Part C – Decision Under Appeal

Under appeal is the reconsideration decision of the Ministry of Social Development and Poverty Reduction ("ministry") dated August 10, 2022, in which the ministry denied coverage for certain dental services in excess of the $1,000 limit for basic dental services, in particular: a partial cast denture and an odontectomy. The ministry also determined that it could not give a reconsideration decision for the other dental services set out in a treatment plan proposal dated May 27, 2022.

Part D – Relevant Legislation

Employment and Assistance for Persons with Disabilities Act ("EAPWDA"), sections 16 and 25
Employment and Assistance for Persons with Disabilities Regulation ("EAPWDR"), sections 63, 63.1, 64, 69 and Schedule C, sections 1, 4 and 5
Schedule of Fee Allowances – Dentist

Full text of the legislation is provided in the Schedule of Legislation at the end of the decision.

Part E – Summary of Facts

Evidence Before the Ministry at Reconsideration:

The appellant is in receipt of benefits under the EAPWDA.

The ministry has authorized Pacific Blue Cross ("PBC") under section 25 of the EAPWDA to assess and approve or reject requests for coverage for dental services on behalf of the ministry.

The appellant has many issues with pain and infection in his teeth. He has had dental treatment at a dental clinic, but those services are limited to extractions and fillings, and the appellant has not been satisfied with the quality of the dental work at the clinic.

The appellant visited another dentist, who stated in a letter dated May 5, 2022 that the appellant had extreme tooth pain and swelling and has 4 teeth (2 back teeth on each side of the lower jaw) that must be extracted due to severe decay and infection. Once the teeth were removed, the dentist would fill cavities in the remaining teeth to prevent further infections and pain. Lastly, the dentist recommended a partial denture to replace the missing teeth. The dentist did not recommend full dentures because the other teeth only needed minor fillings. The dentist provided a treatment plan proposal for dental services, including multiple extractions, fillings, and partial cast dentures, for a total cost of $6,763.08. The treatment plan proposal included a dental service, commercial laboratory procedures (fee code 99111), for a fee of $1,000.

The appellant provided a letter from a nurse practitioner stating that the appellant needs the required dental care.

On June 10, 2022, the dentist requested pre-authorization from PBC for coverage of the partial cast denture in the amount of $2224, which the dentist advised included the fee for commercial laboratory procedures. PBC approved coverage for $550.31, which was the amount remaining in the appellant's basic dental coverage then. The dentist did not request coverage for any other items in the treatment plan.

On June 27, 2022, the appellant had tooth #47 removed, as recommended in the treatment plan proposal, and PBC approved coverage of $130.27, which was the maximum rate for that procedure under the Schedule of Fee Allowances – Dentist.

In a letter to the ministry, the appellant stated:

- he has had problems with his teeth all his life;
- he has had repeated infections in his teeth, and the most recent infection spread to his throat and caused sores in his mouth, which mean that he could "barely eat, talk or sleep for an entire week";
- if he cannot have his teeth fixed as the dentist recommends, they all may have to be extracted, and his mental and emotional health would be affected if he had to have full dentures at his young age;
- he is experiencing extreme anxiety over the need for dental services and the inability to have the treatment covered.

Additional Evidence:

At the hearing, the appellant stated:

- fillings done at the dental clinic have fallen out;
- he is seeing his doctor later today because he is being treated for an infected tooth, which is causing him pain that now has spread to his ear, and he is seeing the dentist again later in the month;
- he believes the dental work at the dental clinic is below standard, because of an inexperienced dentist and because the dental clinic provides dental services at no charge.

In answer to a question from the ministry, the appellant stated that he had his wisdom teeth extracted several years ago.

In answer to questions from the panel, the ministry representative confirmed that there is not a dentist in the appellant's community that provides dental services for the fees set out in the Schedule of Fee Allowances – Dentist, and that dentists set their own fees.

The panel finds the additional evidence to be admissible under section 22(4) of the Employment and Assistance Act because it provides further information about the appellant's dental condition, treatment, and available services, and therefore is reasonably required for the full and fair disclosure of all matters related to the decision under appeal.

Part F – Reasons for Panel Decision

The issues on appeal are:

1. whether the ministry was reasonable in its decision to deny the appellant coverage for a partial cast denture and odontectomy in excess of the $1,000 two-year limit for basic dental services;

2. whether the ministry was reasonable in its determination that it could not make a reconsideration decision about the appellant's request for the rest of the dental services in the treatment plan proposal because no request for coverage had been submitted to PBC.

Legislation:

Under EAPWDR section 63 and Schedule C, sections 1 and 4(5), the ministry may provide a health supplement for "basic dental services" listed in the Schedule of Fee Allowances – Dentist, at the rate set out in that Schedule, up to a maximum of $1,000 in a 2-year period. The current 2-year period runs from January 1, 2021 to December 31, 2022 (Schedule C, section 4(1)).

If the cost of partial dentures is more than the $1,000 coverage limit, the ministry can give a dental supplement for acrylic dentures, if:
1. the patient has had at least 1 extraction for relief of pain in the past 6 months; and
2. the extractions result in at least 3 contiguous teeth missing on the same arch

(EAPWDR, Schedule C, section 4(3) and Schedule of Fee Allowances – Dentist – Denture Policy).

Under EAPWDR section 64 and Schedule C, sections 1 and 5, the ministry may also provide coverage for emergency dental services necessary for the immediate relief of pain, if the dental service is listed in the Schedule of Fee Allowances, at the rate set out in that Schedule.

Appellant's Position:

The appellant maintains that he needs the dental treatment set out in the Treatment Plan Proposal so that he can keep his remaining teeth and avoid having them all extracted and replaced with full dentures. The ongoing pain and infections are affecting his physical, mental, and emotional health, as is the fear of losing all his teeth. He trusts the dentist to give him good quality dental care and does not trust the dental treatment he would receive at the dental clinic that provides services at no cost. Further, the dental clinic only performs extractions and fillings, and the fillings he received there have fallen out. The appellant is afraid that if he must wait until January 2023 to have further dental work done, it will be too late to save the rest of his teeth.

Ministry's Position:

The ministry says that it can only provide coverage for "basic dental services" as set out in the EAPWDR, up to $1,000 in a 2-year period. The ministry is only authorized to pay for the dental services and the amounts listed in the Schedule of Fees – Dentist. The ministry is not authorized to provide coverage for dental services that are not listed in the Schedule of Fees –

Dentist, such as the commercial laboratory fees (fee code 99111) listed in the treatment plan proposal.

Requests for coverage must be submitted to PBC. PBC has approved the fees for the only dental services that the dentists submitted to them, up to the amounts permitted by the legislation. The ministry says that it does not have discretion to pay more for basic dental services.

The ministry says that it has considered whether there is coverage for the dental services under any other supplement under the EAPWDR and determined that dental services are not eligible for coverage as a life threatening health need or as a crisis supplement.

The ministry says that it cannot make a reconsideration decision about the rest of the dental services in the treatment proposal plan because the dentist has not submitted a request for coverage to PBC, and therefore there is no decision that it is authorized to reconsider under EAPWDA section 16.

Panel Decision:

The appellant's main concern is for coverage of all the dental services the dentist recommends, to relieve his current pain and infections, address the overall condition of his teeth, and allow him to keep his teeth rather than have them all extracted and replaced with full dentures. He has asked the ministry to reconsider the decision that limited coverage to $1,000 for basic dental services in the current 2-year period, and to provide coverage for all the dental services in the treatment plan proposal.

1. Basic Dental Services:

Under EAPWDR Schedule C section 4, the ministry may provide a dental supplement for basic dental services listed in the Schedule of Fee Allowances – Dentist, up to a maximum of $1,000 in a 2-year period. Under EAPWDR Schedule C section 1, the fees for basic dental services provided by a dentist are limited to the amounts set out in the Schedule of Fee Allowances – Dentist.

a. Odontectomy, Tooth #47:

PBC approved a fee of $130.27 for the extraction of tooth #47, which is the maximum fee allowed under the Schedule of Fee Allowances – Dentist. The ministry is not authorized to provide a supplement to cover fees that are more than the rate set out in the Schedule of Fee Allowances. Therefore, the panel finds that the ministry's decision that it could not provide coverage for the dentist's fee in excess of $130.27 was a reasonable application of the legislation.

b. Partial Cast Denture:

Under EAPWDR Schedule C section 4(3), the ministry may provide coverage for partial dentures if the person needs the denture to replace at least 3 contiguous missing teeth on the same arch, and at least one of those teeth was extracted in the previous 6 months. Partial dentures, including cast dentures, are included as a basic dental service, at the fee set out in the Schedule of Fee Allowances – Dentist.

The partial cast denture in the treatment plan proposal would be covered as a basic dental service at the fee set out in the Schedule of Fee Allowances, up to the amount remaining in the appellant's $1,000 coverage limit. When PBC approved the request, there was $550.31 left; by the time of the reconsideration decision there was $420.04 left.

If the cost of a partial denture is more than the amount left in the person's $1,000 coverage limit, the ministry may provide additional coverage for dentures, under EAPWDR Schedule C section 4(3). However, under Schedule C section 4(5), that additional coverage is limited to services under Fee Codes 52101 to 52402 in the Schedule of Fee Allowances – Dentist, which cover acrylic dentures, not cast dentures. A note in the Schedule of Fee Allowances – Dentist highlights that information.

The panel finds that the ministry's decision that the appellant was eligible for coverage of the partial cast denture as a basic dental service, up to the balance remaining of the appellant's $1,000 coverage limit, was a reasonable application of the legislation. The rest of the cost of the partial cast denture cannot be covered as a basic dental service because the dental supplement does not cover cast dentures. Therefore, the panel finds that the ministry was reasonable in its decision to deny coverage for the cost of the partial cast denture over the $1,000 coverage limit.

In its reconsideration decision, the ministry discusses eligibility for coverage of commercial laboratory procedures (fee code 99111), and states that the ministry cannot provide coverage for that service because it is not one of the dental services set out in the Schedule of Fee Allowances. While the panel agrees that the ministry cannot provide a dental supplement for a dental service that is not listed in the Schedule of Fee Allowances, the panel also notes that commercial laboratory procedures (fee code 99111) only appears in the treatment proposal plan. The dentist did not submit a request to PBC for payment of that fee code, although it appears that they included the amount of the laboratory fee in the denture fee. Having found that the ministry was reasonable in its decision about the denture fee, the panel considers it unnecessary to make a further finding about eligibility for coverage of the laboratory fee as a separate item.

The panel notes the ministry's advice in the reconsideration decision and at the hearing, that if the appellant could use an acrylic denture instead of a cast denture, the appellant and the dentist could submit that request to PBC for consideration as a dental supplement in excess of the $1,000 coverage limit under EAPWDR Schedule C section 4(3).

2. Life threatening health need:

EAPWDR section 69 authorizes the ministry to provide general health supplements and certain specified medical equipment, devices, and supplies if an eligible person faces "a direct and imminent life threatening need," but dental services and dentures are not included as eligible benefits under that section. Therefore, the panel finds that the ministry was reasonable not to provide coverage for the partial cast denture or the odontectomy as life threatening health needs.

3. Crisis supplement:

EAPWDR section 59(3) specifically states that the ministry cannot provide a crisis supplement "for the purpose of obtaining a supplement described in Schedule C" or "for any health care

goods or services." Dental services and dentures are a supplement described in Schedule C and therefore cannot be provided as a crisis supplement. The panel finds that the ministry was reasonable in its decision not to provide a crisis supplement for the partial denture or the odontectomy.

4. Balance of Dental Services in the Treatment Plan Proposal:

The ministry determined that it could not provide a reconsideration decision about the rest of the dental services in the treatment plan proposal.

The ministry has authorized PBC to assess and approve requests for coverage. The dentist only submitted requests for coverage to PBC for the partial denture and the odontectomy of tooth #47. Without an initial decision from PBC about coverage for the rest of the treatment plan proposal, the ministry is not authorized, under EAPWDA section 16, to make a reconsideration decision about those dental services. Therefore, the panel finds that the ministry's determination, that it could not give a reconsideration decision about a dental supplement for the dental services in the treatment plan proposal that had not been submitted to PBC for approval, was a reasonable application of the legislation.

Additional Considerations:

The panel notes the evidence of the ministry representative and the appellant, that there does not appear to be a dentist in the appellant's community who provides dental services at the rates set out in the Schedule of Fee Allowances, which was set in 2017. The ministry representative explained that access to services can depend on dentists who either agree to provide services below their usual fees, or who will accept a payment plan out of a recipient's monthly benefits. The ministry representative told the panel that the ministry had contacted the dentist, and neither of those options were available to the appellant.

The ministry representative had some suggestions that they said might help the appellant as he continues to look for the dental treatment he needs. Those suggestions included:

- find an advocate, or ask his nurse practitioner to help navigate the pre-authorization process with PBC;
- ask the dentist to submit the rest of the treatment plan proposal to PBC for approval, and consider whether some of the dental services in the treatment plan proposal might be covered as "emergency dental services" as defined in EAPWDR Schedule C;
- consider whether previous extraction of wisdom teeth, together with the extractions of 2 teeth on each side of the lower jaw, might mean that 3 contiguous teeth were missing, to meet the requirements in the EAPWDR for a partial denture;
- consider whether any of the dental services could be provided by a denturist at a lower cost.

The panel understands that the appellant has been suffering with pain and infections that have meant he has needed medical care, as well as dental treatment. The panel also recognizes that the appellant has had a lot of difficulty accessing dental services given the limits imposed by the legislation.

However, the role of the panel in the appeal is limited to considering the outcome of the request for reconsideration and determining whether the ministry's decision was reasonable. The

legislation does not give the panel, or the ministry, authority to approve dental fees outside the limits set out in the legislation.

Conclusion:

The panel finds that the ministry's decision was a reasonable application of the legislation in the appellant's circumstances. Therefore, the panel confirms the reconsideration decision. The appellant is not successful in the appeal.

Schedule of Legislation

Employment and Assistance for Persons with Disabilities Act

Reconsideration and appeal rights

Section 16(1) Subject to section 17, a person may request the minister to reconsider any of the following decisions made under this Act:

(a) a decision that results in a refusal to provide disability assistance, hardship assistance or a supplement to or for someone in the person's family unit;

(b) a decision that results in a discontinuance of disability assistance or a supplement provided to or for someone in the person's family unit;

(c) a decision that results in a reduction of disability assistance or a supplement provided to or for someone in the person's family unit;

(d) a decision in respect of the amount of a supplement provided to or for someone in the person's family unit if that amount is less than the lesser of

(i) the maximum amount of the supplement under the regulations, and

(ii) the cost of the least expensive and appropriate manner of providing the supplement;

(e) a decision respecting the conditions of an employment plan under section 9 *[employment plan]*.

(2) A request under subsection (1) must be made, and the decision reconsidered, within the time limits and in accordance with any rules specified by regulation.

