DENTAL SURGERY
(GENERAL DENTAL PRACTITIONERS)
SCHEDULE A

Effective February 1, 2018

Ministry of Health
Beneficiary Services Branch

SCHEDULE A: INSURED DENTAL SURGERY
(GENERAL DENTAL PRACTITIONERS)

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DENTAL SURGERY
(GENERAL DENTAL PRACTITIONERS)
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Tariff of Fees Approved and/or Prescribed as the Payment Schedule
Effective February 1, 2018

Explanatory Notes:

(*i*) *Covered services generally include consultations, extractions, orthognathic surgery, trauma, etc. Services not covered by 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 the Medical Services Plan, 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 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 anaesthetic, 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 restorative, prosthetic, periodontal reasons or for routine extractions). 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 oral 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.*

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
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).	89.00	89.45
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	20.01	20.11
Non-Emergent Consultation/Exam			
27005	Initial consultations by request of physician 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).	89.00	89.45
27006	In-hospital consultation on the referral of a physician regarding a distinct medical diagnostic problem. Requires diagnostic tests and follow-up by the consulting dentist ***Note:*** *Call-out fee not payable in addition.*	121.30	121.91

Hospital Visits

Fee Code	Description	$ Feb 1, 2018	$Apr 1, 2018
27008	Hospital visit for medical management of oral disease for a patient in hospital when surgical intervention may-not be required (e.g.: infection) ***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*	18.14	18.23

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 ***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.*	211.58	212.64

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
	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)	50.28	50.53
27014	Night (call placed and service rendered between 2300 hours and 0800 hours)	70.58	70.93
27015	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours)	50.28	50.53
	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	50.27	50.52
	- maximum charge	346.71	348.44
27024	Night (2300 hours to 0800 hours) - 52.54% of surgical (or assistant)		
	- minimum charge	70.58	70.93
	- maximum charge	486.88	489.31
27025	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours) - 32.77% of surgical (or assistant) fee		
	- minimum charge	50.27	50.52
	- maximum charge	346.71	348.44
	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 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) 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"*

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
Uncomplicated			
27030	First tooth per quadrant – single tooth - uncomplicated	63.82	64.14
27031	Each additional tooth, same quadrant, same appointment	42.06	42.27
Complicated			
	Erupted tooth, surgical approach, requiring surgical flap and/or sectioning of tooth		
27033	Each tooth	124.74	125.36
27034	Each additional tooth, same quadrant	88.44	88.88
Impacted Teeth			
	Soft Tissue Coverage		
	Requiring incision of overlying soft tissue and removal of tooth		
27040	Single tooth	124.74	125.36
27041	Each additional tooth same quadrant	82.33	82.74
	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	143.79	144.51
27046	Each additional – partial bony, same quadrant	67.99	68.33
27050	Full bony	200.96	201.96
27051	- each additional “full bony” impaction per quadrant	100.72	101.22
27054	Full bony impaction of extreme difficulty re: morphology or position ***Note**: Radiographs must be supplied*	214.26	215.33
27055	- each additional “full bony of extreme difficulty” per quadrant	148.34	149.08
27058	Removal of a tooth follicle (enucleation)	118.82	119.41
27059	- each additional “removal of a tooth follicle (enucleation)” per quadrant	95.01	95.49
Residual Roots			
27060	Soft tissue coverage first per quadrant	76.40	76.78
27061	- each additional “soft tissue coverage root” per quadrant	33.82	33.99
27063	Bone coverage first per quadrant	143.86	144.58
27064	- each additional “bone coverage root” per quadrant	53.72	53.99

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
27070	Tooth transplantation (including splinting, donor removal and recipient bed preparation)	247.22	248.46
27071	Tooth transplantation - each additional per quadrant	123.61	124.23
27073	Surgical uprighting/repositioning/uncovering of a tooth	174.83	175.70
27074	Surgical uprighting/repositioning /uncovering of a tooth - each additional per quadrant	87.49	87.93
27076	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device	210.23	211.28
27077	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device - each additional per quadrant	105.11	105.64
	SURGICAL ENDODONTICS		
	Apicoectomy		
27082	Bicuspids and buccal roots of maxillary molars	288.44	289.88
27084	Palatal roots of maxillary molars and roots of mandibular molars	275.67	277.05
27086	Per root end fill, add	27.52	27.66
27088	Hemisection	102.70	103.21
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.*	67.69	68.03
	Root Amputations (includes tooth and furca recontouring)		
27090	One root per tooth	205.44	206.47
27092	Two roots per tooth	246.47	247.70
	OSSEOUS RECONTOURING		
	Alveoloplasty (Full fee per sextant)		
27100	Per edentulous sextant	83.29	83.71
27102	In conjunction with multiple extractions	62.64	62.95
27105	Tuberosity reduction with bone removal (as a separate procedure and not in conjunction with removal of an impacted tooth)	173.06	173.93
	Removal of torus/exostosis		
27107	Per quadrant	136.16	136.84
27108	Palatal torus	214.74	215.81
	SOFT TISSUE RECONTOURING (Full fee per sextant)		
27120	Uncomplicated excision of hyperplastic tissue with primary closure, e.g., soft tissue tuberosities and epuli	76.40	76.78
27122	Operculectomy (as an isolated procedure - not to be billed as part of a routine extraction procedure)	35.71	35.89

