsy or seizures that are difficult to control,

(iii) significant cerebral palsy, myasthenia gravis, muscular dystrophy,

(iv) significant dementia such as Alzheimer's Disease,

(v) other forms of active central nervous disorders where there is loss of sensory, motor, or autonomic function under medical treatment;

(b) Cardiovascular Disorders

(i) significant disability due to myocardial infarction,

(ii) unstable angina on active treatment,

(iii) unstable, significantly elevated blood pressure on active treatment,

(iv) significant congestive heart failure,

(v) other forms of unstable cardiac disease under active treatment,

(vi) other cardiovascular disorders under treatment, including situations requiring extractions prior to cardiovascular surgery;

(c) Respiratory Disorders

(i) unstable pulmonary disease under active management;

(d) Renal Disorders

(i) unstable renal disease under active management;

(e) Hematologic Disorders

(i) leukemias under chemotherapy,

(ii) hemophilias or other bleeding diathesis,

(iii) anemia with hemoglobin less than 10 grams %,

(iv) other unstable hematologic disorders under active management;

(f) Hepatic Disorders

(i) hepatitis A, hepatitis B, hepatitis C under active management
(ii) other significant hepatic diseases under active management;

(g) Endocrine Disorders

(i) hypothalamic and pituitary disorders requiring steroid therapy,

(ii) (those patients with) insulin dependent diabetes mellitus requiring monitoring of blood glucose,
(iii) other unstable endocrine disorders under active management;

(h) Neoplastic Disorders

(i) (those patients with) active cancer treatment and/or chemotherapy and/or radiotherapy,
(ii) other unstable neoplastic disorders under active treatment;

(i) Viral, Non Viral, Bacterial, Infectious or Immune Deficiency

(i) active herpes simplex,

(ii) acquired immune deficiency syndrome,

(iii) other unstable infectious disorders under active treatment;

(j) Metabolic Disorders

(i) malignant hyperthermia,

(ii) other significant metabolic disorders under active treatment;

(k) Other Disorders or Conditions
(i) medially proven contra-indication (e.g. allergy) to local anesthesia,
(ii) pre-radiation of the head and neck including situations involving extractions prior to radiation treatment,
(iii) post radiation necrosis or sepsis,

(iv) significant mental illness or incompetence,

(v) significant disability due to age or infirmity;

Erupted Teeth

Uncomplicated

35030	First tooth per quadrant – single – tooth - uncomplicated	86.54
35031	Each additional, same quadrant, same appointment	57.08

Complicated

Erupted tooth, surgical approach, requiring surgical flap and/or sectioning of tooth

35033	Each tooth	169.20
35034	Each additional tooth, same quadrant	111.64

Soft Tissue Coverage

Requiring incision of overlying soft tissue and removal of tooth

35040	Single tooth	169.20
35041	Each additional tooth, same quadrant	111.64

Tissue and/or Bone Coverage

Requiring incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of tooth

35045	Partial bony – single tooth	195.02
35046	Each additional – partial bony same quadrant	92.25
35050	Full bony	272.62
35051	- each additional “full bony” impaction per quadrant	136.62
35054	Full bony impaction of extreme difficulty re: morphology or position. Radiographs must be supplied	290.64
35055	- each additional “full bony of extreme difficulty” per quadrant	201.22
35058	Removal of a tooth follicle (enucleation)	161.20
35059	- each additional “removal of a tooth follicle (enucleation)” per quadrant	128.87

Residual Roots

35060	Soft tissue coverage first per quadrant	92.81
35061	Each additional “soft tissue coverage root” per quadrant	45.86
35063	Bone coverage first per quadrant	169.44
35064	Each additional “bone coverage root” per quadrant	72.91

EXPOSURE AND REPOSITIONING OF TEETH

35070	Tooth transplantation (including splinting, donor removal and recipient bed preparation)	335.37
35071	Tooth transplantation - each additional per quadrant	167.68
35073	Surgical uprighting/repositioning/uncovering of a tooth	237.14
35074	Surgical uprighting/repositioning /uncovering of a tooth - each additional per quadrant	118.69
35076	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device	285.19
35077	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device - each additional per quadrant	142.59

SURGICAL ENDODONTICS

Apicoectomy

35080	Anterior	315.03
35082	Bicuspids and buccal roots of maxillary molars	391.27
35084	Palatal roots of maxillary molars and roots of mandibular molars	373.94
35086	Per root end fill, add	37.34
35088	Hemisection	139.31

Root Amputations (includes tooth and furca recontouring)

35090	One root per tooth	278.65
35092	Two roots per tooth	334.35

OSSEOUS RECONTOURING

Alveoloplasty (Full fee per sextant)

35100	Per edentulous sextant	103.17
35102	In conjunction with multiple extractions	84.96
35105	Tuberosity reduction with bone removal as a separate procedure and not in conjunction with removal of an impacted tooth	234.74

Removal of torus/exostosis

35107	Per quadrant	184.66
35108	Palatal torus	291.30

SOFT TISSUE RECONTOURING (Full fee per sextant)

35120	Uncomplicated excision of hyperplastic tissue with primary closure, e.g., soft tissue tuberosities and epuli	89.52
35122	Operculectomy (as an isolated procedure - not to be billed as part of a routine extraction procedure)	43.53
35124	Gingivoplasty, per sextant	112.24
	***Note**: Not in conjunction with tooth removal unless with systemic etiology - e.g.- drug induced hyperplasia.*	
35126	Surgical treatment of palatal papillary hyperplasia	222.94
35128	Frenectomy	234.00
35129	Frenectomy - second at same surgery	117.01

Vestibuloplasty

A surgical procedure involving the mucosa, musculature, and periosteum of the jaws which establishes a new vestibular depth.

- this does not include soft tissue harvest
- each fee paid at full on a sextant basis

35131	Each sextant	343.01
35132	Mucous membrane or skin graft - add per sextant	83.84
35134	Detachment of mylohyoid muscle in conjunction with lowering of the floor of the mouth	302.52

RECONSTRUCTION OF THE ALVEOLAR RIDGE

These fees include placement but do not include harvesting of hard (bone) and/or soft tissues. If these fees (35140-35149) are billed together, then the first will be paid at 100% and any subsequent procedures will be paid at 50%

35140	Preprosthetic augmentation with bone or alloplast of the edentulous ridge - per sextant	503.01
35142	Preprosthetic maxillary antrum/nasal floor augmentation with bone or alloplast	503.01
35143	Preprosthetic maxillary antrum augmentation with bone or alloplast contralateral maxilla	251.54
35145	Placement of alloplastic membrane/barrier per sextant	50.32
35149	Removal barrier/membrane per sextant	50.32

Preprosthetic Augmentation By Osteotomy

(These fees do not include harvesting of bone)

35150	Without bone grafting - first sextant	544.83
35151	- each additional sextant	335.37
35153	With bone grafting - first sextant	586.87
35154	- each additional sextant with bone grafting	363.28

DENTAL IMPLANTS

Intraosseous Implants

35165	Placement of first unit	223.55
35166	Each additional unit placed at the same surgical session	139.73
35168	Exposure of first unit	113.81

35169	Each additional unit exposed at the same surgical session	56.92

Removal of Implants

35172	Subperiosteal or mandibular staple	670.70
35174	Intraosseous, first unit	111.80
35175	Intraosseous, each additional unit	55.89

SURGICAL EXCISION

Incisional Biopsies

35180	Soft tissue	124.43
35182	Hard tissue (bone/cartilage)	223.55

Lip Surgery

35184	Vermilionectomy	307.40
35186	Cheiloplasty	307.40
35188	Wedge resection to the vermilion border	112.91
35190	Wedge resection to the depth of the sulcus	279.48

LESIONS

Extraoral Soft Tissue Lesions

Primary Closure

35200	Lesion based ≤ 2cm	167.68
35201	Lesion based > 2cm	335.37

Complicated Closure

35205	Free skin graft – placement	241.21
35206	Each additional graft – placement	120.71
35210	Arterial island flap	471.47
35211	Each additional pedicle flap	235.82
35215	Local tissue shifts: - advancements, rotations, transpositions, “z” plasty, etc.	235.10

INTRAORAL SOFT TISSUE LESIONS

Primary Closure

35220	Lesion base ≤ 1cm	252.94
35221	Each additional lesion ≤ 1cm	126.46
35225	Lesion base > 1cm	498.46
35226	Each additional lesion > 1cm	249.25

Complicated Closure

35230	Soft tissue graft placement, add	65.78
35231	Island and rotation flaps, add	131.52

Cryotherapy/Chemotherapy

35235	Cryotherapy or chemotherapy used to remove or reduce the incidence or re-occurrence of soft tissue lesion of the mouth, face or jaw	244.91

Notes:

(i) Payable once per patient per day.