(3) Subject to a regulation under subsection (5) and to sections 9 (7) *[employment plan]*, 17 and 18 (2) *[overpayments]*, a person who is dissatisfied with the outcome of a request for a reconsideration under subsection (1) (a) to (d) may appeal the decision that is the outcome of the request to the tribunal.

(4) A right of appeal given under subsection (3) is subject to the time limits and other requirements set out in the *Employment and Assistance Act* and the regulations under that Act.

(5) The Lieutenant Governor in Council may designate by regulation

(a) categories of supplements that are not appealable to the tribunal, and

(b) circumstances in which a decision to refuse to provide disability assistance, hardship assistance or a supplement is not appealable to the tribunal.

Delegation of minister's powers and duties

Section 25(1) Subject to the regulations, the minister may delegate to any person or category of persons any or all of the minister's powers, duties or functions under this Act except

(a) the power to prescribe forms, and

(b) the power to enter into an agreement under section 21 (2) or (2.1), unless section 21 (2.2) applies in relation to the agreement.

(2) A delegation of the powers, duties or functions of the minister must be in writing and may include any limits or conditions the minister considers advisable.

Employment and Assistance for Persons with Disabilities Regulation

Crisis supplement

Section 57(1) The minister may provide a crisis supplement to or for a family unit that is eligible for disability assistance or hardship assistance if

(a) the family unit or a person in the family unit requires the supplement to meet an unexpected expense or obtain an item unexpectedly needed and is unable to meet the expense or obtain the item because there are no resources available to the family unit, and

(b) the minister considers that failure to meet the expense or obtain the item will result in

(i) imminent danger to the physical health of any person in the family unit, or

(ii) removal of a child under the *Child, Family and Community Service Act*.

(2) A crisis supplement may be provided only for the calendar month in which the application or request for the supplement is made.

(3) A crisis supplement may not be provided for the purpose of obtaining

(a) a supplement described in Schedule C, or

(b) any other health care goods or services.

(4) A crisis supplement provided for food, shelter or clothing is subject to the following limitations:

(a) if for food, the maximum amount that may be provided in a calendar month is $40 for each person in the family unit;

(b) if for shelter, the maximum amount that may be provided in a calendar month is the smaller of

(i) the family unit's actual shelter cost, and

(ii) the sum of

(A) the maximum set out in section 2 of Schedule A and the maximum set out in section 4 of Schedule A, or

(B) the maximum set out in Table 1 of Schedule D and the maximum set out in Table 2 of Schedule D,

as applicable, for a family unit that matches the family unit;

(c) if for clothing, the amount that may be provided must not exceed the smaller of

(i) $100 for each person in the family unit in the 12 calendar month period preceding the date of application for the crisis supplement, and

(ii) $400 for the family unit in the 12 calendar month period preceding the date of application for the crisis supplement.

(5) and (6) Repealed. [B.C. Reg. 248/2018, App. 2, s. 2.]

(7) Despite subsection (4) (b), a crisis supplement may be provided to or for a family unit for the following:

(a) fuel for heating;

(b) fuel for cooking meals;

(c) water;

(d) hydro.

Dental supplements

Section 63 The minister may provide any health supplement set out in section 4 *[dental supplements]* of Schedule C to or for

(a) a family unit in receipt of disability assistance,

(b) a family unit in receipt of hardship assistance, if the health supplement is provided to or for a person in the family unit who is under 19 years of age, or

(c) a family unit, if the health supplement is provided to or for a person in the family unit who is a continued person.

Crown and bridgework supplement

Section 63.1 The minister may provide a crown and bridgework supplement under section 4.1 of Schedule C to or for

(a) a family unit in receipt of disability assistance, if the supplement is provided to or for a person in the family unit who is a person with disabilities, or

(b) a family unit, if the supplement is provided to or for a person in the family unit who

(i) is a continued person, and

(ii) was, on the person's continuation date, a person with disabilities.

Emergency dental and denture supplement

Section 64 The minister may provide any health supplement set out in section 5 *[emergency dental supplements]* of Schedule C to or for

(a) a family unit in receipt of disability assistance,

(b) a family unit in receipt of hardship assistance, or

(c) a family unit, if the health supplement is provided to or for a person in the family unit who is a continued person.

Health supplement for persons facing direct and imminent life threatening health need

Section 69 (1) The minister may provide to a family unit any health supplement set out in sections 2 (1) (a) and (f) *[general health supplements]* and 3 *[medical equipment and devices]* of Schedule C, if the health supplement is provided to or for a person in the family unit who is otherwise not eligible for the health supplement under this regulation, and if the minister is satisfied that

(a) the person faces a direct and imminent life threatening need and there are no resources available to the person's family unit with which to meet that need,

(b) the health supplement is necessary to meet that need,

(c) the adjusted net income of any person in the family unit, other than a dependent child, does not exceed the amount set out in section 11 (3) of the Medical and Health Care Services Regulation, and

(d) the requirements specified in the following provisions of Schedule C, as applicable, are met:

(i) paragraph (a) or (f) of section (2) (1);

(ii) sections 3 to 3.12, other than paragraph (a) of section 3 (1).

(2) For the purposes of subsection (1) (c),

(a) "adjusted net income" has the same meaning as in section 7.6 of the Medical and Health Care Services Regulation, and

(b) a reference in section 7.6 of the Medical and Health Care Services Regulation to an "eligible person" is to be read as a reference to a person in the family unit, other than a dependent child.

Schedule C

Definitions

Section 1 In this Schedule:

"basic dental service" means a dental service that

(a) if provided by a dentist,

(i) is set out in the Schedule of Fee Allowances — Dentist that is effective September 1, 2017 and is published on the website of the ministry of the minister, and

(ii) is provided at the rate set out in that Schedule for the service and the category of person receiving the service,

(b) if provided by a denturist,

(i) is set out in the Schedule of Fee Allowances — Denturist that is effective September 1, 2017 and is published on the website of the ministry of the minister, and

(ii) is provided at the rate set out in that Schedule for the service and the category of person receiving the service, and

(c) if provided by a dental hygienist,

(i) is set out in the Schedule of Fee Allowances — Dental Hygienist that is effective September 1, 2017 and is published on the website of the ministry of the minister, and

(ii) is provided at the rate set out in that Schedule for the service and the category of person receiving the service;

"denture services" means services and items that

(a) if provided by a dentist

(i) are set out under fee numbers 51101 to 51302 in the Schedule of Fee Allowances — Dentist that is effective September 1, 2017 and is published on the website of the ministry of the minister, and

(ii) are provided at the rate set out in that Schedule for the service or item and the category of person receiving the service or item, and

(b) if provided by a denturist

(i) are set out under fee numbers 31310 to 31321 in the Schedule of Fee Allowances — Denturist that is effective September 1, 2017 and is published on the website of the ministry of the minister, and

(ii) are provided at the rate set out in that Schedule for the service or item and the category of person receiving the service or item;

"emergency dental service" means a dental service necessary for the immediate relief of pain that,

(a) if provided by a dentist,

(i) is set out in the Schedule of Fee Allowances — Emergency Dental — Dentist, that is effective September 1, 2017 and is published on the website of the ministry of the minister, and

(ii) is provided at the rate set out in that Schedule for the service and the category of the person receiving the service, and

(b) if provided by a denturist,

(i) is set out in the Schedule of Fee Allowances — Emergency Dental — Denturist, that is effective

September 1, 2017 and is published on the website of the ministry of the minister, and

(ii) is provided at the rate set out in that Schedule for the service and the category of the person receiving the service;

Dental supplements

Section 4 (1) In this section, "period" means

(a) in respect of a person under 19 years of age, a 2 year period beginning on January 1, 2017, and on each subsequent January 1 in an odd numbered year, and

(b) in respect of a person not referred to in paragraph (a), a 2 year period beginning on January 1, 2003 and on each subsequent January 1 in an odd numbered year.

(1.1) The health supplements that may be paid under section 63 *[dental supplements]* of this regulation are basic dental services to a maximum of

(a) $2 000 each period, if provided to a person under 19 years of age, and

(b) $1 000 each period, if provided to a person not referred to in paragraph (a).

(c) Repealed. [B.C. Reg. 163/2005, s. (b).]

(2) Dentures may be provided as a basic dental service only to a person

(a) who has never worn dentures, or

(b) whose dentures are more than 5 years old.

(3) The limits under subsection (1.1) may be exceeded by an amount necessary to provide dentures, taking into account the amount remaining to the person under those limits at the time the dentures are to be provided, if

(a) a person requires a full upper denture, a full lower denture or both because of extractions made in the previous 6 months to relieve pain,

(b) a person requires a partial denture to replace at least 3 contiguous missing teeth on the same arch, at least one of which was extracted in the previous 6 months to relieve pain, or

(c) a person who has been a recipient of disability assistance or income assistance for at least 2 years or a dependant of that person requires replacement dentures.

(4) Subsection (2) (b) does not apply with respect to a person described in subsection (3) (a) who has previously had a partial denture.

(5) The dental supplements that may be provided to a person described in subsection (3) (b), or to a person described in subsection (3) (c) who requires a partial denture, are limited to services under

(a) fee numbers 52101 to 52402 in the Schedule of Fee Allowances — Dentist referred to in paragraph (a) of the definition "basic dental service" in section 1 of this Schedule, or

(b) fee numbers 41610, 41612, 41620 and 41622 in the Schedule of Fee Allowances — Denturist referred to in paragraph (b) of the definition "basic dental service" in section 1 of this Schedule.

(6) The dental supplements that may be provided to a person described in subsection (3) (c) who requires the replacement of a full upper, a full lower denture or both are limited to services under

(a) fee numbers 51101 and 51102 in the Schedule of Fee Allowances — Dentist referred to in paragraph (a) of the definition "basic dental service" in section 1 of this Schedule, or

(b) fee numbers 31310, 31320 or 31330 in the Schedule of Fee Allowances — Denturist referred to in paragraph (b) of the definition "basic dental service" in section 1 of this Schedule.

(7) A reline or a rebase of dentures may be provided as a basic dental service only to a person who has not had a reline or rebase of dentures for at least 2 years.

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Part A - Preamble - Dental Supplements - Dentist

The overall intent of the Ministry of Social Development and Poverty Reduction (Ministry) Dental Supplements is to provide coverage for basic and emergency dental services to eligible individuals who receive assistance through the BC Employment and Assistance (BCEA) Program and children in low-income families. The attached Part B - *Schedule of Fee Allowances - Dentist* outlines the eligible services and fees associated with the Ministry's Dental Supplements and the provision of basic dental services. It contains the rules, frequency and financial limits associated with each service. All frequency limitations include services performed by dentists, denturists and hygienists.

The following information provides details on the Ministry's Dental Supplements, how to confirm eligibility and obtain payment for services rendered.

Eligibility for Dental Supplements

It is important to note that the Ministry provides varying levels of benefits and some individuals may have coverage for basic dental services with a 2-year limit while others are limited to coverage of emergency dental services only. To ensure active coverage is in place and to confirm the type and amount of coverage available, eligibility must be confirmed for all patients prior to proceeding with any treatment. Procedures for confirming eligibility for your patients are outlined on page (v) under the Eligibility Information section.

BCEA Adults

Adults who are eligible for basic dental services under Ministry Dental Supplements are eligible for a $1,000 limit every 2-year period beginning on January 1st of every odd numbered year. The applicable fees for services provided to adult patients are listed in the *Schedule of Fee Allowances – Dentist* under the column marked "Adult".

BCEA Children

Children (under 19 years of age) covered under the Ministry Dental Supplement are eligible for a $2,000 limit for basic dental services every 2-year period beginning on January 1st of every odd numbered year.

Healthy Kids

Dependent children (under 19 years of age) whose parent(s) receive premium assistance through the Medical Services Plan (MSP) are eligible for dental supplements through the Healthy Kids Program.

Children covered under the Healthy Kids Program have a $2,000 limit for basic dental services every 2-year period beginning on January 1st of every odd numbered year.

The applicable fees for services provided to BCEA Children and Healthy Kids patients are listed in the *Schedule of Fee Allowances – Dentist* under the column marked "Child".

Emergency Dental Supplements

For Ministry clients who are not eligible for the previously noted 2-year limit or those who have exhausted their limit, some short-term assistance may be available through Emergency Dental Supplements. Children covered under the Healthy Kids program are also eligible for Emergency Dental Supplements. Emergency Dental allows for treatment of an eligible person who needs immediate attention to relieve pain, or to control infection or bleeding or if a person's health or welfare is otherwise immediately jeopardized.

Specific and comprehensive information regarding allowable emergency services along with their associated fees, rules and restrictions and billing information can be found under Part C - *Preamble - Emergency Dental Supplements* and Part D - *Schedule of Fee Allowances - Emergency Dental - Dentist*. Emergency services must be billed on a separate claim form and clearly marked as "Emergency".

Denture Policy

Initial Placement – Complete Denture(s)

All Ministry clients, including those with Emergency Dental Supplement coverage only, are eligible for a single complete denture (upper or lower), or complete dentures if the dentures are required as a result of extractions for the relief of pain resulting in full clearance of the arch/arches. This clearance must have taken place in the preceding six months. If extractions were completed in the hospital, a comment must be noted on the claim form that indicates date and place of surgery. To ensure active coverage is in place, eligibility must be confirmed for all patients prior to proceeding with any treatment. Procedures for confirming eligibility for your patients are outlined on page (v) under the Eligibility Information section.

The number of extractions required is not limited, but the extractions must result in full clearance and either be completed using the patient's basic dental limit or meet the criteria under the Emergency Dental Supplements. Refer to the Part D - *Schedule of Fee Allowances - Emergency Dental – Dentist* for detailed information.

The denture fee items are restricted to 51101, 51102, 51301 and 51302.

For those patients that have a 2-year limit, funds still available within that limit will be utilized to pay for the denture(s) with the remaining balance for the denture(s) paid over limit.

Note: Coverage for dentures is normally limited to once per arch every five years, however, payment of a **partial** denture within the past five years will not preclude provision of a complete denture as a result of full clearance. Conversely, partial dentures should not be used as provisional or temporary appliances.

Denture Policy, continued

Initial Placement – Partial Denture(s) in excess of the 2-year basic dental limit

It is important to note that not all Ministry clients qualify for partial dentures. Eligibility for this service must be confirmed prior to beginning treatment. See the Eligibility Information section on page (v).

For eligible patients, partial dentures will be considered in excess of their 2-year limit, if all of the following conditions apply:

1. At least one extraction is required for relief of pain and the extraction has been donein the preceding six months,
2. The extraction(s) must result in 3 or more adjacent/contiguous missing teeth on thesame arch, and
3. The Ministry has not paid for a denture on the same arch within the past five years.

Fee items will be restricted to the 52000 series outlined in the *Schedule of Fee Allowances - Dentist*. No cast dentures will be covered in excess of the patient's limit.

Funds still available within the patient's limit will be utilized first with the remaining balance for denture(s) paid over limit. It is expected that the patient's basic treatment (extractions, filling, etc.) will have been accomplished within the confines of the patient's limit unless treatment qualifies under the Emergency Dental Supplements criteria. Referto the *Schedule of Fee Allowances - Emergency Dental - Dentist* for detailed information. There is no ability to approve extractions, fillings, etc. over the patient's limit or outside the Emergency Dental Supplements.

