PEDIATRIC DENTAL SPECIALISTS

SCHEDULE F

Effective February 1, 2018

Ministry of Health
Beneficiary Services Branch

SCHEDULE F: PEDIATRIC DENTAL SPECIALISTS

PEDIATRIC DENTAL SPECIALISTS
SCHEDULE F

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 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.

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018

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 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 (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).	96.33	96.81
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	21.78	21.89

Non-Emergent Consultation/Exam

28005	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 (to include interpretation of x-rays)..	96.33	96.81
28006	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.*	132.12	132.78

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018

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) — 19.75 — 19.85

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 — 230.42 — 231.57

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.

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
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)	54.76	55.03
28014	Night (call placed and service rendered between 2300 hours and 0800 hours)	76.88	77.26
28015	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours)	54.76	55.03
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	54.75	55.02
	- maximum charge	377.60	379.49
28024	Night (2300 hours to 0800 hours) - 52.54% of surgical (or assistant)		
	- minimum charge	76.88	77.26
	- maximum charge	530.24	532.89
28025	Saturday, Sunday or Statutory Holiday (call placed between 0800 hrs and 1800 hrs) - 32.77% of surgical (or assistant) fee		
	- minimum charge	54.75	55.02
	- maximum charge	377.60	379.49
	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.*		

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018

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,

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018

(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.*

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018

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

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
	(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;		

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
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	69.50	69.85
28031	Each additional tooth, same quadrant, same appointment	45.79	46.02
Complicated			
	Erupted tooth, surgical approach, requiring surgical flap and/or sectioning of tooth		
28033	Each tooth	135.87	136.55
28034	Each additional tooth, same quadrant	96.30	96.78
Impacted Teeth			
	Soft Tissue Coverage		
	Requiring incision of overlying soft tissue and removal of tooth		
28040	Single tooth	135.87	136.55
28041	Each additional tooth same quadrant	89.65	90.10
	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	156.59	157.37
28046	Each additional – partial bony, same quadrant	74.04	74.41
28050	Full bony	218.84	219.93
28051	- each additional "full bony" impaction per quadrant	109.68	110.23
28054	Full bony impaction of extreme difficulty re: morphology or position ***Note****: Radiographs must be supplied*	233.37	234.54
28055	- each additional "full bony of extreme difficulty" per quadrant	161.55	162.36
28058	Removal of a tooth follicle (enucleation)	129.41	130.06
28059	- each additional "removal of a tooth follicle (enucleation)" per quadrant	103.47	103.99
Residual Roots			
28060	Soft tissue coverage first per quadrant	83.21	83.63
28061	- each additional "soft tissue coverage root" per quadrant	36.83	37.01
28063	Bone coverage first per quadrant	156.66	157.44
28064	- each additional "bone coverage root" per quadrant	58.52	58.81

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
EXPOSURE AND REPOSITIONING OF TEETH			
28070	Tooth transplantation (including splinting, donor removal and recipient bed preparation)	269.25	270.60
28071	Tooth transplantation - each additional per quadrant	134.62	135.29
28073	Surgical uprighting/repositioning/uncovering of a tooth	190.41	191.36
28074	Surgical uprighting/repositioning /uncovering of a tooth - each additional per quadrant	95.30	95.78
28076	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device	228.95	230.09
28077	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device - each additional per quadrant	114.47	115.04
SURGICAL ENDODONTICS			
Apicoectomy			
28082	Bicuspids and buccal roots of maxillary molars	314.14	315.71
28084	Palatal roots of maxillary molars and roots of mandibular molars	300.23	301.73
28086	Per root end fill, add	29.96	30.11
28088	Hemisection	111.85	112.41
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 **Note:** *May be done as adjunct to soft tissue drainage.*	73.74	74.11
Root Amputations (includes tooth and furca recontouring)			
28090	One root per tooth	223.72	224.84
28092	Two roots per tooth	268.44	269.78
OSSEOUS RECONTOURING			
Alveoloplasty (Full fee per sextant)			
28100	Per edentulous sextant	90.72	91.17
28102	In conjunction with multiple extractions	68.22	68.56
28105	Tuberosity reduction with bone removal (as a separate procedure and not in conjunction with removal of an impacted tooth)	188.47	189.41
Removal of torus/exostosis			
28107	Per quadrant	148.29	149.03
28108	Palatal torus	233.89	235.06
SOFT TISSUE RECONTOURING (Full fee per sextant)			
28120	Uncomplicated excision of hyperplastic tissue with primary closure, e.g., soft tissue tuberosities and epuli	83.21	83.63
28122	Operculectomy (as an isolated procedure - not to be billed as part of a routine extraction procedure)	38.90	39.09