(ii) See 35267 when cryotherapy/chemotherapy performed following enucleation of Intraosseous

OSSEOUS LESIONS

Surface Osseous Lesions (other than tori and alveoloplasties)

35240	Lesion base ≤ 1cm	202.34
35241	- each additional lesion base ≤ 1cm	101.18
35245	Lesion base > l cm	382.76
35246	Each additional lesion base > l cm	191.39

Intraosseous Lesions

a) Treatment by Simple Excision, Enucleation, or Curettage

35250	≤ 1cm in greatest diameter	252.94
35252	1cm to 5cm	498.46
35255	> 5cm	558.92
35260	Each additional lesion same jaw is paid at 50%	
35265	Each additional lesion alternate jaw is paid at 75%	
35267	Cryotherapy performed in conjunction with enucleation of intraosseous lesion is billed at 50% of the corresponding enucleation of Intraosseous lesion fee (for fee codes 35250, 35252, 35255, 35260 and 35265 only).	279.46

b) Treatment Requiring Block Section (does not include harvesting/placement of graft or fixation)

35270	≤ 2cm greatest diameter	503.01
35272	> 2cm	726.62

c) Resection Results in a Discontinuity Defect (does not include harvesting/placement of graft or fixation)

35280	Unilateral resection	1,006.08
35282	Bilateral resection	1,564.98

d) Secondary Repair of Discontinuity Defect with Osseous Grafting (Includes Preparation of the Recipient Bed And Flap Mobilization)

35290	Unilateral	1,106.66
35292	Bilateral	1,676.77
35295	Microvascular repair requiring operating microscope, including closure of defect at donor site	2,682.82

CLEFT LIP AND PALATE SURGERY

Primary Repair Cleft Lip

35300	Unilateral repair	654.25
35302	Bilateral repair	939.36

Primary Repair Cleft Palate

35305	Surgical repair	627.72

Secondary Repair Cleft Lip, Palate, Alveolus, Oronasal Fistula

35310	Soft tissue closure only oronasal fistula	633.72
35311	Each additional fistula at the same operation	316.85
35315	Pharyngoplasty or pharyngeal flap	419.21
35320	Push-back of palate - with pharyngeal flap or similar procedure	614.82

Secondary Repair Of Cleft Palate, Alveolus, Oronasal Fistula

35330	Unilateral	760.42
35332	Bilateral	1,013.90

MANAGEMENT OF INFLAMMATORY PROCESSES

Soft Tissue Incision And Drainage

35350	Vestibular or subperiosteal abscess	61.35
35355	Intraoral superficial (buccal, subcutaneous, infraorbital, and infratemporal spaces)	95.05
35360	Intraoral deep (parapharyngeal, pterygomandibular, masseteric, temporal, sublingual and submandibular spaces)	291.50
35365	Extraoral superficial (submental, subcutaneous and buccal spaces)	153.92
35370	Extraoral deep (submandibular, masseteric, pterygomandibular, temporal, parotid, panfacial, and Ludwig's angina)	554.88
35375	Sequestrectomy for osteomyelitis	286.78
35380	Sequestrectomy with extensive saucerization and management	697.07

TREATMENT OF TRAUMATIC INJURIES

I) Dentoalveolar Trauma

35381	Management of a non-avulsed tooth with wire, composite, ribbon, or splint to stabilize displacement due to a traumatic event. Fee includes removal of splint after completion of stabilization. Removal can be done in a dentist's office	82.69
35382	Onetime fee for all additional teeth treated at same time for management of non-avulsed teeth with wire, composite, ribbon, or splint to stabilize displaced teeth due to a traumatic event. Fee includes removal of splint after completion of stabilization. Removal can be done in a dentist's office	41.34
35383	Removal of splint after stabilization if done by another dentist in a different geographic location	50.44
35400	Implantation and splinting of an avulsed tooth (not including root canal therapy)	358.23
35402	Reduction of alveolar fracture including debridement and necessary extractions	557.67

II) Facial Trauma

Soft Tissue Injuries

(a) Simple

35405	Single layer suture of laceration	136.18

(b) Complicated (involving multiple layers and/or avulsion defects)

The following conditions are necessary for these codes to apply:

(i) A layered closure (see #5 below) is required in at least one of the following:

(a) injuries involving necrotic tissue requiring debridement such that simple suture closure is precluded, or

(b) injuries involving tissue loss such that simple suture is precluded,

(c) wounds requiring tissue shifts for closure aside from minor undermining or advancement flaps, or

(d) skived, ragged or stellate wounds where excision of tissue margins is necessary to obtain 90 degree closure, or

(e) contaminated wounds that require excision of foreign material, or

(ii) Lacerations requiring layered closure and key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or

(iii) Lacerations into the subcutaneous tissue requiring alignment and repair of cartilage and layered closure.

(iv) A note record indicating how the service meets the above criteria must accompany claims billed under these fee items.

(v) A layered closure is required when the defect would require too much tension for an acceptable primary closure. It involves at least two layers of deep dissolving sutures to close off dead space and take tension off the wound. A deep cartilage closure is also considered a layered closure.

35410	Closed with a free graft (not to include harvesting graft or arterial island flap)	309.64
	Forehead/Scalp/Neck	
35412	≤ 5cm laceration	266.16
35413	> 5cm laceration	346.53
	Nose/Ear/Cheek/Chin	
35415	≤ 5cm laceration	266.57
35416	> 5cm laceration	346.55
	Eyelid/Lip	
35420	Complicated Repair	346.55

Hard Tissue Injuries

(a) Frontal/orbital

35430	Frontal sinus fractures	670.70
35432	Naso-orbital-ethmoid fractures – open	1,006.08

35433	Naso-orbital-ethmoid fractures – closed	447.14
	Orbital fractures not to be billed with zygomatic complex fracture repairs - does not include harvesting or grafting of bone.	
35435	Isolated fractures - orbital wall or rim	391.23
35436	Floor of orbit fractures	614.82
	(b) Midface Fractures	
	Closed Reductions	
35440	Closed reduction of maxilla with arch bars or other tooth anchored fixation	495.66
35442	Closed reduction of maxilla using gunning type splints or modified dentures and including stabilization of the splints/modified dentures	670.70
35444	Closed reduction zygomatic complex by temporal or buccal sulcus approach and elevation	253.50
	Open Reductions	
35451	Le Fort I	1,383.29
35452	Le Fort II	1,542.64
35453	Le Fort III	1,844.47
	Notes (applies to 35451, 35452 and 35453 – above)	
	1) When fractures of the maxilla or mandible involve the dento-alveolar tissues, and are compounded, no additional fee should be paid. This includes fractures into the tooth socket where a tooth is lost, or a fracture into a partially erupted wisdom tooth, or a diastasis to two teeth at the fracture site where the compounding component does not extend further than the dento-alveolar area.	
	2) Significant external compounding of facial fractures is recognized as a factor which compromises the treatment and possible outcome of patients with these injuries. Treatment of these fractures should be billed at the listed fee item as well as fee item 35495. Operative notes should accurately describe such an injury to support these billings when submitted to MSP.	
	3) Fractures of the maxilla and mandible with intraoral compounding beyond the dento-alveolar bone, therefore exposing basal bone, complicates treatment and possible outcome e.g. degloving of the maxilla or mandible. Treatment for these injuries should be billed at the listed fee item as well as fee item 35945.	
35455	Cranioplasty for traumatic/congenital deformities – unilateral	8701.70
35456	Cranioplasty for traumatic/congenital deformities – bilateral	1,307.51
35457	Open reduction of zygomatic arch with the placement of internal fixation	558.92
35459	Open reduction of zygomatico-orbital complex	760.42
	(c) Nasal Fractures	
35460	Simple reduction	76.05
	Septal Surgery	
35461	Correction of post-traumatic and/or developmental deviated nasal septum restricting functional airway - isolated or in combination with maxillary osteotomies	188.36
35462	Reduction and splinting	152.10
35464	Comminuted nasal fractures requiring internal fixation	316.85

(d) Mandibular Fractures

Closed Reductions

35470	Closed reduction of mandible with arch bars or other tooth anchored fixation	842.94
35472	Closed reduction of mandible using gunning type splints or modified dentures	1,140.66

Open Reductions

Each open reduction code refers to a single fracture which would be billed at 100% of that fee.

Each additional open reduction would be billed at 50% of the appropriate fee.

Open Reductions – Intraoral:

35475	Subcondylar fracture	1,093.15
35477	Angle/body fracture	1,093.15

Notes (applies to Fee Items 35470, 35472, 35475 and 35477 – above)

1) When fractures of the maxilla or mandible involve the dento-alveolar tissues, and are compounded, no additional fee should be paid. This includes fractures into the tooth socket where a tooth is lost, or a fracture into a partially erupted wisdom tooth, or a diastasis to two teeth at the fracture site where the compounding component does not extend further than the dento-alveolar area.

2) Significant external compounding of facial fractures is recognized as a factor which compromises the treatment and possible outcome of patients with these injuries. Treatment of these fractures should be billed at the listed fee item as well as fee item 35495. Operative notes should accurately describe such an injury to support these billings when submitted to MSP.

3) Fractures of the maxilla and mandible with intraoral compounding beyond the dento-alveolar bone, therefore exposing basal bone, complicates treatment and possible outcome e.g. degloving of the maxilla or mandible. Treatment for these injuries should be billed at the listed fee item as well as fee item 35945.

35479	Symphyseal/parasymphyseal fractures	621.01

Open Reductions – Extraoral:

35480	Subcondylar	728.75
35482	Angle/body	728.75
35484	Symphyseal/parasymphyseal	621.01
35491	Unilateral, add	279.48
35492	Bilateral, add	391.23

(f) Complex Fracture

35495	Complex Fracture	332.24

Notes (applies to Fee Item 35495 – above)

1) When fractures of the maxilla or mandible involve the dento-alveolar tissues, and are compounded, no additional fee should be paid. This includes fractures into the tooth socket where a tooth is lost, or a fracture into a partially erupted wisdom tooth, or a diastasis to two teeth at the fracture site where the compounding component does not extend further than the dento-alveolar area.

2) Significant external compounding of facial fractures is recognized as a factor which compromises the treatment and possible outcome of patients with these injuries. Treatment of these fractures should be billed at the listed fee item as well as fee item 35495. Operative notes should accurately describe such an injury to support these billings when submitted to MSP.

3) Fractures of the maxilla and mandible with intraoral compounding beyond the dento-alveolar bone, therefore exposing basal bone, complicates treatment and possible outcome e.g. degloving of the maxilla or mandible. Treatment for these injuries should be billed at the listed fee item as well as fee item 35945.

