Memorandum of Agreement

for the period of April 1, 2014 to March 31, 2018

Memorandum of Agreement

HER MAJESTY IN RIGHT OF NEWFOUNDLAND AND LABRADOR, as represented by the Minister of Health and Community Services

And

The Newfoundland and Labrador Dental Association

This Agreement covers the fees for insured Surgical/Dental services provided to MCP beneficiaries of Newfoundland and Labrador for the period of April 1, 2014 to March 31, 2018.

Payments for these services are as per the MCP Surgical Dental Schedule, attached hereto.

1.0 Duration

(a) Both parties agree that this Agreement will be effective April 1, 2014 and will expire March 31, 2018. The first year of the Agreement will commence April 1, 2014 and will expire March 31, 2015.

(b) The second year of the Agreement will commence April 1, 2015 and will expire March 31, 2016.

(c) The third year of the Agreement will commence on April 1, 2016 and will expire March 31, 2017.

(d) The fourth year of the Agreement will commence on April 1, 2017 and will expire on March 31, 2018.

(e) The NLDA will inform the Department of Health and Community Services in writing no sooner than 6 months prior to the expiry date of this Agreement of its intention to negotiate a new Agreement.

2.0 Fees

(a) For this Agreement the fee schedule will use the MCP Surgical Dental Schedule of Benefits as a base and apply increases as per the table in 2(b).

(b) Payments for insured services are as per the MCP Surgical Dental Schedule, attached hereto, and will be increased in accordance with the following schedule.

April 1, 2014	April 1, 2015	April 1, 2016	April 1, 2017
0%	0%	2%	3%

(c) (i) Notwithstanding 2(a), and effective the date of signing of this agreement, the following six procedures will be paid at 65% of the 2014 NLDA fee code only if performed in the office of the Oral Surgeon.

1. Extractions (erupted and impacted)
2. Biopsies (oral soft tissue) exempt from hospital requirement
3. Removal of cysts
4. Oro antral fistula closure
5. Haemorrhage control.
6. Panorex

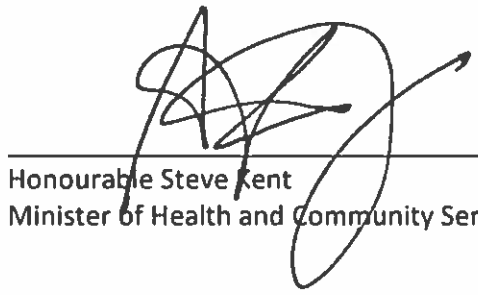
(ii) In an effort to ensure fiscal responsibility and the ability to provide insured services within the Surgical Dental Program, it is understood by all parties that the Department of Health and Community Services will monitor the volume of work and costs arising under Article 2(c)(i). Should the volume of work increase costs to the Surgical Dental Program by more than 30% at any point in time during the fiscal year over the total cost to the SDP of providing those six procedures in the previous fiscal year, Government will, at its sole discretion, return to paying 40% of the 2014 NLDA rates.

(d) (i) Effective April 1, 2017 the following six procedures will be paid at 80% of the 2014 NLDA fee code only if performed in the office of the Oral Surgeon.

1. Extractions (erupted and impacted)
2. Biopsies (oral soft tissue) exempt from hospital requirement
3. Removal of cysts
4. Oro antral fistula closure
5. Haemorrhage control.
6. Panorex

(ii) In an effort to ensure fiscal responsibility and the ability to provide insured services within the Surgical Dental Program, it is understood by all parties that the Department of Health and Community Services will monitor the volume of work and costs arising under Article 2(d)(i). Should the volume of work increase costs to the Surgical Dental Program by more than 30% at any point in time during the fiscal year over the total cost to the SDP of providing those six procedures in the previous fiscal year, Government will, at its sole discretion, return to paying 65% of the 2014 NLDA rates.

SIGNED on behalf of Her Majesty in Right of Newfoundland and Labrador



Honourable Steve Kent
Minister of Health and Community Services

October 14/15
Date

SIGNED on behalf of the Newfoundland and Labrador Dental Association

Dr. Jacqueline Tucker
President
Newfoundland and Labrador Dental Association

October 6, 2015
Date

PREAMBLE

This Payment Schedule identifies the amounts prescribed as payable and rules and conditions of payment under the Physicians and Fee Regulations, adopted under the *Medical Care Insurance Act, 1999* for insured services rendered by licensed General Dentists (hereafter referred to as Dentists) and Specialists. The fees listed apply to services rendered on or after the "effective date" at the top of each page.