Replacement Dentures (partial or complete) in excess of the 2-year basic dental limit

It is important to note that not all Ministry clients qualify for replacement dentures. Eligible clients must have 2 years continuous Ministry coverage. Eligibility for this service must be confirmed prior to beginning treatment. See the Eligibility Information section on page (v).

The Ministry will pay for denture(s) only once every five years. Note: an exception to this would be if the current denture(s) was a partial and the replacement denture(s) is complete in conjunction with full clearance of teeth (see above under Initial Placement – Complete Dentures).

Fee items will be restricted to the 51100 series for complete dentures and 52000 for partial dentures outlined in the *Schedule of Fee Allowances - Dentist*. No cast dentures will be covered in excess of the patient's 2-year limit. Funds still available within the patient's limit will be utilized first with the remaining balance for denture(s) paid over limit.

Relines, Rebases and other denture related treatment

No other denture treatment will be considered over the patient's 2-year limit as urgent needs can be met through the Emergency Dental Supplements.

Anaesthesia and Sedation

Conscious Sedation

Limited coverage for conscious sedation is available for children under 19 years of age, and only when necessary for the safe performance of dental treatment or when the dentist is prevented from providing necessary treatment without sedation.

Refer to detailed information and restrictions noted under fee items 92411 to 92418 and 92431 to 92438 in the *Schedule of Fee Allowance - Dentist*.

General Anaesthetic (GA) and IV sedation in Dental Office

Limited coverage for GA/IV sedation in office is available under fee code 92215. Referto the detailed information and restrictions noted under fee code 92215 in the *Scheduleof Fee Allowances – Dentist*. Eligibility for this service must be confirmed prior to treatment. See the Eligibility Information section on page (v).

General Anaesthetic (GA) and IV Sedation in a Private Facility

The Ministry does not cover GA and IV sedation facility fees. Effective April 2003, the management of private facility fees was transferred to the Provincial Health Services Authority (PHSA) at BC Children's Hospital (BCCH). For specific information on coverage of facility fees through the PHSA, visit the Community Dental Partners Program website at http://www.bcchildrens.ca/health-professionals/clinical-resources/dentistry or contact them at CommunityDentalPartners@phsa.ca.

Access to additional $1000 of Basic Dental Services when treatment is completed in an approved Private Facility Or Hospital

If your patient is found eligible and dental treatment is performed under GA/IV sedation in hospital through the Medical Services Plan (MSP) or in an approved facility through the Community Dental Partners Program, access to an additional $1000 of basic dental services is available. You must ensure you have noted on your claim form that treatment was performed under GA or IV sedation in an approved private facility or hospital. The name of the private facility or hospital is also required.

The additional $1000 over the patient's limit is a once yearly supplement but can be utilized over multiple GA/IV sedation appointments should more than one appointment be necessary. An example would be if a child has a GA and uses up their $1400 biennial limit plus $100 of the additional limit and then a second GA is necessary, the patient would have access to the remaining $900 that year.

Note: The additional $1000 of basic dental services is not available when treatment is done in office. The eligible dental services will be paid at rates in accordance withthe *Schedule of Fee Allowances – Dentist.* All rules, frequency and financial limits associated with each service still apply. There is no provision to exceed time and financial limited services (i.e.: 2 year filling limits).

Crown and Bridge Supplement

Specific and comprehensive information regarding allowable services along with their associated fees, rules and restrictions and billing information can be found under Part E - *Preamble - Crown and Bridgework Supplement* and Part F - *Schedule of Fee Allowances - Crown and Bridgework.*

Eligibility Information

Eligibility must be confirmed for all patients prior to treatment, including those covered by the Emergency Dental Supplement. We recommend you request picture identification in addition to their Personal Health Number (PHN) from new patients.

You must confirm that there are sufficient funds available within your patient's limit to pay for scheduled services and previous dental history should be checked for time-limited procedures. Treatment involving more than one practitioner or a specialist should be coordinated to ensure sufficient funds are available for all services planned.

To ensure that your patient has active Ministry sponsored coverage and to determine the level of this coverage, eligibility must be confirmed immediately prior to providing service, as coverage can change from month to month.

Steps to confirm a patient's eligibility:

1. **Obtain the patient's Personal Health Number (PHN) from their CareCard or BC Services Card.**

Vancouver: 1-604-419-2780 All other Communities: 1-800-665-1297

If Ministry clients or parents of children covered through the Healthy Kids Program have questions related to their coverage, they should be referred to the Ministry's Dental Information Line at 1-866-866-0800.

Payment Process

Claims under the Ministry's Dental Supplements will be paid in accordance with the *Schedule of Fee Allowances - Dentist* and these fees represent the maximum amount the Ministry can pay for the services billed.

Claim Submission:

Dentists can submit claims electronically to Pacific Blue Cross via CDAnet for services provided under a patient's Basic Coverage (2-year limit). Some exclusions from CDAnet are:

1. **Submissions that require explanations on the claim form (e.g.: Emergency claims, General Anaesthetic, Crown and Bridge, etc.) and/or,**

Claims, including previously noted claims excluded from CDAnet process, may also be submitted on a standard dental claim form and sent to:

Pacific Blue CrossPO Box 65339
Vancouver, BCV5N 5P3

Certified specialists, including oral surgeons may receive an additional 10% on services billed. Refer to page 24 of the *Schedule of Fee Allowances – Dental – Dentist*

Treatment completed under the Emergency Dental Supplements must be submitted on a separate claim form and will be paid in accordance with the *Schedule of Fee Allowances - Emergency Dental – Dentist*.

To facilitate payment, it is essential that the submitted claim form be completed as accurately and thoroughly as possible using the patient's name and PHN. Where a claim form is correctly completed and the service provided is an eligible service coveredby the Ministry, payment can be expected within 30 days of receipt of the claim.
Rebilling within 30 days may not only hold up payment of the original claim, but will also delay the processing of subsequent claims.

Note: Claims requiring review by a dental consultant may take longer to process.

All claims are processed on a "first come, first served" basis therefore timely submission is encouraged. Claims must be submitted within one year of the date of service. No payment will be made on any claim received later than one year from the date of service.If there is an error on your billing, subsequent claims may jeopardize the payment of your rebilling.

The dentist must bill the actual service(s) rendered. An alternative fee item number should not be substituted. All claims must be submitted under the payment number of the dentist performing the service(s). Claims, resubmissions and adjustment requests must bear the dentist's signature. This confirms the work was completed and accurately billed. The dentist remains solely responsible for all claims submitted.

Every time a claim is submitted, it indicates the dental practitioners understanding of, and agreement with the terms, conditions and guidelines set out in this fee schedule. The Ministry will not pay for services rendered by a dental practitioner who is not registered to practice in BC, or provides services outside their scope of practice, or outside of limits and conditions on their practice.

Where payment of a claim has been adjusted or refused, the remittance statement will include an explanation code.

Note: Oral and dental surgery performed in hospital is to be billed to the Medical Services Plan of British Columbia. Claim forms and billing information can befound at: http://www2.gov.bc.ca/gov/content/health.

Specialist Referrals

Certified specialists, including oral surgeons may receive an additional 10% on services billed from the *Schedule of Fee Allowances – Dentist.* The Ministry contractor must have a record of the specialty on their billing system and the referring practitioner must be indicated on the claim form. If either of these is missing, the claim will be refused or reduced. If the referring practitioner is a Medical Doctor, please indicate this clearly on the claim form. As fee item 01601 – Examination and Diagnosis, Surgical by Oral Surgeon is restricted for use by Oral Surgeons only the additional 10% will not be applied to this fee item.

Unit of Time

One unit of time = 15 minutes.

Procedures billed on a per unit basis must reflect the predominant service done during the unit, or half unit of time.

Supernumerary Teeth

To identify where the tooth is located, use the following tooth numbers when submitting a claim for services performed on supernumerary teeth. Also indicate the tooth numbersin the area around the supernumerary tooth on the claim form.

Quadrant	Supernumerary tooth #
Quadrant # 1	19
Quadrant # 2	29
Quadrant # 3	39
Quadrant # 4	49

Services Per Sextant

When an entire sextant is not involved, the fee will be adjusted according to the number of teeth treated. When more than one sextant is billed, each should be on a separate claim line. This also applies if only one or two teeth are involved. In this instance, indicate both the sextant number and specific tooth numbers of the area treated. See example below:

Procedure Code	Description ofService	Tooth/Sextant Code	Total Fee (adult)
42311	Gingivectomy	05	146.85
42311	Gingivectomy Anterior	04 - 11	24.48
42311	Gingivectomy Posterior	08 - 47	29.37
	Or		
42311	Gingivectomy Anterior	07 - 31, 32, 33	73.44

AND POVERTY REDUCTION

Schedule of Fee Allowances – DentistEffective September 1, 2017

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	DIAGNOSTIC SERVICES		
	CLINICAL ORAL EXAMINATIONS (by Dentist)		
Note:	All examinations are limited to once per calendar year for adults and twice per calendar year for children under 19 years of age with the exception of fee items 01204/01205 - Specific or Emergency Oral Examinations and 01601 - Examination and Diagnosis, Surgical by OralSurgeon. 60 days must elapse between exams with the exception of 1204, 1205and 01601. A complete examination will not be paid for any patient more than oncein any three-year period. In addition, fee items 01101 to 01103 are limited to once per patient per lifetime to any one practitioner and are billable for a new patient only, previous emergency or specific examinations (fee items 01204 and 01205) excepted.		
01101	Complete Examination and Diagnosis on Primary Dentition – Recording history, charting, treatment planning and case presentation.To include: a) History, detailed medical and dental b) Clinical examination and diagnosis of hard and soft tissues, including carious lesions, missing teeth, determination of sulcular depth and location of periodontal pockets, gingival contours, mobility of teeth, recession, interproximal tooth contact relationships, occlusion of teeth, TMJ, pulp vitality tests where necessary and any other pertinent factors	40.13	46.97
01102	Complete Examination and Diagnosis on Mixed Dentition – Recording history, charting, treatment planning and case presentation.To include: a) Extended examination as described above under fee item 01101 b) Eruption sequence, tooth size, jaw size assessment	56.15	65.30
Note:	Fee items 01101 and 01102 are to be utilized for a new patient only with significant clinical problems, either abnormal craniofacial growth and development (e.g., cleft palate), or a medically compromised patient (e.g., hemophilia) or unusual dental disease such as amelogenesis imperfecta, dentiogenesis imperfecta, and abnormal periodontal conditions. Excessive decay alone does not constitute a significant clinical problem as noted above. Nature of significant clinical problem must be indicated on claim.		

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)

		Adult	Child
01103	Complete Examination and Diagnosis on Permanent Dentition – Recording history, charting, treatment planning and case presentation.To include: a) History, detailed medical and dental b) Clinical examination and diagnosis of hard and soft tissues, including carious lesions, missing teeth, determination of sulcular depth and location of periodontal pockets, gingival contours, mobility of teeth, recession, interproximal tooth contact relationships, occlusion of teeth, TMJ, pulp vitality tests where necessary and any other pertinent factors.	58.74	70.12
01201	Standard Oral Examination of New Patient – Examination with mirror and explorer of hard and soft tissues including checking and recording of occlusions and appliances but not including specific tests.	24.35	31.98
Note:	Fee item 01201 will only be paid if the practitioner has not seen the patient before; previous emergency or specific examinations (fee items 01204 and 01205) are exempted.		
01202	Previous Patient (recall) Oral Examination – Re-examination of a patient who is attending on a regular basis as described under 01201.	17.40	20.55
01204	Specific Oral Examination – (not included in the per year exam limit) Examination, evaluation, diagnosis and recording of a specific situation.	21.75	27.23
01205	Emergency Oral Examination – (not included in the per year exam limit) Examination and diagnosis for the investigation of discomfort and/or infection in a localized area. Not to be used as a substitute for 01201 or 01202.	21.75	39.77
Note:	Multiple billings of fee items 01204/01205 will be subject to review by the Ministry.		

01601	Examination and Diagnosis, Surgical by Oral Surgeon(not included in the per year exam limit) To include: a) History, Medical and Dental b) Clinical examination as above, may include in-depth analysis of medical status, medication, anaesthetic and surgical risk, initial consultation with referring dentist or physician, parent or guardian, evaluation of source of chief complaint, evaluation of pulpal vitality, mobility of teeth, occlusal factors, TMJ, or where the patient is to be admitted to hospital for dental procedures.	64.61	69.60

Note: Billing of fee item 01601 is limited to Certified Oral Surgeons only. Fee items 01204/01205 should be used for subsequent examinations of same patient and/or where examination does not include components outlined above. The additional 10% specialist fee does not apply to fee item 01601.

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
01701	Edentulous Examination and Diagnosis – Detailed medical and dental history (including prosthetic history), visual and digital examination of the oral structures, head and neck (including TMJ), lips, oral mucosa, tongue, oral pharynx, salivary glands, and lymphnodes.	39.37	46.67
	Note: Fee item 01701 is limited to one in a five-year period.		
01702	Specific Edentulous Examination, Note and Record – Visual and digital examination of the oral structures, head and neck, including T.M.J., lips, oral mucosa, tongue, oral pharynx, salivary glands,and lymph nodes.	18.53	21.96
	<u>RADIOGRAPHS</u>		
	Note: Radiographs are limited to: • $54.71 every 2 calendar years for adults, and • $70.49 every 2 calendar years for children under 19 years of age. A complete series, fee items 02101 or 02102 or thirteen films, fee item 02123, will be paid only once every 3 years. Fee item 02601, panoramic radiograph, is excluded from the two year radiograph limit for children.		
	<u>Complete Full Mouth Series</u> (including bitewings)		
02101	Minimum 12 films	50.52	65.74
02102	Minimum 16 films	54.71	70.49
	<u>Intraoral – Periapical</u>		
02111	Single Film	9.95	12.84
02112	Two Films	13.59	17.59
02113	Three Films	17.31	22.41
02114	Four Films	21.04	27.23
02115	Five Films	24.76	32.13

02116	Six Films	28.44	36.95
02117	Seven Films	32.12	41.63
02118	Eight Films	35.88	46.52
02119	Nine Films	39.52	51.35
02120	Ten Films	43.31	56.10
02121	Eleven Films	47.11	60.92
02122	Twelve Films	50.90	65.74
02123	Thirteen Films	54.71	70.49
	Intraoral – Occlusal		
02131	Single Film	13.92	18.33
02132	Two Films	19.47	25.30
02133	Three Films	25.89	33.69
	Intraoral – Bitewing		
02141	Single Film	9.95	12.84
02142	Two Films	13.59	17.59
02143	Three Films	17.31	22.41
02144	Four Films	21.04	27.23
FEE NO.	**FEE DESCRIPTION**	**FEE AMOUNT ($)**	
		Adult	**Child**
	Extraoral		
	Temporomandibular joint film one film = 2 views		
02501	Single film	25.32	33.39
02502	Two films	42.02	55.50
02601	Panoramic Film	38.76	48.82
Note:	Fee item 02601 is limited to once in a three-year period. Not included inthe two year radiograph limit for children under 19 years of age.		
	Cephalometric Films		
02701	Single Film	25.80	33.39
02702	Two Films	42.54	55.50
	TEST AND LABORATORY EXAMINATIONS		
	Biopsy		
04311	Soft Tissue – by Puncture	54.53	64.55
04312	Soft Tissue – by Incision	88.11	104.62
04322	Hard Tissue – by Incision	176.38	208.50
	Pulp vitality test		
Note:	Limited to 1 unit per quadrant in a six-month period. Tooth number required on claim.		
04501	One unit	45.88	54.39

04507	½ unit	22.91	27.23

DIAGNOSTIC MODELS (Including interpretation and laboratory costs)

Diagnostic models will be limited to once every three years.