TEMPOROMANDIBULAR JOINT

35500	Reduction of dislocation	139.73
35502	Manipulation under anesthesia (as an isolated procedure only)	139.73
35504	Arthrocentesis (injection or aspiration, as an isolated procedure)	139.73
35506	Therapeutic arthrocentesis and manipulation for meniscal mobilization (as a separate procedure)	195.63

Open Joint Procedures

35510	Arthrotomy (open joint procedure)	894.29
35511	Condyloplasty, add	100.60
35512	Eminoplasty, add	100.60
35513	Meniscoplasty or menisectomy, add	100.60
35514	Muscle flap and/or dermal, facial, bone or cartilage graft, add	114.07
35515	Alloplastic fossa, meniscus, or condylar surface replacement, add	114.07
35516	Ramus/condylar head alloplast or bone graft replacement, add	279.48
35520	Total joint replacement (condyle, ramus and fossa)	1,676.77

Treatment of Temporomandibular Joint Ankylosis

35525	Gap arthroplasty for ankylosis	1,084.28
35526	Significant surgical soft tissue/muscle release associated with mandibular hypomobility, add	195.63
35527	Coronoidectomy, add	195.63

Reoperation

35530	Reoperation of temporomandibular joint, add 25% to the listed fee for the pertinent repeat surgery.	411.13

Arthroscopy

35532	Diagnostic arthroscopy (to include manipulation under anesthesia if necessary)	217.98
35534	Diagnostic arthroscopy including blunt lysis and lavage of adhesions through a single port technique	441.55
35536	Arthroscopy if performed in conjunction with immediate open arthrotomy	106.18
35538	Arthroscopic surgery through more than one port (includes diagnostic arthroscopy)	586.87

Notes:

(i) *The total fee for arthrotomy under fee item 35510 plus additional procedures performed under fee items 35511, 35512, 35513, 35514, 35515, 35516 must not exceed the fee for total joint replacement under fee item 35520.*

(ii) *When bilateral temporomandibular arthrotomy and/or arthroscopy procedures are performed under the same anesthetic, the contralateral procedure is payable to 75% of the unilateral fee.*

(iii) *Fee item 35530 is not applicable to arthroscopy and also does not apply to simple revisions or secondary procedures but rather refers to complicated reconstructive procedures where previous surgical procedures have failed and where other forms of therapy also have failed to correct the problem.*

(iv) *Fee item 35538 is not payable in addition to open arthrotomy procedures.*

(v) *Fee items 35532, 35534, 35536 and 35538 are not payable with each other.*

(vi) *Temporomandibular joint procedures when billed with orthognathic surgery would be paid at 75% of their fee.*

SURGICAL TREATMENT OF DENTOFACIAL DEFORMITIES

Interdental Corticotomy or Ostectomy

35550	First tooth per arch	217.98
35551	Second and subsequent teeth	106.18
35560	Per segment	397.07
35562	Total alveolar osteotomy of mandible	1,291.54

Mandibular symphyseal surgery is paid at 100% when performed as an isolated procedure only for post-traumatic corrections or for lip dysfunction. When mandibular symphyseal surgery is completed along with other mandibular osteotomies or maxillary and mandibular osteotomies together, the symphyseal surgery would be paid at 50%. When mandibular symphyseal surgery is completed along with maxillary surgery alone, then the symphyseal surgery is paid at 100% of the existing fee.

35570	By osteoplasty	430.91
35572	By ostectomy and/or osteotomy	760.42
35574	By augmentation bone graft	728.75
35576	By alloplastic material	411.90

Note: *If mandibular symphyseal surgery is the only procedure performed, the billing must be supported by an explanation of medical necessity and an operative report for payment to be considered.*

Mandibular Osteotomies

Ramus Osteotomies

35580	Unilateral – intraoral	1,077.28
35581	Unilateral – extraoral	1,140.68
35583	Bilateral – intraoral	1,742.67
35584	Bilateral – extraoral	1,837.72

Body Osteotomies

35586	Unilateral	1,077.28
35587	Bilateral	1,742.67
35589	Inferior border osteotomy/ostectomy	823.81
	Note: When a body osteotomy is performed through a separate incision from a ramus osteotomy, both are paid at 100% of each fee.	

Osteotomy of Zygomatic Complex

35591	Unilateral	1,077.28
35592	Bilateral	1,774.37
35595	Post traumatic or syndrome associated reconstruction of zygoma/zygomatic arch with autogenous/alloplastic materials (includes placement of graft only - not harvesting)	633.72

Maxillary Osteotomies

35600	Le Fort I	1,774.37
35601	First additional segment	202.79
35602	Each additional alveolar segment	101.39
35605	Le Fort II	2,154.57
35607	Le Fort III, extracranial	3,041.77
35608	Le Fort III, intracranial	3,802.19
35610	Orbital rim osteotomies (intracranial approach) – unilateral	3,041.77
35611	Orbital rim osteotomies (intracranial approach) – bilateral	3,802.19
	Note: *When maxillary and mandibular osteotomies are performed at the same operation, both shall be paid at full fee.*	
35620	Unilateral – intraoral	937.87
35621	Unilateral – extraoral	1,140.68
35624	Bilateral – intraoral	1,444.83
35625	Bilateral – extraoral	1,647.62

Other

35630	When rigid fixation is used for osteotomies or treatment of traumatic injuries pay at 10% of the fee for each procedure/jaw	372.91
35632	Reoperation of a dentofacial deformity - add 25% of the listed fee for the pertinent repeat surgery. *Note: This listing does <u>not</u> apply to simple revisions or secondary procedures, but rather refers to complicated reconstructive procedures where previous surgical procedures have failed and where all other forms of therapy also have failed to correct the problem*	1,688.97
35634	Distraction osteogenesis - surgical application of distraction devices associated with osteotomies - paid at 20% of the listed osteotomy fee.	745.80
35636	Placement of arch bars or other tooth anchored fixation ***Notes:*** *(i) Only to be used in conjunction with a listed osteotomy procedure of the jaw(s)/TMJ procedures.* *(ii) Shall be paid at full fee.*	348.56

35638	Placement of gunning type splints or modified dentures stabilized with wire or screw fixation ***Notes:*** *(i) Only to be used in conjunction with a listed osteotomy procedure of the jaw(s)/TMJ procedures.* *(ii) Shall be paid at full fee.*	443.58
35640	Cheiloplasty (V/Y, double V/Y closure) in conjunction with a Le Fort I osteotomy	122.95

Removal of Intraoral and Extraoral Fixation Devices

Notes:

i) Included in surgical placement fee if placed and removed at same surgical session.

35642	Removal of splints, suspension ligatures, and/or arch bars, per jaw ***Note**: Payable only once per jaw, regardless of number of devices removed or location*	126.72
35647	Removal of splints, suspension ligatures, and/or arch bars from alternate jaw at same surgery *The following two fee items (35643 and 35645) are to be paid at 100% of the fee for the first surgical site and 50% of the fee for each other site*.	63.36
35643	Removal of intraosseous wires/pins via an intraoral approach	223.55
35645	Removal of internal fixation devices by an intraoral or extraoral approach and intraosseous wires by an extraoral approach only.	456.27

NASAL SURGERY

Turbinectomies

35650	In conjunction with maxillary osteotomy – unilateral, add	82.41
35651	In conjunction with maxillary osteotomy - bilateral, add	107.75

Closure Oronasal Fistula

35656	Transpositional flap closure	234.73
35657	Arterial pedicle flap closure	419.34
35659	Tongue flap closure	470.93

GRAFTING PROCEDURES

Placement of Hard/Soft Tissue Grafts

35670	Bone/Alloplast grafting when necessary, in conjunction with any procedures listed in this guide when grafting is not included by definition (payment of the first surgical site is at 100% of the fee with other sites paid at 50% of the fee. A Le Fort I osteotomy site is considered one surgical site.) *Note: The number of services for fee item 35670 should normally not exceed one. Multiple billings of fee item 35670 must be supported by an operative report for payment to be considered, and the donor site must not be from the same incision and/or the same jaw.*	304.17
35675	Soft tissue grafting in conjunction with any procedures listed in this guide when grafting is not included by definition (first surgical site is paid at 100% of the fee while others are paid at 50% per surgical site)	167.68

Harvesting of Hard Tissue Grafts

35680	Local sites (through the same incision as the primary surgical procedure), add	44.71

***Notes**: This does not include harvesting of a graft if by definition the harvest is part of the procedure - e.g:*

(i) Harvesting bone from the distal fragment of a sagittal split osteotomy during a setback is included in the surgical procedure whereas harvesting bone through the same incision for a sagittal split advancement of the mandible would be payable under this listing;

(ii) Using bone harvested during a maxillary superior repositioning is included in the maxillary surgical procedure.

