ORAL AND MAXILLOFACIAL SPECIALISTS

SCHEDULE B

Effective April 1, 2020

Ministry of Health
Beneficiary and Diagnostic Services Branch

SCHEDULE B: ORAL AND MAXILLOFACIAL SPECIALISTS

ORAL AND MAXILLOFACIAL SPECIALISTS
SCHEDULE B

This Fee Schedule is Limited to
Certified Oral and Maxillofacial Specialists by Referral Only

Tariff of Fees Approved and/or Prescribed as the Payment Schedule
Effective April 1, 2020

Explanatory Notes:

(i) *Covered services generally include consultations, extractions, orthognathic surgery, trauma, etc. Services not covered by 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 use Schedule A if the patient has come into their care without referral by a dentist or medical practitioner.*

(iii) *Oral and Maxillofacial specialists shall use Schedule B if the patient has come into their care upon referral by either a dentist or a medical practitioner. 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).*

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

(v) *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.*

(vi) *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.*

(vii) *When a dental/oral surgical procedure is a benefit listed in the Payment Schedule and therefore, payable by the 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 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.

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020

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 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 (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).	112.07	116.60
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	25.58	26.61

Non-Emergent Consultation/Exam

35005	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 and maxillofacial surgical procedure covered by the Plan(to include interpretation of x-rays).	114.31	116.60
35006	In-hospital consultation on the referral of a physician 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.*	176.57	180.10

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
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) ***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*	23.64	24.12

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 **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*	294.26	300.14

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
	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)	52.44	53.49
35014	Night (call placed and service rendered between 2300 hours and 0800 hours)	73.61	75.09
35015	Saturday, Sunday or Statutory Holiday (call placed between 0800 hours and 1800 hours)	52.44	53.49
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	52.44	53.73
	- maximum charge	361.63	368.86
35024	Night (2300 hours to 0800 hours) - 52.54% of surgical (or assistant) fee		
	- minimum charge	73.61	75.46
	- maximum charge	507.83	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	52.44	53.73
	- maximum charge	361.63	368.86
	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	$Apr 1, 2019	$Apr 1, 2020

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,

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020

(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.*

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020

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 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 unstable hematologic disorders under active management;

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
(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, (iii) other unstable endocrine disorders under active management;		
(h)	Neoplastic Disorders (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, (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	83.18	84.84
35031	Each additional, same quadrant, same appointment	54.87	55.96
Complicated			
	Erupted tooth, surgical approach, requiring surgical flap and/or sectioning of tooth		
35033	Each tooth	162.63	165.88
35034	Each additional tooth, same quadrant	107.30	109.45
	Soft Tissue Coverage		

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
	Requiring incision of overlying soft tissue and removal of tooth		
35040	Single tooth	162.63	165.88
35041	Each additional tooth, same quadrant	107.30	109.45
	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	187.46	191.20
35046	Each additional – partial bony same quadrant	88.67	90.44
35050	Full bony	262.03	267.27
35051	- each additional “full bony” impaction per quadrant	131.31	133.94
35054	Full bony impaction of extreme difficulty re: morphology or position. Radiographs must be supplied	279.36	284.94
35055	- each additional “full bony of extreme difficulty” per quadrant	193.40	197.27
35058	Removal of a tooth follicle (enucleation)	154.94	158.04
35059	- each additional “removal of a tooth follicle (enucleation)” per quadrant	123.86	126.34
Residual Roots			
35060	Soft tissue coverage first per quadrant	89.21	90.99
35061	Each additional “soft tissue coverage root” per quadrant	44.07	44.96
35063	Bone coverage first per quadrant	162.86	166.12
35064	Each additional “bone coverage root” per quadrant	70.07	71.48
EXPOSURE AND REPOSITIONING OF TEETH			
35070	Tooth transplantation (including splinting, donor removal and recipient bed preparation)	322.34	328.79
35071	Tooth transplantation - each additional per quadrant	161.17	164.39
35073	Surgical uprighting/repositioning/uncovering of a tooth	227.93	232.49
35074	Surgical uprighting/repositioning /uncovering of a tooth - each additional per quadrant	114.08	116.36
35076	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device	274.11	279.60
35077	Surgical uprighting/repositioning/uncovering of a tooth with placement of a traction device - each additional per quadrant	137.05	139.79