Note: Not billable up to 90 days prior to space maintainers, occlusal guardsor prosthetic appliances being fabricated.

04911	Casts, diagnostic, unmounted, trimmed	43.29	57.06

PREVENTIVE SERVICES

Polishing - The removal of stain and plaque with the use of rubber cups, brushes or air polishers. Polishing should also consist of interproximal flossing and a recall review of oral hygiene procedures and techniques.

Note: The Ministry will pay a maximum of one polishing per adult in a calendaryear. Children under 19 years of age are covered for two polishing procedures per calendar year.

A minimum of 60 days must elapse between preventive (exam, polishing) visits. For patients with half of their natural dentition, i.e., edentulous on one arch, fee 11101 will be paid at one-half of the listed fee.

11101	Polishing	24.03	27.23

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Scaling		
Note:	Fee item numbers 11111 to 11119, 43421 to 43429, and 42111 in total are limited to a dollar maximum of: • $266.04 per calendar year for adults, and • $373.92 per calendar year for children under 19 years of age.		
11111	Scaling – one unit	22.17	31.16
11112	Scaling – two units	44.34	62.32
11113	Scaling – three units	66.51	93.48
11114	Scaling – four units	88.68	124.64
11115	Scaling – five units	110.85	155.80
11116	Scaling – six units	133.02	186.96
11117	Scaling – ½ unit	11.08	15.58
11119	Scaling – each additional unit over six	22.17	31.16
	Topical Fluoride Treatment		
Note:	Coverage for the application of topical fluoride is limited to children under 19 years of age and to a maximum of two fluoride treatments per calendar year.		
12101	Topical Fluoride Treatment	n/a	10.61
	Pit and Fissure Sealants		
Note:	Sealants will be paid once per tooth per lifetime on permanent caries-free occlusal surfaces on bicuspids and molars for children under 15 years of age. If an occlusal restoration is necessary within one year of a sealant, the fee for the sealant will be deducted from the restoration charge if performed by the same practitioner.		
13401	Single tooth	n/a	19.74
13409	Each additional tooth in same quadrant	n/a	10.83
New	Preventative Restorative Resin		
Note:	Coverage for Preventative Restorative Resins is limited to children under 19 years of age. This procedure involves some preparation of the pits and/or fissures in tooth enamel and may extend into dentin in limited areas.		
13411	Tooth number required.	n/a	39.55
New	Topical Silver Diamine Fluoride (SDF) Application		
Note:	Coverage for application of topical SDF is limited to children under19 years of age and to a maximum of 8 units per patient per year.		
13601	One unit	n/a	24.34
13602	Two units	n/a	48.68

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Appliances, periodontal (bruxing or occlusal guard).		
Note:	Fees 14611 and 14612 are inclusive of lab fees and the cost of studymodels. Patients are limited to one guard (either 14611 or 14612) in any five-year period. Patients that have upper and/or lower complete dentures are not eligible for these fee items.		
14611	Maxillary	244.35	287.15
14612	Mandibular	244.35	287.15
	Space Maintenance (including design, models, fabrication, lab fees,and insertion)		
Note:	Space maintainers will only be paid in cases when used to maintain space where a deciduous tooth has been lost prematurely and the appliance is used to retain space pending the normal eruption of the subsequent permanent tooth. It is not billable when used to obtain more space or maintain space when no permanent tooth eruption is expected. Limited to 1 unilateral space maintainer per quadrant OR 1 bilateral space maintainer per arch per 12 months.		
15101	Unilateral - Band Type – Fixed	138.36	184.02
Note:	Tooth number of extracted tooth required.		
15103	Bilateral - Band Type – Fixed (soldered lingual arch)	201.47	244.86
Note:	Tooth number of extracted tooth required.		
15601	Adjustment and/or Re-cementation of Space Maintainers	32.69	37.10
Note:	Tooth number required. Fee item 15601 will not be paid to the practitioner who seated the appliance within 6 months of insertion.		
15603	Repair of Space Maintainers	32.69	37.10
Note:	Tooth number required. Fee item 15603 includes re-cementation and is limited to a maximum of: • $65.38 per adult per calendar year, and • $74.20 per child under 19 years of age per calendar year.		
	Disking of Primary Teeth (interproximal)		
Note:	Tooth numbers required. Maximum one unit per date of service to a maximum of 2 units per calendar year. Limited to primary dentition.		
16201	Disking, per unit	30.99	40.22

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Occlusal Adjustment/Equilibration		
Note:	May require several sessions and is not to be used by the dentist responsible for the delivery and post-insertion care of: 1. single restorations (20000 Restorative code series) at the same appointment; 2. removable prostheses (50000 Removable Prosthodontics code series) by the same dentist for a period of six months. Services billed under fees 16511 to 16519 will be limited to a dollar maximum of: • $385.14 per adult per calendar year, and • $430.36 per child under 19 years of age per calendar year.		
	Tooth numbers required.		
16511	One unit	48.14	53.80
16512	Two units	96.28	107.59
16513	Three units	144.42	161.39
16514	Four units	192.57	215.18
16517	½ unit	24.07	26.93
16519	Each additional units over four	48.14	53.80
	RESTORATIVE SERVICES		
	Treatment of Dental Caries		
	Removal of carious lesion or existing restoration and placement of sedative/protective dressing. Includes local anaesthetic and pulp pr otection.		
Note:	Tooth number required. Fee items 20111/20119 will not be paid subsequent root canal therapy or in conjunction with a restoration, an open and(Fedrain 39201/39202), pulp-capping (Fee 20141), pulpotomy (Fee 32231/32222/32231/32232) or pulpectomy (Fee 32321/32322) .		
20111	Treatment of Dental Caries - First tooth	57.20	80.14
20119	Each additional tooth in same quadrant	28.56	39.85
	Pulp Capping		
	Performed at the same appointment as the permanent restoration, to include placement of Ca(OH)2. This base material procedure is to be used where pulp exposure is evident. It is not to be used where decay removal is slightly below ideal preparation depths. This service is not eligible when performed in conjunctionwith an open and drain, treatment of dental caries, pulpotomy or pulpectomy. Tooth number required.		
20141	Direct pulp capping – in conjunction with final restoration	19.34	26.71

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
	AMALGAM RESTORATIONS		
Note:	Maximum fee allowance is five surfaces or the dollar equivalent per tooth in a two-year period. Tooth numbers are required. When billing for restorations, the total number of surfaces restored in that sitting on that tooth should be billed cumulatively. Where two different filling materials are used, these restorations may be billed separately.		
	Amalgam – Primary Teeth		
	Non-bonded		
21111	One surface	53.72	72.27
21112	Two surfaces	64.49	92.75
21113	Three surfaces	69.50	100.17
21114	Four surfaces	73.79	109.07
21115	Five surfaces (maximum)	98.47	146.17
	Bonded		
21121	One surface	63.60	86.07
21122	Two surfaces	74.44	102.40
21123	Three surfaces	79.29	113.53
21124	Four surfaces	83.34	123.17
21125	Five surfaces (maximum)	108.34	153.59
	Amalgam – Permanent Teeth		
	Non-bonded - Anterior and Bicuspid Teeth		
21211	One surface	57.20	83.10
21212	Two surfaces	72.90	105.36
21213	Three surfaces	86.09	124.66
21214	Four surfaces	101.06	150.63
21215	Five surfaces (maximum)	118.29	176.60
	Non-bonded - Molars		
21221	One surface	64.16	88.30
21222	Two surfaces	86.09	126.14
21223	Three surfaces	98.87	145.43
21224	Four surfaces	125.17	189.21
21225	Five surfaces (maximum)	143.21	218.15
	Bonded - Anterior and Bicuspid Teeth		
21231	One surface	66.99	93.49
21232	Two surfaces	82.69	112.78
21233	Three surfaces	95.65	138.75
21234	Four surfaces	114.16	164.72
21235	Five surfaces (maximum)	127.92	191.44
	Bonded - Molars		
21241	One surface	74.03	102.40
21242	Two surfaces	95.80	155.82
21243	Three surfaces	108.82	188.47
21244	Four surfaces	134.63	225.57
21245	Five surfaces (maximum)	152.92	267.86

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Retentive Pins		
Note:	Pins are only paid in conjunction with an amalgam or tooth coloure restoration to a maximum of four pins per tooth in a two-year period.		
21401	One pin	18.04	23.74
21402	Two pins	25.00	35.84
21403	Three pins	31.72	45.78
21404	Four pins (maximum)	38.35	56.10
	FULL COVERAGE PRE-FABRICATED RESTORATIONS		
Note:	Limited to one per tooth in a two-year period. No further restorations on the same tooth will be paid within 2 years of placement of a stainless steel or plastic pre-fabricated restoration. If a pre-fabricated restoration is placed within 2 years of a restoration, the fee for the restoration will be deducted from the pre-fabricated restoration charge.		
22201	Stainless steel restoration (primary anterior)	119.10	151.37
22211	Stainless steel restoration (primary posterior)	119.10	147.66
22301	Stainless steel restoration (permanent anterior)	119.10	152.11
22311	Stainless steel restoration (permanent posterior)	119.10	152.11
22401	Plastic pre-fabricated restoration (primary anterior)	119.10	152.11
22501	Plastic pre-fabricated restoration (permanent anterior)	135.52	175.11
	TOOTH COLOURED RESTORATIONS		
Note:	Maximum fee allowance is five surfaces or the dollar equivalent perin a tooth two-year period. Tooth numbers are required. When billing for restorations, the total number of surfaces restored in that sitting on tooth should be billed cumulatively. Where two different filling matare used, these restorations may be billed separately.	th at er ial s	
	Tooth Coloured – Permanent Teeth		
	Bonded - Anterior		
23111	One surface	75.47	90.52
23112	Two surfaces	90.56	109.07
23113	Three surfaces	114.46	137.27
23114	Four surfaces	141.99	171.40
23115	Five surfaces (maximum)	171.65	202.57
	Bonded - Bicuspids		
23311	One surface	87.91	104.62
23312	Two surfaces	122.65	144.69
23313	Three surfaces	144.04	176.60
23314	Four surfaces	177.11	216.66
23315	Five surfaces (maximum)	203.58	239.67
	Bonded - Molars		
23321	One surface	94.21	113.53
23322	Two surfaces	144.04	173.63

23323	Three surfaces	174.08	209.24
23324	Four surfaces	209.19	250.80
23325	Five surfaces (maximum)	243.18	297.54

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
	Tooth Coloured – Primary Teeth		
	Bonded - Anterior		
23411	One surface	69.63	88.30
23412	Two surfaces	88.21	113.53
23413	Three surfaces	98.30	126.14
23414	Four surfaces	112.33	144.69
23415	Five surfaces (maximum)	127.50	164.72
	Bonded - Molars		
23511	One surface	78.43	94.98
23512	Two surfaces	111.12	135.39
23513	Three surfaces	128.95	158.05
23514	Four surfaces	153.98	188.47
23515	Five surfaces (maximum)	179.08	219.63
	Posts		
Note:	Limited to once per tooth in a 5 year period and only paid in conjunctionwith a restoration.		
25731	Prefabricated, Retentive - 1 post	94.66	122.43
25732	Prefabricated, Retentive - 2 posts same tooth	151.78	198.11
29101	Recementation of crowns or bridge abutments 1 unit	41.95	54.61
Note:	Fee item 29101 is limited to 1 unit per tooth, per calendar year. Tooth number required.		
	ENDODONTICS		
	TREATMENT OF PULP CHAMBER (excluding final restoration)		
	Pulpotomy, Permanent teeth (as a separate emergency procedure)		
Note:	Limited to once per tooth per lifetime and cannot be billed in conjunction with open and drain, pulp capping, treatment of dental caries, pulpectomyor RCT.		
32221	Anterior and bicuspids	66.44	83.10
32222	Molars	66.44	83.85
	Pulpotomy, Primary teeth		
32231	As a separate procedure	48.62	60.92
32232	Concurrent with restorations (but excluding final restoration)	41.57	52.01

Pulpectomy

Note: Limited to primary teeth only and payable once per tooth per lifetime.

32321	Anterior tooth	88.14	111.30
32322	Posterior tooth	139.49	177.34

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	ROOT CANAL THERAPY		
Note:	Paid once per tooth per lifetime on permanent teeth or retained primary teeth ONLY. Where there is no permanent successor, the dentist must indicate on claim that tooth is a retained primary tooth. To include treatment plan, clinical procedures, with appropriate radiographs, including temporary restoration but excluding final restoration.Post-operative radiographs may be requested to support claims for two canals on permanent cuspid or anterior teeth.		
33111	One canal	254.17	327.96
33121	Two canals	330.93	421.46
33131	Three canals	469.13	600.28
33141	Four or more canals	521.77	671.51
	Apexification (induced apical closure)		
Note:	Paid on permanent teeth only once per tooth per lifetime and to include		
33601	Apexification one canal (first visit including pulpectomy)	83.21	105.36
33602	Apexification two canals (first visit including pulpectomy)	117.34	149.14
33603	Apexification three canals (first visit including pulpectomy)	154.51	197.37
33604	Apexification four canals (first visit including pulpectomy)	159.66	204.79
Note:	Re-insertion of dentogenic media will be paid on permanent teeth only toa maximum of three times per tooth per lifetime.		
33611	Re-Insertion of dentogenic media per visit one canal	27.76	34.80
33612	Re-Insertion of dentogenic media per visit two canals	38.84	49.12
33613	Re-Insertion of dentogenic media per visit three canals	55.52	70.49
33614	Re-Insertion of dentogenic media per visit four canals	62.58	80.14
	PERIAPICAL SERVICES		
	Apicoectomy – Separate procedure with curettage		
Note:	An apicoectomy performed on the same day as root canal therapy on the same tooth will be paid at one-half of the listed fee. If an apicoectomy and a surgical excision are performed on the same date of service, the surgical excision is paid at 100% of the listed fee and the apicoectomy is paid at 50%.		
	Maxillary Anterior		
34111	One root	218.37	277.51
34112	Two roots	259.33	327.22
	Maxillary Bicuspid		
34121	One root	223.45	287.90
34122	Two roots	271.16	350.22

34123	Three roots	311.06	395.49
	Maxillary Molar		
34131	One root	259.10	333.90
34132	Two roots	306.36	395.49
34133	Three roots	350.73	446.68
34134	Four or more roots	395.03	502.33
	Mandibular Anterior		
34141	One root	223.45	284.19
34142	Two root or more roots	267.90	337.61

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
	Mandibular Bicuspid		
34151	One root	223.45	288.64
34152	Two roots	267.90	341.32
34153	Three or more roots	312.27	396.97
	Mandibular Molar		
34161	One root	259.10	334.64
34162	Two roots	306.36	396.97
34163	Three roots	350.73	448.17
34164	Four or more roots	395.03	505.30
	Retrofilling performed in conjunction with Apical Surgery		
	Maxillary Anterior		
34211	One canal	38.84	48.60
34212	Two canals	77.52	96.46
	Maxillary Bicuspid		
34221	One canal	40.43	50.98
34222	Two canals	85.63	108.33
34223	Three canals	124.24	156.56
34224	Four or more canals	163.08	204.79
	Maxillary Molar		
34231	One canal	40.43	50.98
34232	Two canals	85.63	108.33
34233	Three canals	124.24	156.56
34234	Four or more canals	163.08	204.79
	Mandibular Anterior		
34241	One canal	40.43	50.98
34242	Two or more canals	85.63	108.33
	Mandibular Bicuspid		
34251	One canal	40.43	50.98
34252	Two canals	85.63	108.33
34253	Three canals	124.24	156.56
34254	Four canals	163.08	204.79
	Mandibular Molar		
34261	One canal	40.43	50.98
34262	Two canals	85.63	108.33

34263	Three canals	124.24	156.56
34264	Four or more canals	163.08	204.79

Amputations (include recontouring tooth and furca)

Note: Root amputations performed at the same time as root canal therapy and/or apicoectomy will be paid at one-half of the listed fee.