Harvesting Hard/Soft Tissue Grafts

35683	Local site (through separate incision from that of primary surgical procedure), add	133.08
35685	Distant site (separate extra oral incision), add	380.24

REMOVAL FOREIGN BODIES

35690	Within deep tissue	380.10
35692	Superficially located	106.59
35695	Surgical removal	335.37
35701	Primary nerve repair	243.73
35702	Secondary nerve repair	546.43
35704	Nerve repair with graft	1,242.04
35706	Decompression/transposition of mandibular nerve	333.32

ANTRAL SURGERY

35711	Immediate recovery of a tooth or foreign body from the maxillary antrum	106.18
35712	Secondary recovery of a tooth or foreign body from the maxillary antrum	335.37
35715	Radical antrostomy/Caldwell Luc	391.23
35717	Nasal antrostomy	126.92
35720	Closure of an oral antral fistula - immediate closure - sliding advancement buccal flap with periosteal release (not to be billed with codes 35711/35715)	231.78
35722	Closure oral antral fistula - secondary closure - buccally pedicled transposition flap using fat/muscle/mucosa (not to be used for simple closures)	245.92
35723	Closure oral antral fistula - secondary closure - gold foil technique	279.48
35724	Closure oral antral fistula - secondary closure - palatal island flap closure	452.63
35726	Antral lavage - unilateral (as a separate procedure)	38.03
35727	Antral lavage - bilateral (as a separate procedure)	69.72
35729	Diagnostic sinus endoscopy, with or without biopsy	120.38
35730	Sinus endoscopic surgical procedure	316.85

SALIVARY GLANDS

35740	Dilation of salivary duct	45.15
35742	Sialodochoplasty	139.73
35744	Repair of salivary fistula	509.94

Intraductal sialolithotomy

35747	Submandibular	139.73
35749	Parotid	285.19
35752	Intraglandular sialolithotomy	307.40
35754	Excision of sublingual gland, intraorally	349.41
35756	Excision of submandibular gland	447.14
35758	Excision ranula/superficial	99.57
35760	Excision ranula/plunging	447.14
35762	Removal benign parotid tumour	950.57

DENTOALVEOLAR COMPLICATIONS

35770	Treatment of a dentoalveolar complication resulting from treatment by another surgeon	50.32
35771	Treatment of a dentoalveolar complication resulting from treatment by another surgeon - subsequent office visits past 8 weeks of surgery for ongoing complications.	28.77

SURGICAL ASSISTANT

35800	Certified surgical assistant for any item over **$667.47** (for 2015-16)**/$670.81** (for 2016-17) **and fee items 35330, 35475, 35480 and 35560**. All other circumstances require satisfactory written explanation, otherwise rate applicable to fee item 35801 will apply.	583.02
35801	Surgical assistant	447.14
35802	After three hours continuous surgical assistance for one patient, for each additional 15 minutes, or fraction thereof, add	27.94

- *Odontectomy (all)*
- *Exposure and repositioning of teeth (all)*
- *Osseous recontouring (all)*
- *Soft tissue recontouring (all)*
- *Biopsies (all)*
- *Lip surgery - wedge resection of lip and vermilionectomy*
- *Soft tissue lesions (fee codes 35200, 35220 and 35221)*
- *Surface Osseous lesions (fee codes 35240 and 35241)*
- *Intraosseous lesions (fee code 35250)*
- *Soft tissue incision and drainage (fee codes 35350, 35355,35360, 35365)*
- *Osteomyelitis (fee code 35375)*
- *Foreign bodies (fee code 35692)*
- *Temporomandibular joint (fee codes 35500, 35502, and 35504)*
- *Salivary glands (fee codes 35740, 35742 and 35747)*
- *Surgical endodontic procedures (all)*
- *Dentoalveolar complications (fee code 35770)*

MISCELLANEOUS FEE

35999 To be used for unusually complex oral and maxillofacial procedures, for established but infrequently performed procedures which are not listed in this payment schedule, for unlisted “team” procedures or for any medically required service for which the practitioner desires independent consideration to be given by the plan, a claim should be submitted using this code. When submitting claims using a miscellaneous fee code, you should include your estimate of an appropriate fee, details of the calculation of that fee and sufficient documentation of your services (such as an operative report) to substantiate the claim. Claims made under the miscellaneous code will be adjudicated in equity with services of similar responsibility, skill, and duration.

SCHEDULE C - ORTHODONTIC SPECIALISTS

Tariff of Fees Approved and/or Prescribed as the Payment Schedule
Effective April 1, 2021

The additional MSP benefit for the payment of orthodontic services for MSP beneficiaries reads as follows:

(i) Consequential necessary orthodontic service in the care of a cleft lip and (or) cleft palate only where that service arises as part of or following plastic surgical repair performed by a medical practitioner in the treatment of severe congenital facial abnormalities as the Commission may determine, when provided by a dental surgeon who is a member in good standing of the College of Dental Surgeons of British Columbia for an insured person 20 years of age or younger, shall be paid under the Plan at a tariff of fees approved or prescribed by the Commission in the schedule of costs, but there shall be no payment for dentures, appliances or prostheses or for general dental services.

(ii) Consequential necessary orthodontic services in the care of a cleft lip or cleft palate or both, performed outside the Province but in Canada by a person entitled to practise dental surgery in the place where the service is rendered, at a tariff of fees approved by the Commission in the schedule of costs, so long as the service is rendered
(a) as part of or following plastic surgical repair of the cleft lip or cleft palate by a medical practitioner,
(b) to an insured person 20 years of age or younger who resides in an area in the Province where the nearest location for the service is outside the Province, and
(c) following approval of payment of the service by the Commission.

(iii) Fee items designated with an asterisk (*) are only billable when done in conjunction with treatment planning in association with the Cleft Lip/Palate Program at the Children's and Women's Health Centre of BC Branch.

(iv) When the orthodontic procedure is listed in the Schedule C payment schedule and therefore payable by MSP, that payment at the rate listed in the schedule is considered to be payment in full, and there shall not be any additional charges to the patient or any other third-party.

ORTHODONTIC SERVICES FOR SEVERE CONGENITAL CRANIAL-FACIAL ANOMALIES (OTHER THAN CLEFT LIP/PALATE)

03952	Initial examination - includes a clinical orthodontic examination and an explanation as to the nature of the problem and an approximation of the treatment time and fee involved	95.05
03953	Diagnostic phase - if treatment is contemplated, further information is required. In addition to the initial examination a complete orthodontic diagnosis is necessary and will include diagnostic models and facial, profile, and intraoral photographs and radiographs	304.18
03954	Case analysis and consultation phase - includes treatment planning, consultation, and case presentation based on the materials gathered in the diagnostic phase	221.78

DECIDUOUS (ages 0-6 years approx.)

03955	(a) Simple - Malocclusion requiring the use of a removable appliance or simple fixed appliance for a period not expected to exceed six months	Individual Consideration
03956	(b) Complex - Malocclusion requiring two or more removable appliances or simple fixed appliances for a period not expected to exceed twelve months	Individual Consideration
03957	(c) Severe - Malocclusion requiring two or more removable appliances and/or fixed appliances for a period expected to exceed twelve months	Individual Consideration

MIXED DENTITION (Ages 7-10 Years Approx.)

03958	(a) Simple - Malocclusion requiring the use of removable appliance or simple fixed appliance for a period not expected to exceed six months	Individual Consideration
03959	(b) Complex - Malocclusion requiring two or more removable appliances or simple fixed appliances for a period not expected to exceed twelve months	Individual Consideration
03960	(c) Severe - Malocclusion requiring two or more removable appliances and/or fixed appliances for a period expected to exceed twelve months	Individual Consideration

PERMANENT DENTITION (ages 11-20 years approx.)

03961	(a) Simple - Malocclusion possibly requiring a removable appliance and usually requiring fixed appliances in both arches and retention in which the total treatment and supervision period is not expected to exceed 26 months	Individual Consideration
03962	(b) Complex - Malocclusion possibly requiring a removable appliance and usually requiring full fixed appliances of both arches in which the total treatment period plus the retention period is not expected to exceed 30 months	Individual Consideration

03963	(c) Severe - Malocclusion possibly requiring a removable appliance and usually requiring full fixed appliances of box arches in which the total treatment period is expected to exceed 36 months	Individual Consideration

CLEFT LIP AND/OR PALATE - CARE OF NEWBORN

03964	Initial examination - will include a clinical orthodontic examination and an explanation as to the nature of the problem and an approximation of the treatment time and fee involved	95.05
03965	Orthodontic care of newborn (less than two years of age): Bone moving procedures, including post-procedural visits. Additional procedures by report.	1,325.02
	Orthodontic care of newborn requiring a nasal stent – to include examination and post-procedural visits. Fee includes of laboratory component and appropriate continuing care:	
039966*	- unilateral	3,809.01
039967*	- bilateral	4,847.85
039968	Orthodontic care of infant requiring a post-surgical nasal stent – to include examination and post-procedural visits. Fee includes laboratory component and appropriate continuing care	1,500.00

OBSERVATION AND ADJUSTMENTS

(a) Observations (as a separate procedure) to be payable up to a maximum of once per quarter

03966	Tooth eruption, position, etc.	38.03
03967	Serial extraction supervision with tooth guidance	57.34

(b) Adjustments and activation (where not included in treatment plan)

03968	Removable appliance	43.10
03969	Fixed appliance - to be payable to a maximum of 12 per year	39.98

INITIAL EXPANSION AND CORRECTIVE DENTAL ALIGNMENT

03970	Initial examination - will include a clinical orthodontic examination and an explanation as to the nature of the problem and an approximation of the treatment time and fee involved	95.05
03971	Diagnostic phase - if treatment is contemplated, further information is required. In addition to the initial examination, a complete orthodontic diagnosis is necessary and will include diagnostic models, facials, profile, and intraoral photographs and radiographs	304.18
03972	Case analysis and consultation phase - includes treatment planning, consultation and case presentation based on the materials gathered in the diagnostic phase	221.78

TREATMENT PHASE (includes prophylaxis)

Professional component for fabrication and placement of orthodontic bands or full chromium crowns with brackets and the necessary rotation and expansion mechanism. Also instruction in oral hygiene. This phase also includes alignment of dental units, tooth guidance, adjustment or change of orthodontic appliances, retainers, and retention adjustments:

03973	(a) Simple - Malocclusions requiring uncomplicated expansion mechanics and limited banding in the upper arch only	2,758.48
03974	(b) Complex - Malocclusions requiring one complex fixed expansion appliance and limited banding in the upper dental arch only	4,131.74
	Quarterly rate:	1,032.93
03975	(c) Severe - Malocclusions that require one or more complex expansion appliances and limited banding in both dental arches	5,069.64
	Quarterly rate:	1,267.41