Additions, deletions and changes made to the Payment schedule require approval by the Minister of Heath and Community Services based on recommendations from MCP, in consultation with the Newfoundland and Labrador Dental Association.

Any changes made during the effective life of the Payment Schedule are published in MCP Newsletters. It is the responsibility of claiming Dentists and Specialists to ensure these changes are reflected in their billings.

1. INTRODUCTION

The Payment Schedule is divided into a number of sections:

- General Preamble
- Appendices
- Consultations Visits
- Surgical Procedures

1.1 General Preamble

This section sets out the general definitions and constituent elements common to all insured services, as well as the specific elements for these services.

1.2 Appendices

This section gives details on specific policies referred to within the Preamble. These include:

- Extraction of Erupted Teeth
- Extraction of Impacted Teeth

1.3 Consultations/Visits

(a) Consultation/Visit codes are listed for Dentists and Specialists

(b) Each Consultation/Visit Section is divided into sub-sections based on the site where the insured service is rendered. Namely:

- Hospital In-Patient
- Hospital Out-Patient/Emergency
- Oral Surgeon's Office

1.4 Surgical Procedures

Fees for Dentist and Specialists may be listed for each procedure. Dentists bill for procedures using rates listed in the Dentist Column. Specialists bill for procedures using rates listed in the Specialist Column. Where no fee is listed in the Dentist Column, 83.3% of the amount listed in the Specialist Column will apply.

2. INSURED/NON-INSURED SERVICES

2.1 Insured Services

An insured service is defined as one that is:

(a) listed in Section 3(b) of the *Medical Care Insurance Insured Services Regulations under the Medical Care Insurance Act, 1999*; and

(b) medically necessary. The clinical need of the provision and claim of an insured service may be evaluated by the Dental Monitoring Committee of MCP;

Policies on pre-existing conditions necessary to define "medical necessity" exist for the specific services to qualify as MCP insured services. These are listed as appendices to this Preamble or may be published in MCP Newsletters.

2.2 Non-Insured Services

The following situations/conditions qualify as non-insured services:

(a) Specific services as listed in Section 4 of the *Medical Care Insurance Insured Services Regulations*.

Queries as to the insurability of a specific service should be directed to the office of the Director of Dental Services.

(b) Any dental services provided at the request of a third party, or which are covered by other agencies.

(c) Dental services provided to patients not insured by MCP or any other provincial Health Care Plan.

(d) Services provided as a result of dental research and experimentation.

Payment for dental and professional services which are research-related or experimental are not the financial responsibility of MCP. Only those related to routine, accepted care of a patient's problem and that are not in support of the research related or experimental services are considered to be an insured service.

3. CLAIM SUBMISSION AND DOCUMENTATION REQUIREMENTS

3.1 General Information

3.1.1 All service items billed to MCP are the sole responsibility of the Dentist or Specialist rendering the service with respect to the appropriate documentation and billing.

3.1.2 If a specific fee code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution.

3.1.3 Claims for services rendered in hospitals must include the hospital/facility number of the institution where the service was rendered.

3.1.4 For claiming purposes, date of the service is the date of the patient contact.

3.1.5 Documentation of services which are to be billed to MCP must be completed before claims for these services are submitted to MCP.

3.1.6 All claims submitted must be verifiable from the Dentist's and Specialist's records with regard to the examination and/or procedure claimed. Where specific elements of record requirement are listed in this Preamble, but do not appear in the patient record of that service, that element of the service is deemed not to have been rendered and the fee component represented by that element is not payable.

3.1.7 Referrals to a Dentist or Specialist that meet the conditions of eligibility for i) extraction of impacted teeth, or ii) extraction of erupted teeth, should be accompanied by a Referral Form which clearly states the medical/dental history that necessitates the extraction.

3.1.8 A Dentist or Specialist shall, upon request by MCP, make available to MCP copies of patient records as may be required to clarify or verify services for which fees have been claimed.

