Ministry of Health

Healthy Smiles Ontario Schedule of Dental Services and Fees for Dentist Providers

Effective January 1, 2016

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Ontario

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The Healthy Smiles Ontario Schedule of Dental Services and Fees for Dentist Providers is not intended nor should it be relied upon to determine the scope of practice of dentists in Ontario. The Schedule is an administrative tool distributed to dentists, so that they may provide services to clients in the Healthy Smiles Ontario program and bill for the services provided. Questions regarding the scope of practice of dentists in Ontario should be referred to the Royal College of Dental Surgeons of Ontario (RCDSO).

Table of Contents

The Schedule Explained

This schedule describes the services covered and eligible for payment under the Healthy Smiles Ontario (HSO) Program for dentist providers recognized by the Royal College of Dental Surgeons of Ontario. Specific limitations are noted in the "limit" column where applicable. Some services require pre-authorization. For these services, "pre-authorization required" is stated in bold in the limit column of the Schedule. Criteria for pre-authorization are also described in the "limit" column.

This schedule also includes services and specific limitations for the Dental Special Care Plan (DSCP). DSCP services and limitations are denoted in a bolded, shaded box within the schedule marked "DSCP".

Healthy Smiles Ontario Program

The HSO Program provides free dental care for eligible children and youth aged 17 and under. HSO has three streams to address a continuum of oral health need in the eligible population:

- The Core Services Stream;
- The Emergency and Essential Services Stream; and
- The Preventive Services Only Stream (delivered through Public Health Unit clinics).

Eligibility for the HSO Program

Core Services Stream

Children from low-income families are eligible for the Healthy Smiles Ontario program if they meet the following criteria:

- 17 years of age or younger; and

- Resident of Ontario; and
- Adjusted Family Net Income at or below the level at which they would qualify for at least 90% of the maximum Ontario Child Benefit.

Income eligibility is based on a household's Adjusted Family Net Income (AFNI), as is the case for the Ontario Child Benefit (OCB), and adjusts based on the number of dependent children.

In addition, social assistance recipients, or children from families in receipt of social assistance benefits, 17 years of age and under, will be automatically enrolled in the Healthy Smiles Ontario Program. Specifically, this includes children aged 17 and under in receipt of:

- Basic financial assistance or extended health benefits under Ontario Works (including Temporary Care Assistance but excluding Emergency Assistance);
- Income support or Extended Health Benefits or Transitional Health Benefits under the Ontario Disability Support Program; or
- Assistance for Children with Severe Disabilities (child in receipt of the benefit only).

Children of families with other insurance are not excluded; however they are required to access their other dental insurance prior to accessing the HSO Program.

Emergency and Essential Services Stream (EESS)

The HSO program includes the Emergency and Essential Services Stream (EESS) to address emergency and/or essential dental needs. Eligibility for the EESS is determined by clinical assessment and attestation of financial hardship by the child (parent/guardian).

I. Clinical Eligibility:

A child/youth is identified with an emergency or essential dental condition, where:

Emergency: The patient presents with pain, infection, haemorrhage, trauma, or pathology that requires immediate clinical treatment.

Essential: The patient presents with lost restorations, caries into the dentine, periodontal conditions, or pathology that, without treatment, will lead to haemorrhage, pain or infection requiring immediate clinical treatment.

Where:

- Pain is defined as a condition(s) which is/are presently causing pain or have/has caused pain in the week immediately preceding (excluding pain related to exfoliation and/or eruption of teeth);
- Infection is defined as abscesses and/or acute gingival conditions requiring immediate clinical treatment (e.g. necrotizing ulcerative gingivitis);
- Haemorrhage is defined as a sudden or serious loss of blood associated with trauma to the orofacial tissues;
- Trauma is defined as injury to the orofacial tissues that requires clinical treatment;
- Caries is defined as open carious lesions into the dentine. The lesions should be obvious enough that the parent or guardian can easily see them. Lesions would be equivalent to the International Caries Detection and Assessment System (ICDAS) codes 5 or 6[1];

Periodontal conditions are defined as a condition of the periodontium which is not reversible by adequate oral hygiene, and require clinical treatment; and

- Pathology is defined as any specific pathological condition of the orofacial tissues where investigation is required for diagnosis and clinical treatment[2].

[1] ICDAS Foundation. International Caries Detection and Assessment System (ICDAS) [Internet]. Leeds, UK: ICDAS Foundation; c2017 [cited 2017 Dec 29]. Available from: https://iccms-web.com/content/icdas

[2] Regezi JA, Sciubba JJ , Jordan RCK. Oral pathology: clinical pathologic correlations. 6th ed. St. Louis, MO: Elsevier; 2012.

II. Financial Eligibility:

The child/youth or family's income is equivalent to a level at which they would be in receipt of the Ontario Child Benefit; OR

The child/youth or family would suffer "financial hardship" if providing the necessary dental care would result in any one of the following:

- Inability to pay rent/mortgage;
- Inability to pay for household bills;
- Inability to buy groceries for the family; or
- The child/youth or family will be required to seek help from a food bank in order to provide food.

Children and youth meeting the eligibility criteria for the EESS will be enrolled by the Public Health Unit or a fee-for-service provider. The majority of children will be identified and enrolled by local Public Health Units; however there may be some circumstances where a child may be identified by a fee-for-service provider (e.g., outside of business hours). If the fee-for-service provider performs an examination to determine clinical eligibility for the EESS, the provider will be reimbursed for an emergency or specific examination.

- If the child is determined to be clinically eligible for the EESS, the child (parent/guardian) may fill out an application form for the EESS, including attesting to financial hardship. Further details on enrolment for the EESS are described on page 11 below.
- If the child is determined to be clinically ineligible for the EESS (does not present with an emergency and/or essential dental condition), the child (parent/guardian) is not required to attest to financial hardship on the EESS application form. The provider must indicate on the EESS application form that the child/youth was ineligible. The provider must then submit the application form to Accerta (via mail or secure fax). Accerta will respond with an ID number to permit billing for the exam.

Children and youth enrolled in the EESS have access to the full basket of services covered in the Schedule. They will have 12 months to complete their treatment from the date of their enrolment, or up to the date of their 18th birthday (the earlier of the two dates), as indicated by the expiry date on the front of their HSO dental card. Children and youth enrolled in the EESS will not be *automatically* re-assessed on an annual basis but can re-apply.

Note: Children and youth that present after hours with a dental emergency and who meet the clinical and financial criteria for EESS are covered for a limited basket of emergency services prior to full enrollment (which can only be completed during business hours Monday-Friday 8am-8pm). See "After-Hours Emergency Visits" on page 17 for details.

Program Enrolment

Core Services Stream

To apply for dental coverage through the Healthy Smiles Ontario Program, applicants (the child or parent/guardian) must complete and submit an application to the Ministry of Health and Long-Term Care.

There are two ways to apply:

1. Through an online application portal at www.ontario.ca/healthysmiles (English) or www.ontario.ca/beauxsourires (French). To complete the application, a signed Consent Form must also be completed and mailed.
2. By mailing an HSO application form. Applicants can download application forms from the HSO website at www.ontario.ca/healthysmiles (English) or www.ontario.ca/beauxsourires (French) or obtain application forms from their local Public Health Unit or Service Ontario locations. Completed applications must be mailed to:

Healthy Smiles Ontario
33 King Street West
PO Box 645
Oshawa ON
L1H 8X1

Applicants will receive a notification by mail once the application form has been processed.

Once a child or youth is enrolled in the Healthy Smiles Ontario Program, their eligibility will be automatically assessed each benefit year and annual notices will be sent to the client on their enrolment status. The full benefit year runs from August 1 – July 31 each year. Applications may be submitted at any time during the year.

Eligible social assistance recipients and/or children from families in receipt of social assistance benefits 17 years of age and under will be automatically enrolled in the Healthy Smiles Ontario Program.

Emergency and Essential Services Stream (EESS)

Once a child has been identified with an emergency and/or essential dental condition, they may apply to the Emergency and Essential Services Stream of the HSO program. Applicants must complete an EESS application form and attest to financial hardship (defined on page 9). The EESS is designed to ensure that no child goes without emergency or essential dental care due to the inability to pay.

Applicants may enrol for the EESS through their local Public Health Unit or through a fee-for-service dental provider. It is expected that the majority of children will continue to be identified and enrolled by local Public Health Units; however there may be some circumstances where a child may be identified by a fee-for-service provider and/or may seek service directly at a dental office.

A child/youth must meet both clinical and financial eligibility criteria for the EESS. Providers are asked to assess the child/youth for clinical eligibility and assist the child/youth and/or family to complete the EESS application form which includes attesting to financial hardship.

EESS application forms will be available online at www.ontario.ca/healthysmiles (English) or www.ontario.ca/beauxsourires (French) as of January 1, 2016.

EESS application forms must be mailed or submitted via secure fax to Accerta for processing:

AccertaClaim Servicorp Inc.
Healthy Smiles Ontario Contact Centre
Station P, P.O. Box 2286
Toronto, ON
M5S 3J8
Secure Fax: 416-354-2354 or toll-free at 1-877-258-3392

Eligibility will be assessed and confirmed by the Program Administrator as quickly as possible. Application forms submitted that do not require any clarification, follow-up and/or additional information will be processed within 15 minutes when received by fax during Accerta's Contact Centre business hours (Monday to Friday 8am-8pm). If an EESS application form is received outside of regular business hours, the application will be processed when regular business hours resume and a response will be provided to the provider with an eligibility determination within one business day.

Once enrolment has been confirmed and the provider has been notified by fax or telephone, the provider may proceed with treatment. An HSO dental card will be mailed to the client by Accerta. The dental provider may also choose to notify the client of the result of their application.

Children and youth enrolled in the EESS will have access to the full basket of services covered in the Schedule. They will have 12 months to complete their treatment from the date of enrolment, or up to the date of their 18th birthday (the earlier of the two dates), as indicated by the expiry date on the front of their dental card. Children and youth enrolled in the EESS will not be automatically re-assessed on an annual basis however they can re-apply.

In situations [which are expected to be limited] where a fee-for-service provider performs an examination to determine clinical eligibility for the EESS, and the child/youth is deemed clinically ineligible, the provider will still be

reimbursed for an emergency or specific examination. The provider must indicate on the EESS application form that the child/youth was clinically ineligible. The provider must then submit the application form to Accerta (via mail or secure fax). Accerta will respond with an ID number to permit billing for the exam.

Length of Eligibility

Core Services Stream

Each HSO dental card is issued for a full benefit year (August 1—July 31) or up to the date of the client's 18th birthday (the earlier of the two dates), as indicated by the expiry date on the front of the card. Enrolment is automatically re-assessed on an annual basis.

Emergency and Essential Services Stream

Eligibility duration for EESS is based on a 12 month rolling duration from the date of enrolment. Children and youth enrolled in the EESS have 12 months to complete their treatment from the date of their enrolment, or up to the date of their 18th birthday (the earlier of the two dates), as indicated by the expiry date on their dental card. Once enrolled, children and youth will be eligible to receive the services required to treat their emergency and/or essential dental conditions. Children and youth enrolled in the EESS will not be re-assessed on an annual basis but can re-apply.

Verification of Eligibility: Healthy Smiles Ontario Dental Card

Once a client has been deemed eligible for the program, a Healthy Smiles Ontario dental card will be issued and mailed.