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
27124	Gingivoplasty - per sextant ***Note**: Not in conjunction with tooth removal unless with systemic etiology - e.g. - drug induced hyperplasia*	82.75	83.16
27128	Frenectomy	172.49	173.35
27129	Frenectomy - second at same surgery	86.27	86.70

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	316.08	317.66
27132	Mucous membrane graft - add per sextant	61.80	62.11

DENTAL IMPLANTS

Intraosseous Implants

27165	Placement of first unit	164.81	165.63
27166	- each additional unit placed at the same surgical session	103.02	103.54
27168	Exposure of first unit	83.90	84.32
27169	- each additional unit exposed at the same surgical session	41.97	42.18

Removal of Implants

27172	Subperiosteal or mandibular staple	494.46	496.93
27174	Intraosseous, first unit	82.42	82.83
27175	Intraosseous, each additional unit	41.20	41.41

SURGICAL EXCISION

Incisional Biopsies

27180	Soft tissue	91.74	92.20
27182	Hard tissue	164.81	165.63

LESIONS

INTRAORAL SOFT TISSUE LESIONS

Primary Closure

27220	Lesion base $\leq$ 1cm	186.47	187.40
27221	- each additional lesion $\leq$ 1cm	93.24	93.71
27225	Lesion base > 1cm	367.47	369.31
27226	- each additional lesion > 1cm	183.73	184.65

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
OSSEOUS LESIONS			
Surface Osseous Lesions (other than tori and alveoloplasties)			
27240	Lesion base ≤ 1cm	149.16	149.91
27241	- each additional lesion base ≤ 1cm	74.58	74.95
27245	Lesion base > l cm	282.18	283.59
27246	- each additional lesion base > l cm	141.08	141.79
Intraosseous Lesions			
	a) Treatment by Simple Excision, Enucleation, or Curettage		
27250	≤ 1 cm in greatest diameter	186.47	187.40
27252	1cm to 5cm	367.47	369.31
27260	Each additional lesion same jaw is paid at 50%	180.21	181.11
27265	Each additional lesion second jaw is paid at 75%	270.30	271.65
MANAGEMENT OF INFLAMMATORY PROCESSES			
Soft Tissue Incision and Drainage			
27350	Vestibular or subperiosteal abscess	45.23	45.46
27355	Intraoral superficial (buccal, subcutaneous, infraorbital, and infratemporal spaces)	70.08	70.43
27365	Extraoral superficial (submental, subcutaneous and buccal spaces)	103.69	104.21
27375	Sequestrectomy for osteomyelitis	211.42	212.48
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	60.96	61.26
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	30.48	30.63
27383	Removal of splint after stabilization if done by another dentist	46.48	46.71
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.	106.44	106.97
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	55.85	56.13

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
27400	Implantation and splinting of an avulsed tooth (not including root canal therapy	264.10	265.42
27402	Reduction of alveolar fracture including debridement and necessary extractions	411.10	413.16
	II) Facial Trauma		
	Soft Tissue Injuries		
27405	Single layer suture of laceration	100.38	100.88
	Hard Tissue Injuries		
	a) Midface Fractures		
	Closed Reductions		
27440	Closed reduction of maxilla with arch bars or other tooth anchored fixation	365.41	367.24
	b) Mandibular Fractures		
	Closed Reduction		
27470	Closed reduction of mandible with arch bars or other tooth anchored fixation	414.29	416.36
	Open Reduction - Intraoral		
27475	Simple fracture of mandible (includes immobilization with tooth anchored fixation)	537.25	539.94
	TEMPOROMANDIBULAR JOINT		
27500	Reduction of dislocation	103.02	103.54
27502	Manipulation under anesthesia (as an isolated procedure only)	103.02	103.54
	REMOVAL FOREIGN BODIES		
(a)	**Removal of foreign body from soft tissue (as a separate procedure only)**		
27692	Superficially located	78.61	79.00
(b)	**Removal of foreign body from bone (as a separate procedure only and not to include dental implants)**		
27695	Surgical removal	247.22	248.46
	ANTRAL SURGERY		
27711	Immediate recovery of a tooth or foreign body from the maxillary antrum	78.28	78.67
27712	Secondary recovery of a tooth or foreign body from the maxillary antrum	247.22	248.46
27720	Closure of an oral antral fistula - immediate closure – sliding advancement buccal flap with periosteal release (not to be billed with code 27711)	170.87	171.72
	SALIVARY GLANDS		
27740	Dilation of salivary duct	33.27	33.44
27742	Sialodochoplasty	103.02	103.54

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
Intraductal sialolithotomy			
27747	- submandibular	103.02	103.54
DENTOALVEOLAR COMPLICATIONS			
27770	Post-operative complications	37.08	37.27
SURGICAL ASSISTANT			
27801	G.P. surgical assistant	412.04	414.10
27802	After three hours continuous surgical assistance for one patient, for each additional 15 minutes, or fraction thereof, add	20.61	20.71

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)*
- *Soft tissue injuries (fee code 27405 unless there are multiple lacerations and/or associated with other injuries)*
- *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