SURGICAL ENDODONTICS

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
Apicoectomy			
35080	Anterior	302.80	308.85
35082	Bicuspids and buccal roots of maxillary molars	376.07	383.60
35084	Palatal roots of maxillary molars and roots of mandibular molars	359.42	366.61
35086	Per root end fill, add	35.89	36.61
35088	Hemisection	133.91	136.58
Root Amputations (includes tooth and furca recontouring)			
35090	One root per tooth	267.83	273.19
35092	Two roots per tooth	321.36	327.79
OSSEOUS RECONTOURING			
Alveoloplasty (Full fee per sextant)			
35100	Per edentulous sextant	99.16	101.15
35102	In conjunction with multiple extractions	81.66	83.29
35105	Tuberosity reduction with bone removal as a separate procedure and not in conjunction with removal of an impacted tooth	225.62	230.14
Removal of torus/exostosis			
35107	Per quadrant	177.49	181.04
35108	Palatal torus	279.99	285.59
SOFT TISSUE RECONTOURING (Full fee per sextant)			
35120	Uncomplicated excision of hyperplastic tissue with primary closure, e.g., soft tissue tuberosities and epuli	86.04	87.86
35122	Operculectomy (as an isolated procedure - not to be billed as part of a routine extraction procedure)	41.84	42.68
35124	Gingivoplasty, per sextant	107.89	110.04
	***Note**: Not in conjunction with tooth removal unless with systemic etiology - e.g.- drug induced hyperplasia.*		
35126	Surgical treatment of palatal papillary hyperplasia	214.28	218.57
35128	Frenectomy	224.91	229.41
35129	Frenectomy - second at same surgery	112.48	114.72
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	329.68	336.28
35132	Mucous membrane or skin graft - add per sextant	80.59	82.20

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
35134	Detachment of mylohyoid muscle in conjunction with lowering of the floor of the mouth	290.77	296.59

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	483.48	493.15
35142	Preprosthetic maxillary antrum/nasal floor augmentation with bone or alloplast	483.48	493.15
35143	Preprosthetic maxillary antrum augmentation with bone or alloplast contralateral maxilla	241.77	246.61
35145	Placement of alloplastic membrane/barrier per sextant	48.36	49.33
35149	Removal barrier/membrane per sextant	48.36	49.33

Preprosthetic Augmentation By Osteotomy

(These fees do not include harvesting of bone)

35150	Without bone grafting - first sextant	523.68	534.15
35151	- each additional sextant	322.34	328.79
35153	With bone grafting - first sextant	564.08	575.36
35154	- each additional sextant with bone grafting	349.18	356.16

DENTAL IMPLANTS

Intraosseous Implants

35165	Placement of first unit	214.87	219.17
35166	Each additional unit placed at the same surgical session	134.30	136.99
35168	Exposure of first unit	109.40	111.58
35169	Each additional unit exposed at the same surgical session	54.70	55.80

Removal of Implants

35172	Subperiosteal or mandibular staple	644.66	657.55
35174	Intraosseous, first unit	107.46	109.61
35175	Intraosseous, each additional unit	53.71	54.79

SURGICAL EXCISION

Incisional Biopsies

35180	Soft tissue	119.60	121.99
35182	Hard tissue (bone/cartilage)	214.87	219.17

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
Lip Surgery			
35184	Vermilionectomy	295.46	301.37
35186	Cheiloplasty	295.46	301.37
35188	Wedge resection to the vermilion border	108.53	110.70
35190	Wedge resection to the depth of the sulcus	268.63	274.00
LESIONS			
Extraoral Soft Tissue Lesions			
Primary Closure			
35200	Lesion based ≤ 2cm	161.17	164.39
35201	Lesion based > 2cm	322.34	328.79
Complicated Closure			
35205	Free skin graft – placement	231.85	236.48
35206	Each additional graft – placement	116.01	118.34
35210	Arterial island flap	453.17	462.23
35211	Each additional pedicle flap	226.66	231.20
35215	Local tissue shifts: - advancements, rotations, transpositions, "z" plasty, etc.	225.97	230.49
INTRAORAL SOFT TISSUE LESIONS			
Primary Closure			
35220	Lesion base ≤ 1cm	243.12	247.98
35221	Each additional lesion ≤ 1cm	121.55	123.98
35225	Lesion base > 1cm	479.10	488.69
35226	Each additional lesion > 1cm	239.57	244.36
Complicated Closure			
35230	Soft tissue graft placement, add	63.23	64.49
35231	Island and rotation flaps, add	126.41	128.94
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 **Notes:** *(i) Payable once per patient per day.* *(ii) See 35267 when cryotherapy/chemotherapy performed following enucleation of Intraosseous*	235.41	240.11