Core Services Stream

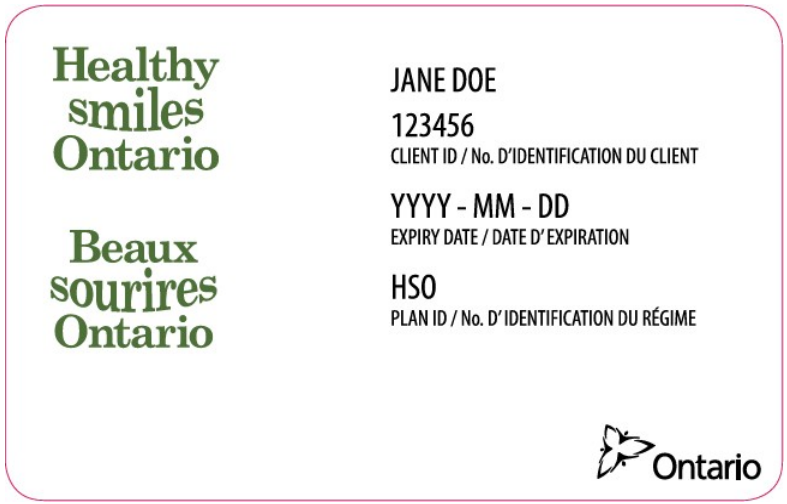
Cards for children and youth enrolled in the Core Services Stream are valid for up to one benefit year (August 1 – July 31) from the enrolment date and will expire at the end of each benefit year (July 31) or the 18th birthday of the recipient (the earlier of the two dates), as indicated by the expiry date on the front of their HSO dental card.

Emergency and Essential Services Stream

Cards for children and youth enrolled in the EESS are valid for 12 months from the date of enrolment, or up to the date of their 18th birthday (the earlier of the two dates), as indicated by the expiry date on the front of their HSO dental card.

The HSO dental card is non-transferable and can only be used by the registered child. Clients must present their dental card to the dental provider at each visit in order to obtain services. Dental providers should not render services under the HSO Program unless a valid HSO card is presented.

A sample of the Healthy Smiles Ontario dental card is show below.



In situations of misuse of a dental card by the client, Accerta will immediately terminate the child's coverage under the program and may seek reimbursement directly from the client for services rendered. In these instances, Accerta is responsible for notifying the dental provider that the client is no longer eligible for dental services under the Program. Claims rendered in good faith prior to this date will be processed.

For lost or stolen cards, the client and/or parent/guardian must contact the ServiceOntario INFOline toll-free at 1-

844-296- 6306 (Canada). TTY users can call 416-327-4282 (TTY GTA) or toll-free at 1-800-387-5559 (TTY Canada).

Dental Special Care Plan

The Dental Special Care Plan provides coverage for additional services and/or limitations for Ontario Disability Support Program (ODSP) and Assistance for Children with Severe Disabilities (ACSD) clients whose medical and/or psychosocial condition, or prescribed medication or medical treatment impacts their oral health and/or dental treatment. Or whose oral health impacts their medical and/or psychosocial condition and/or their medical treatment.

DSCP services and limitations are denoted in a bolded, shaded box within the schedule marked “DSCP”. DSCP services include:

- Additional Recall Examinations (01202)
- Additional Polishing (11101, 11107)
- Additional Scaling/Root Planing (11111-11119, 43421-43429)
- Additional Fluoride (12111, 12112, 12113)
- Additional Topical Application to Hard Tissue Lesion(s) of Antimicrobial or Remineralization Agent (13601)
- Custom Fluoride Appliances (12601, 12602)
- Periodontal Appliances (14611-14612)
- Crowns (27211, 27215, 27301)
- Periodontal Surgery, Grafts, Soft Tissue (42511,42521,42531,42551, 42552, 42561)

A treating provider can submit a request to enrol a child in the DSCP using a standard dental pre-treatment form which must include:

- Dentist name, address & unique identification number;

- Dentist signature (using Ontario Dental Association issued “Office verification stamp”);
- Client name & HSO number;
- The medical and/or psychosocial condition, prescribed medication or medical treatment that impacts their oral health and/or dental treatment AND/OR their oral health condition that impacts their medical and/or psychosocial condition and/or their medical treatment; and
- If available, a list of any supporting documentation provided (e.g., letter from physician/specialist, etc.).

This enrollment request must clearly indicate “DSCP” and must be submitted by the provider to Accerta, with any supporting documentation. The request and supporting documentation will be reviewed by Accerta. A response will be provided by telephone or fax within 2 business days from the date the pre-authorization request is received.

Once Accerta has confirmed eligibility, DSCP clients can receive DSCP services and limitations in the Schedule for up to 5 years or up to the date of their 18th birthday as long as they continue to be eligible for HSO. For DSCP clients requiring crowns (codes 27211, 27215 and 27301), providers must identify or list the pre-authorization criteria described in the “limit” column.

Prior to the child’s DSCP eligibility expiration date, providers will be notified by Accerta to re-submit a new DSCP pre- authorization request.

After-Hours Emergency Visits

An after-hours emergency situation occurs when a child or youth not enrolled on the HSO Program presents at a dental clinic with an emergency dental condition outside of the Program Administrator's Contact Centre business hours (Monday to Friday 8am-8pm).

If the child meets the clinical eligibility requirements for EESS, the dental provider must have the child (parent/guardian) complete and sign the EESS application form. This includes attesting to financial hardship as defined on the application form. This ensures that the eligibility criteria for the EESS have been met and the child (parent/guardian) has provided consent for the collection, use and disclosure of their information for purposes of delivering and administering the HSO program.

The following business day, providers must submit the completed and signed application form to Accerta. Accerta will notify the dental provider the following business day to confirm whether the child has been successfully enrolled onto the EESS and to provide the child's unique HSO number. The dental provider will then submit any claims for emergency services performed during the visit using the client's HSO number. Once enrolment has been confirmed, the dental provider may also proceed with any subsequent treatment of emergency or essential dental conditions. An HSO dental card will be mailed to the client. The dental provider may also choose to notify the client of the result of their application.

If the child does not meet the clinical eligibility for EESS, the provider must have the child (parent/guardian) complete and sign Sections 1, 2, and 4 only in the EESS application form.

The following business day, providers must submit the application form to Accerta. Accerta will notify the provider the following business day to provide the child's unique HSO number. The provider can then submit a claim for an emergency or specific examination.

For children/youth already enrolled in HSO (presents with a valid HSO dental card), providers will be reimbursed for any services within the limitations described in the Schedule. An emergency or specific exam and any radiographs

will also be reimbursed in the event the child/youth has exceeded the limitations in the Schedule.

Only treatment for the relief of pain for the presenting emergency condition will be covered prior to Accerta enrolling the child onto the EESS. Only the services in the table below will be considered for payment at the fees set out in the Schedule.

Code(s)	Service Description	Limitation
01205	Examination and Diagnosis, Emergency Examination	
02111 02112 02113	Radiographs, Periapical	Maximum 3 per emergency visit, per patient, per dentist, per address.
02131	Radiographs, Occlusal	Maximum 1 per emergency visit, per patient, per dentist, per address.
02141 02142	Radiographs, Bitewing	Maximum 2 per emergency visit, per patient, per dentist, per address.
02601	Radiographs, Panoramic	Maximum 1 per emergency visit, per patient, per dentist, per address.
20111 20119	Caries/Trauma/Pain Control (removal of carious lesions or existing restorations or gingivally attached tooth fragment and placement of sedative/protective dressings, includes pulp caps when necessary, as a separate procedure)	
20121 20129	Caries/Trauma/Pain Control (removal of carious lesions or existing restorations or gingivally attached tooth fragment and placement of sedative/protective dressings, includes pulp caps when necessary and the use of a band for retention and support, as a separate procedure)	

Code(s)	Service Description	
21111-21115	Restorations, Amalgam, Non-Bonded, Primary Teeth	Restrictions apply. Refer to "Restorative Services" in the Schedule.
21121-21125	Restorations, Amalgam, Bonded, Primary Teeth	
21211-21215	Restorations, Amalgam, Non-Bonded, Permanent Bicuspids and Anteriors	
21221-21225	Restorations, Amalgam, Non-Bonded, Permanent Molars	
21231-21235	Restorations, Amalgam, Bonded, Permanent Bicuspids and Anteriors	
21241-21245	Restorations, Amalgam, Bonded, Permanent Molars	
22201 22211	Restorations, Prefabricated, Metal, Primary Teeth	Restrictions apply. Refer to "Restorative Services" in the Schedule.
22301 22311	Restorations, Prefabricated, Metal, Permanent Teeth	
22401	Restorations, Prefabricated, Plastic, Primary Teeth	
22501	Restorations, Prefabricated, Plastic, Permanent Teeth	
23401-23405	Restorations, Tooth Coloured, Primary Anterior, Non Bonded	
23501-23505	Restorations, Tooth Coloured / Plastic With / Without Silver Filings, Primary, Posterior, Non Bonded	
23101-23105	Restorations, Tooth Coloured Permanent Anteriors Non Bonded Technique	
23211-23215	Restorations, Tooth Coloured / Plastic With / Without Silver Filings, Permanent Posteriors, Non Bonded Permanent Bicuspids	

Code(s)	Service Description	Limitation
23221-23225	Restorations, Tooth Coloured / Plastic With / Without Silver Filings, Permanent Posteriors, Non-Bonded Permanent Molars	Restrictions apply. Refer to "Restorative Services" in the Schedule.
23411-23415	Restorations, Tooth Coloured, Primary Anterior, Bonded Technique	
23511-23515	Restorations, Tooth Coloured / Plastic, Primary Posterior, Bonded Technique	
23111-23115	Restorations, Permanent Anteriors, Bonded Technique (not to be used for Veneer Applications or Diastema Closures)	
23311-23315	Restorations, Tooth Coloured, Permanent Posteriors - Bonded Permanent Bicuspids	
23321-23325	Restorations, Tooth Coloured, Permanent Posteriors - Bonded Permanent Molars	
32221 32222	Pulpotomy, Permanent Teeth (as a separate emergency procedure)	Restrictions apply. Refer to "Endodontic Services" in the Schedule.
32231 32232	Pulpotomy, Primary Teeth	
32311-32314	Pulpectomy, Permanent Teeth / Retained Primary Teeth	
32321 32322	Pulpectomy, Primary Teeth	

Code(s)	Service Description	Limitation
42831	Periodontal Abscess or Pericoronitis, may include one or more of the following procedures: Lancing, Scaling, Curettage, Surgery or Medication	Maximum 1 per emergency visit, per patient, per dentist, per address.
71101 71109	Removals, Erupted Teeth, Uncomplicated	
71201 71209	Removals, Erupted Teeth, Complicated	
72311 72319	Removals, Residual Roots, Erupted	
72321 72329	Removals, Residual Roots, Soft Tissue Coverage	
72331 72339	Removals, Residual Roots, Bone Tissue Coverage	
75111	Surgical Incision and Drainage and/or Exploration, Intraoral , Soft Tissue	
76941 76949	Replantation, Avulsed Tooth/Teeth (including splinting)	
76951	Repositioning of Traumatically Displaced Teeth	
76961 76962	Repairs, Lacerations, Uncomplicated, Intraoral or Extraoral	
79602 79604	Post Surgical Care (Required by complications and unusual circumstances)	

Once the child is enrolled onto the EESS, the child will have access to all of the services in the HSO Schedule. The services delivered during the emergency appointment will count towards the limitations in the HSO Schedule.