SPEECH OBTURATOR

39976*	Palatal Fistula Obturator – Professional procedures for a palatal fistula obturator - to include impressions, models, fabrication, delivery, adjustments and instructions - for the first 6 months	1,152.68
39977*	Continuing care of Palatal Fistula Obturator – Professional adjustments and instructions for a palatal fistula obturator, spaced at minimum intervals of 3 months	48.75
39978*	Remake of Palatal Fistula Obturator – Professional procedures for the replacement of a palatal fistula obturator due to significant dental development - to include impressions, models, fabrication, delivery, adjustments and instructions for the first 6 months for a patient with an existing palatal fistula obturator that has been in service at least 18 months	764.42
39979*	Speech Obturator – Professional procedures for a speech obturator with a nasopharyngeal bulb - to include impressions, radiographs, models, fabrication, delivery, adjustments, consultations with the speech pathologists and instructions - for the first 9 months	7,598.06
39980*	Simple Continuing Care of Speech Obturator – Professional adjustments and instructions for speech obturator, spaced at minimum intervals of 3 months	97.47
39981*	Complex Continuing Care of Speech Obturator – Professional procedures for speech obturator - to include complex changes and instructions requiring at least two appointments and lab time – at minimum intervals of 6 months	487.44

39982*	Speech Obturator Remake – Professional procedures for the replacement of a speech obturator due to significant dental development - to include impressions, radiographs, models, fabrication, delivery, adjustments, consultations with the speech pathologists and instructions for a patient with an existing speech obturator that has been in service at least 18 months	5,063.27
39983*	Speech Lift – Professional procedures for a speech lift with soft palate extension - to include impressions, radiographs, models, fabrication, delivery, adjustments, consultations with the speech pathologists and instructions for the first 6 months	5,760.33
39984*	Continuing Care of Speech Lift – Professional adjustments and instructions for speech lift spaced at minimum intervals of 3 months	73.12
39985*	Speech Lift Remake – Professional procedures for the replacement of a speech lift due to significant dental development - to include impressions, radiographs, models, fabrication, delivery, adjustments, consultations with the speech pathologists and instructions for a patient with a speech lift that has been in service at least 18 months	3,840.22

FULL ALIGNMENT AND RETENTION

03978	Initial examination - includes a clinical orthodontic examination and an explanation as to the nature of the problem and an approximation of the treatment time and fee involved	95.05
03979	Diagnostic phase - if treatment is contemplated further information is required. In addition to the initial examination, a complete orthodontic diagnosis is necessary and will include diagnostic models, and facial, profile, and intraoral photographs and radiographs	304.18
03980	Case analysis and consultation phase - includes treatment planning, consultation, and case presentation based on the materials gathered in the diagnostic phase	221.78

TREATMENT PHASE (includes prophylaxis)

Professional component for fabrication and placement of orthodontic bands or full chromium crowns with brackets and the necessary rotation and expansion mechanisms. Also instruction in oral hygiene. This phase also includes alignment of dental units, tooth guidance, adjustment or change of orthodontic appliances, retainers, and retention adjustments:

CLASS I MALOCCLUSIONS

03981	(a) Simple - malocclusions requiring banding in both arches and retention in which the total treatment and supervision period is not expected to exceed 26 months	7,097.49
	Quarterly rate:	1,774.37

03982	(b) Complex - malocclusions usually requiring full banding of both arches and in which the total treatment period plus the retention period is not expected to exceed 30 months	7,477.65
	Quarterly rate:	1,869.42
03983	(c) Severe - malocclusions usually requiring full banding of both arches and in which the total treatment period plus the retention period is not expected to exceed 36 months	7,857.83
	Quarterly rate:	1,964.46

CLASS II MALOCCLUSIONS

03984	(a) Simple - malocclusions requiring banding in both arches and retention in which the total treatment and supervision period is not expected to exceed 26 months	7,857.83
	Quarterly rate:	1,964.46
03985	(b) Complex - malocclusions usually requiring full banding of both arches and in which the total treatment period plus the retention period is not expected to exceed 30 months	8,238.07
	Quarterly rate:	2,059.52
03986	(c) Severe - malocclusions usually requiring full banding of both arches and in which the total treatment period plus the retention period is not expected to exceed 36 months	8,618.24
	Quarterly rate:	2,154.56

CLASS III MALOCCLUSIONS

03987	(a) Simple - Malocclusions requiring banding in both arches and retention in which the total treatment and supervision period is not expected to exceed 26 months	7,857.83
	Quarterly rate:	1,964.46
03988	(b) Complex - Malocclusions usually requiring full banding of both arches and in which the total treatment period plus the retention period is not expected to exceed 30 months	8,238.07
	Quarterly rate:	2,059.52
03989	(c) Severe - Malocclusions usually requiring full banding of both arches and in which the total treatment period plus the retention period is not expected to exceed 36 months	8,618.24
	Quarterly rate:	2,154.56

Explanatory Notes:

1. For unusually complex procedures, for established but infrequently performed procedures which are not listed in the Orthodontic Payment Schedule, for which the orthodontist desires independent consideration to be given by MSP, a claim should be submitted under miscellaneous fee code 09998. When submitting claims under a miscellaneous fee code, you should include your estimate of an appropriate fee, details of the calculation of that fee and sufficient documentation of your services (such as the operative report) to substantiate the claim. Claims made under the miscellaneous codes will be adjudicated in equity with services of similar responsibility, skill and duration.

2. The bracketed fee amounts listed for fee items 03974 - 03975, and 03981 - 03989 are approximate amounts for the initial 25% down payment of the total contract fee value.

SCHEDULE D - ORAL MEDICINE/ORAL PATHOLOGY SPECIALISTS

This Fee Schedule is Limited to Those Specialists Certified in Oral Medicine
Effective April 1, 2021

OUT-OF-OFFICE HOURS PREMIUMS

Explanatory Notes:

(i) A call- out charge is **in addition to fee item 35000 and emergency surgery.** It applies only to those consultations/surgeries initiated and rendered within the designated time limits.

(ii) Call-out charges apply only when the Oral Medicine Specialist is specially called to render emergency or non-elective services and only when the Oral Medicine Specialist must travel to the hospital to attend the patient(s).

(iii) For these fee items the claim must state both the time called and the time service rendered.

(iv) The continuing care surcharge applies also to surgical assistant fees also.

(v) Continuing care surcharges are payable to Oral Medicine Specialists only when the primary service to which the continuing care surcharges apply are payable by MSP on a fee-for-service basis.

CALL-OUT CHARGES

03730	Evening (call placed between 1800 hours and 2300 hours) and service rendered between 1800 hours and 0800 hours)	54.56
03731	Night (call placed and service rendered between 2300 hours and 0800 hours)	76.59
03732	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours)	54.56

CONTINUING CARE OPERATIVE SURCHARGES

Applicable only to emergency surgery or non-emergency surgery which, because of intervening emergency surgery, commences within the designated times. Applicable only to surgical procedure(s) requiring general anesthesia or neuroleptic anesthesia and/or requiring at least 45 minutes of surgical time.

35023	Evening (1800 hours to 2300 hours) - 32.77% of surgical (or assistant) fee	
	- minimum charge	53.49
	- maximum charge	368.86

35024	Night (2300 hours to 0800 hours) - 52.54% of surgical (or assistant) fee	
	- minimum charge	75.09
	- maximum charge	517.98
35025	Saturday, Sunday or Statutory Holiday (call placed between 0800 hrs and 1800 hrs) - 32.77% of surgical (or assistant) fee	
	- minimum charge	54.56
	- maximum charge	376.24

Notes:

(i) *When surgery commences within evening time period (1800 – 2300 hrs) and continues into night time period (2300 – 0800 hrs), the appropriate item for billing is determined by the period in which the major portion of the surgical time is spent.*

(ii) *When emergency surgery commences prior to 1800, even if the major portion of surgical time is after 1800, surgical surcharges are not applicable.*

(iii) *If emergency surgery commences prior to 0800 and continues after 0800, surcharges are applicable to the entire surgical time.*

(iv) *Claim must state time surgery commenced.*

CONSULTATIONS/VISITS

03768	Diagnostic Examination and Consultation: Stomatognathic, dysfunctional, oral pathology (involving review of records, head and neck examination, appropriate diagnostic tests, and simple charting/hospital notes) - Can only be billed once per new patient; or - For a new referral for another oral issue, after 6 months	198.90
03769	Complex Diagnostic Examination and Consultation: Stomatognathic, dysfunctional, oral pathology (involving review of records, head and neck examination, appropriate diagnostic tests, and comprehensive correspondence) - Can only be billed once per new patient; or - For a new referral for another oral issue, after 6 months ***Note:*** *Complex patients are described as patients with any of: more than one systemic co-morbidity, oral lesions involving multiple oral sites, or oro-facial pain.* *Simple patients are described as having none of the above-noted conditions, but may have: up to one systemic co-morbidity, oral lesions involving a single oral site, and/or localized intra-oral pain.*	281.90
03785	Hospital visit, follow-up ***Note:*** *Not payable when performed same day as procedure*	65.82

BIOPSY, INCISION

03771	Soft tissue	141.10
03772	Hard tissue	203.42

BIOPSY, EXCISION

03773	Soft tissue ≤ 1 cm	276.91
03774	Soft tissue >1 cm	537.15
03775	Hard tissue <1 cm	272.40

CRYOTHERAPY AND TOPICAL PHOTODYNAMIC THERAPY

Topical treatment for removal of a histologically diagnosed oral pre-malignant lesion:

03710	Under local anesthesia – Cryotherapy (<1cm)	153.00
03711	Under local anesthesia – Cryotherapy, multiple intra-oral sites (>1cm)	224.40
03728	Under local anesthesia – Topical photodynamic therapy (< 2 cm)	357.00
03729	Under local anesthesia – Topical photodynamic therapy, multiple intra-oral sites (2-4cm)	510.00

Notes:

(i) *If topical treatment performed same day as incisional biopsy, each claim must state time service was rendered.*

(ii) *03773, 03774, 03775 not billable same day as topical treatment.*

(iii) *The above codes can be charged only once per anatomical site per year.*

ANESTHETIC / ANALGESIC PROCEDURES

03776	Regional nerve block	42.45
03777	Divisional nerved block	141.50
03778	Trigger point injection therapy	49.53
03797	Trigger point injection therapy – each additional injection same side, same appointment, to a total of at most 4 additional injections per side after the first injection on that side	33.19
03779	Anesthetic and analgesic procedure: vapocoolant spray	91.98
03782	Intralesional injection - per site	44.75

SALIVARY GLAND PROCEDURES

03783	Measurement of salivary flow, resting and stimulated, whole or per gland	35.36
03784	Salivary gland duct dilatation and/or catheterization	63.69
03785	Hospital visit, follow-up ***Note:*** *Not payable when performed same day as procedure*	65.82

OROFACIAL PAIN AND TEMPOROMANDIBULAR DISORDERS

	Closed reduction of TM joint dislocation	
03788	- without sedation/anesthesia	151.29
03789	- with sedation/anesthesia	183.97
03790	TM joint luxation - without sedation/anesthesia	151.29
03791	TM joint luxation - with sedation/anesthesia	183.98
03792	Arthrocentesis	151.94
03793	Arthrocentesis and lavage	151.29

INCISION AND DRAINAGE OF ABSCESS

03794	Intraoral (superficial)	89.06
03795	Intraoral (deep)	253.50

COUNSELLING

03796	Rehabilitation Conference – where a certified specialist in Oral Medicine is involved with the patient and one or more family members - per half hour or major portion thereof, to a maximum of two hours for any one patient.	70.54

SCHEDULE E - DENTAL TECHNICAL PROCEDURES

Tariff of Fees Approved and/or Prescribed as the Payment Schedule
Effective April 1, 2021

NOTES:

1. Only covered by the Medical Services Plan when done by an oral and maxillofacial specialist or orthodontist for the following:

(a) In conjunction with the hospital-based surgical correction of malocclusion of patients registered with the Orthodontic Program for Cleft Lip/Palate and Severe Congenital Cranial-facial Anomalies. This includes all children whose orthodontic care is paid for by the Government of BC and where the severity of the case involves both orthodontic treatment and in hospital surgery of the facial skeletal structure.

(b) Patients registered with the British Columbia Cancer Agency Dental Department;

(c) Patients registered with the Prosthodontic Management of Severe Dental Facial Anomalies Program administered by the B.C.D.A.

2. Maximum Fees - Patient Cannot be extra billed

(a) Maximum fee per jaw/per patient/per lifetime. Patient cannot be extra billed.		1,523.58
(b) Maximum fee for 2 jaw surgery per patient/per lifetime. Patient cannot be extra billed.		2,539.35

3. A unit of time is 15 minutes.

INTRAORAL RADIOGRAPHS

	Periapical:	
03831	Single film	16.00
03832	Two films	22.05
03833	Three films	28.03
03834	Four films	34.03
03835	Five films	39.99
03836	Six films	46.00
	Occlusal:	
03841	Single film	20.91
03842	Two films	30.93

PANORAMIC RADIOGRAPHS

03803	Pre-treatment, post-treatment (each) (*maximum 3*)	62.74

CEPHALOMETRIC RADIOGRAPHS, PRE-TREATMENT, POST-TREATMENT

03804	Single film	40.97
03805	Two films	67.87
03806	Additional films (*maximum 6*)	26.91
03807	*Per unit of time	76.05

TMJ RADIOGRAPHS

03809	Tomography, single view	56.31
03810	Tomography, two views	70.56
03811	Radiographs, TMJ, one film	40.97
03812	Radiographs, TMJ, two films	67.87
03813	Radiographs, TMJ, three films	94.54
03814	Radiographs, TMJ, four films	124.21
03830	Each additional film over four (*maximum 6*)	26.91

RADIOGRAPHS/DUPLICATIONS

03844	Single film	7.36
03845	Two films	14.50
03846	Three films	21.88
03847	Each additional film over three (*maximum 10*)	4.20
	Photographs:	
03815	First photograph	16.41
03816	Each additional (*maximum 36*)	5.45
	Diagnostic models:	
03817	Upper and lower	69.43
	Duplicate models:	
03818	Upper and lower	38.03
	Casts, Diagnostic, Mounted:	
03819	- Per mounting (one or more sets may be required depending upon necessity for segmental model surgery)	82.53
	Casts, Diagnostic:	
03820	Mounted using facebow and occlusal records	301.28
	Diagnostic (gnathological wax-up) model surgery:	
03821	*One unit of time	76.05
03822	*Two units of time	152.10
03823	*Three units of time	228.14

APPLIANCES – REMOVABLE/RETENTION (SPLINT)

	Orthognathic Splint:	
03824	Maxillary	316.85
03825	Mandibular	316.85
	Palatal Stent:	
03826	Palatal stent	63.36

SCHEDULE F - PEDIATRIC DENTAL SPECIALISTS

This Fee Schedule is Limited to those Pediatric Dentists Specialists recognized by the College of Dental Surgeons of British Columbia as a specialist in this field

Tariff of Fees Approved and/or Prescribed as the Payment Schedule Effective April 1, 2021

Explanatory Notes:

(*i*) *Covered services generally include consultations, extractions, orthognathic surgery, trauma, etc. when performed in a hospital or other locations that meet the criteria outlined in Section 19(a.1) of the* Medical and Health Care Services Regulation*. Services not covered by the Medical Services Plan (MSP) include restorations, as well as radiographs and other diagnostic services, unless specifically listed in these Schedules. Please note that booking or admitting fees for covered services are not permitted under Section 17 of the* Medicare Protection Act*. Given the mix of private and public coverage, it is important that patients be clearly advised what portion of their services are covered by MSP and what is the patient's responsibility.*

(ii) The dentist's responsibility includes post-operative care of the operative site up to 8 weeks.

(iii) Should any surgical procedure require simple revision/reoperation within 6 weeks of the first surgery, then that procedure shall be billed using the corresponding surgical code and will be paid at 50% of that surgical fee.

(iv) When a dental/oral surgical procedure is a benefit listed in the Payment Schedule and therefore, payable by MSP, that payment at the rate listed in the Schedule is considered to be payment in full and there may be no additional charges to the patient or any other third-party for in-hospital surgical procedures, associated in-hospital care, or for the professional component of associated out-of-hospital services (e.g.: assessments, planning, patient counselling, post-operative follow-up within 8 weeks of surgery).

(v) When two or more procedures are performed under the same anesthetic, the procedure with the greater listed fee may be claimed in full and the fees for the additional procedure are reduced to 50% unless otherwise indicated in the Schedule.

Examinations:

Includes history and physical examination and interpretation of diagnostic data, (i.e. laboratory findings, radiographs, and pathology reports) where appropriate.

CONSULTATIONS / VISITS

***Explanatory Notes**:*

(i) *Emergency consultation fee (28000) is payable for admitted patients in the emergency or out-patient department of a hospital when the dentist is requested to see the patient in consultation on referral from a physician/dentist/oral and maxillofacial specialist on an urgent or emergency basis.*

(ii) *Consultations are not payable if the referral is for routine dental treatment (defined as fillings, prosthetic or periodontal reasons). This includes registered long-term care residents in facilities attached to an acute care facility.*

(iii) *Consultations are not insured services for patients seen in a private dental office, even if the office is located in a hospital, unless the consultation is associated with and followed by an in-hospital surgical procedure insured by the Plan.*

(iv) *Payment for non-emergent consultations (28005) will be honoured if the patient is booked in good faith with a hospital for a procedure and the patient cancels at a later date. Also, the non-emergent consultation fee may be billed a second time after six months from the initial consultation if the surgery has been delayed by the hospital and the patient requires an update to their condition because of this delay.*

Emergency Consultation

28000	Consultation in a hospital (including emergency room) by a dentist on referral from a physician, or dentist, or another oral and maxillofacial specialist on an urgent or emergency basis for immediate patient management (to include interpretation of x-rays).	104.53
28001	Emergency Consultation Surcharge – Emergency consultation service rendered between 1800 hours and 0800 hours or emergency consultation service rendered on a Saturday, Sunday or Statutory Holiday	23.63

Non-Emergent Consultation/Exam

28005	Initial consultations by request of physician or nurse practitioner or dentist, presenting a distinct diagnostic problem requiring diagnostic tests and/or telephone time and written report, and associated with and followed by an in-hospital oral surgical procedure covered by the Plan (to include interpretation of x-rays).	104.53
T28101	Initial consultations by request of physician or nurse practitioner or dentist, presenting a distinct diagnostic problem requiring diagnostic tests and/or telephone time and written report, and associated with and followed by an in hospital oral surgical procedure covered by the Plan (to include interpretation of x rays). ***Notes:*** *i) To be billed when consultation occurs by videoconference.* *ii) This is a temporary fee only be in effect until the March 17, 2020 Notice declaring COVID-19 to be a public health emergency under the section of the Public Health Act is repealed.*	116.05

28006 In-hospital consultation on the referral of a physician or nurse practitioner regarding a distinct medical diagnostic problem. Requires diagnostic tests and follow-up by the consulting dentist — 143.37

Note: *Call-out fee not payable in addition.*

Hospital Visits

28008 Hospital visit for medical management of oral disease for a patient in hospital when surgical intervention may-not be required (e.g.: infection) — 21.44

Notes:

i) Not payable on day of initial consultation.

ii) Limit of one per day

iii) Applicable only to patients in acute care facilities

(iv) Repeat visits to monitor condition may be billed when done in dental office if this is more convenient for the patient and the dentist

OUT-OF-OFFICE HOURS PREMIUMS

Explanatory Notes:

(i) *The call-out charge 28012 (28013, 28014, 28015 for surgical assistants) is* ***in addition to fee item 28000 and emergency surgery.*** *It applies only to those consultations/surgeries initiated and rendered within the designated time limits*

(ii) *Call-out charges apply only when the dentist is specially called to render emergency or non-elective services and only when the dentist must travel to the hospital to attend the patient(s).*

(iii) *For these fee items the claim must state both the time called and the time service is rendered*.