3.1.9 For MCP Audit purposes, it is required that Dentists and Specialists maintain records supporting services billed to MCP for a period of six years. An MCP Audit routinely covers two years.

3.2 Timed Based Services

Where an afterhours fee code is applicable based on the time the consultation service is rendered, the starting time indicator for that service must appear in the patient's record.

3.3 Procedures

When a procedural fee is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the fee(s) claimed.

For additional documentation requirements, refer to the specific codes being claimed.

3.4 Independent Consideration (IC)

3.4.1 Specific services in this Schedule are designated as billable on an IC basis only. Dentists and Specialists are required to identify claims for these services as IC and to provide additional applicable information.

3.4.2 Medically necessary services not listed in this Schedule, or for which a set fee is not listed, must be billed IC. For these services an IC claim must include:

(a) the time involved performing the procedure claimed,

(b) a list of all procedures performed which are represented by the claim,

(c) the actual size of lesions removed or laceration repaired or the area of any defect which was repaired, if applicable,

(d) comparison in scope and difficulty of the procedure with other procedures listed in the Payment Schedule, and

(e) a copy of the operative report along with the actual operating time for complex surgical procedures.

3.5 Use of Provider Number

3.5.1 Claims must be submitted using the Provider Number of the Dentist or Specialist who actually rendered the service.

3.5.2 Dentists and Specialists are required to request prior approval from MCP for all arrangements where payment is to be directed to a designated payee. The claim must indicate a designated payee in the Payee number section.

3.6 Time Limitations on Claim Submission

3.6.1 All claims must be submitted within 90 days of the date of service. In exceptional circumstances this time period may be extended. A letter giving a full explanation for lateness must be submitted to the Manager of Claims Processing for special consideration.

3.6.2 All queries from MCP must be answered within the times specified on the queries. If no time is specified, a reply must be received within 90 days of the date of query.

3.6.3 All requests for changes to claims and queries regarding claims must be submitted within 90 days after the date of payment for the claims concerned.

4. DEFINITIONS OF TERMS/CONDITIONS

4.1 Specialty Designation

Registration and designation as a Dentist or within a specialty field are as determined by the Newfoundland and Labrador Dental Board for MCP billing purposes.

4.2 Age (unless otherwise specified)

(a) Newborn (neonate) - up to and including 28 days of age,
(b) Infant - 29 days up to but less than 2 years,
(c) Child - 2 years up to and including 15 years,
(d) Adolescent - 16 years up to and including 17 years, and
(e) Adult - 18 years and over.

4.3 Transferal

4.3.1 A transferal, as distinguished from a referral, takes place where the responsibility for the care of an in-patient is completely transferred permanently or temporarily, from one Dentist or Specialist to another (e.g. where the first Dentist or Specialist is leaving temporarily on holidays and is unable to continue to care for the patient).
Subject to the requirements of Article 6(a) through to and inclusive of 6(e) of this MOA, a transferal of an in-patient to a Dentist or Specialist should be considered as continuing care and the Dentist or Specialist to whom the patient is transferred is not entitled to claim for a consultation but may be entitled to claim for a new patient examination.

5. DEFINITIONS/REQUIREMENTS OF CONSULTATIONS

5.1 General Definition

A consultation refers to a situation wherein a Dentist or Physician, in light of his/her professional knowledge of a patient, requests the opinion of a Specialist because of the complexity, obscurity or seriousness of the case. The consultant is obliged to assess that problem fully, review the laboratory or other data and submit his/her views in writing to the referring physician or dentist on the consultation form customarily used. Such an assessment requires a direct physical encounter with the patient including an appropriate physical examination.

5.2 Site

A consultation should be claimed under the appropriate fee code based on the site where the service was provided.

5.2.1 Hospital In-patient:

When a consultation is rendered to a registered hospital in-patient.

5.2.2 Hospital Out-Patient/Emergency Department:

When a consultation is rendered to a patient who is not a registered in-patient, in an out-patient emergency Department of a designated hospital.

5.2.3 Office:

When a consultation is rendered to a patient by an Oral Surgeon in an Oral Surgeon's office.

Consultation and/or examination of a patient at a satellite clinic or a private dental office located in a hospital is not an insured service, with the exception of an Oral Surgeon's office.