Pre-Authorizations

Eligible children may be granted access to additional services and/or limitations in the schedule. For these services,

"**pre-authorization required**" is stated in the limit column of the Schedule. Criteria for pre-authorization are also described in the "limit" column. Pre-authorization is required prior to beginning treatment.

A dental provider may submit a pre-authorization request using a standard dental pre-treatment form. Pre-authorization requests must include:

- Dentist name, address & unique identification number;
- Dentist signature or stamp (using Ontario Dental Association issued "Office verification stamp");
- Client name & HSO number;
- The services that are recommended (including total number of units);
- Identification or listing of pre-authorization criteria;
- If available, a list of any supporting documentation provided (e.g., letter from physician/specialist, etc.)

Pre-authorization requests must be submitted by the dental provider to Accerta with any supporting documentation. The dental provider must note pre-authorization criteria on the request as indicated in the "limit" column of the Schedule.

The request and any supporting documentation will be reviewed by Accerta. Accerta will respond to pre-authorization requests within 2 business days from the date the pre-authorization request is received. Once approved, pre- authorizations are valid for up to 12 months provided the client remains eligible and enrolled in the Program.

Submission of Dental Claims

Treating dentists must submit a claim form to Accerta to obtain payment for services rendered under this Program. By submitting a claim for services under this program, the dentist is assumed to have accepted the terms and conditions set out in this Schedule.

Claims may be mailed, sent via secure fax, or submitted electronically (EDI) to Accerta:

AccertaClaim Servicorp Inc.
Healthy Smiles Ontario Contact Centre
Station P, P.O. Box 2286
Toronto, ON
M5S 3J8

Secure Fax: 416-354-2354 or toll-free at 1-877-258-3392

Accerta Carrier Code: 311140

For mailed paper-based claims forms, the treating dentist must sign, or stamp [using Ontario Dental Association (ODA) issued "Office verification stamp"] each claim form submitted. Additionally, treating dentists must list their unique identification number under the "Unique No" field of the Dentist section of the form. The "Patient Signature" section does not apply to the program, and therefore should not be signed by the patient. If using the "Standard Dental Claim Form", the client's identification number located on the front of their HSO dental card should be listed under the "Patient ID No" field of the "Patient Information" section of the form. In the "Employee/Plan Member/Subscriber" section of the form, the "Group Policy No" should be listed as "HSO". Accerta's carrier code 311140 should be listed under the "Division/Section No." The name of the program (Healthy Smiles Ontario) should be listed under "Name of Insuring Agency or Plan" field.

For EDI submission of claims, transmission types include:

1. Dental Claim Submission
2. Dental Claim

Reversal EDI responses include:

1. Explanation of Benefit (EOB)
    a. Results of adjudication.
    b. Partial or full reimbursement notices.
2. Acknowledgements (ACK)
    a. Response status message indicates the reason for the response.
        i. Claim is rejected because of errors (please call Accerta at 416-363-3377 or toll-free at 1-877-258-2658 for assistance).
        ii. Claim is received successfully by the carrier and is held for further processing.

The Primary Policy/Plan Number is HSO. Please use Accerta's carrier code 311140 by adding it under the Instream network.

Claim forms must be completed using Fédération Dentaire Internationale (FDI) nomenclature and tooth charting codes (i.e., international tooth numbers). Incomplete forms include forms with incorrect, illegible, or missing information and will be returned for clarification and/or correction. If it is necessary to re-submit a claim form, it must be clearly marked "duplicate".

Providers should endeavour to submit claims for initial processing within **30 days** from the date the services were provided. Claims are to be sent in as treatment occurs, except for multiple appointment procedures, such as root canals, which should be submitted on completion of the treatment.

Accerta, on behalf of the Ministry of Health and Long-Term Care, reserves the right to require the submission of further information by the provider to substantiate a claim, in accordance with applicable law (including, for greater certainty, claims for which payment may have already been made at the time of the request).

Dental providers will not be reimbursed for retroactive billing for services rendered to children before they were enrolled onto the HSO Program except for the specific list of emergency services noted under the EESS (for after-hours/emergency circumstances).

If services are rendered without a valid HSO dental card, or if services provided are not covered and paid under the Program as described in this Schedule, service providers may be responsible for making payment arrangements directly with the child (parent/guardian).

Service providers agree to repay to Accerta, or the Ministry of Health and Long-Term Care, on demand, any amounts that may be paid in respect of: fraudulent claims, claims for which reasonably requested supporting information is not provided, claims that are not submitted in accordance with any of the terms set out in this Schedule, or payments that may be made in error.

Claims Processing and Adjudication

In order to ensure that the correct practitioner is reimbursed and that reimbursement is sent to the correct practice address, the following information is required on all claim forms:

- The treating dentist's name;
- The treating dentist's unique identification number; and
- The treating dentist's address.

Extra billing is not permitted for services covered and paid for under this Schedule. A dentist may bill the client (parent/guardian) for services not covered and not paid for under this Schedule.

Providers can find information about claims, pre-authorizations and payment by accessing Accerta's secure web portal AccertaWorX at https://accertaworx.accerta.ca

AccertaWorX also provides access to electronic copies of the HSO Schedule(s), program forms and newsletters.

To gain access to AccertaWorX, dental providers must complete and sign an application form. Application forms can be obtained by contacting Accerta.

Reimbursement Rates

The maximum payable fees for HSO covered services are set out in this Schedule. Providers may not extra-bill for services covered and paid for under this Schedule.

Specialists recognized by the Royal College of Dental Surgeons of Ontario will be reimbursed at the specialist rate with or without a referral from another dental or health practitioner.

The Ministry of Health and Long-Term Care will notify practitioners if changes are made to the Schedule.

Coordination of Benefits

Any existing dental insurance coverage for clients must be utilized before resorting to the HSO Program. As well, if a specific service is not covered in the private insurance plan's fee schedule (e.g., the patient has exhausted the total value of their coverage, or their plan offers a specific service at a lesser frequency/volume than HSO), benefits may be coordinated.

Authorized Service Providers

Children and youth can receive services through a local Public Health Unit, community dental clinic and/or a participating fee-for-service dental professional. Participating providers include:

- A dentist in good standing with the Royal College of Dental Surgeons of Ontario (RCDSO);
- A registered dental hygienist in good standing with the College of Dental Hygienists of Ontario (CDHO);
- A registered denturist in good standing with the College of Denturists of Ontario (CDO); or
- A physician anaesthetist in good standing with the College of Physicians and Surgeons of Ontario.

Referrals to Other Providers/Specialists

If a referring dentist completes an examination (with or without radiographs) and refers all treatment to another provider, the first dentist will be reimbursed for an emergency or specific examination and any radiographs.

Responsibility of the Program Administrator (Accerta)

Accerta is responsible for enrolling children and youth onto the HSO program and issuing dental cards for enrolled clients. Accerta also re-issues expired, lost or misplaced cards to eligible clients according to program policies.

Accerta reviews, processes and adjudicates all Healthy Smiles Ontario claims. Accerta is responsible for remitting remuneration to treating dentists for completed claims as soon as reasonably possible, and not more than thirty (30) days after receipt of a claim or invoice where no follow-up, clarifications and/or further action is required. Accerta also reviews, processes and adjudicates all pre-authorization requests, including requests for the DSCP.

Accerta is also responsible for coordinating benefits for clients and addressing a variety of inquiries from clients, their families and providers.

Program Administrator Contact Information

AccertaClaim Servicorp Inc.
Healthy Smiles Ontario Contact Centre
Station P, P.O. Box 2286
Toronto, ON
M5S 3J8

Accerta Carrier Code: 311140
Telephone: 416-363-3377 / 1-877-258-2658
Secure Fax: 416-354-2354 / 1-877-258-3392
Email: HSOInfo@accerta.ca

For information about claims, pre-authorizations and payment, providers may access Accerta's secured web portal AccertaWorX at https://accertaworx.accerta.ca

AccertaWorX also provides access to electronic copies of the HSO Schedule(s), program forms and newsletters.

To gain access to AccertaWorX, dental providers must complete and sign an application form. Application forms can be obtained by contacting Accerta.

Responsibility of the Local Public Health Unit

Public Health Units are responsible for assisting children and/or families to enrol in the Healthy Smiles Ontario Program. Public Health Units will help children and families to establish a dental home, including helping to ensure that young children receive their first dental visit within 6 months of the eruption of the first tooth, or by one year of age.

Public Health Units have a role in identifying children and youth in need of dental services and providing oral health services (where clinics are in operation) and/or assisting clients in finding participating providers.

Public Health Units will also provide case management (e.g., following children from screening to ensure treatment is initiated) and providing follow-up services to clients and their families, including communicating with Accerta and dental providers to ensure that clients have completed treatment.

Public Health Unit Contact Information

Contact information for all Public Health Units in Ontario can be found on the Ministry of Health and Long-Term Care's website using the following URL: www.ontario.ca/healthysmiles

Notice of Collection

Personal Health and other Information collected for the purposes of the Healthy Smiles Ontario Program, is collected under the authority of the *Health Protection and Promotion Act, 1990* and the *Personal Health Information Protection Act, 2004*. This information is used for claims payment and program management. Questions concerning the collection of this information should be directed to the relevant Public Health Unit (where relevant and/or known), the Ministry of Health and Long-Term Care or Accerta.

Consent pertaining to the collection, use and disclosure of personal information is included on the Healthy Smiles Ontario Application Form(s) and Parent Notification Forms (PNF). The collection of this consent authorizes the dental provider to release confidential personal information contained on the forms to Accerta, the Ministry of Health and Long-Term Care and local Public Health Units for the purposes of delivering the Program.

Privacy

Personal health information collected from dental providers under this Program is used by the Ministry of Health and Long-Term Care, Accerta and local Public Health Units for claims payment and other program management purposes. Accordingly, dental providers may disclose personal health information to the Ministry of Health and Long-Term Care or Accerta without additional patient consent, in accordance with sections 38(1)(b) and 39(1)(b) of the *Personal Heath Information Protection Act, 2004*. Questions concerning the collection of this information should be directed to Accerta, the local Public Health Unit (where relevant and/or known) or the ServiceOntario INFOline at 1-866-532-3161 (Toll-free) or 1- 800-387-5559 (TTY toll-free) or 416-327-4282 (Toronto only).

1. Diagnostic Services

First Dental Visit/Orientation				
Code	**Description**	**GP**	**SP**	**Limit**
01011	Oral assessment for patients up to age 3 years inclusive. Assessment to include: medical history, familial dental history; dietary/feeding practices; oral habits; oral hygiene; fluoride exposure. Anticipatory guidance with parent/guardian.	27.64	33.17	Maximum 1 per patient, per dentist, per address.
Examination and Diagnosis, Clinical Oral				
Only one complete exam OR recall exam per patient, per dentist, per address will be covered if performed on the same patient within a 6 month period.				
Examination and Diagnosis, Complete Oral, to include: a) History, Medical and Dental b) Clinical Examination and Diagnosis of Hard and Soft tissues, including carious lesions, missing teeth, determination of sulcular depth, gingival contours, mobility of teeth, interproximal tooth contact relationships, occlusion of teeth, TMJ, pulp vitality tests/analysis, where necessary and any other pertinent factors. c) Radiographs extra, as required.				