(iv) *The continuing care surcharge applies to surgical assistant fees also.*

(v) *Continuing care surcharge are payable to dentists only when the primary service to which the continuing care surcharges apply are payable by MSP on a fee-for-service basis*.

Call-Out Charges:

28012 Call out when dentist is called by a health authority to attend a patient in hospital – per call — 250.04

Notes:

(i) Response time based on patient's clinical circumstances, but dentist must attend within 24 hours of receiving call.

(ii) Not applicable to surgical assistants.

(iii) Time call placed and service rendered must be indicated in time fields.

(iv) Not payable where existing paid call arrangements are in place.

(v) The call-out charge applies only to the first patient examined or treated on any one special visit. A call-out charge is applicable to each special call-out whether or not a previous call-out charge has been billed for the same patient on the same day.

(vi) For a second or subsequent call-out on the same day, supporting documentation must be submitted identifying why an additional visit was required.

Call-out Charges for Surgical Assistants:

28013	Evening (call placed between 1800 hours and 2300 hours and service rendered between 1800 hours and 0800 hours)	59.42
28014	Night (call placed and service rendered between 2300 hours and 0800 hours)	83.43
28015	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours)	59.42

Continuing Care Operative Surcharges

Applicable only to emergency surgery or non-emergency surgery which, because of intervening emergency surgery, commences within the designated times.

Applicable only to surgical procedure(s) requiring general anesthesia or neuroleptic anesthesia and/or requiring at least 45 minutes of surgical time.

28023	Evening (1800 hours to 2300 hours) - 32.77% of surgical (or assistant) fee	
	- minimum charge	59.40
	- maximum charge	409.76
28024	Night (2300 hours to 0800 hours) - 52.54% of surgical (or assistant)	
	- minimum charge	83.43
	- maximum charge	575.41
28025	Saturday, Sunday or Statutory Holiday (call placed between 0800 hrs and 1800 hrs) - 32.77% of surgical (or assistant) fee	
	- minimum charge	59.40
	- maximum charge	409.76

Notes:

(i) When surgery commences within evening time period (1800 – 2300 hrs) and continues into night time period (2300 – 0800 hrs), the appropriate item for billing is determined by the period in which the major portion of the surgical time is spent.

(ii) When emergency surgery commences prior to 1800, even if the major portion of surgical time is after 1800, surgical surcharges are not applicable.

(iii) If emergency surgery commences prior to 0800 and continues after 0800, surcharges are applicable to the entire surgical time.

(iv) Claim must state time surgery commenced.

DENTOALVEOLAR SURGERY

REMOVAL OF TEETH

A. Impacted Third Molar

"The tooth is completely or partially unerupted and positioned against another tooth, bone or soft tissue, so that further eruption is unlikely." Surgical removal of am impacted third molar, is an MSP insured service when performed by an enrolled dentist/oral maxillofacial specialist only when hospitalization is medically required for the proper performance of the procedure and criteria (i) or (ii) or (iii) are met, or if the patient has a pre-existing medical condition that requires hospital monitoring during the peri-operative period (*See Appendix 1, paragraph 2).*

(i) there is or has been a recent history of associated pathology, or

(ii) growth and development disturbances of the third molar impedes the eruption of another tooth, or

(iii) the impacted molar impedes the imminent placement of a prosthesis.

Without limiting the application of the foregoing, examples of pathology related to the extraction of an impacted third molar are:

- Infection
- A non-restorable carious lesion
- Non- treatable pulpal and/or periapical pathology
- Cellulitis
- Abscess and osteomyelitis
- Internal/external resorption of the tooth or adjacent tooth
- Fracture of tooth
- Disease of follicle including cyst/tumour
- Impeding surgery or reconstructive jaw surgery
- Involved in or within the field of tumour resection

B. Other Teeth

All other extractions are MSP insured services when, in the opinion of the dentist/oral maxillofacial specialist or attending medical practitioner, hospitalization is required for the proper performance of the procedure and:

(a) Where such treatment is an integral part of the management or treatment of a systemic condition or trauma, or,

(b) the surgical extraction is significantly complex or invasive in nature, such that it requires general anesthesia, or,

(c) the patient is a hospital in-patient and the performance of the procedure is medically necessary to the patient's care, or,

(d) there is difficult access to the airway or surgical site so as to cause significant anesthesia risk in a non-hospital environment, or,

(e) the emergent nature of the dental condition requires immediate surgical attention under general anesthesia, or,

(f) a demonstrated medical contra-indication (e.g. allergy) to local anesthesia precluding the performance of the extraction under local anesthesia, or,

(g) when indicated to safely complete another MSP insured surgical procedure such as fracture or osteotomy, or,

(h) the patient's age or physical and/or mental disability makes treatment impossible or unsafe outside a hospital setting

Notes:

(i) *If another surgical procedure is being completed at the same time as removal of multiple teeth, the higher gross fee item shall be paid at 100% and the extractions in that quadrant shall be paid as per "each additional tooth per quadrant".*

(ii) *When cysts, tumours, or other pathological lesions are intimately related to the teeth, and when extraction of these teeth are necessitated by this pathology, then only one surgical fee is applicable. This fee would be the major fee, either for the extractions or for the surgery to eradicate this pathology. In no instance would two fees be paid for these procedures completed concurrently. Other teeth removed in the same quadrant would be paid as per "each additional tooth per quadrant". On these occasions, a note record is required to confirm additional teeth removed in same segment are not associated with cyst/tumour/lesion.*

(iii) *When extractions are completed with osteotomies or fractures, the extractions will be billed as per "each additional tooth per quadrant" regardless of the quadrant or numbers of quadrants involved.*

(iv) *Prior approval may be sought for those cases not fulfilling the criteria listed above when the dentist/oral maxillofacial surgeon is of the opinion that the hospitalization is medically required and essential for the safe and efficient performance of the extraction(s). Requests for prior approval should be forwarded in writing (with appropriate documentation to make a decision) to the Adjudication Supervisor, Medical Services Plan Operations, Health Insurance BC.*

APPENDIX 1
Pre-existing Medical Conditions

Pre-existing medical conditions refers to serious and/or complex medical problems (usually under active treatment) which have a significant potential of increasing the risk of the dental procedure.

For patients with a pre-existing medical condition as listed below whose dental treatment plan involves the extraction of at least one impacted third molar, meeting the above extraction criteria the Medical Services Plan will pay for the anesthesia and extraction fee for the removal of additional impacted third molars at the same time if the dentist/oral maxillofacial specialist determines that it is in the best interest of the patient's health – e.g.: where a second general anesthetic has a significant potential of increasing the risk to the patient.

These pre-existing medical conditions include but are not limited to:

(a) Central Nervous System Disorders

(i) significant disability due to cerebrovascular accident,

(ii) epilepsy or seizures that are difficult to control,

(iii) significant cerebral palsy, myasthenia gravis, muscular dystrophy,

(iv) significant dementia such as Alzheimer's Disease,

(v) other forms of active central nervous disorders where there is loss of sensory, motor, or autonomic function under medical treatment;

(b) Cardiovascular Disorders

(i) significant disability due to myocardial infarction,

(ii) unstable angina on active treatment,

(iii) unstable, significantly elevated blood pressure on active treatment,
(iv) significant congestive heart failure,

(v) other forms of unstable cardiac disease under active treatment,

(vi) other cardiovascular disorders under treatment, including situations requiring extractions prior to cardiovascular surgery;

(c) Respiratory Disorders

(i) unstable pulmonary disease under active management;

(d) Renal Disorders

(i) unstable renal disease under active management;

(e) Hematologic Disorders

(i) leukemias under chemotherapy,

(ii) hemophilias or other bleeding diathesis,

(iii) anemia with hemoglobin less than 10 grams %,

(iv) other

(v) unstable hematologic disorders under active management;

(f) Hepatic Disorders

(i) hepatitis A, hepatitis B, hepatitis C under active management,

(ii) other significant hepatic diseases under active management;

(g) Endocrine Disorders

(i) hypothalamic and pituitary disorders requiring steroid therapy,

(ii) (those patients with) insulin dependent diabetes mellitus requiring monitoring of blood glucose,

(iii) other unstable endocrine disorders under active management;

(h) Neoplastic Disorders

(i) (those patients with) active cancer treatment and/or chemotherapy and/or radiotherapy,

(ii) other unstable neoplastic disorders under active management;

(i) Viral, Non-Viral, Bacterial, Infectious or Immune Deficiency

(i) active herpes simplex,

(ii) acquired immune deficiency syndrome,

(iii) other unstable infectious disorders under active treatment;

(j) Metabolic Disorders

(i) malignant hyperthermia,

(ii) other significant metabolic disorders under active treatment;

(k) Other Disorders or Conditions

(i) medically proven contra-indication (e.g. allergy) to local anesthesia,
(ii) pre-radiation of the head and neck including situations involving extractions prior to radiation treatment,

(iii) post radiation necrosis or sepsis,

(iv) significant mental illness or incompetence,

(v) significant disability due to age or infirmity;

Erupted Teeth

Note: *For removal of multiple teeth and/or roots, the higher fee item shall be paid at 100% per quadrant and other teeth and/or roots in the same quadrant shall be paid as per "each additional tooth and/or root per quadrant"*