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
28124	Gingivoplasty - per sextant	90.11	90.56
	***Note**: Not in conjunction with tooth removal unless with systemic etiology - e.g. - drug induced hyperplasia*		
28128	Frenectomy	187.86	188.80
28129	Frenectomy - second at same surgery	93.95	94.42

Vestibuloplasty

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

28131	Each sextant	344.26	345.98
28132	Mucous membrane graft - add per sextant	67.30	67.64

DENTAL IMPLANTS

Intraosseous Implants

28165	Placement of first unit	179.49	180.39
28166	- each additional unit placed at the same surgical session	112.20	112.76
28168	Exposure of first unit	91.37	91.83
28169	- each additional unit exposed at the same surgical session	45.70	45.93

Removal of Implants

28172	Subperiosteal or mandibular staple	538.49	541.18
28174	Intraosseous, first unit	89.75	90.20
28175	Intraosseous, each additional unit	44.88	45.10

SURGICAL EXCISION

Incisional Biopsies

28180	Soft tissue	99.92	100.42
28182	Hard tissue	179.49	180.39

LESIONS

INTRAORAL SOFT TISSUE LESIONS

Primary Closure

28220	Lesion base $\leq$ 1cm	203.09	204.11
28221	- each additional lesion $\leq$ 1cm	101.54	102.05
28225	Lesion base > 1cm	400.21	402.21
28226	- each additional lesion > 1cm	200.09	201.09

OSSEOUS LESIONS

Fee Code	Description	$Feb 1, 2018	$Apr 1, 2018
Surface Osseous Lesions (other than tori and alveoloplasties)			
28240	Lesion base ≤ 1cm	162.44	163.25
28241	- each additional lesion base ≤ 1cm	81.22	81.63
28245	Lesion base > l cm	307.32	308.86
28246	- each additional lesion base > l cm	153.64	154.41
Intraosseous Lesions			
	Treatment by Simple Excision, Enucleation, or Curettage		
28250	≤ 1 cm in greatest diameter	203.09	204.11
28252	1cm to 5cm	400.21	402.21
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	49.26	49.51
28355	Intraoral superficial (buccal, subcutaneous, infraorbital, and infratemporal spaces)	76.31	76.69
28365	Extraoral superficial (submental, subcutaneous and buccal spaces)	112.92	113.48
28375	Sequestrectomy for osteomyelitis	230.26	231.41
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	60.66	60.96
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	30.34	30.49
28202	Removal of splint after stabilization if done by another dentist	46.48	46.71
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.	105.94	106.47
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.	55.61	55.89
28205	Implantation and splinting of an avulsed tooth (not including root canal therapy	287.62	289.06
28206	Reduction of alveolar fracture including debridement and necessary extractions	447.73	449.97

II) Facial Trauma

Soft Tissue Injuries

a) Simple

28207	Single layer suture of laceration	109.35	109.90

Hard Tissue Injuries

a) Midface Fractures

Closed Reductions

28208	Closed reduction of maxilla with arch bars or other tooth anchored fixation	397.94	399.93

b) Mandibular Fractures

Closed Reduction

28209	Closed reduction of mandible with arch bars or other tooth anchored fixation	451.18	453.44

Open Reduction - Intraoral

28210	Simple fracture of mandible (includes immobilization with tooth anchored fixation)	585.11	588.04

TEMPOROMANDIBULAR JOINT

28211	Reduction of dislocation	112.20	112.76
28212	Manipulation under anesthesia (as an isolated procedure only)	112.20	112.76

REMOVAL FOREIGN BODIES

(a)	**Removal of foreign body from soft tissue (as a separate procedure only)**		
28213	Superficially located	85.59	86.02
(b)	**Removal of foreign body from bone (as a separate procedure only and not to include dental implants)**		
28214	Surgical removal	269.25	270.60

ANTRAL SURGERY

28215	Immediate recovery of a tooth or foreign body from the maxillary antrum	85.26	85.69
28216	Secondary recovery of a tooth or foreign body from the maxillary antrum	269.25	270.60
28217	Closure of an oral antral fistula - immediate closure – sliding advancement buccal flap with periosteal release (not to be billed with code 28215)	186.10	187.03

SALIVARY GLANDS

28218	Dilation of salivary duct	36.23	36.41
28219	Sialodochoplasty	112.20	112.76

Intraductal sialolithotomy

28247	- submandibular	112.20	112.76

DENTOALVEOLAR COMPLICATIONS

28270	Post operative complications	40.39	40.59

SURGICAL ASSISTANT

28300	G.P. surgical assistant	448.75	450.99
28301	After three hours continuous surgical assistance for one patient, for each additional 15 minutes, or fraction thereof, add	22.44	22.55

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