Code	Description	GP	SP	Limit
01101	Examination and Diagnosis, Complete, Primary Dentition, to include: Extended examination and diagnosis on primary dentition, recording history, charting, treatment planning and case presentation, including above description.	38.01	45.62	1 per 60 months, per patient, per dentist, per address.
01102	Examination and Diagnosis, Complete, Mixed Dentition to include: a) Extended examination and diagnosis on mixed dentition, recording history, charting, treatment planning and case presentation, including above description b) b) Eruption sequence, tooth size - jaw size assessment	57.01	68.42	
01103	Examination and Diagnosis, Complete, Permanent Dentition to include: Extended examination and diagnosis on permanent dentition, recording history, charting, treatment planning and case presentation, including above description.	76.02	91.22	1 per 60 months, per patient, per dentist, per address.

Examination and Diagnosis, Limited Oral

Only one complete exam OR recall exam per patient, per dentist, per address will be covered if performed on the same patient within a 6 month period.

Code	Description	GP	SP	Limit
01202	Examination and Diagnosis, Limited Oral, Previous Patient (Recall) Examination of hard and soft tissues, including checking of occlusion and appliances, but not including specific tests/analysis as for Complete Oral Examination	19.00	22.81	Maximum 1 per 6 months, per patient, per dentist, per address.
01204	Examination and Diagnosis, Specific Examination and evaluation of a specific situation	19.00	22.81	Maximum 1 per 12 months, per patient, per dentist, per address.
01205	Examination and Diagnosis, Emergency Examination and diagnosis for the investigation of discomfort and/or infection in a localized area	19.00	22.81	

DSCP

Examination and Diagnosis, Limited Oral

Code	Description	GP	SP	Limit
01202	Examination and Diagnosis, Limited Oral, Previous Patient (Recall) Examination of hard and soft tissues, including checking of occlusion and appliances, but not including specific tests/analysis as for Complete Oral Examination.	19.00	22.81	Combined maximum HSO and DSCP of 4 per 12 months, per patient, per dentist, per address. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).

Radiographs (includes radiographic examination, diagnosis and interpretation)

Radiographs, Periapical

Code	Description	GP	SP	Limit
02111	Single image	13.35	16.02	Maximum 8 images per 12 months, per patient, per dentist, per address.
02112	Two images	16.33	19.60	
02113	Three images	20.12	24.14	
02114	Four images	22.52	27.03	
02115	Five images	27.02	32.42	
02116	Six images	30.42	36.50	
02117	Seven images	34.35	41.43	
02118	Eight images	37.78	45.38	

Radiographs, Occlusal

Code	Description	GP	SP	Limit
02131	Single image	15.76	18.91	Maximum 1 image per 12 months, per patient, per dentist, per address.

Radiographs, Bitewing

Code	Description	GP	SP	Limit
02141	Single image	13.35	16.02	Maximum 2 images per 6 months, per patient, per dentist, per address.
02142	Two images	16.33	19.60	

Radiographs, Panoramic

Code	Description	GP	SP	Limit
02601	Single image	31.54	37.85	Maximum 1 per 24 months, per patient, per dentist, per address except in emergency situations. Only covered when: 1. There is facial trauma with symptoms of possible jaw fracture; or 2. There is a significant delayed eruption pattern; or 3. Diagnosis cannot be made using a periapical image. One of the above criteria (listing the number is acceptable) must appear on the dental claim for consideration of payment.

Test/Analysis, Histopathological (technical procedure only)

Tests/Analysis, Histological, Soft Tissue

Code	Description	GP	SP	Limit
04311	Biopsy, Soft Oral Tissue - by Puncture + L	38.02	45.62	
04312	Biopsy, Soft Oral Tissue - by Incision + L	38.02	45.62	

Tests/Analysis, Histological, Hard Tissue				
Code	**Description**	**GP**	**SP**	**Limit**
04321	Biopsy, Hard Oral Tissue - by Puncture + L	88.70	106.44	
04322	Biopsy, Hard Oral Tissue - by Incision + L	88.70	106.44	

2. Preventive Services

Polishing				
Code	**Description**	**GP**	**SP**	**Limit**
11107	One half unit (7.5 minutes)	12.67	12.67	Maximum 1 per 6 months per patient, per dentist, per address.

	Polishing				
	Code	**Description**	**GP**	**SP**	**Limit**
DSCP	11101	One unit of time (15 minutes)	24.64	24.64	Combined maximum HSO and DSCP of 3 units per 12 months, per patient, per dentist, per address. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on page 15 - 16 for details).
	11107	One half unit of time (7.5 minutes)	12.67	12.67	

Scaling				
Code	**Description**	**GP**	**SP**	**Limit**
11111	One unit of time (15 minutes)	38.02	45.62	Maximum 1 unit per 12 months, per patient, per dentist, per address, for patients 11 years of age and younger. Additional units require **pre-authorization** up to a maximum of 4 units combined (Scaling/Root Planing) per 12 months, per patient, per dentist, per address. Combined maximum (Scaling/Root Planing) 2 units per 12 months, per patient, per dentist, per address, for patients aged 12-17 years. Additional units require **pre-authorization** up to a maximum of 4 units combined (Scaling/Root Planing) per 12 months, per patient, per dentist, per address. Pre-authorization criteria include: 1. Presence of calculus; and 2. Evidence of gingival inflammation; and/or 3. Dental or medical condition where gingival or periodontal disease is not reversible by adequate oral hygiene, and requires clinical instrumentation or treatment; and/or 4. Prior to major cardiac, transplant or other surgery where dental cleaning is requested by the patient's medical/dental practitioner. Criteria (listing the numbers is acceptable) must appear on the pre-authorization request. If applicable, the dental or medical condition must also be noted on the pre-authorization request.
11112	Two units (30 minutes)	76.02	91.22	
11113	Three units (45 minutes)	114.04	136.85	
11114	Four units (60 minutes)	152.03	182.44	
11117	One half unit (7.5 minutes)	19.00	22.80	

DSCP

Scaling

Code	Description	GP	SP	Limit
11111	One unit of time (15 minutes)	38.02	45.62	Combined maximum (Scaling/Root Planing) of 12 units HSO and DSCP combined, per 12 months, per patient, per dentist, per address. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).
11112	Two units (30 minutes)	76.02	91.22	
11113	Three units (45 minutes)	114.04	136.85	
11114	Four units (1 hour)	152.03	182.44	
11115	Five units (75 minutes)	189.63	227.55	
11116	Six units (90 minutes)	228.05	273.66	
11117	One half unit (7.5 minutes)	19.00	22.80	
11119	Each additional unit over six (15 minutes)	38.01	45.61	

Fluoride Treatments

Code	Description	GP	SP	Limit
12111	Rinse	15.21	18.25	Combined maximum 4 applications per 12 months, per patient, per dentist, per address.
12112	Gel or Foam	15.21	18.25	
12113	Varnish	15.21	18.25	

DSCP	**Fluoride Treatments**				
	Code	**Description**	**GP**	**SP**	**Limit**
	12111	Rinse	15.21	18.25	As required. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).
	12112	Gel or Foam	15.21	18.25	As required. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).
	12113	Varnish	15.21	18.25	As required. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).
DSCP	**Fluoride, Custom Appliances (home application)**				
	Code	**Description**	**GP**	**SP**	**Limit**
	12601	Fluoride, Custom Appliance – Maxillary Arch + L	38.01	38.01	As required. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).
	12602	Fluoride, Custom Appliance – Mandibular Arch + L	38.01	38.01	

Preventive Services, Miscellaneous				
Sealants, Pit and Fissure (mechanical and/or chemical preparation included)				
Code	**Description**	**GP**	**SP**	**Limit**
13401	First tooth	15.97	15.97	Coverage is limited to permanent molars (16, 26, 36, 46 and 17, 27, 37, 47). Replacement is not covered within 1 year.
13409	Each additional tooth same quadrant	8.77	8.77	

Topical Application to Hard Tissue Lesion(s) of an Antimicrobial or Remineralization Agent				
Code	**Description**	**GP**	**SP**	**Limit**
13601	One unit of time (15 minutes) + E	30.47	35.57	Maximum 2 units per 12 months, per patient, per dentist, per address. E = included in the fee.

DSCP	Topical Application to Hard Tissue of Antimicrobial or Remineralization Agents				
	Code	**Description**	**GP**	**SP**	**Limit**
	13601	One unit of time (15 minutes) + E	30.47	35.57	As required. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details). E = included in the fee.

Appliances, Protective Mouth Guards				
Code	**Description**	**GP**	**SP**	**Limit**
14502	Appliance, Protective Mouth Guard, Processed + L	63.35	63.35	Maximum 1 per 12 months, per patient, per dentist, per address.

DSCP	Appliances, Periodontal (including bruxism appliance); Includes Impression, Insertion and Insertion Adjustment (no post insertion adjustment)				
	Code	**Description**	**GP**	**SP**	**Limit**
	14611	Maxillary Appliance + L	152.03	182.44	As required. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).
	14612	Mandibular Appliance + L	152.03	182.44	

3. Restorative Services

The fee for amalgam or tooth coloured restorations is determined by counting the total number of surfaces restored. Maximum allowable for amalgam/tooth coloured restorations is five surfaces per tooth.

When separate amalgam or tooth coloured restorations are performed on the same tooth at the same appointment, reimbursement will be calculated by counting the total number of surfaces restored. Reimbursement will be limited to five surfaces per tooth, per dentist, per address, per 12 months except where a restoration is required to close the access opening after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma, resulting in fracture of the restoration and/or surrounding tooth structure. The treating dentist must note that treatment was required as a result of trauma on the claim form for reimbursement.

Payment for restorations on primary teeth shall not exceed the cost of stainless steel/polycarbonate full coverage restorations. In (amalgam or tooth coloured) restorative situations where this limitation applies, an alternative benefit, equivalent to the cost of codes 22201, 22211 and 22401 shall be provided for settlement purposes.

Crowns, posts and cores are covered for permanent/retained primary teeth only. Maximum one crown, core and post per tooth per lifetime.

1. **Primary Incisors:** For children 5 years of age and older, the maximum payable for restorative services for primary incisors is equivalent to a temporary restoration (Caries, Trauma and Pain Control codes 20111, 20119, 20121 or 20129) except under special clinical circumstances (e.g. no permanent successor tooth or markedly delayed eruption or where greater than half of the root structure is remaining).
2. **Primary First Molars:** For children 10 years of age and older, the maximum payable for restorative services for primary first molars is equivalent to a temporary restoration (Caries, Trauma and Pain Control codes 20111, 20119, 20121 or 20129) except under special clinical circumstances (e.g., no permanent successor tooth or markedly delayed eruption or where greater than half of the root structure is remaining).

3. **Primary Cuspids and Second Primary Molars:** For children 11 years of age and older, the maximum payable for restorative services for primary cuspids and secondary primary molars is equivalent to a temporary restoration (Caries, Trauma and Pain Control codes 20111, 20119, 20121 or 20129) except under special clinical circumstances (e.g., no permanent successor tooth or markedly delayed eruption or where greater than half of the root structure is remaining).
4. **Tooth Surfaces:** No surface (or pins) will be covered more than once in any 12 month period except where a restoration is required to close the access opening after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma, resulting in fracture of the restoration and/or surrounding tooth structure. The treating dentist must note that treatment was required as a result of trauma on the claim form for reimbursement.