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
OSSEOUS LESIONS			
Surface Osseous Lesions (other than tori and alveoloplasties)			
35240	Lesion base ≤ 1cm	194.48	198.37
35241	- each additional lesion base ≤ 1cm	97.26	99.20
35245	Lesion base > l cm	367.89	375.25
35246	Each additional lesion base > l cm	183.96	187.64
Intraosseous Lesions			
	a) Treatment by Simple Excision, Enucleation, or Curettage		
35250	≤ 1cm in greatest diameter	243.12	247.98
35252	1cm to 5cm	479.10	488.69
35255	> 5cm	537.21	547.96
35260	Each additional lesion same jaw is paid at 50%	263.44	273.98
35265	Each additional lesion alternate jaw is paid at 75%	395.15	410.97
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).	263.44	273.98
	b) Treatment Requiring Block Section (does not include harvesting/placement of graft or fixation)		
35270	≤ 2cm greatest diameter	483.48	493.15
35272	> 2cm	698.40	712.37
	c) Resection Results in a Discontinuity Defect (does not include harvesting/placement of graft or fixation)		
35280	Unilateral resection	967.01	986.35
35282	Bilateral resection	1,504.20	1,534.29
	d) Secondary Repair of Discontinuity Defect with Osseous Grafting (Includes Preparation of the Recipient Bed And Flap Mobilization)		
35290	Unilateral	1,063.69	1,084.96
35292	Bilateral	1,611.66	1,643.89
35295	Microvascular repair requiring operating microscope, including closure of defect at donor site	2,578.65	2,630.22
CLEFT LIP AND PALATE SURGERY			
Primary Repair Cleft Lip			
35300	Unilateral repair	628.84	641.42
35302	Bilateral repair	902.88	920.94
Primary Repair Cleft Palate			
35305	Surgical repair	603.34	615.41

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
Secondary Repair Cleft Lip, Palate, Alveolus, Oronasal Fistula			
35310	Soft tissue closure only oronasal fistula	609.10	621.29
35311	Each additional fistula at the same operation	304.55	310.64
35315	Pharyngoplasty or pharyngeal flap	402.93	410.99
35320	Push-back of palate - with pharyngeal flap or similar procedure	590.94	602.76
Secondary Repair Of Cleft Palate, Alveolus, Oronasal Fistula			
35330	Unilateral	730.89	745.51
35332	Bilateral	974.53	994.02
MANAGEMENT OF INFLAMMATORY PROCESSES			
Soft Tissue Incision And Drainage			
35350	Vestibular or subperiosteal abscess	58.97	60.15
35355	Intraoral superficial (buccal, subcutaneous, infraorbital, and infratemporal spaces)	91.36	93.19
35360	Intraoral deep (parapharyngeal, pterygomandibular, masseteric, temporal, sublingual and submandibular spaces)	280.17	285.78
35365	Extraoral superficial (submental, subcutaneous and buccal spaces)	147.94	150.90
35370	Extraoral deep (submandibular, masseteric, pterygomandibular, temporal, parotid, panfacial, and Ludwig's angina)	533.34	544.00
35375	Sequestrectomy for osteomyelitis	275.64	281.16
35380	Sequestrectomy with extensive saucerization and management	670.00	683.40
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	79.48	81.07
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	39.74	40.53
35383	Removal of splint after stabilization if done by another dentist in a different geographic location	48.48	49.45
35400	Implantation and splinting of an avulsed tooth (not including root canal therapy)	344.32	351.21
35402	Reduction of alveolar fracture including debridement and necessary extractions	536.02	546.74

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
II) Facial Trauma			
	Soft Tissue Injuries		
	(a) Simple		
35405	Single layer suture of laceration	130.90	133.51
	(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)	297.62	303.57
	Forehead/Scalp/Neck		
35412	≤ 5cm laceration	255.83	260.94
35413	> 5cm laceration	333.08	339.74
	Nose/Ear/Cheek/Chin		
35415	≤ 5cm laceration	256.21	261.34
35416	> 5cm laceration	333.09	339.75
	Eyelid/Lip		
35420	Complicated Repair	333.09	339.75