Uncomplicated

28030	First tooth per quadrant – single tooth - uncomplicated	75.42
28031	Each additional tooth, same quadrant, same appointment	49.69

Complicated

Erupted tooth, surgical approach, requiring surgical flap and/or sectioning of tooth

28033	Each tooth	147.44

28034	Each additional tooth, same quadrant	104.50

Impacted Teeth

Soft Tissue Coverage

Requiring incision of overlying soft tissue and removal of tooth

28040	Single tooth	147.44
28041	Each additional tooth same quadrant	97.29

Tissue and/or Bone Coverage

Requiring incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of tooth

28045	Partial bony – single tooth	169.92
28046	Each additional – partial bony, same quadrant	80.35
28050	Full bony	237.48
28051	- each additional “full bony” impaction per quadrant	119.02
28054	Full bony impaction of extreme difficulty re: morphology or position ***Note**: Radiographs must be supplied*	253.25
28055	- each additional “full bony of extreme difficulty” per quadrant	175.31
28058	Removal of a tooth follicle (enucleation)	140.44
28059	- each additional “removal of a tooth follicle (enucleation)” per quadrant	112.28

Residual Roots

28060	Soft tissue coverage first per quadrant	90.30
28061	- each additional “soft tissue coverage root” per quadrant	39.96
28063	Bone coverage first per quadrant	170.00
28064	- each additional “bone coverage root” per quadrant	63.51

EXPOSURE AND REPOSITIONING OF TEETH

28070	Tooth transplantation (including splinting, donor removal and recipient bed preparation)	292.19
28071	Tooth transplantation - each additional per quadrant	146.08
28073	Surgical uprighting/repositioning/uncovering of a tooth	206.63
28074	Surgical uprighting/repositioning /uncovering of a tooth - each additional per quadrant	103.43
28076	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device	248.45
28077	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device - each additional per quadrant	124.22

SURGICAL ENDODONTICS

Apicoectomy

28082	Bicuspids and buccal roots of maxillary molars	340.89
28084	Palatal roots of maxillary molars and roots of mandibular molars	325.80
28086	Per root end fill, add	32.52
28088	Hemisection	121.38
28089	Open and drain when done in hospital as a last resort modality to bring relief for a patient with acute abscess causing excessive pain and swelling	80.03

Note: *May be done as adjunct to soft tissue drainage.*

Root Amputations (includes tooth and furca recontouring)

28090	One root per tooth	242.77
28092	Two roots per tooth	291.30

OSSEOUS RECONTOURING

Alveoloplasty (Full fee per sextant)

28100	Per edentulous sextant	98.45
28102	In conjunction with multiple extractions	74.03
28105	Tuberosity reduction with bone removal (as a separate procedure and not in conjunction with removal of an impacted tooth)	204.52

Removal of torus/exostosis

28107	Per quadrant	160.93
28108	Palatal torus	253.81

SOFT TISSUE RECONTOURING (Full fee per sextant)

28120	Uncomplicated excision of hyperplastic tissue with primary closure, e.g., soft tissue tuberosities and epuli	90.30
28122	Operculectomy (as an isolated procedure - not to be billed as part of a routine extraction procedure)	42.21
28124	Gingivoplasty - per sextant	97.78
	***Note**: Not in conjunction with tooth removal unless with systemic etiology - e.g. - drug induced hyperplasia*	
28128	Frenectomy	203.86
28129	Frenectomy - second at same surgery	101.95

Vestibuloplasty

- this does not include tissue harvest
- each fee paid at full on a sextant basis

28131	Each sextant	373.58
28132	Mucous membrane graft - add per sextant	73.03

SURGICAL EXCISION

Incisional Biopsies

28180	Soft tissue	108.44
28182	Hard tissue	194.79

LESIONS

INTRAORAL SOFT TISSUE LESIONS

Primary Closure

28220	Lesion base $\leq$ 1cm	220.39
28221	- each additional lesion $\leq$ 1cm	110.20
28225	Lesion base > 1cm	434.30

28226	- each additional lesion > 1cm	217.14

OSSEOUS LESIONS

Surface Osseous Lesions (other than tori and alveoloplasties)

28240	Lesion base ≤ 1cm	176.28
28241	- each additional lesion base ≤ 1cm	88.15
28245	Lesion base > l cm	333.51
28246	- each additional lesion base > l cm	166.73

Intraosseous Lesions

Treatment by Simple Excision, Enucleation, or Curettage

28250	≤ 1 cm in greatest diameter	220.39
28252	1cm to 5cm	434.30
28260	Each additional lesion same jaw is paid at 50%	
28265	Each additional lesion second jaw is paid at 75%	

MANAGEMENT OF INFLAMMATORY PROCESSES

Soft Tissue Incision and Drainage

28350	Vestibular or subperiosteal abscess	53.47
28355	Intraoral superficial (buccal, subcutaneous, infraorbital, and infratemporal spaces)	82.80
28365	Extraoral superficial (submental, subcutaneous and buccal spaces)	122.53
28375	Sequestrectomy for osteomyelitis	249.87

TREATMENT OF TRAUMATIC INJURIES

28200	Management of a non-avulsed tooth with wire, composite, ribbon, or splint to stabilize displacement due to a traumatic event. Fee includes removal of splint after completion of stabilization. Removal can be done in a dentist's office	65.83
28201	Onetime fee for all additional teeth treated at same time for management of non-avulsed teeth with wire, composite, ribbon, or splint to stabilize displaced teeth due to a traumatic event. Fee includes removal of splint after completion of stabilization. Removal can be done in a dentist's office	32.92
28202	Removal of splint after stabilization if done by another dentist	50.44
28203	Management of a fractured tooth with a deep Class 2 fracture involving the dentin and or Class 3 fracture exposing the pulp, whereby the patient is in pain and requires a composite bonded and/or glass ionomer restoration.	114.96
28204	Management of a fractured tooth with a deep Class 2 fracture involving the dentin and or Class 3 fracture exposing the pulp, whereby the patient is in pain and requires a composite bonded and/or glass ionomer restoration.	60.35
28205	Implantation and splinting of an avulsed tooth (not including root canal therapy	312.12
28206	Reduction of alveolar fracture including debridement and necessary extractions	485.87

II) Facial Trauma

Soft Tissue Injuries

a) Simple

28207	Single layer suture of laceration	118.67

Hard Tissue Injuries

a) Midface Fractures

Closed Reductions

28208	Closed reduction of maxilla with arch bars or other tooth anchored fixation	431.84

b) Mandibular Fractures

Closed Reduction

28209	Closed reduction of mandible with arch bars or other tooth anchored fixation	489.62

Open Reduction - Intraoral

28210	Simple fracture of mandible (includes immobilization with tooth anchored fixation)	634.95

TEMPOROMANDIBULAR JOINT

28211	Reduction of dislocation	121.76
28212	Manipulation under anesthesia (as an isolated procedure only)	121.76

REMOVAL FOREIGN BODIES

(a) Removal of foreign body from soft tissue (as a separate procedure only)

28213	Superficially located	92.89

(b) Removal of foreign body from bone (as a separate procedure only and not to include dental implants)

28214	Surgical removal	292.19

ANTRAL SURGERY

28215	Immediate recovery of a tooth or foreign body from the maxillary antrum	92.52
28216	Secondary recovery of a tooth or foreign body from the maxillary antrum	292.19
28217	Closure of an oral antral fistula - immediate closure – sliding advancement buccal flap with periosteal release (not to be billed with code 28215)	201.95

SALIVARY GLANDS

28218	Dilation of salivary duct	39.32
28219	Sialodochoplasty	121.76

Intraductal sialolithotomy

28247	- submandibular	121.76

DENTOALVEOLAR COMPLICATIONS

28270	Post operative complications	43.83

SURGICAL ASSISTANT

28300	G.P. surgical assistant	486.97
28301	After three hours continuous surgical assistance for one patient, for each additional 15 minutes, or fraction thereof, add	24.35

Note: *Claims for a surgical assist will only be paid with major surgical procedures such as osteotomies, reconstructive surgery, etc. Assistants at the following procedures will not be paid unless substantiated by an explanation of the medical necessity supporting the need of an assistant:*

- *Odontectomy (all)*
- *Exposure and repositioning of teeth (all)*
- *Osseous recontouring (all)*
- *Soft tissue recontouring (all)*
- *Biopsies (all)*
- *Lip surgery - wedge resection of lip and vermilionectomy*
- *Soft tissue lesions (fee codes 28220 and 28221)*
- *Surface Osseous lesions (fee codes 28240 and 28241)*
- *Intraosseous lesions (fee code 28250)*
- *Soft tissue incision and drainage (fee codes 28350, 28355, 28365)*
- *Osteomyelitis (fee code 28375)*
- *Foreign bodies (fee code 28213)*
- *Traumatic injuries of the teeth and skeleton (fee codes 28350, 28206, and 28208)*
- *Soft tissue injuries (fee code 28207 unless multiple lacerations and/or associated with other injuries)*
- *Temporomandibular joint (fee codes 28211 and 28212)*
- *Antral Surgery (fee codes 28215 and 28217)*
- *Salivary glands (fee codes 28218, 28219 and 28247)*
- *Surgical endodontic procedures (all)*
- *Dentoalveolar complications (fee code 28270)*

MISCELLANEOUS FEE

28199 To be used for unusually complex procedures, for established but infrequently performed procedures which are not listed in this payment schedule, for unlisted "team" procedures or for any medically required service for which the practitioner desires independent consideration to be given by the Plan, a claim should be submitted using this code. When submitting claims using a miscellaneous fee code, you should include your estimate of an appropriate fee, details of the calculation of that fee and sufficient documentation of your services (such as an operative report) to substantiate the claim. Claims made under the miscellaneous code will be adjudicated in equity with services of similar responsibility, skill, and duration