Caries, Trauma and Pain Control				
Caries/Trauma/Pain Control (removal of carious lesions or existing restorations or gingivally attached tooth fragment and placement of sedative/protective dressings, includes pulp caps when necessary, as a separate procedure)				
Code	**Description**	**GP**	**SP**	**Limit**
20111	First tooth	31.68	38.02	
20119	Each additional tooth same quadrant	31.68	38.02	
Caries/Trauma/Pain Control (removal of carious lesions or existing restorations or gingivally attached tooth fragment and placement of sedative/protective dressings, includes pulp caps when necessary and the use of a band for retention and support, as a separate procedure)				
Code	**Description**	**GP**	**SP**	**Limit**
20121	First tooth	31.68	38.02	
20129	Each additional tooth same quadrant	31.68	38.02	

Restorations, Amalgam

Restorations, Amalgam, Non-Bonded, Primary Teeth

Code	Description	GP	SP	Limit
21111	One surface	25.34	30.41	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 21115 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
21112	Two surfaces	55.49	66.59	
21113	Three surfaces	63.35	76.02	
21114	Four surfaces	76.02	91.22	
21115	Five surfaces or maximum surfaces per tooth	76.02	91.22	

Restorations, Amalgam, Bonded, Primary Teeth

Code	Description	GP	SP	Limit
21121	One surface	25.35	30.42	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 21125 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
21122	Two surfaces	55.51	66.61	
21123	Three surfaces	63.35	76.02	
21124	Four surfaces	76.02	91.22	
21125	Five surfaces or maximum surfaces per tooth	76.02	91.22	

Restorations, Amalgam, Non-Bonded, Permanent Bicuspids and Anteriors				
Code	**Description**	**GP**	**SP**	**Limit**
21211	One surface	25.35	30.42	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 21215 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
21212	Two surfaces	55.51	66.61	
21213	Three surfaces	63.35	76.02	
21214	Four surfaces	76.02	91.22	
21215	Five surfaces or maximum surfaces per tooth	76.02	91.22	
Restorations, Amalgam, Non-Bonded, Permanent Molars				
Code	**Description**	**GP**	**SP**	**Limit**
21221	One surface	31.68	38.02	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 21225 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
21222	Two surfaces	63.35	76.02	
21223	Three surfaces	79.34	95.21	
21224	Four surfaces	79.34	95.21	
21225	Five surfaces or maximum surfaces per tooth	79.34	95.21	

Restorations, Amalgam, Bonded, Permanent Bicuspids and Anteriors				
Code	**Description**	**GP**	**SP**	**Limit**
21231	One surface	25.35	30.42	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 21235 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
21232	Two surfaces	55.51	66.61	
21233	Three surfaces	63.35	76.02	
21234	Four surfaces	76.02	91.22	
21235	Five surfaces or maximum surfaces per tooth	76.02	91.22	
Restorations, Amalgam, Bonded, Permanent Molars				
Code	**Description**	**GP**	**SP**	**Limit**
21241	One surface	31.68	38.02	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 21245 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
21242	Two surfaces	63.35	76.02	
21243	Three surfaces	79.34	95.21	
21244	Four surfaces	79.34	95.21	
21245	Five surfaces or maximum surfaces per tooth	79.34	95.21	
Pins, Retentive per restoration (for amalgams and tooth coloured restorations)				
Code	**Description**	**GP**	**SP**	**Limit**
21401	One pin	10.91	13.09	
21402	Two pins	18.20	21.84	
21403	Three pins	24.28	29.14	
21404	Four pins	24.28	29.14	
21405	Five pins or more	24.28	29.14	

Posts, Prefabricated Retentive + E				
Code	**Description**	**GP**	**SP**	**Limit**
25731	One post + E	80.97	101.02	Coverage is for permanent teeth only. Maximum 1 per tooth, per lifetime. **Pre-authorization required.** Pre-authorization criteria: 1. The tooth has had root canal therapy; or 2. The tooth is fractured; or 3. The tooth is heavily restored and prone to cusp fracture; and 4. There is adequate height of sound tooth structure; and 5. The patient has good oral hygiene; and 6. The overall condition of the mouth is healthy; and 7. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre-authorization request. E = included in the fee.

Restorations Prefabricated/Full Coverage				
Restorations, Prefabricated, Metal, Primary Teeth				
Code	**Description**	**GP**	**SP**	**Limit**
22201	Primary Anterior	95.02	114.03	
22211	Primary Posterior	95.02	114.03	
Restorations, Prefabricated, Metal, Permanent Teeth				
Code	**Description**	**GP**	**SP**	**Limit**
22301	Permanent Anterior	95.02	114.03	
22311	Permanent Posterior	95.02	114.03	
Restorations, Prefabricated, Plastic, Primary Teeth				
Code	**Description**	**GP**	**SP**	**Limit**
22401	Primary Anterior	95.02	114.03	
Restorations, Prefabricated, Plastic, Permanent Teeth				
Code	**Description**	**GP**	**SP**	**Limit**
22501	Permanent Anterior	95.02	114.03	

Restorations, Tooth Coloured/Plastic With/Without Silver Filings

Restorations, Tooth Coloured/Plastic With/Without Silver Filings, Non Bonded

Restorations, Tooth Coloured, Primary Anterior, Non Bonded

Code	Description	GP	SP	Limit
23401	One surface	44.34	53.22	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23405 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23402	Two surfaces	57.01	68.42	
23403	Three surfaces	79.34	95.21	
23404	Four surfaces	79.34	95.21	
23405	Five surfaces or maximum surfaces per tooth	79.34	95.21	

Restorations, Tooth Coloured / Plastic With / Without Silver Filings, Primary, Posterior, Non Bonded

Code	Description	GP	SP	Limit
23501	One surface	44.34	53.22	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23505 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23502	Two surfaces	79.34	95.21	
23503	Three surfaces	87.17	104.60	
23504	Four surfaces	95.02	114.03	
23505	Five surfaces or maximum surfaces per tooth	95.02	114.03	

Restorations, Tooth Coloured Permanent Anteriors Non Bonded Technique				
Code	**Description**	**GP**	**SP**	**Limit**
23101	One surface	44.34	53.22	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23105 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23102	Two surfaces	57.01	68.42	
23103	Three surfaces	87.17	104.60	
23104	Four surfaces	87.17	104.59	
23105	Five surfaces (maximum surfaces per tooth)	97.56	117.07	
Restorations, Tooth Coloured / Plastic With / Without Silver Filings, Permanent Posteriors, Non Bonded Permanent Bicuspids				
Code	**Description**	**GP**	**SP**	**Limit**
23211	One surface	44.34	53.22	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23215 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23212	Two surfaces	79.32	95.21	
23213	Three surfaces	87.17	104.60	
23214	Four surfaces	104.66	125.58	
23215	Five surfaces or maximum surfaces per tooth	104.66	125.58	

Restorations, Tooth Coloured / Plastic With / Without Silver Filings, Permanent Posteriors, Non-Bonded Permanent Molars

Code	Description	GP	SP	Limit
23221	One surface	50.68	60.82	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23225 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23222	Two surfaces	87.17	104.60	
23223	Three surfaces	95.02	114.03	
23224	Four surfaces	114.04	136.85	
23225	Five surfaces or maximum surfaces per tooth	114.04	136.85	

Restorations, Tooth Coloured, Bonded Technique

Restorations, Tooth Coloured, Primary Anterior, Bonded Technique

Code	Description	GP	SP	Limit
23411	One surface	50.68	60.82	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23415 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23412	Two surfaces	63.35	76.02	
23413	Three surfaces	87.17	104.60	
23414	Four surfaces	87.17	104.60	
23415	Five surfaces or maximum surfaces per tooth	87.17	104.60	

Restorations, Tooth Coloured / Plastic, Primary Posterior, Bonded Technique				
Code	**Description**	**GP**	**SP**	**Limit**
23511	One surface	50.68	60.82	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23515 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23512	Two surfaces	87.17	104.60	
23513	Three surfaces	95.02	114.03	
23514	Four surfaces	95.02	114.03	
23515	Five surfaces or maximum surfaces per tooth	95.02	114.03	
Restorations, Permanent Anteriors, Bonded Technique (not to be used for Veneer Applications or Diastema Closures)				
Code	**Description**	**GP**	**SP**	**Limit**
23111	One surface	50.68	60.82	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23115 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23112	Two surfaces	63.35	76.02	
23113	Three surfaces	95.02	114.03	
23114	Four surfaces	95.02	114.03	
23115	Five surfaces (maximum surfaces per tooth)	106.44	127.73	

Restorations, Tooth Coloured, Permanent Posteriors - Bonded Permanent Bicuspids				
Code	**Description**	**GP**	**SP**	**Limit**
23311	One surface	50.68	60.82	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23315 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23312	Two surfaces	87.17	104.60	
23313	Three surfaces	95.02	114.03	
23314	Four surfaces	114.04	136.85	
23315	Five surfaces or maximum surfaces per tooth	114.04	136.85	
Restorations, Tooth Coloured, Permanent Posteriors - Bonded Permanent Molars				
Code	**Description**	**GP**	**SP**	**Limit**
23321	One surface	57.01	68.42	The maximum payable per tooth, per patient, per dentist, per address per 12 month period is 23325 except in situations where the access opening must be closed after root canal treatment where the tooth was restored in the preceding 12 months OR in the event of trauma.
23322	Two surfaces	95.02	114.03	
23323	Three surfaces	102.88	123.46	
23324	Four surfaces	123.66	148.39	
23325	Five surfaces or maximum surfaces per tooth	123.66	148.39	

Restorations, Amalgam Cores				
Code	**Description**	**GP**	**SP**	**Limit**
21301	Restorations, Amalgam Core, Non-Bonded in conjunction with crown or fixed bridge retainer	114.04	118.40	Coverage is for permanent teeth only. Maximum 1 per tooth, per lifetime. **Pre-authorization required.** Pre-authorization criteria: 1. The tooth has had root canal therapy; or 2. The tooth is fractured; or 3. The tooth is heavily restored and prone to cusp fracture; and 4. There is adequate height of sound tooth structure; and 5. The patient has good oral hygiene; and 6. The overall condition of the mouth is healthy; and 7. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre-authorization request.

Restorations, Tooth Coloured/Plastic with/without Silver Filings, Cores				
Code	**Description**	**GP**	**SP**	**Limit**
23602	Restoration, Tooth Coloured, Bonded, Core in conjunction with crown or fixed bridge retainer	114.04	139.42	Coverage is for permanent teeth only. Maximum 1 per tooth, per lifetime. **Pre-authorization required.** Pre-authorization criteria : 1. The tooth has had root canal therapy; or 2. The tooth is fractured; or 3. The tooth is heavily restored and prone to cusp fracture; and 4. There is adequate height of sound tooth structure; and 5. The patient has good oral hygiene; and 6. The overall condition of the mouth is healthy; and 7. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre-authorization request.