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
Hard Tissue Injuries			
	(a) Frontal/orbital		
35430	Frontal sinus fractures	644.66	657.55
35432	Naso-orbital-ethmoid fractures – open	967.01	986.35
35433	Naso-orbital-ethmoid fractures – closed	429.78	438.37
	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	376.04	383.56
35436	Floor of orbit fractures	590.94	602.76
	(b) Midface Fractures		
	Closed Reductions		
35440	Closed reduction of maxilla with arch bars or other tooth anchored fixation	476.41	485.94
35442	Closed reduction of maxilla using gunning type splints or modified dentures and including stabilization of the splints/modified dentures	644.66	657.55
35444	Closed reduction zygomatic complex by temporal or buccal sulcus approach and elevation	243.66	248.53
	Open Reductions		
35451	Le Fort I	1,329.58	1,356.17
35452	Le Fort II	1,482.73	1,512.39
35453	Le Fort III	1,772.84	1,808.30
	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.		

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
35455	Cranioplasty for traumatic/congenital deformities – unilateral	837.85	854.61
35456	Cranioplasty for traumatic/congenital deformities – bilateral	1,256.73	1,281.87
35457	Open reduction of zygomatic arch with the placement of internal fixation	537.21	547.96
35459	Open reduction of zygomatico-orbital complex	730.89	745.51
	(c) Nasal Fractures		
35460	Simple reduction	73.09	74.56
	Septal Surgery		
35461	Correction of post-traumatic and/or developmental deviated nasal septum restricting functional airway - isolated or in combination with maxillary osteotomies	181.05	184.67
35462	Reduction and splinting	146.20	149.12
35464	Comminuted nasal fractures requiring internal fixation	304.55	310.64
	(d) Mandibular Fractures		
	Closed Reductions		
35470	Closed reduction of mandible with arch bars or other tooth anchored fixation	810.21	826.41
35472	Closed reduction of mandible using gunning type splints or modified dentures	1,096.37	1,118.29
	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	1,050.70	1,071.72
35477	Angle/body fracture	1,050.70	1,071.72
	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.		

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
	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	596.89	608.83
	Open Reductions – Extraoral:		
35480	Subcondylar	700.45	714.46
35482	Angle/body	700.45	714.46
35484	Symphyseal/parasymphyseal	596.89	608.83
	(e) Pericranial/Periauricular Flaps (for repair of complicated traumatic injuries or complicated osteotomies)		
35491	Unilateral, add	268.63	274.00
35492	Bilateral, add	376.04	383.56
	(f) Complex Fracture		
35495	Complex Fracture	316.17	322.49
	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	134.30	136.99
35502	Manipulation under anesthesia (as an isolated procedure only)	134.30	136.99
35504	Arthrocentesis (injection or aspiration, as an isolated procedure)	134.30	136.99
35506	Therapeutic arthrocentesis and manipulation for meniscal mobilization (as a separate procedure)	188.03	191.79

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
Open Joint Procedures			
35510	Arthrotomy (open joint procedure)	859.55	876.75
35511	Condyloplasty, add	96.70	98.63
35512	Eminoplasty, add	96.70	98.63
35513	Meniscoplasty or menisectomy, add	96.70	98.63
35514	Muscle flap and/or dermal, facial, bone or cartilage graft, add	109.64	111.83
35515	Alloplastic fossa, meniscus, or condylar surface replacement, add	109.64	111.83
35516	Ramus/condylar head alloplast or bone graft replacement, add	268.63	274.00
35520	Total joint replacement (condyle, ramus and fossa)	1,611.66	1,643.89
Treatment of Temporomandibular Joint Ankylosis			
35525	Gap arthroplasty for ankylosis	1,042.17	1,063.02
35526	Significant surgical soft tissue/muscle release associated with mandibular hypomobility, add	188.03	191.79
35527	Coronoidectomy, add	188.03	191.79
Reoperation			
35530	Reoperation of temporomandibular joint, add 25% to the listed fee for the pertinent repeat surgery.	395.17	403.07
Arthroscopy			
35532	Diagnostic arthroscopy (to include manipulation under anesthesia if necessary)	209.52	213.71
35534	Diagnostic arthroscopy including blunt lysis and lavage of adhesions through a single port technique	424.40	432.89
35536	Arthroscopy if performed in conjunction with immediate open arthrotomy	102.06	104.10
35538	Arthroscopic surgery through more than one port (includes diagnostic arthroscopy)	564.08	575.36

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.