34411	Amputation of one root	193.11	247.83
34412	Amputation of two roots	231.72	298.28

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**

Hemisection

Note: Hemisections performed at the same time as root canal therapy and/or apicoectomy will be paid at one-half of the listed fee.

34422	Maxillary molar	109.45	141.02
34423	Mandibular molar	104.29	134.30

Open and Drain (Separate Emergency Procedure)

Note: Limited to once per tooth per lifetime. Tooth number required. If this procedure is followed within 60 days by Root Canal Therapy (RCT), the fee for the open and drain will be deducted. Following an open and drain,a permanent restoration on a posterior tooth will not be paid without evidence of intervening RCT. If open and drain (Fee 39201/39202) and intraoral incision and drainage of abscess (Fee 75112) are performed on the same day, fee 75112 will be paid at one-half of the listed fee.

39201	Anterior and Bicuspids	46.04	57.58
39202	Molars	46.04	57.58

PERIODONTAL SERVICES

Management of Oral Disease

Oral Manifestations, Oral Mucosal Disorders

Note: Mucocutaneous disorders and diseases of localized mucosal conditions, for example: lichen planus, aphthous stomatitis, benign mucous membranepemphigoid, pemphigus, salivary gland tumours, leukoplakia with and without dysplasia, neoplasms, hairy leukoplakia, polyps, verrucae, or fibroma.

Fee items 41211 to 41213 in total is limited to a dollar maximum of:

- $359.20 per adult per calendar year, and
- $531.28 per child under 19 years of age per calendar year.

Indicate diagnosis on claim form.

41211	One unit	44.90	66.41
41212	Two units	89.80	132.82
41213	Three units	134.70	199.23

Periodontal Surgery

Note: Fee item numbers 11111 to 11117, 43421 to 43429, and 42111 in total islimited to a dollar maximum of:

- $266.04 per adult per calendar year, and
- $373.92 per child under 19 years of age per calendar year.

Sextant number and the tooth numbers of the area treated are required inorder to process claims for fee item 42111. When an entire sextant is notinvolved, the fee will be adjusted according to the number of teeth treated.

42111	Surgical curettage, to include Definitive Root Planing			
		Per sextant	146.85	191.44
		Per anterior tooth	24.48	31.91
		Per posterior tooth	29.37	38.29

FEE NO.	FEE DESCRIPTION		FEE AMOUNT ($)	
			Adult	**Child**

Note: Fee item numbers 42201, 42311 and 42411 are limited to once per sextantin a five-year period. Sextant number and the tooth numbers of the area treated must be noted on claim. When an entire sextant is not involved,
the fee will be adjusted according to the number of teeth treated.

42201	Periodontal Surgical, Gingivoplasty			
		Per sextant	146.85	149.88
		Per anterior tooth	24.48	24.98
		Per posterior tooth	29.37	29.98
42311	Periodontal Surgical, Gingivectomy			
	The procedure by which gingival deformities are reshapedand reduced to create normal and functional forms, when the pocket is uncomplicated by extension into the underlying bone.			
		Per sextant	146.85	195.15
		Per anterior tooth	24.48	32.52
		Per posterior tooth	29.37	39.03

Periodontal Surgery, Flap Approach

42411	Flap Approach with Osteoplasty/Ostectomy			
		Per sextant	615.30	813.23
		Per anterior tooth	102.55	135.54
		Per posterior tooth	123.06	162.65

Periodontal Splinting or Ligation

43231	Wire Ligation	Per joint	62.20	81.62

Note: Tooth number required and limited to a maximum 4 joints per calendar year.

Root Planing, Periodontal

Note: Fee item numbers 11111 to 11117, 43421 to 43429, and 42111 in total will be limited to a dollar maximum of:

- $266.04 per adult per calendar year, and
- $373.92 per child under 19 years of age per calendar year.

43421	Root planing – one unit	22.17	31.16
43422	Root planing – two units	44.34	62.32
43423	Root planing – three units	66.51	93.48
43424	Root planing – four units	88.68	124.64
43425	Root planing – five units	110.85	155.80
43426	Root planing – six units	133.02	186.92
43427	Root planing – ½ unit	11.08	15.58
43429	Root planing – each additional unit over six	22.17	31.16

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	PROSTHODONTICS - REMOVABLE		
Note:	Dentures are an eligible item once every five years. The replacement of dentures within five years of original insertion will normally not be paid bythe Ministry. Refer to Denture Policy in Part A – Preamble to Dental Supplements - Dentist.		
	Lab fees are included in the listed fee unless otherwise indicated.		
	COMPLETE DENTURES Includes: – impressions – initial and fina jaw relation records – try-in evaluation and check records – insertion – adjustments (includes 6 months post-insertion care)		
51101	Complete Maxillary Denture	757.50	957.20
51102	Complete Mandibular Denture	780.75	1045.00
	IMMEDIATE COMPLETE DENTURES Also includes six month post-insertion care, including all tissue conditioners but does not include hard/permanent relines.		
51301	Immediate Complete Maxillary Denture	789.75	1182.28
51302	Immediate Complete Mandibular Denture	816.00	1266.37
	PARTIAL DENTURES Includes: – diagnostic models, analysis and design – tooth preparation and master impression – bite registration, mold selection and shade – try-in, insertion and occlusal equilibration – adjustments – (up to 6 months post-insertion)		
Note:	These services are not billable if to be followed by fixed prosthetic replacements.Temporary or provisional appliances are not covered.		
	Partial dentures, Acrylic		
	Acrylic base, with or without clasps		
52101	Maxillary	306.00	353.69
52102	Mandibular	320.25	385.85
	Acrylic partial with Resilient Retainer		
52201	Maxillary	630.00	928.76
52202	Mandibular	696.75	1011.61
	Acrylic partial with metal wrought/cast clasps and/or rests		
52301	Maxillary	468.00	555.27
52302	Mandibular	489.00	604.74

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Acrylic partial with metal wrought palatal/lingual bar and clasps and/orrests		
52401	Maxillary	510.00	623.29
52402	Mandibular	539.25	678.94
	Partial dentures, Cast		
	Free End, Cast Frame/Connector with clasps and rests		
53101	Maxillary	902.25	1215.67
53102	Mandibular	947.25	1325.73
	Tooth Borne, Cast Frame/Connector with clasps and rests		
53201	Maxillary	819.75	1036.35
53202	Mandibular	809.25	1036.35
	Minor denture adjustments		
Note:	Limited to one unit per arch, per date of service to a maximum of 2 units per arch in a calendar year. Arch code required. These items are not payable within six months of insertion of prostheses.		
54201	One unit	36.18	47.78
54202	Two units	72.40	95.57
	Denture Repairs/Additions		
Note:	Fees paid for denture repairs and additions are based on the listed dentist fee plus total lab fee charged. The Ministry will cover lab fees at reasonable and customary amounts for Denture Repairs/Additions (fee codes 55101-55402). The amount charged must be billed as two amounts (dentist professional fee plus lab fee) and lab slips must be available on request. Multiple billings for repairs to dentures are subject to review by the Ministry.		
	Complete Denture		
	Not Requiring an Impression		
55101	Maxillary	46.50 + L	60.99 + L
55102	Mandibular	46.50 + L	60.99 + L
	Impression Required		
55201	Maxillary	91.48 + L	121.69 + L
55202	Mandibular	91.48 + L	121.69 + L
	Partial Denture		
	Not Requiring an Impression		
55301	Maxillary	46.50 + L	60.99 + L
55302	Mandibular	46.50 + L	60.99 + L
	Impression Required		
55401	Maxillary	91.48 + L	121.69 + L
55402	Mandibular	91.48 + L	121.69 + L

Billing change

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Denture Relines and Rebases		
Note:	Relines and rebases are limited to a combined maximum of once per archin a two-year period and are not billable within the six-month post-insertion period of the dentures. Lab fees included.		
	Relines		
56211	Reline maxillary complete denture (direct)	108.39	180.31
56212	Reline mandibular complete denture (direct)	108.39	204.05
56221	Reline maxillary partial denture (direct)	72.29	143.95
56222	Reline mandibular partial denture (direct)	72.29	156.56
56231	Reline maxillary complete denture (processed)	212.38	300.52
56232	Reline mandibular complete denture (processed)	229.07	340.09
56241	Reline maxillary partial denture (processed)	172.94	293.92
56242	Reline mandibular partial denture (processed)	186.59	260.94
56251	Reline maxillary complete denture (processed), functional impressionrequiring 3 appointments	264.72	400.69
56252	Reline mandibular complete denture (processed), functional impression requiring 3 appointments	284.44	440.26
56261	Reline maxillary partial denture (processed), functional impression requiring 3 appointments	236.65	340.09
56262	Reline mandibular partial denture (processed) functional impression requiring 3 appointments	246.51	359.88
	Rebases		
56311	Rebase maxillary complete denture	232.86	334.20
56312	Rebase mandibular complete denture	250.31	340.09
56321	Rebase maxillary removable partial denture	191.76	288.23
56322	Rebase mandibular removable partial denture	210.86	296.09
	Tissue Conditioning		
Note:	Fee item numbers 56511, 56512, 56521 and 56522 are billable twice per arch per year only before a reline or the fabrication of a replacement denture.They are not billable during 6 months post-insertion period.		
56511	Maxillary complete denture – per appointment	54.31	72.12
56512	Mandibular complete denture – per appointment	54.31	72.12
56521	Maxillary partial denture – per appointment	54.31	72.12
56522	Mandibular partial denture – per appointment	54.31	72.12
	Miscellaneous Denture Services		
56601	Resilient liner in new, relined or rebased denture(s) – arch code required.	54.31	120.21

59601	Examination and Diagnosis, Prosthetic by Prescribing Dentist	22.68	30.13

Note: Post-insertion examination of the partial prosthesis made and inserted bya denturist. Evaluation of fit of framework, acrylic saddle area(s) and occlusion.

Limited to one per partial denture in a five-year period.

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	ORAL SURGERY		

Note: When multiple surgical procedures are performed on one quadrant on the same date of service, the most expensive procedure will be paid at 100% and the lesser procedures will be paid at 50%, with the exception of multiple extractions in the same quadrant.

Surgical services include the necessary local anaesthetic, removal of excess gingival tissue, suturing and all routine post-operative care. Pre-operative radiograph(s) may be requested to support claims for the extraction of impacted teeth.

EXTRACTIONS (REMOVALS)

Erupted teeth

Uncomplicated

71101	Single tooth	69.02	89.04
71109	Each additional tooth in same quadrant	45.59	58.77

Complicated (surgical approach)

Extraction, erupted tooth, requiring surgical flap and/or sectioning of tooth

71201	Single tooth	130.27	173.63
71209	Each additional tooth in same quadrant	85.98	130.59

Extraction, erupted tooth, requiring elevation of a flap, removal of bone AND section of tooth for removal of tooth

71211	Single Tooth	201.55	273.80
71219	Each additional tooth in same quadrant	133.03	205.53

Impacted teeth (Unerupted)

Extraction, impacted tooth, soft tissue coverage requiring incision ofoverlying soft tissue and removal of tooth

72111	Single tooth	130.27	174.37
72119	Each additional tooth in same quadrant	85.98	130.59

Extraction, impacted tooth involving tissue and/or bone coverage requiring incision of overlying soft tissue, elevation of a flap and EITHER removal of bone and tooth OR sectioning and removal of tooth (Partial Bone Covered).

72211	Single tooth	150.25	273.80
72219	Each additional tooth in same quadrant	99.17	205.53

Extraction, impacted tooth involving tissue and bone coverage requiringincision of overlying soft tissue, elevation of flap, removal of bone AND sectioning of tooth for removal (Complete Bone Covered).

72221	Single tooth	209.96	284.93
72229	Each additional tooth in same quadrant	138.58	213.70

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
	Extractions (removals), Residuals Roots		
Note:	Residual root removal is paid on a per tooth basis, not per root and are paid once per tooth per lifetime. Residual root removal will not be paid to the same practitionerwho performed the original extraction within 90 days of the extraction.		
	Residual root – Erupted		
72311	First tooth	63.84	89.78
72319	Each additional tooth, same quadrant	42.15	67.15
	Residual root - Soft Tissue Coverage		
72321	First Tooth	124.76	175.85
72329	Each additional tooth in same quadrant	88.84	132.08
	Residual root - Bone Tissue Coverage		
72331	First Tooth	143.78	204.05
72339	Each additional tooth in same quadrant	94.91	152.85
	Surgical Exposure of Teeth		
72511	Surgical Exposure, unerupted, uncomplicated, soft tissue coverage(includes operculectomy)	124.20	152.11
72521	Surgical Exposure, complex, hard tissue coverage	183.27	224.08
72611	Transplantation of erupted tooth (including splinting)	307.62	380.65
	Enucleation, Surgical		
Note:	Extraction of associated primary tooth included in fee.		
72711	Unerupted Tooth and Follicle first tooth	124.20	152.85
72719	each additional tooth, same quadrant	99.21	121.69
	Alveolar or Gingival Reconstruction		

Alveoplasty - Bone remodeling of ridge with soft tissue revisions

Note: Fee item 73111 will only be paid when two or more extractions are donein the same sextant. Fee paid for fee items 73111 and 73121 is based on the number of teeth or tooth areas treated. Sextant number and the tooth numbers of the area treated must be noted on claim.