Posts				
Posts, Prefabricated, with Non-Bonded Core for Crown Restoration or Fixed Bridge Retainer [including pin(s) where applicable] + E				
Code	**Description**	**GP**	**SP**	**Limit**
25751	One post, with Non bonded amalgam core and pin(s) + E	114.04	136.85	Coverage is for permanent teeth only. Maximum 1 per tooth, per lifetime. **Pre-authorization required.** Pre-authorization criteria : 1. The tooth has had root canal therapy; or 2. The tooth is fractured; or 3. The tooth is heavily restored and prone to cusp fracture; and 4. There is adequate height of sound tooth structure; and 5. The patient has good oral hygiene; and 6. The overall condition of the mouth is healthy; and 7. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre-authorization request. E = included in the fee.

Posts, Prefabricated, with Bonded Core for Crown Restoration or Fixed Bridge Retainer [including pin(s) where applicable] + E				
Code	**Description**	**GP**	**SP**	**Limit**
25764	One post, with Bonded composite core and pin(s) + E	126.16	151.39	Coverage is for permanent teeth only. Maximum 1 per tooth, per lifetime. **Pre-authorization required.** Pre-authorization criteria: 1. The tooth has had root canal therapy; or 2. The tooth is fractured; or 3. The tooth is heavily restored and prone to cusp fracture; and 4. There is adequate height of sound tooth structure; and 5. The patient has good oral hygiene; and 6. The overall condition of the mouth is healthy; and 7. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre-authorization request. E = included in the fee.

Crowns, Single Units (only)				
Crowns, Acrylic/Composite/Compomer, Indirect				
Code	**Description**	**GP**	**SP**	**Limit**
27113	Crown, Acrylic/Composite/Compomer, Provisional (Long Term), Indirect (lab fabricated/relined intra-orally) + L	95.02	114.02	Coverage is for permanent teeth only. Maximum 1 per tooth, per lifetime. **Pre-authorization required.** Pre-authorization criteria include: 1. The tooth has had root canal therapy; or 2. The tooth is fractured; or 3. The tooth is heavily restored and prone to cusp fracture; and 4. There is adequate height of sound tooth structure; and 5. The patient has good oral hygiene; and 6. The overall condition of the mouth is healthy; and 7. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre-authorization request.

Crowns, Acrylic/Composite/Compomer, Direct				
Code	**Description**	**GP**	**SP**	**Limit**
27121	Crown, Acrylic/Composite/Compomer, Direct, Provisional (chair side) + E	126.70	152.04	Coverage is for permanent teeth only. Maximum 1 per tooth, per lifetime. **Pre-authorization required.** Pre-authorization criteria include: 1. The tooth has had root canal therapy; or 2. The tooth is fractured; or 3. The tooth is heavily restored and prone to cusp fracture; and 4. There is adequate height of sound tooth structure; and 5. The patient has good oral hygiene; and 6. The overall condition of the mouth is healthy; and 7. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre-authorization request. E = included in the fee.

DSCP

Crowns, Single Units (Only)

Crowns, Porcelain/Ceramic/Polymer Glass Fused to Metal

Code	Description	GP	SP	Limit
27211	Crown, Porcelain/Ceramic/Polymer Glass Fused to Metal Base + L	443.43	532.12	Maximum 1 crown, per tooth, per lifetime. The fee for crowns on posterior teeth will be limited to the cost of a cast metal crown. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details). **Pre-authorization required**. Pre-authorization criteria: 1. The patient is dependent on their dentition to operate a device that is mouth operated (e.g. wheelchair); or 2. The tooth has had root canal therapy; or 3. The tooth is fractured; or 4. The tooth is heavily restored and prone to cusp fracture; and 5. There is adequate height of sound tooth structure; and 6. Prognosis of the tooth is favourable. The above criteria (listing the numbers is acceptable) must appear on the pre- authorization request. E = included in the fee.
27215	Crown, Porcelain/Ceramic/Polymer Glass Fused to Metal Base, Implant-Supported + L + E	354.74	425.69	

Crowns, Cast Metal

27301	Crown, Cast Metal +L	364.88	437.86	

4. Endodontic Services

Pulpotomy
Where services are provided, within 3 months by the same dentist, the maximum fee payable, for any combination of pulpotomy, pulpectomy and root canal therapy, will be limited to the fee for the root canal therapy.

Pulpotomy, Permanent Teeth (as a separate emergency procedure)

Code	Description	GP	SP	Limit
32221	Anterior and Bicuspid Teeth	63.35	76.02	Maximum 1 per tooth, per lifetime.
32222	Molar Teeth	114.04	136.85	

Pulpotomy, Primary Teeth

Code	Description	GP	SP	Limit
32231	Primary Dentition, as a Separate Procedure	63.35	76.02	Maximum 1 per tooth, per lifetime.
32232	Primary Dentition, Concurrent with Restorations (but excluding final restoration)	31.68	38.02	

Pulpectomy (An emergency procedure and/or as a pre-emptive phase to the preparation of the root canal system for obturation)
Where services are provided, within 3 months by the same dentist, the maximum fee payable, for any combination of pulpotomy, pulpectomy and root canal therapy, will be limited to the fee for the root canal therapy.

Pulpectomy, Permanent Teeth / Retained Primary Teeth

Code	Description	GP	SP	Limit
32311	One canal	63.35	76.02	Maximum 1 per tooth, per lifetime.
32312	Two canals	76.02	91.22	
32313	Three canals	114.04	136.85	
32314	Four or more canals	132.71	159.64	

Pulpectomy, Primary Teeth

Code	Description	GP	SP	Limit
32321	Anterior Tooth	63.35	76.02	Maximum 1 per tooth, per lifetime.
32322	Posterior Tooth	63.35	76.02	

Root Canal Therapy

To include: treatment plan, clinical procedures (i.e.: pulpectomy, biomechanical preparation, chemotherapeutic treatment and obturation), with appropriate radiographs and excluding final restoration. Also included in root canal therapy are any necessary temporary restorations. To exclude: pre-operative examination and diagnosis, diagnostic radiographs and tests and final restoration.

Only one root canal procedure is payable per tooth.

1. Primary Incisors: For children 6 years of age and older, the maximum payable for endodontic services for primary incisors is equivalent to a temporary restoration (Caries, Trauma and Pain Control codes 20111, 20119, 20121 or 20129) except under special clinical circumstances (e.g. no permanent successor tooth).
2. Primary First Molars: For children 10 years of age and older, the maximum payable for endodontic services for primary first molars is equivalent to a temporary restoration (Caries, Trauma and Pain Control codes 20111, 20119, 20121 or 20129) except under special clinical circumstances (e.g., no permanent successor tooth).
3. Primary Cuspids and Second Primary Molars: For children 11 years of age and older, the maximum payable for endodontic services for primary cuspids and secondary primary molars is equivalent to a temporary restoration (Caries, Trauma and Pain Control codes 20111, 20119, 20121 or 20129) except under special clinical circumstances (e.g., no permanent successor tooth).

Where services are provided, within 3 months by the same dentist, the maximum fee payable for any combination of pulpotomy, pulpectomy and root canal therapy, will be limited to the fee for the root canal therapy.

Root Canals, Permanent Teeth / Retained Primary Teeth

Code	Description	GP	SP	Limit
33111	One Canal	253.39	304.07	Maximum 1 per tooth, per lifetime.
33121	Two Canals	316.74	380.09	
33131	Three Canals	494.11	592.93	
33141	Four or More Canals	570.13	684.14	

Root Canals, Primary Teeth

Code	Description	GP	SP	Limit
33401	One canal	95.02	145.33	Maximum 1 per tooth, per lifetime.
33402	Two canals	132.92	192.48	
33403	Three canals or more	132.92	192.48	

Apexification/Apexogenesis/Induction of Hard Tissue Repair (to include biomechanical preparation and placement of dentogenic media)

Code	Description	GP	SP	Limit
33601	One canal	228.05	273.66	Maximum 1 apexification procedure and one root canal therapy per tooth, per lifetime.
33602	Two canals	304.07	364.88	
33603	Three canals	380.08	456.10	
33604	Four or more canals	456.48	516.55	

Reinsertion of Dentogenic Media per visit

Code	Description	GP	SP	Limit
33611	One canal	76.01	91.21	
33612	Two canals	95.02	114.02	
33613	Three canals	114.04	136.85	
33614	Four or more canals	114.04	205.28	

Apicoectomy/Apical Curettage

Maxillary Anterior

Code	Description	GP	SP	Limit
34111	One root for permanent anterior teeth.	221.72	266.06	Maximum 1 per tooth, per lifetime.

Mandibular Anterior

Code	Description	GP	SP	Limit
34141	One root for permanent anterior teeth.	221.72	266.06	Maximum 1 per tooth, per lifetime.

Retrofilling

Maxillary Anterior

Code	Description	GP	SP	Limit
34211	One root for permanent anterior teeth.	44.34	53.22	Maximum 1 per tooth, per lifetime.

Mandibular Anterior

Code	Description	GP	SP	Limit
34241	One root for permanent anterior teeth.	44.34	53.22	Maximum 1 per tooth, per lifetime.

5. Periodontal Services

Periodontal Services, Non-Surgical Oral Disease, Management Of				
Oral Manifestations, Oral Mucosal Disorders, Mucocutaneous Disorders and diseases of localized mucosal conditions, e.g. lichen planus, aphthous stomatitis, benign mucous membrane pemphigoid, pemphigus, salivary gland tumors, leukoplakia with and without dysplasia, neoplasms, hairy leukoplakia, polyps, verrucae, fibroma, etc.				
Code	**Description**	**GP**	**SP**	**Limit**
41211	One unit of time (15 minutes)	38.01	45.61	
41212	Two units (30 minutes)	76.02	91.22	
Oral Manifestations of Systemic Disease or complications of medical therapy, e.g. complications of chemotherapy, radiation therapy, post-operative neuropathics, post-surgical or radiation therapy, dysfunction, oral manifestation of lupus rythematosus and systemic disease including leukaemia, diabetes and bleeding disorders (e.g. haemophilia).				
Code	**Description**	**GP**	**SP**	**Limit**
41231	One unit of time (15 minutes)	38.01	45.61	
41232	Two units (30 minutes)	76.02	91.22	

Periodontal Services, Surgical (Includes local anaesthetic, suturing and the placement and removal of initial surgical dressing. A surgical site is an area that lends itself to one or more procedures. It is considered to include a full quadrant, sextant or a group of teeth or in some cases a single tooth).				
Periodontal Surgery, Gingivectomy (The procedure by which gingival deformities are reshaped and reduced to create normal and functional form, when the pocket is uncomplicated by extension into the underlying bone).				
Gingivectomy, Uncomplicated				
Code	**Description**	**GP**	**SP**	**Limit**
42311	Per Sextant	199.68	239.62	Maximum 6 different sextants per 12 months, per patient, per dentist, per address. Coverage is limited to cases involving gingival hyperplasia directly related to a specific drug or hereditary syndrome. The drug or syndrome must be noted on the dental claim for consideration of payment.

DSCP

Periodontal Surgery, Grafts, Soft Tissue

Note: Instructions on using grafts, free soft tissue codes – For free soft tissue grafts involving two adjacent teeth in the same sextant at the same appointment, this is considered to be a single graft, single site.