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
(iii)	*Fee item 35530 is not applicable to arthroscopy and also 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 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

This section includes the treatment of both congenital and acquired deformities as well as the treatment of nonunions and malunions of the dentofacial complex.

Interdental Corticotomy or Ostectomy

35550	First tooth per arch	209.52	213.71
35551	Second and subsequent teeth	102.06	104.10

Segmental Osteotomies (Maxilla and Mandible) - as a separate procedure

35560	Per segment	670.00	683.40
35562	Total alveolar osteotomy of mandible	1,241.39	1,266.22

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	414.18	422.46
35572	By ostectomy and/or osteotomy	730.89	745.51
35574	By augmentation bone graft	700.45	714.46
35576	By alloplastic material	395.90	403.82

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	1,035.45	1,056.16
35581	Unilateral – extraoral	1,096.38	1,118.31
35583	Bilateral – intraoral	1,675.00	1,708.50
35584	Bilateral – extraoral	1,766.36	1,801.69

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
Body Osteotomies			
35586	Unilateral	1,035.45	1,056.16
35587	Bilateral	1,675.00	1,708.50
35589	Inferior border osteotomy/ostectomy	791.83	807.66
	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	1,035.45	1,056.16
35592	Bilateral	1,705.47	1,739.58
35595	Post traumatic or syndrome associated reconstruction of zygoma/zygomatic arch with autogenous/alloplastic materials (includes placement of graft only - not harvesting)	609.10	621.29
Maxillary Osteotomies			
35600	Le Fort I	1,705.47	1,739.58
35601	First additional segment	194.91	198.81
35602	Each additional alveolar segment	97.45	99.40
35605	Le Fort II	2,070.91	2,112.32
35607	Le Fort III, extracranial	2,923.66	2,982.13
35608	Le Fort III, intracranial	3,654.55	3,727.64
35610	Orbital rim osteotomies (intracranial approach) – unilateral	2,923.66	2,982.13
35611	Orbital rim osteotomies (intracranial approach) – bilateral	3,654.55	3,727.64
	Note: *When maxillary and mandibular osteotomies are performed at the same operation, both shall be paid at full fee.*		
35620	Unilateral – intraoral	901.46	919.48
35621	Unilateral – extraoral	1,096.38	1,118.31
35624	Bilateral – intraoral	1,388.73	1,416.50
35625	Bilateral – extraoral	1,583.64	1,615.31
Other			
35630	When rigid fixation is used for osteotomies or treatment of traumatic injuries pay at 10% of the fee for each procedure/jaw	358.43	365.60
35632	Reoperation of a dentofacial deformity - add 25% of the listed fee for the pertinent repeat surgery.	1,623.38	1,655.85
	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		

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
35634	Distraction osteogenesis - surgical application of distraction devices associated with osteotomies - paid at 20% of the listed osteotomy fee.	716.85	731.18
35636	Placement of arch bars or other tooth anchored fixation	335.03	341.73
	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.		
35638	Placement of gunning type splints or modified dentures stabilized with wire or screw fixation	426.35	434.88
	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.		
35640	Cheiloplasty (V/Y, double V/Y closure) in conjunction with a Le Fort I osteotomy	118.18	120.54

Removal of Intraoral and Extraoral Fixation Devices

Notes:

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

ii) May be paid within 8-week post-operative period if removed by other than surgeon who placed the original fixation device due to patient distance from original surgeon. Note record required.

35642	Removal of splints, suspension ligatures, and/or arch bars, per jaw	121.81	124.24
	***Note**: Payable only once per jaw, regardless of number of devices removed or location*		
35647	Removal of splints, suspension ligatures, and/or arch bars from alternate jaw at same surgery	60.90	62.12
	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.		
35643	Removal of intraosseous wires/pins via an intraoral approach	214.87	219.17
35645	Removal of internal fixation devices by an intraoral or extraoral approach and intraosseous wires by an extraoral approach only	438.55	447.32

NASAL SURGERY

Turbinectomies

35650	In conjunction with maxillary osteotomy - unilateral, add	79.20	80.79
35651	In conjunction with maxillary osteotomy - bilateral, add	103.57	105.64