73111	Alveoplasty with multiple extractions	per sextant	65.38	80.14
		per anterior tooth	10.90	13.36
		per posterior tooth	13.08	16.03

Edentulous, not in conjunction with extractions

73121	Alveoplasty, edentulous			
		per sextant	79.53	97.20
		per anterior tooth area	13.26	16.20
		per posterior tooth area	15.91	19.44

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**

Excision of Bone

73152	Excision of Torus Palatinus	224.44	276.02

Excision of Torus Mandibularis

73153	Unilateral	142.32	175.11
73154	Bilateral	231.00	284.19
73222	Excision of Vestibular Hyperplasia	140.55	172.14
73223	Surgical shaving of papillary hyperplasia of the palate	140.55	172.14
73224	Excision of pericoronal gingiva for retained teeth	33.50	40.88

Note: Fee item 73224 is not covered if done for crown lengthening.

73231	Excision of hyperplastic tissue	per	144.87	177.34
	sextant		24.15	29.56
	per anterior tooth		28.97	35.47
	per posterior tooth			
73421	Vestibuloplasty - sulcus deepening and ridge reconstruction per sextant		255.16	315.35

Surgical Excision

Note: Claims for fee item numbers 74111, 74112, 74121, 74122, 74611, 74612, 74631 and 74632 are paid inclusive of any associated extraction(s). The fee paid is based on the size of the lesion NOT length of the incision.

If an apicoectomy and a surgical excision are performed on the same date of service, the surgical excision is paid at 100% and the apicoectomy is paid at 50%.

74111	Resection of benign tumor of soft tissue	1 cm and under	179.30	213.70
74112		1 - 2 cm	349.21	418.49

74121	Resection of benign tumor of bone tissue	1 cm and under	177.11	212.21
74122		1 - 2 cm	347.10	417.75
	Enucleation of Cyst/Granuloma, Odontogenic and Non-Odontogenicrequiring prior removal of bony tissue and subsequent suture(s)			
74611		1 cm and under	215.87	264.89
74612		1 – 2 cm	380.77	469.69
74631	Excision of Cyst	1 cm and under	186.42	228.54
74632		1 - 2 cm	349.21	418.49
75112	Intraoral incision and drainage of abscess		47.25	57.80

Note: Fee item 75112 is limited to once per tooth per lifetime. Tooth number required. If open and drain (Fee 39201/39202) or RCT and intraoral incision and drainage of abscess are performed on the same day, fee 75112 will be paid at one-half of the listed fee.

Not billable in conjunction with an extraction.

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
75211	Extraoral incision and drainage of abscess (superficial)	86.90	106.85
	Surgical incision for removal of foreign bodies(does not include wire or bar splints)		
75301	Removal, from skin or subcutaneous alveolar tissue	82.12	100.91
75302	Removal of reaction-producing foreign bodies	82.12	100.91
	Fractures and Dislocations		
76201	Simple fracture of the mandible (closed reduction)	373.16	460.04
76301	Simple fracture of the maxilla (closed reduction)	404.35	496.84
76911	Fracture of Alveolus including debridement and necessary extractions	310.13	383.61
	Replantation of an avulsed tooth (including splinting)		
76941	Replantation, first tooth	221.29	273.06
76949	Each additional tooth	84.09	102.40
	Repositioning of Traumatically Displaced Teeth		

Note: Limited to permanent anterior teeth only, including repositioning, repair and splinting. Tooth number required. Maximum 3 units will be paid per tooth.

76951	One unit		38.27	46.75
76952	Two unit		76.54	93.49
76959	Each additional unit over two		38.27	46.75
	Repair of Uncomplicated Lacerations, Intraoral or Extraoral			
76961	2 cm or less		84.15	103.14
76962		2 – 4 cm	115.70	141.72
76963		over 5 cm	138.76	170.66

	Frenectomy		
Note:	Fee items 77801 and 77802 are limited to three per arch per lifetime and must be billed with an arch code.		
77801	Upper	146.29	178.82
77802	Lower	146.29	178.82
	Temporomandibular Joint		
78102	Management of TMJ dislocation, closed reduction, uncomplicated	98.06	120.20
78601	Management of TMJ by injection with anti-inflammatory drugs	98.76	120.20
79101	Dilation of salivary duct	34.82	42.67
79111	Sialolithotomy of salivary duct (anterior 1/3 of canal)	93.69	114.27
	Antral Surgery		
79311	Immediate recovery of a dental root or foreign body from the antrum (associated with and at the same time as extraction)	83.90	103.14
79331	Oro-antral fistula closure with buccal flap (same session)	178.57	219.63
79341	Oro-antral fistula closure with buccal flap (subsequent session)	187.14	230.02

FEE NO.	**FEE DESCRIPTION**	**FEE AMOUNT ($)**	
		Adult	**Child**
	Post-operative complications		
79601	Post-operative complications, subsequent to initial post surgical treatment.	33.50	40.81
Note:	Post-operative complications will be paid only if performed 4 or more days after surgery and not after 45 days post surgery. This fee item is limited to three services per patient per quadrant per lifetime and is inclusive of the examination fee.		
	MISCELLANEOUS		
	Anesthesia		
Note:	When delivering sedation and general anaesthetic, dentists must meet the regulatory requirements set out by the College of Dental Surgeons of BC.		
	General Anaesthetic and Intravenous sedation (in office)		
92215	per hour or portion thereof	50.57	192.92
Note:	GA or IV sedation (in office) will only be considered for coverage for children under 19 years of age where necessary for the safe performance of dental treatment; and children and adults with a severe mental or physical disability that prevents a dentist from providing necessary treatment without the administration of a GA or sedation.		
	Treatment start and finish times must accompany your claim. Pre andpost-operative observation periods are not included.		

Conscious Sedation

Note: Conscious sedation is only covered for children under 19 years of age, and only when necessary for the safe performance of dental treatment or when the dentist is prevented from providing necessary treatment without sedation.

Fee items 92411 to 92418 and 92431 to 92438 in total will be limited to a maximum of 8 units per calendar year.

Treatment start and finish times must accompany your claim. Time is measured from the placement of the inhalation device and terminates with the removal of the inhalation device. Pre and post-operative observation periods are not included.

New Nitrous Oxide

92411	One Unit	n/a	30.64
92412	Two Units	n/a	55.20
92413	Three Units	n/a	79.39
92414	Four Units	n/a	103.88
92415	Five Units	n/a	129.11
92416	Six Units	n/a	153.59
92417	Seven Units	n/a	178.08
92418	Eight Units	n/a	202.57

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**

New Nitrous Oxide with Oral Sedation

Refer to detailed notes under Conscious Sedation

92431	One Unit	n/a	86.07
92432	Two Units	n/a	120.95
92433	Three Units	n/a	155.08
92434	Four Units	n/a	189.95
92435	Five Units	n/a	224.08
92436	Six Units	n/a	258.96
92437	Seven Units	n/a	293.09
92438	Eight Units	n/a	327.96

Professional Consultations

93111	Consultation, with Member of the Profession (by dentist other thanpractitioner providing treatment)	30.58	39.99

Note: Includes the practitioner's examination fee but does not include such diagnostic items as pulp vitality tests, radiographs or study models. This fee is only to be used by a practitioner other than the practitioner providing treatment and a referral must be noted on the claim card.

93320	Pre-Anaesthetic Work-up Fee	40.02	n/a
	Administrative preparation for an adult patient who is physically and/or mentally disabled and requires dental treatment under General Anaesthetic or IV sedation in a hospital or an accredited private GA facility. To include consultation with physicians, group home administrators or care workers.		
Note:	This fee will only be paid in conjunction with treatment performed in hospital or an accredited private GA facility and must be billed at the same time as the dental treatment. Name of facility must be noted on claim form. This item will not be paid in conjunction with fee item 92215 – GA or IV sedation (in office).		
	Professional Visits		
94102	Emergency Visit – House Call When one must immediately leave home, office or hospital.	44.60	53.65
94301	Hospital (Institutional) Visit	39.37	47.56
Note:	Fee item 94301 is billable only when treating a patient who resides in a hospital or institutional facility. It is not billable if the patient is admitted to the hospital specifically for the purpose of dental services. A practitioner is restricted to billing a maximum of one visit per day regardless of the number of patients attended, or institutions visited. The name andaddress of the institution must be noted on the claim.		

Specialist Referrals

Certified specialists, including oral surgeons may receive an additional 10% on services billed from the *Schedule of Fee Allowances – Dentist.* The Ministry contractor must havea record of the specialty on their billing system and the referring practitioner must be indicated on the claim form. If either of these is missing, the claim will be refused or reduced. If the referring practitioner is a Medical Doctor, please indicate this clearly on the claim form. As fee item 01601 – Examination and Diagnosis, Surgical by Oral Surgeon is restricted for use by Oral Surgeons only the additional 10% will not be applied to this fee item.

Unit of Time

One unit of time = 15 minutes.

Procedures billed on a per unit basis must reflect the predominant service done during the unit, or half unit of time.

Supernumerary Teeth

To identify where the tooth is located, use the following tooth numbers when submitting a claim for services performed on supernumerary teeth. Also indicate the tooth numbers in the area around the supernumerary tooth on the claim form.

Quadrant	Supernumerary tooth #
Quadrant # 1	19
Quadrant # 2	29
Quadrant # 3	39
Quadrant # 4	49

Services Per Sextant

When an entire sextant is not involved, the fee will be adjusted according to the number of teeth treated. When more than one sextant is billed, each should be on a separate claim line. This also applies if only one or two teeth are involved. In this instance, indicate both the sextant number and specific tooth numbers of the area treated. See example below:

Procedure Code	Description ofService	Tooth/Sextant Code	Total Fee (adult)
42311	Gingivectomy	05	146.85
42311	Gingivectomy Anterior	04 - 11	24.48
42311	Gingivectomy Posterior	08 - 47	29.37
	Or		
42311	Gingivectomy Anterior	07 - 31, 32, 33	73.44

Note: All frequency limitations in this schedule also include services performed by a denturist or hygienist.

Part C - Preamble - Emergency Dental Supplements - Dentist

Emergency Dental Supplements is available for all eligible Ministry of Social Development and Poverty Reduction (Ministry) clients, including those who do not havea 2-year limit under the Ministry's Dental Supplements or those who have exhausted their limit. Children covered under the Healthy Kids program are also eligible for Emergency Dental Supplements. Emergency Dental allows for treatment of an eligible person who needs immediate attention to relieve pain, or to control infection or bleedingor if a person's health or welfare is otherwise immediately jeopardized.

The attached Part D - *Schedule of Fee Allowances – Emergency Dental – Dentist* outlines the allowable services and fees associated with the Ministry's Emergency Dental Supplements. It contains the rules, frequency and financial limits associated witheach service. All frequency limitations also include services performed by a denturist and hygienist.

Each emergency visit is restricted to the procedures and limitations outlined in this schedule (i.e., two restorations for pain relief per visit). Services outside this schedule (i.e., dentures, root canal treatment, restorations in excess of the 2 year maximum) will not be covered and any work beyond the immediate relief of pain will not be considered.

Frequency of emergencies (i.e., individual patients with multiple visits) and treatment provided will be monitored by the Ministry. Where concerns arise, Ministry staff will

address these issues with the dentist.

The following information provides details on how to confirm eligibility and obtain payment for services rendered.

Eligibility Information

Eligibility must be confirmed for all patients prior to treatment. We recommend you request picture identification in addition to their Personal Health Number (PHN) from new patients.

You must confirm that there is active coverage and previous dental history should be checked for time-limited procedures. Treatment involving more than one practitioner ora specialist should be coordinated to ensure no duplicated services are planned.

To ensure that your patient has active Ministry sponsored coverage and to determine the level of this coverage, eligibility must be confirmed immediately prior to providing service, as coverage can change from month to month.

Steps to confirm a patient's eligibility:

1. **Obtain the patient's Personal Health Number (PHN) from their CareCard or BCServices Card.**

Vancouver: 1-604-419- All other Communities: 1-800-665-

If Ministry clients or parents of children covered through the Healthy Kids Program have questions related to their coverage, they should be referred to the Ministry's Dental Information Line at 1-866-866-0800.

Payment Process

Claims for any treatment completed under the Emergency Dental Supplements must besubmitted on a separate claim form and you must clearly indicate that the services wereprovided for the immediate relief of pain or as an emergency.

Claims for emergency treatment must be submitted on a standard dental claim form andsent to:

Pacific Blue Cross
PO Box 65339
Vancouver, BC V5N 5P3

Claims under the Ministry's Dental Supplements will be paid in accordance with the *Schedule of Fee Allowances – Emergency Dental - Dentist* and these fees represent themaximum amount the Ministry can pay for the services billed.

Certified specialists, including oral surgeons may receive an additional 10% on servicesbilled.

Refer to page 11 of the *Schedule of Fee Allowances – Emergency Dental – Dentist.*

To facilitate payment, it is essential that the submitted claim form be completed as accurately and thoroughly as possible using the patient's name and PHN. Where a claim form is correctly completed and the service provided is an eligible service coveredby the Ministry, payment can be expected within 30 days of receipt of the claim.
Rebilling within 30 days may not only hold up payment of the original claim, but will alsodelay the processing of subsequent claims.

Note: Claims requiring review by a dental consultant may take longer to process.

All claims are processed on a "first come, first served" basis therefore timely submission is encouraged. Claims must be submitted within one year of the date of service. No payment will be made on any claim received later than one year from the date of service.If there is an error on your billing, subsequent claims may jeopardize the payment of your rebilling.

The dentist must bill the actual services(s) rendered. An alternative fee item number should not be substituted. All claims must be submitted under the payment number of the dentist performing the service(s). Claims, resubmissions and adjustment requests must bear the dentist's signature. This confirms the work was completed and accuratelybilled. The dentist remains solely responsible for all claims submitted.

Every time a claim is submitted, it indicates the dental practitioners understanding of,and agreement with the terms, conditions and guidelines set out in this fee schedule.The Ministry will not pay for services rendered by a dental practitioner who is not registered to practice in BC, or provides services outside their scope of practice, or outside of limits and conditions on their practice.

Payment Process, continued

Where payment of a claim has been adjusted or refused, the remittance statement willinclude an explanation code.

Note: Oral and dental surgery performed in hospital is to be billed to the Medical Services Plan of British Columbia. Claim forms and billing information can befound at:
http://www2.gov.bc.ca/gov/content/health.

Specialist Referrals

Certified specialists, including oral surgeons may receive an additional 10% on servicesbilled from the *Schedule of Fee Allowances – Dentist.* The Ministry contractor must have a record of the specialty on their billing system and the referring practitioner must be indicated on the claim form. If either of these is missing, the claim will be refused or reduced. If the referring practitioner is a Medical Doctor, please indicate this clearly on the claim form. As fee item 01601 – Examination and Diagnosis, Surgical by Oral Surgeon is restricted for use by Oral Surgeons only the additional 10% will not be applied to this fee item.