Code	Description	GP	SP	Limit
Grafts, Soft Tissue, Pedicle (Including Apically or Lateral Sliding and Rotated Flaps)				Where required to improve the prognosis of the dentition. Note: Identify surgical site(s) on the dental claim form. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details). E = included in the fee.
42511	Per site	266.06	319.27	
Grafts, Soft Tissue, Pedicle (Pedicle (Coronally Positioned)				
42521	Per site	266.06	319.27	
Grafts, Free Soft Tissue				
42531	Per site	266.06	319.27	
Grafts, (For root or implant coverage)				
42551	Autograft (free connective tissue), for root coverage, includes harvesting from donor site - per site	380.08	456.10	
42552	Allograft, for root coverage - per site + E	278.73	339.37	
Grafts, (For ridge augmentation)				
42561	Per site	380.08	456.10	

Periodontal Surgery, Miscellaneous Procedures				
Periodontal Abscess or Pericoronitis, may include one or more of the following procedures: Lancing, Scaling, Curettage, Surgery or Medication				
Code	**Description**	**GP**	**SP**	**Limit**
42831	One unit of time (15 minutes)	38.01	45.61	Maximum 3 units per 12 months, per patient, per dentist, per address. Not covered on the same service date as scaling and/or root planing (codes 11111-11114 & 11117 or 43421-43424 & 43427).

Root Planing, Periodontal				
Root Planing				
Code	**Description**	**GP**	**SP**	**Limit**
43421	One unit of time (15 minutes)	38.01	45.61	Combined maximum (Scaling/Root Planing) of 2 units per 12 months, per patient, per dentist, per address, for patients aged 12-17 years. Additional units require **pre-authorization** up to a maximum of 4 units combined (Scaling/Root Planing) per 12 months, per patient, per dentist, per address. Pre-authorization criteria include: 1. Presence of calculus; and 2. Evidence of gingival inflammation; and/or 3. Dental or medical condition where gingival or periodontal disease is not reversible by adequate oral hygiene, and requires clinical instrumentation or treatment; and/or 4. Prior to major cardiac, transplant or other surgery where dental cleaning is requested by the client's medical/dental practitioner. Criteria (listing the numbers is acceptable) must appear on the pre-authorization request. If applicable, the dental or medical condition must also be noted on the pre-authorization request.
43422	Two units (30 minutes)	76.02	91.22	
43423	Three units (45 minutes)	114.03	136.83	
43424	Four units (60 minutes)	152.03	182.44	
43427	One half unit (7.5 minutes)	19.00	22.81	

DSCP	Root Planing				
	Code	**Description**	**GP**	**SP**	**Limit**
	43421	One unit of time (15 minutes)	38.01	45.61	Combined maximum (Scaling) of 12 units HSO and DSCP combined per 12 months, per patient, per dentist, per address. Child/youth must meet DSCP criteria and must be enrolled in the DSCP (see Dental Special Care Plan on pages 15-16 for details).
	43422	Two units (30 minutes)	76.02	91.22	
	43423	Three units (45 minutes	114.03	136.83	
	43424	Four units (1 hour)	152.03	182.44	
	43425	Five units of time (75 minutes)	189.63	227.55	
	43426	Six units of time (90 minutes)	228.05	273.66	
	43427	One half unit of time (7.5 minutes)	19.00	22.81	
	43429	Each additional unit of time over six (15 minutes)	38.01	45.61	

6. Prosthetics – Removable

Partial dentures are covered for the replacement of permanent anterior teeth only (13-23 and 33-43).

Dentures, Complete (includes: impressions, initial and final jaw relation records, try-in evaluation and check records, insertion and adjustments, including three months post insertion care)

Dentures, Complete, Standard

Code	Description	GP	SP	Limit
51101	Maxillary + L	418.10	501.72	Note the reason that complete dentures are needed, where known (e.g. trauma, caries) on the claim form.
51102	Mandibular + L	532.11	638.53	

Dentures, Partial, Acrylic

Dentures, Partial, Acrylic, With Metal Wrought/Cast Clasps and/or Rests

Code	Description	GP	SP	Limit
52301	Maxillary + L	304.07	364.88	For the replacement of permanent anterior teeth only (13-23 and 33-43). List of missing teeth and reason for replacement where known (e.g., trauma, caries, etc.) must be noted on the claim form.
52302	Mandibular + L	304.07	364.88	

Dentures, Adjustments (after three months post insertion or by other than the dentist providing prosthesis)

Denture Adjustments, Partial or Complete Denture, Minor (after three months post insertion or by other than the dentist providing prosthesis)

Code	Description	GP	SP	Limit
54201	One unit of time (15 minutes) + L	31.68	38.02	

Dentures, Repairs/Additions				
Denture Repair, Complete Denture, No Impression Required				
Code	**Description**	**GP**	**SP**	**Limit**
55101	Maxillary + L	15.97	19.16	
55102	Mandibular + L	15.97	19.16	
Denture Repair, Complete Denture, Impression Required				
Code	**Description**	**GP**	**SP**	**Limit**
55201	Maxillary + L	31.68	38.02	
55202	Mandibular + L	31.68	38.02	
Denture Repair, Partial Denture, No Impression Required				
Code	**Description**	**GP**	**SP**	**Limit**
55301	Maxillary + L	15.97	19.16	
55302	Mandibular + L	15.97	19.16	
Denture Repair, Partial Denture, Impression Required				
Code	**Description**	**GP**	**SP**	**Limit**
55401	Maxillary + L	31.68	38.02	
55402	Mandibular + L	31.68	38.02	

Dentures, Replication, Provisional

Denture Reline, Direct Complete Denture

Code	Description	GP	SP	Limit
56211	Maxillary + L	108.67	134.36	Maximum 1 per 12 months, per patient, per dentist, per address.
56212	Mandibular + L	108.67	175.96	

Denture Reline, Direct Partial Denture

Code	Description	GP	SP	Limit
56221	Maxillary + L	86.01	148.04	Maximum 1 per 12 months, per patient, per dentist, per address.
56222	Mandibular + L	86.01	150.64	

Denture Reline, Processed Complete Denture

Code	Description	GP	SP	Limit
56231	Maxillary + L	126.70	152.04	Maximum 1 per 12 months, per patient, per dentist, per address.
56232	Mandibular + L	158.37	190.04	

Denture Reline, Processed Partial Denture

Code	Description	GP	SP	Limit
56241	Maxillary + L	126.70	152.04	Maximum 1 per 12 months, per patient, per dentist, per address.
56242	Mandibular + L	126.70	152.04	

7. Prosthodontic Services – Fixed

Fixed prostheses are covered for the replacement of permanent anterior teeth only (13-23 and 33-43).

Pontics, Bridge

Pontics, Porcelain/Ceramic/Polymer Glass

Code	Description	GP	SP	Limit
62501	Pontics, Porcelain/Ceramic/Polymer Glass Fused to Metal + L	219.60	263.52	List of missing teeth and reason for replacement where known (e.g., trauma, caries, etc.) must be noted on the claim form.

Pontics, Acrylic/Composite/Compomer

Code	Description	GP	SP	Limit
62701	Pontics, Acrylic/Composite/Compomer, Processed to Metal + L	175.94	211.13	List of missing teeth and reason for replacement where known (e.g., trauma, caries, etc.) must be noted on the claim form.

Repairs, Reinsertion/Recementation

Repairs, Reinsertion/Recementation (+ L where charges are incurred during the repair of bridge)

Code	Description	GP	SP	Limit
66301	One unit of time (15 minutes) + L	38.02	45.62	

Retainers, Cast Metal				
Retainers, Cast Metal, Onlay (bonded external retention/partial coverage – e.g., Maryland Bridge)				
Code	**Description**	**GP**	**SP**	**Limit**
67341	**P** - Retainer, Cast Metal, Onlay, with or without perforations, Bonded to Abutment Tooth, (Pontic extra) + L	95.02	114.02	List of missing teeth and reason for replacement where known (e.g., trauma, caries, etc.) must be noted on the claim form.

8. Oral and Maxillofacial Surgery

The following surgical services include necessary local anaesthetic, removal of excess gingival tissue, suturing, and one post-operative treatment, when required. A surgical site is considered to include a full quadrant, a sextant or a group of several teeth or in some cases a single tooth.

Extractions for orthodontic purposes are NOT covered. Removal of third molars is only covered when:

1. There is advanced dental caries; and/or
2. Repeated pericoronitis; and/or
3. Disease of the follicle; and/or
4. External or internal resorption of the tooth or adjacent tooth.

One or more of the above criteria (listing the number is acceptable) must appear on the dental claim form for consideration of payment for the removal of more than one bicuspid or the removal of more than one third molar at one time.

Removals, (Extractions), Erupted Teeth

Removals, Erupted Teeth, Uncomplicated

Code	Description	GP	SP	Limit
71101	Single tooth, Uncomplicated	38.02	45.62	
71109	Each additional tooth same quadrant, same appointment	19.00	22.81	

Removals, Erupted Teeth, Complicated				
Code	**Description**	**GP**	**SP**	**Limit**
71201	Odontectomy, (extraction), Erupted Tooth, Surgical Approach, Requiring Surgical Flap and/or Sectioning of Tooth	88.70	106.44	
71209	Each additional tooth, same quadrant	88.70	106.44	
Removals, Impactions, Soft Tissue Coverage				
Removals, Impaction, Requiring Incision of Overlaying Soft Tissue and Removal of the Tooth				
Code	**Description**	**GP**	**SP**	**Limit**
72111	Single tooth	88.70	106.44	
72119	Each additional tooth, same quadrant	88.70	106.44	

Removals, Impactions, Involving Tissue And/or Bone Coverage				
Removals, Impactions, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap and EITHER Removal of Bone and Tooth OR Sectioning and Removal of Tooth				
Code	**Description**	**GP**	**SP**	**Limit**
72211	Single tooth	133.04	159.65	
72219	Each additional tooth, same quadrant	133.04	159.65	

Removals, Impaction, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap, Removal of Bone AND Sectioning of Tooth for Removal

Code	Description	GP	SP	Limit
72221	Single Tooth	177.37	212.84	
72229	Each additional tooth, same quadrant	177.37	212.84	

Removals, Impactions, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap, Removal of Bone, AND/OR Sectioning of the Tooth for Removal AND/OR presents Unusual Difficulties and Circumstances

Code	Description	GP	SP	Limit
72231	Single tooth	202.71	243.25	
72239	Each additional tooth, same quadrant	202.71	243.25	

Removals, (Extractions), Residual Roots
Note: a residual root is defined as the remaining portion of a root from a previous extraction.