Closure Oronasal Fistula

35656	Transpositional flap closure	225.61	230.13
35657	Arterial pedicle flap closure	403.06	411.12
35659	Tongue flap closure	452.65	461.70

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
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.*	292.36	298.21
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)	161.17	164.39
Harvesting of Hard Tissue Grafts			
35680	Local sites (through the same incision as the primary surgical procedure), add ***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;* *(iii) Using bone harvested during a maxillary superior repositioning is included in the maxillary surgical procedure.*	42.97	43.83
Harvesting Hard/Soft Tissue Grafts			
35683	Local site (through separate incision from that of primary surgical procedure), add	127.91	130.47
35685	Distant site (separate extra oral incision), add	365.47	372.78
REMOVAL FOREIGN BODIES			
a) Removal of foreign body from soft tissue (as a separate procedure only)			
35690	Within deep tissue	365.34	372.65
35692	Superficially located	102.45	104.50
b) Removal of foreign body from bone (as a separate procedure only and not to include dental implants)			
35695	Surgical removal	322.34	328.79

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
NEUROSURGICAL PROCEDURES ASSOCIATED WITH ORAL-MAXILLARY FACIAL SURGICAL PROCEDURES			
35701	Primary nerve repair	234.26	238.95
35702	Secondary nerve repair	525.22	535.72
35704	Nerve repair with graft	1,193.82	1,217.69
35706	Decompression/transposition of mandibular nerve	320.37	326.78
ANTRAL SURGERY			
35711	Immediate recovery of a tooth or foreign body from the maxillary antrum	102.06	104.10
35712	Secondary recovery of a tooth or foreign body from the maxillary antrum	322.34	328.79
35715	Radical antrostomy/Caldwell Luc	376.04	383.56
35717	Nasal antrostomy	121.99	124.43
35720	Closure of an oral antral fistula - immediate closure - sliding advancement buccal flap with periosteal release (not to be billed with codes 35711/35715)	222.79	227.24
35722	Closure oral antral fistula - secondary closure - buccally pedicled transposition flap using fat/muscle/mucosa (not to be used for simple closures)	236.37	241.10
35723	Closure oral antral fistula - secondary closure - gold foil technique	268.63	274.00
35724	Closure oral antral fistula - secondary closure - palatal island flap closure	435.05	443.75
35726	Antral lavage - unilateral (as a separate procedure)	36.55	37.28
35727	Antral lavage - bilateral (as a separate procedure)	67.01	68.35
35729	Diagnostic sinus endoscopy, with or without biopsy	115.71	118.02
35730	Sinus endoscopic surgical procedure	304.55	310.64
SALIVARY GLANDS			
35740	Dilation of salivary duct	43.39	44.26
35742	Sialodochoplasty	134.30	136.99
35744	Repair of salivary fistula	490.14	499.94
Intraductal sialolithotomy			
35747	Submandibular	134.30	136.99
35749	Parotid	274.11	279.60
35752	Intraglandular sialolithotomy	295.46	301.37
35754	Excision of sublingual gland, intraorally	335.85	342.56
35756	Excision of submandibular gland	429.78	438.37
35758	Excision ranula/superficial	95.71	97.62
35760	Excision ranula/plunging	429.78	438.37
35762	Removal benign parotid tumour	913.65	931.93

Fee Code	Description	$Apr 1, 2019	$Apr 1, 2020
DENTOALVEOLAR COMPLICATIONS			
35770	Treatment of a dentoalveolar complication resulting from treatment by another surgeon	48.36	49.33
35771	Treatment of a dentoalveolar complication resulting from treatment by another surgeon - subsequent office visits past 8 weeks of surgery for ongoing complications.	27.39	27.93
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.	560.38	571.59
35801	Surgical assistant	429.78	438.37
35802	After three hours continuous surgical assistance for one patient, for each additional 15 minutes, or fraction thereof, add	26.86	27.39

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 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)*
- *Traumatic injuries of the teeth and skeleton (fee codes 35400, 35402, and 35440)*
- *Soft tissue injuries (fee codes 35405, 35412 and 35415 unless there are multiple lacerations and/or associated with other injuries)*
- *Temporomandibular joint (fee codes 35500, 35502, and 35504)*
- *Removal intra-oral and extra-oral fixation devices (fee codes 35642 and 35643)*
- *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.