Unit of Time One unit of time = 15 minutes
Procedures billed on a per unit basis must reflect the predominant service done duringthe unit, or half unit of time.

Supernumerary Teeth

To identify where the tooth is located, use the following tooth numbers when submitting a claim for services performed on supernumerary teeth. Also indicate the tooth numbersin the area around the supernumerary tooth on the claim form.

Quadrant	Supernumerary tooth #
Quadrant # 1	19
Quadrant # 2	29
Quadrant # 3	39
Quadrant # 4	49

Services Per Sextant

When an entire sextant is not involved, the fee will be adjusted according to the numberof teeth treated. When more than one sextant is billed, each should be on a separate claim line. This also applies if only one or two teeth are involved. In this instance, indicate both the sextant number and specific tooth numbers of the area treated. See example below:

Procedure Code	Description ofService	Tooth/Sextant Code	Total Fee (adult)
42311	Gingivectomy	05	146.85
42311	Gingivectomy Anterior	04 - 11	24.48
42311	Gingivectomy Posterior	08 - 47	29.37
	Or		
42311	Gingivectomy Anterior	07 - 31, 32, 33	73.44

MINISTRY OF SOCIAL DEVELOPMENTAND POVERTY REDUCTION

Schedule of Fee Allowances – Emergency Dental – Dentist
Effective September 1, 2017

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	DIAGNOSTIC SERVICES		
	ORAL EXAMINATIONS (by dentist)		
01204	Specific Oral Examination (not included in the per year exam limit)	21.75	27.23
	Examination, evaluation, diagnosis and recording of a specificsituation.		

01205	Emergency Oral Examination (not included in the per year exam limit)	21.75	39.77
	Examination and diagnosis for the investigation of discomfort and/or infection in a localized area.		
Note:	Multiple billings of fee items 01204/01205 will be subject to review by the Ministry.		
	RADIOGRAPHS		
Note:	Maximum 2 intraoral films per emergency visit		
	Intraoral – Periapical		
02111	Single film	9.95	12.84
02112	Two films	13.59	17.59
	Intraoral – Bitewing		
02141	Single film	9.95	12.84
02142	Two films	13.59	17.59
	Extraoral		
02601	Panoramic Film	38.76	48.82
Note:	Fee item 02601 is limited to once every three years. Not included inthe two year radiograph limit for children under 19 years of age.		
	SCALING		
Note:	Only one unit of either scaling (fee item 11111) or root planing(fee item 43421) will be paid per emergency visit.		
11111	Scaling – one unit	22.17	31.16
FEE NO.	**FEE DESCRIPTION**	**FEE AMOUNT ($)** **Adult**	**Child**
	RESTORATIVE SERVICES		
Note:	**MAXIMUM TWO TEETH MAY BE TREATED PER EMERGENCY VISIT.**		
	Treatment of Dental Caries		
Note:	Removal of carious lesion or existing restoration and placement of sedative/protective dressing. Includes local anaesthetic and pulp protection. Tooth number required. Fee items 20111/20119 will not be paid subsequent to root canal therapy or in conjunction with a restoration, an open and drain, pulp-capping, pulpotomy or pulpectomy.		
20111	Treatment of Dental Caries – First tooth	57.20	80.14
20119	Each additional tooth in same quadrant	28.56	39.85

Pulp Capping

Note: Performed at the same appointment as the permanent restoration, to include placement of $Ca(OH)^2$. This base material procedure is to be used where pulp exposure is evident. It is not to be used where decay removal is slightly below ideal preparation depths. This service is not eligible when performed in conjunction with an open and drain, treatment of dental caries, pulpotomy or pulpectomy. Tooth number required.

20141	Direct pulp capping – in conjunction with final restoration	19.34	26.71

RESTORATIONS

AMALGAM RESTORATIONS

Note: Maximum fee allowance is five surfaces or the dollar equivalent pertooth in a two-year period. Tooth numbers are required. When billi for restorations, then total number of surfaces restored in that sittingthat tooth should be billedg cumulatively. Where two different filling materials are used, theseo restorations may be billed separately. n

Amalgam – Primary teeth

Non-bonded

21111	One surface	53.72	72.27
21112	Two surfaces	64.49	92.75
21113	Three surfaces	69.50	100.17
21114	Four surfaces	73.79	109.07
21115	Five surfaces (maximum)	98.47	146.17

Bonded

21121	One surface	63.60	86.07
21122	Two surfaces	74.44	102.40
21123	Three surfaces	79.29	113.53
21124	Four surfaces	83.34	123.17
21125	Five surfaces (maximum)	108.34	153.59

FEE NO.	**FEE DESCRIPTION**	**FEE AMOUNT ($)** **Adult**	**Child**

Amalgam – Permanent teeth

Non-bonded - Anterior and Bicuspid Teeth

21211	One surface	57.20	83.10
21212	Two surfaces	72.90	105.36
21213	Three surfaces	86.09	124.66
21214	Four surfaces	101.06	150.63
21215	Five surfaces (maximum)	118.29	176.60

Non-bonded – Molars

21221	One surface	64.16	88.30
21222	Two surfaces	86.09	126.14
21223	Three surfaces	98.87	145.43
21224	Four surfaces	125.17	189.21

21225	Five surfaces (maximum)	143.21	218.15
	Bonded - Anterior and Bicuspid Teeth		
21231	One surface	66.99	93.49
21232	Two surfaces	82.69	112.78
21233	Three surfaces	95.65	138.75
21234	Four surfaces	114.16	164.72
21235	Five surfaces (maximum)	127.92	191.44
	Bonded – Molars		
21241	One surface	74.03	102.40
21242	Two surfaces	95.80	155.82
21243	Three surfaces	108.82	188.47
21244	Four surfaces	134.63	225.57
21245	Five surfaces (maximum)	152.92	267.86
	Retentive Pins		
Note:	Pins are only paid in conjunction with an amalgam or tooth coloured restoration to a maximum of four pins per tooth in a two-year period.		
21401	One pin	18.04	23.74
21402	Two pins	25.00	35.84
21403	Three pins	31.72	45.78
21404	Four pins (maximum)	38.35	56.10
	Full Coverage Pre-fabricated Restorations		
Note:	Limited to one per tooth in a two-year period. No further restorations on the same tooth will be paid within 2 years of placement of a stainless steel or plastic pre-fabricated restoration. If a pre-fabricated restoration is placed within 2 years of a restoration, the fee for the restoration will be deducted from the pre-fabricated restoration charge.		
22201	Stainless steel restoration (primary anterior)	119.10	151.37
22211	Stainless steel restoration (primary posterior)	119.10	147.66

FEE NO.	**FEE DESCRIPTION**	**FEE AMOUNT ($)** **Adult**	**Child**
	Full Coverage Pre-fabricated Restorations, continued		
22301	Stainless steel restoration (permanent anterior)	119.10	152.11
22311	Stainless steel restoration (permanent posterior)	119.10	152.11
22401	Plastic Pre-fabricated restoration (primary anterior)	119.10	152.11
22501	Plastic Pre-fabricated restoration (permanent anterior)	135.52	175.11
	TOOTH COLOURED RESTORATIONS		
Note:	Maximum fee allowance is five surfaces or the dollar equivalent per tooth in a two-year period. Tooth numbers are required. When billing for restorations, the total number of surfaces restored in that sitting on that tooth should be billed cumulatively. Where two different filling materials are used, these restorations may be billed separately.		

	Tooth Coloured – Permanent teeth		
	Bonded - Anterior		
23111	One surface	75.47	90.52
23112	Two surfaces	90.56	109.07
23113	Three surfaces	114.46	137.27
23114	Four surfaces	141.99	171.40
23115	Five surfaces (maximum)	171.65	202.57
	Bonded - Bicuspids		
23311	One surface	87.91	104.62
23312	Two surfaces	122.65	144.69
23313	Three surfaces	144.04	176.60
23314	Four surfaces	177.11	216.66
23315	Five surfaces (maximum)	203.58	239.67
	Bonded – Molars		
23321	One surface	94.21	113.53
23322	Two surfaces	144.04	173.63
23323	Three surfaces	174.08	209.24
23324	Four surfaces	209.19	250.80
23325	Five surfaces (maximum)	243.18	297.54
	Tooth Coloured – Primary teeth		
	Bonded - Anterior		
23411	One surface	69.63	88.30
23412	Two surfaces	88.21	113.53
23413	Three surfaces	98.30	126.14
23414	Four surfaces	112.33	144.69
23415	Five surfaces (maximum)	127.50	164.72

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Bonded - Molars		
23511	One surface	78.43	94.98
23512	Two surfaces	111.12	135.39
23513	Three surfaces	128.95	158.05
23514	Four surfaces	153.98	188.47
23515	Five surfaces	179.08	219.63
	Retentive Post		
25731	Prefabricated, Retentive - 1 post	94.66	122.43

Note: Fee item 25731 is limited to once per tooth in a five-year period and only paidin conjunction with a restoration.

29101	Recementation of crowns or bridge abutments	1 unit	41.95	54.61

Note: Fee item 29101 is limited to 1 unit per tooth, per calendar year. Tooth number required.

ENDODONTICS

TREATMENT OF PULP CHAMBER (excluding final restoration)

Pulpotomy, Permanent teeth (as a separate emergency procedure**)**

Note: **MAXIMUM TWO TEETH MAY BE TREATED PER EMERGENCY VISIT.**
Limited to once per tooth per lifetime and cannot be billed in conjunction with open and drain, pulp capping, treatment of dental caries, pulpectomy or RCT.

32221	Anterior and bicuspids	66.44	83.10
32222	Molars	66.44	83.85

Pulpotomy, Primary teeth

32231	As a separate procedure	48.62	60.92
32232	Concurrent with restorations (but excluding final restoration)	41.57	52.01

Open and Drain (Separate Emergency Procedure)

Note: **MAXIMUM OF TWO TEETH MAY BE TREATED PER EMERGENCY VISI**
Open and Drain is limited to once per tooth per lifetime. Tooth number required. Following an open and drain, a permanent restoration on a posterior tooth will not be paid without evidence of intervening root canal treatment. If open and drain and intraoral incision and drainage of abscess (fee item 75112) are performed on the same day, fee 75112 will be paid at one-half of the listed fee.

39201	Anterior and Bicuspids	46.04	57.58
39202	Molars	46.04	57.58

FEE NO.	**FEE DESCRIPTION**	**FEE AMOUNT ($)**	
		Adult	**Child**

PERIODONTAL SERVICES

Oral Manifestations, Oral Mucosal Disorders
Mucocutaneous disorders and diseases of localized mucosal conditions, for example: lichen planus, aphthous stomatitis, benign mucous membrane pemphigoid, pemphigus, salivary gland tumours, leukoplakia with and without dysplasia, neoplasms, hairy leukoplakia,polyps, verrucae, or fibroma.

Note: Maximum two units per emergency visit. Indicate diagnosis on claim form.

41211	One unit	44.90	66.41
41212	Two units	89.80	132.82

Root Planing

Note: Only 1 unit of either scaling (fee item 11111) or root planing (fee item 43411)will be paid per emergency visit.

43421	Root Planing – one unit	22.17	31.16

PROSTHODONTICS

54201	Minor denture adjustments	One unit	36.18	47.78

Note: Limited to two units per arch per calendar year and not more than oneunit per arch per date of service/emergency visit. Adjustments are notpayable within six months of insertion of prosthesis.

Denture Repairs/Additions

Note: Fees paid for denture repairs and additions are based on the listed dentist fee plus total lab fee charged. The Ministry will cover lab fees at reasonable and customary amounts for Denture Repairs/Additions. The amount charged must be billed as two amounts (dentist fee plus lab fee) and lab slips must be available on request. Multiple billings forrepairs to dentures are subject to review by the Ministry. Only repairs without impression are covered. Repairs with impression are not an eligible item under Emergency Dental.

Complete Denture

Not Requiring an Impression

55101	Maxillary	46.50 + L	60.99 + L
55102	Mandibular	46.50 + L	60.99 + L

Partial Denture

Not Requiring an Impression

55301	Maxillary	46.50 + L	60.99 + L
55302	Mandibular	46.50 + L	60.99 + L

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child

Denture Relining

Note: Relines are limited to once per arch in a two-year period and are not billable within the six-month post-insertion period of the denture(s). Only direct relines will be covered. A lab-processed reline is not an eligible item under Emergency Dental.

56211	Reline maxillary complete denture (direct)	108.39	180.31
56212	Reline mandibular complete denture (direct)	108.39	204.05
56221	Reline maxillary partial denture (direct)	72.29	143.95
56222	Reline mandibular partial denture (direct)	72.29	156.56

ORAL SURGERY

Note: If multiple extractions or full clearance of an arch or arches is required, this may be completed in one or more appointments as warranted. When multiple surgical procedures are performed in one quadrant on the same date of service, the most expensive procedure will be paid at 100% and the lesser procedures will be paid at 50%, with the exception of multiple extractions in the same quadrant. Surgical services include the necessary local anaesthetic, removal of excess gingival tissue, suturing and all routine post-operative care. Pre-operative radiograph(s) may be requested to support claims for the extraction of impacted teeth.