Removals, Residual Roots, Erupted

Code	Description	GP	SP	Limit
72311	First tooth	38.02	45.62	
72319	Each additional tooth, same quadrant	38.02	45.62	

Removals, Residual Roots, Soft Tissue Coverage

Code	Description	GP	SP	Limit
72321	First tooth	76.02	91.22	
72329	Each additional tooth, same quadrant	76.02	91.22	

Removals, Residual Roots, Bone Tissue Coverage

Code	Description	GP	SP	Limit
72331	First tooth	88.70	106.44	
72339	Each additional tooth, same quadrant	88.70	106.44	

Surgical Excision, Tumors, Benign

Tumors, Benign, Scar Tissue, Inflammatory or Congenital Lesions of Soft Tissue of the Oral Cavity

Code	Description	GP	SP	Limit
74111	1 cm and under	133.04	159.65	
74112	1 -2 cm	144.08	172.90	
74113	2 - 3 cm	155.11	186.13	

Surgical Excision, Cysts/Granulomas (Based On Cyst Size)

Excision of Cyst

Code	Description	GP	SP	Limit
74631	1 cm and under	133.04	159.65	
74632	1 - 2 cm	144.08	172.90	
74633	2 - 3 cm	155.11	186.13	

Surgical Incision And Drainage And/or Exploration, Intraoral

Surgical Incision and Drainage and/or Exploration, Intraoral , Soft Tissue

Code	Description	GP	SP	Limit
75111	Intraoral, Surgical Exploration, Soft Tissue	38.02	45.62	

Fractures, Reductions, Alveolar				
Replantation, Avulsed Tooth/Teeth (including splinting)				
Code	**Description**	**GP**	**SP**	**Limit**
76941	Replantation, first tooth	88.70	106.44	
76949	Each additional tooth	88.70	106.44	
Repositioning of Traumatically Displaced Teeth Note: procedure code 76951 includes splinting				
Code	**Description**	**GP**	**SP**	**Limit**
76951	One unit of time (15 minutes)	31.68	38.01	
Repairs, Lacerations, Uncomplicated, Intraoral or Extraoral				
Code	**Description**	**GP**	**SP**	**Limit**
76961	2 cm or less	44.34	53.22	
76962	2 - 4 cm	44.34	53.22	
Post Surgical Care (Required by complications and unusual circumstances)				
Code	**Description**	**GP**	**SP**	**Limit**
79602	Post Surgical Care, Minor, by Other Than Treating Dentist	19.32	23.18	
79604	Post Surgical Care, Major, by Other Than Treating Dentist	46.01	55.21	

9. Adjunctive General Services

A maximum of 10 units of any combination of anaesthesia/sedative techniques below are covered in any 12 month period, per patient, per dentist, per address. Additional units require pre-authorization and will only be covered in the situations where the client requires more than one visit to complete dental treatment. Dentists may be required to submit sedation records.

Only one of Parenteral OR Nitrous Oxide sedation will be covered if performed on the same client on the same day.

When a physician-anaesthetist provides the general anaesthetic, the treating dentist should note the physician's name in the comments box on the claim form (for cross-referencing with the physician invoice). Physician-anaesthetists should invoice the program directly for their services.

Anaesthesia, General (includes pre-anaesthetic evaluation and post-anaesthetic evaluation and post-anaesthetic follow-up)

General anaesthesia requires registration with the RCDSO and a facility permit: A drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. Patients often require assistance in maintaining a patent airway. The ability to maintain independent ventilatory function is often impaired. Positive pressure ventilation may be required because of depressed spontaneous ventilation.

General Anaesthesia

Code	Description	GP	SP	Limit
92212	Two units of time (30 minutes)	112.04	134.45	Maximum of 10 units per 12 months per patient, per dentist, per address. Additional units require **pre-authorization.** Pre-authorization request must document reason for additional units.
92213	Three units (45 minutes)	142.72	171.27	
92214	Four units (60 minutes)	173.40	208.08	
92215	Five units (75 minutes)	204.09	244.91	
92216	Six units (90 minutes)	234.76	281.71	
92217	Seven units (105 minutes)	265.44	318.53	
92218	Eight units (120 minutes)	296.11	355.34	
92219	Each additional unit over eight (15 minutes)	28.99	34.79	

Note: The equipment, facilities and support services for general anaesthetic may be provided by the practitioner who provides the dental treatment or the practitioner who provides the general anaesthesia or by a practitioner who provides neither the treatment nor the general anaesthesia. A dentist who provides the dental treatment, the general anaesthetic and the facility cannot use the following codes.

Provision of facilities, equipment and support services, for General Anaesthesia when provided by a separate practitioner

Code	Description	GP	SP	Limit
92222	Two units of time (30 minutes)	38.84	46.61	Maximum of 10 units per 12 months, per patient, per dentist, per address. Additional units require **pre-authorization.** Pre-authorization request must document reason for additional units.
92223	Three units (45 minutes)	58.26	69.91	
92224	Four units (60 minutes)	77.66	93.20	
92225	Five units (75 minutes)	97.07	116.49	
92226	Six units (90 minutes)	116.48	139.78	
92227	Seven units (105 minutes)	135.89	163.07	
92228	Eight units (120 minutes)	155.32	186.38	
92229	Each additional unit over eight (15 minutes)	20.76	24.91	

Anaesthesia, Deep Sedation

Deep sedation requires registration with the RCDSO and a facility permit: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully* following repeated or painful stimulation. Patients may require assistance in maintaining a patent airway. The ability to independently maintain ventilatory function may be impaired and spontaneous ventilation may be inadequate. *reflex withdrawal from painful stimulation is not considered a purposeful response.

Anaesthesia, Deep Sedation (a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including inability to respond purposefully to verbal command. These states apply to any technique that has depressed the patient beyond conscious sedation except general anaesthesia. Any intravenous technique leading to these conditions in a patient including neuroleptanalgesia/anaesthesia would fall within this category of service) (includes pre-anaesthetic evaluation and post anaesthetic follow-up).

Code	Description	GP	SP	Limit
92302	Two units of time (30 minutes)	103.43	124.12	Maximum of 10 units per 12 months, per patient, per dentist, per address. Additional units require **pre-authorization.** Pre-authorization request must document reason for additional units.
92303	Three units (45 minutes)	134.11	160.93	
92304	Four units (60 minutes)	164.79	197.75	
92305	Five units (75 minutes)	195.47	234.56	
92306	Six units (90 minutes)	226.15	271.38	
92307	Seven units (105 minutes)	256.83	308.20	
92308	Eight units (120 minutes)	287.52	345.02	
92309	Each additional unit over eight (15 minutes)	28.99	34.79	

Anaesthesia, Conscious Sedation

Anaesthesia, Conscious Sedation

Conscious sedation (minimal sedation): A drug-induced state during which patients respond normally to verbal commands. Although cognitive functions and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Conscious sedation (moderate sedation) requires registration with the RCDSO and a facility permit): A drug induced depression of consciousness during which patients respond purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate.

*reflex withdrawal from painful stimulation is not considered a purposeful response.

Any technique leading to these conditions in a patient would fall within this category of service. Conscious sedation is a varied technique which can require different levels of monitoring, in accordance with in accordance with the RCDSO Guidelines for the Use of Sedation and General Anaesthesia in Dental Practice.

Nitrous Oxide - Time is measured from the placement of the inhalation device and terminates with the removal of the inhalation device.

Code	Description	GP	SP	Limit
92411	One unit of time (15 minutes)	16.98	20.38	Maximum of 10 units per 12 months, per patient, per dentist, per address. Additional units require **pre-authorization.** Pre-authorization request must document reason for additional units.
92412	Two units of time (30 minutes)	29.66	35.59	
92413	Three units (45 minutes)	42.34	50.81	
92414	Four units (60 minutes)	55.02	66.02	
92415	Five units (75 minutes)	67.70	81.24	
92416	Six units (90 minutes)	80.38	96.44	
92417	Seven units (105 minutes)	93.03	111.64	
92418	Eight units (120 minutes)	105.72	126.85	
92419	Each additional unit over eight (15 minutes)	13.98	16.78	

Oral Sedation - Sedation sufficient to require monitored care.

Note: Time begins with monitoring of the patient and ends when monitoring is no longer required and the patient is medically fit for discharge. As per RCDSO Standard for minimal/moderate sedation, monitoring includes clinical observation for level of consciousness and assessment of vital signs which includes heart rate, blood pressure, oxygen saturation and respiration, pre-operatively, intra-operatively and post operatively with appropriate documentation.

Code	Description	GP	SP	Limit
92421	One unit of time (15 minutes)	29.30	35.15	Maximum of 10 units per 12 months, per patient, per dentist, per address. Additional units require **pre-authorization.** Pre-authorization request must document reason for additional units.
92422	Two units of time (30 minutes)	42.17	50.60	
92423	Three units (45 minutes)	55.03	66.04	
92424	Four units (60 minutes)	67.90	81.48	
92425	Five units (75 minutes)	80.77	96.62	
92426	Six units (90 minutes)	95.66	114.79	
92427	Seven units (105 minutes)	110.75	132.89	
92428	Eight units (120 minutes)	125.83	151.00	
92429	Each additional unit over eight (15 minutes)	12.94	18.94	

Nitrous Oxide with Oral Sedation - Time is measured from the administration of nitrous oxide and terminates with the release of the patient from the treatment/recovery room.

Note: For the combination technique, time is to be measured from the start of the patient monitoring OR placement of the inhalation device, whichever comes first. Time ends when monitoring is no longer required and the patient is medically fit for discharge.

Code	Description	GP	SP	Limit
92431	One unit of time (15 minutes)	26.50	31.80	Maximum of 10 units per 12 months, per patient, per dentist, per address. Additional units require **pre-authorization.** Pre-authorization request must document reason for additional units.
92432	Two units of time (30 minutes)	46.32	55.58	
92433	Three units (45 minutes)	66.13	79.36	
92434	Four units (60 minutes)	85.96	103.15	
92435	Five units (75 minutes)	105.76	126.91	
92436	Six units (90 minutes)	125.60	150.72	
92437	Seven units (105 minutes)	136.06	163.27	
92438	Eight units (120 minutes)	165.23	198.28	
92439	Each additional unit over eight (15 minutes)	19.57	23.48	

Parenteral Conscious Sedation (regardless of method – IM or IV)

Note: Time is to be measured from pre-operative patient evaluation and ends when monitoring is no longer required and the patient is medically fit for discharge. Time does not include operatory set up or breakdown.

Code	Description	GP	SP	Limit
92441	One unit of time (15 minutes)	56.05	67.26	Maximum of 10 units per 12 months, per patient, per dentist, per address. Additional units require **pre-authorization.** Pre-authorization request must document reason for additional units.
92442	Two units of time (30 minutes)	80.10	96.12	
92443	Three units (45 minutes)	104.17	125.00	
92444	Four units (60 minutes)	128.24	153.89	
92445	Five units (75 minutes)	152.32	182.78	
92446	Six units (90 minutes)	176.39	211.67	
92447	Seven units (105 minutes)	200.47	240.56	
92448	Eight units (120 minutes)	224.54	269.45	
92449	Each additional unit over eight (15 minutes)	25.76	30.91	

Laboratory Procedures

Used in conjunction with the "+L" and "+E" designation following the specific codes in the Schedule.

When filling out the third party claim forms, these codes must follow immediately after the corresponding dental procedure code carried out by the dentist, so as to correlate the lab expenses with the correct procedures.

Code	Description	GP	SP	Limit
99111	"+ L" Commercial Laboratory Procedures (A commercial laboratory is defined as an independent business which performs laboratory services and bills the dental practices for these services on a case by case basis)	I.C.	I.C.	99111 and 99333 are covered in conjunction with codes which carry the +L designation. The amount listed on the invoice will be paid in full. Laboratory fees must appear immediately below the procedure code(s) to which they apply.
99222	Laboratory charges for oral pathology biopsy services when provided in conjunction with surgical services from the 30000, 40000 and 70000 code series	I.C.	I.C.	
99333	"+ L" In-Office Laboratory Procedures (an in-office laboratory is defined as (a) laboratory service(s) performed within the same business entity)	I.C.	I.C.	
99555	"+ E" Additional Expense of Materials	N/A	N/A	Material costs for applicable services are included in the fee.