EXTRACTIONS (REMOVALS)

Erupted teeth

Uncomplicated

71101	Single tooth	69.02	89.04
71109	Each additional tooth in same quadrant	45.59	58.77

Complicated (surgical approach)

Extraction, erupted tooth, requiring surgical flap and/or sectioning of tooth

71201	Single tooth	130.27	173.63
71209	Each additional tooth in same quadrant	85.98	130.59

Extraction, erupted tooth requiring elevation of a flap, removal of boneand section of tooth for removal of tooth

71211	Single tooth	201.55	273.80
71219	Each additional tooth in same quadrant	133.03	205.53

Impacted teeth (Unerupted)

Extraction, impacted tooth, soft tissue coverage requiring incision ofoverlying soft tissue and removal of tooth

72111	Single tooth	130.27	174.37
72119	Each additional tooth in same quadrant	85.98	130.59

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Extraction, impacted tooth involving tissue and/or bone coverage requiringincision of overlying soft tissue, elevation of flap and EITHER removal of bone and tooth OR sectioning and removal of tooth (Partial Bone Covered)		
72211	Single tooth	150.25	273.80
72219	Each additional tooth in same quadrant	99.17	205.53
	Extraction, impacted tooth involving tissue and bone coverage requiring incision of overlying soft tissue, elevation of flap, removal of bone AND sectioning of tooth for removal (Complete Bone Covered)		
72221	Single tooth	209.96	284.93
72229	Each additional tooth in same quadrant	138.58	213.70
	Extractions (removals), Residuals Roots		
Note:	Residual root removal is paid on a per tooth basis, not per root and is paid once per tooth per lifetime. Residual root removal will not be paid to the same practitioner who performed the original extraction within 90 days of the extraction.		
	Residual root - Erupted		
72311	First tooth	63.84	89.78

72319	Each additional tooth, same quadrant		42.15	67.15
	Residual root - Soft Tissue Coverage			
72321	First Tooth		124.76	175.85
72329	Each additional tooth in same quadrant		88.84	132.08
	Residual root - Bone Tissue Coverage			
72331	First Tooth		143.78	204.05
72339	Each additional tooth in same quadrant		94.91	152.85
	Alveoplasty - Bone remodeling of ridge with soft tissue revisions			
Note:	Fee item 73111 will only be paid when two or more extractions are done in the same sextant. Fee paid for fee items 73111 and 73121 is based on the number of teeth or tooth areas treated. Sextant number and the tooth numbers of the area treated are required.			
73111	Alveoplasty with multiple extractions	per	65.38	80.14
	sextant	per	10.90	13.36
	anterior tooth	per	13.08	16.03
	Alveoplasty, edentulous	per sextant		
73121	per anterior tooth area	per posterior tooth area	79.53	97.20
			13.26	16.20
			15.91	19.44

FEE NO.	FEE DESCRIPTION		FEE AMOUNT ($) Adult	Child
	Surgical Excision			
Note:	Claims for fee item numbers 74111, 74112, 74121, 74122, 74611, 74612, 74631 and 74632 are paid inclusive of any associated extraction(s). The fee paid is based on the size of the lesion NOT length of the incision.			
74111	Resection of benign tumor of soft tissue	1 cm and under	179.30	213.70
74112		1 - 2 cm	349.21	418.49
74121	Resection of benign tumor of bone tissue	1 cm and under	177.11	212.21
74122		1 – 2 cm	347.10	417.75
	Enucleation of Cyst/Granuloma, Odontogenic and Non-Odontogenic requiring prior removal of bony tissue and subsequent suture(s)			
74611		1 cm and under	215.87	264.89
74612		1 – 2 cm	380.77	469.69
74631	Excision of Cyst	1 cm and under	186.42	228.54
74632		1 - 2 cm	349.21	418.49
75112	Intraoral Incision and Drainage of Abscess		47.25	57.80
Note:	Fee item 75112 is limited to once per tooth per lifetime. Tooth number is required. If open and drain or RCT and intraoral incision and drainage of abscess (fee item 75112) are performed on the same day, fee 75112 will be paid at one-half of the listed fee. Not billable in conjunction with an extraction.			

75211	Extraoral Incision and Drainage of Abscess (superficial)	86.90	106.85
	Fractures and Dislocations		
76201	Simple fracture of the mandible (closed reduction)	373.16	460.04
76301	Simple fracture of the maxilla (closed reduction)	404.35	496.84
76911	Fracture of Alveolus including debridement and necessary extractions	310.13	383.61
	Replantation of an avulsed tooth (including splinting)		
76941	Replantation, first tooth	221.29	273.06
76949	Each additional tooth	84.09	102.40
	Repositioning of Traumatically Displaced Teeth		
Note:	Limited to permanent anterior teeth only, including repositioning, repair and splinting. Tooth number required. Maximum 3 units will be paid per tooth.		
76951	One unit	38.27	46.75
76952	Two unit	76.54	93.49
76959	Each additional unit over two	38.27	46.75
FEE NO.	**FEE DESCRIPTION**	**FEE AMOUNT ($) Adult**	**Child**
	Antral Surgery		
79311	Immediate recovery of a dental root or foreign body from the antrum (associated with and at the same time as extraction)	83.90	103.14
79331	Oro-antral fistula closure with buccal flap (same session)	178.57	219.63
79341	Oro-antral fistula closure with buccal flap (subsequent session)	187.14	230.02
79601	Post-operative complications, subsequent to initial post surgical treatment.	33.50	40.81
Note:	Post-operative complications will be paid only if performed 4 or more days after surgery and not after 45 days post surgery. This fee item is limited to three services per patient per quadrant per lifetime and is inclusive of the examination fee.		
	ANAESTHESIA		
Note:	When delivering sedation and general anaesthetic, dentists must meet the regulatory requirement set out by the College of Dental Surgeons of BC.		

92215	General Anaesthetic (GA) and Intravenous sedation (in office)		
	per hour or portion thereof	50.57	192.92

Note: GA or IV sedation (in office) will only be considered for coverage for children under 19 years of age where necessary for the safe performance of dental treatment; and children and adults with a severe mental or physical disability that prevents a dentist from providing necessary dental treatment without the administration of a GA or sedation.

Treatment start and finish times must accompany your claim. Pre and post-operative observation periods are not included.

New Conscious Sedation

Note: Conscious sedation is only covered for children under 19 years of age, and only when necessary for the safe performance of dental treatment or when the dentist is prevented from providing necessary dental treatment without sedation.

Fee items 92411 to 92418 and 92431 to 92438 in total will be limited to a maximum of 4 units per emergency visit.

Treatment start and finish times must accompany your claim. Time is measured from the placement of the inhalation device and terminates with the removal of the inhalation device. Pre and post-operative observation periods are not included.

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Nitrous Oxide		
92411	One Unit	n/a	30.64
92412	Two Units	n/a	55.20
92413	Three Units	n/a	79.39
92414	Four Units	n/a	103.88
	Nitrous Oxide with Oral Sedation		
92431	One Unit	n/a	86.07
92432	Two Units	n/a	120.95
92433	Three Units	n/a	155.08
92434	Four Units	n/a	189.95

Specialist Referrals

Certified specialists, including oral surgeons, may receive an additional 10% on services billed from the *Schedule of Fee Allowances – Emergency Dental - Dentist.* The Ministry must have a record of the specialty on their billing system and the referring practitioner must be indicated on the claim form. If either of these is missing, the claim will be refused or reduced. If the referringpractitioner is a Medical Doctor, please indicate this clearly on the claim form.

Unit of Time

One unit of time = 15 minutes. Procedures billed on a per unit basis must reflect thepredominant service done during the unit, or half unit of time.

Supernumerary Teeth

Use tooth numbers 19, 29, 39 or 49 when submitting a claim for services performed on supernumerary

teeth. Indicate the tooth numbers of the area around the supernumerary tooth inthe description of service column on the claim form.

Quadrant	Supernumerary tooth #
Quadrant #1	19
Quadrant #2	29
Quadrant #3	39
Quadrant #4	49

Services Per Sextant

When an entire sextant is not involved, the fee will be adjusted according to the number of teethtreated. When more than one sextant is billed, each should be on a separate claim line. This also applies if only one or two teeth are involved. In this instance, indicate both the sextant number and specific tooth numbers of the area treated. See example below:

ProcedureCode	Description ofService	Tooth/Sextant Code	Total Fee (adult)
42311	Gingivectomy	05	146.85
42311	Gingivectomy Anterior	04 - 11	24.48
42311	Gingivectomy Posterior	08 - 47	29.37
	Or		
42311	Gingivectomy Anterior	07 - 31, 32, 33	73.44

Note: All frequency limitations in this schedule also include services performed by adenturist or hygienist.

Part E - Preamble - Crown and Bridgework Supplement

The overall intent of the Ministry of Social Development and Poverty Reduction (Ministry) Dental Supplements is to provide coverage for basic dental services to eligible individualswho receive assistance through the BC Employment and Assistance Program. The attached Part F- *Schedule of Fee Allowances – Crown and Bridgework* outlines the eligible services and fee associated with the Crown and Bridgework Supplement. It contains the rules, and frequency limits associated with each service.

The following information provides details on the Ministry's Crown and Bridgework Supplement, how to confirm eligibility and how to obtain preauthorization and payment forservices rendered.

Eligibility for Crown and Bridgework Supplement

It is important to note that the Ministry provides varying levels of benefits and some individuals may not have coverage for the Crown and Bridgework Supplement.

The Ministry recognizes that in some exceptional circumstances the appropriate treatmentfor a compromised tooth is a crown or bridgework. An exception to the general policy of providing a conservative dental restoration or removable prosthetic may be considered if the individual meets the criteria of specific Ministry categories and the Ministry is of the opinion that the person has a dental condition that cannot be corrected through the provision of basic dental services because:

(a) the dental condition precludes the provision of the restorative services set out under the Restorative Services section of the Ministry's *Schedule of Fee Allowances – Dentist*, and

(b) one or more of the following circumstances exist:
   i. the dental condition precludes the use of a removable prosthetic;
   ii. the person has a physical impairment that makes it impossible for him or her to place a removable prosthetic;
   iii. the person has an allergic reaction or other intolerance to the composition or materials used in a removable prosthetic;
   iv. the person has a mental condition that makes it impossible for him or her to assume responsibility for a removable prosthetic.

It is important to note that when a case presents an option of effective remedial treatmentby the use of either:

- an amalgam, composite or prefabricated restoration or a removable prosthetic, **or**
- a crown or bridgework,

the restoration or removable prosthetic must be used.

In all instances the affected tooth or teeth must have functional occlusion and must be periodontally sound with a good, long-term prognosis.

General Information:

Porcelain-Fused-to-Metal (PFM) crowns/bridges will not be approved for tooth numbers 6,7 and 8. Only full cast metal (gold) crowns/bridges will be covered for molar teeth. It is important to note that if a PFM crown or bridge is placed on molar teeth, the ministry will not pay the equivalent fee to a gold crown or bridge. All crown and bridgework services (crowns, fixed bridge restoration and buildups/cores) are limited to once every five years from the original insertion date.

Treatment plan approval must be obtained in writing through the Ministry dental contractor, prior to treatment. Only treatment outlined in the *Schedule of Fee Allowances - Crown and Bridgework* will be considered for coverage under this program. A Ministry contracted dental consultant reviews the requests for crownand bridgework.

Procedures for Confirming Eligibility:

As not all Ministry clients are eligible for the Crown and Bridgework Supplement and coverage can change from month to month, eligibility must be confirmed priorto requesting treatment approval and again immediately prior to commencing withtreatment to ensure the approval is still valid.

Eligibility is confirmed by obtaining the client's Personal Health Number (PHN) and contacting Pacific Blue Cross at:

Vancouver: 1-604-419-2780 All other Communities: 1-800-665-1297

Note: Eligibility for the Crown and Bridge Supplement cannot be confirmed using PROVIDERnet.

Procedures for Requesting Preauthorization:

A request for preauthorization for a crown or bridge must be submitted in writing toPacific

Blue Cross (PBC) outlining the proposed treatment plan on a standard dental claim form marked “FOR PREAUTHORIZATION.” When submitting a request, it is essential that PBC be provided with all relevant information to supportthe request. Applications for this type of work must include the following:

- crown and/or bridge treatment plan including tooth number(s) and fee codes;
- current, mounted periapical radiograph(s) of the tooth or teeth involved and bitewing or panorex radiograph(s) showing the remaining dentition;*
- a list of client’s missing dentition and existing removable prostheses;
- a clinical explanation as to necessity; (i.e., why the client’s needs cannot be met under the Restorative Services section in the *Schedule of Fee Allowances - Dentist*); and
- relevant information regarding the client’s medical condition(s) that would support the need for a crown or bridge.

*When the patient cannot tolerate a radiograph, a photograph and full explanationis required.

Procedures for Requesting Preauthorization, continued:

Failure to provide any of the above-noted information will result in the treatmentplan being returned and unnecessary delays in the adjudication of the request.

The treatment plan and accompanying documentation should be sent to:

Pacific Blue Cross
P.O. Box 65339Vancouver, BC
V5N 5P3

Once a decision has been reached on the requested dental treatment, the dentaloffice will receive written notification. Treatment should not begin until the dentaloffice has received the decision in writing from PBC and the patient’s eligibility isconfirmed. If treatment is provided prior to approval or if the patient’s coverage has cancelled, payment will be denied.

Approvals are valid for one year from date of approval and only if eligibility requirements have been met at the time the services are provided. The dentist who received approval must provide the treatment. If circumstances change andthe approved treatment is to be completed by another dentist, Pacific Blue Crossmust be contacted to amend the approval before treatment is started.

Payment Process:

When the approved treatment has been completed, claims must be submitted on a standard dental claim form to:

Pacific Blue Cross
P.O. Box 65339Vancouver, BC
V5N 5P3

Treatment that is approved under the Ministry Crown and Bridgework Supplementwill be

paid in excess of the patient's basic dental limit and in accordance with therates outlined in the *Schedule of Fee Allowances – Crown and Bridgework* and, where applicable, are inclusive of lab fees. No lab slips are required. These feesrepresent the maximum amount the Ministry can pay for the services billed.

All other dental treatment must be completed either within the patient's basicdental limit or in accordance with the Emergency Dental and Denture Supplements.

Every time a claim is submitted, it indicates the dental practitioners understanding of, and agreement with the terms, conditions and guidelines set out in this fee schedule. The Ministry will not pay for services rendered by a dental practitioner who is not registered to practice in BC, or provides services outside their scope of practice, or outside of limits andconditions on their practice.

MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION

Schedule of Fee Allowances - Crown and Bridgework

Effective April 1, 2010

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)
	CROWNS	
	Note: Limited to one per tooth in a five-year period. Only full cast metal crowns will be considered on tooth numbers 6, 7 and 8.	
27301	Crown, Full Cast Metal	*539.90
27211	Crown, Porcelain/Ceramic/Polymer Glass, Fused to Metal Base	*624.20
27213	Crown, Porcelain/Ceramic/Polymer Glass, Fused to Metal Base,with Porcelain Margin	*624.20
	BRIDGES	
	Note: Limited to one per tooth in a five-year period. Only full cast metal retainers and pontics will be considered on tooth numbers 6, 7 and 8.	
	Retainers:	
67211	Porcelain/Ceramic/Polymer Glass, Fused to Metal Base	*623.30
67301	Full, Metal Cast	*562.81
	Pontics:	
62101	Cast Metal	*313.75
62501	Porcelain/Ceramic/Polymer Glass, Fused to Metal Base	*372.75
	CORES	

Note: Limited to one per tooth in a five-year period.

21301	Non-Bonded Amalgam Core, in conjunction with Crown	80.70
21302	Bonded Amalgam Core, in conjunction with Crown	90.41
23601	Non-Bonded Composite Core, in Conjunction with Crown	90.56
23602	Bonded Composite Core, in Conjunction with Crown	90.56

*Denotes Lab fee(s) included

APPEAL NUMBER 2022-0195

Part G – Order

The panel decision is: (Check one) ☒**Unanimous** ☐**By Majority**

The Panel ☒**Confirms the Ministry Decision** ☐**Rescinds the Ministry Decision**

If the ministry decision is rescinded, is the panel decision referred back to the Minister for a decision as to amount? Yes☐ No☐

Legislative Authority for the Decision:

Employment and Assistance Act

Section 24(1)(a)☐ or Section 24(1)(b) ☒
Section 24(2)(a)☒ or Section 24(2)(b) ☐

Part H – Signatures

Print Name Susan Ferguson	
Signature of Chair	Date (Year/Month/Day) 2022/09/20

Print Name Linda Pierre	
Signature of Member	Date (Year/Month/Day) 2022/09/20
Print Name Jean Lorenz	
Signature of Member	Date (Year/Month/Day) 2022/09/20