5.3 Rules for Governing the Billing of a Consultation:

5.3.1 Referral for Treatment Only

For purposes of the Surgical Dental Program, it is recognized that inherent in a Dental Consultation is the intent of the requesting practitioner to treat the patient, guided by the Consultant's advice. The referral of a patient to another practitioner for treatment only does not constitute a Dental Consultation.

A consultation is not to be claimed when:

(a) the patient presents to an Oral Surgeon's office without prior knowledge of the primary Dentist or Specialist. The sending of a report to the primary Dentist or Specialist under these circumstances does not justify a consultation.

(b) the primary Dentist or Specialist is not asked for professional advice but is simply asked by the patient for the name of an Oral Surgeon and the patient seeks out the specialist her/himself.

5.3.2 Consultation in Addition to Subsequent Surgical Procedure

An in-hospital consultation may be billed in addition to a subsequent surgical procedure only when:

(a) the case is complex and requires extended time to investigate and treat trauma, infection, pathology or the medically compromised patient, or

(b) a patient is admitted to hospital with a psychiatric illness.

A claim for a consultation in such a case will require adequate documentation and must be submitted for independent consideration (IC).

5.4 Interval for the Billing of Consultations

Not more than one out-patient/emergency consultation may be claimed by the same Dentist or Specialist for the same patient within a 90 day period, for the same issue.

Not more than one office consultation may be claimed by the same Oral Surgeon for the same patient within a 90 day period for the same issue.

Not more than one in-patient consultation may be claimed by the same Dentist or Specialist for the same patient within a 30 day period for the same issue.

5.5 Subsequent Consultations

A subsequent consultation requires all the elements of a full consultation and implies interval care by the primary Dentist or Specialist. The situation in which the consultant requests the patient to return for a later examination is not to be claimed as another consultation.

5.6 Documentation

The acceptable method of documenting consultations will vary according to the site where the service is rendered:

(a) Office consultations performed by Oral Surgeons must be documented with a written request from the referring Dentist, Specialist or Physician, a record of the history and physical examination, and a letter back to the referring Dentist, Specialist or Physician.

(b) For in-patient consultations, the written request, history and physical examination, and reply to the referring Dentist, Specialist or Physician must be documented on the patient's hospital chart or the official hospital "Consultation Report" Form.

(c) For emergency department consultations made at the request of the emergency physician, the written request, history and physical examination, and reply to the referring physician must be documented on the patient's emergency department record or the official hospital "Consultation Report" form.

(d) Emergency department consultations made at the request of a Dentist, Specialist or Physician who saw the patient in the community or at another facility must be documented with a written request from the referring Dentist, Specialist or Physician, a record of the history and physical examination, and a written reply to the referring Dentist, Specialist or Physician.

6. DEFINITIONS/REQUIREMENT OF NEW PATIENT EXAMINATION

A new patient examination refers to a situation wherein a patient is referred by another practitioner to an Oral Surgeon for treatment. The referral must include a written request for treatment and patient history.

(a) A new patient examination would require a direct physical encounter with the new patient in order to decide upon appropriate treatment.

(b) A new patient examination can be claimed under the appropriate fee code only when performed in conjunction with insured services.

(c) Not more than one new patient examination may be claimed by the same Oral Surgeon per referral.

(d) When a new patient examination is performed by an Oral Surgeon, it shall be billed to the SDP concurrently with the bill for the completion of the related insured service. For further clarity, the new patient examination cannot be billed as a separate procedure.

(e) A new patient examination cannot be billed simultaneously with, in lieu of, or in addition to a consultation.

7. DEFINITIONS/REQUIREMENT OF SPECIFIC EXAMINATION

7.1 A specific examination may be claimed by a Dentist or Specialist for the management of severe oral infection or facial pain which is not related to the provision of routine post-operative care for that surgery.

7.2 Payment will require IC documentation, and a limit of three such examinations will apply per patient admission.

8. SURGICIAL PROCEDURES

8.1 Surgical fee codes are "bundled" and not divisible. Unless otherwise stated, the fee listed for a surgical procedure includes the following:

(a) investigation and preparation of the patient at the site of surgery,

(b) the operative procedure,

(c) total post-operative care of the patient within a period of 6 weeks including:
   (i) all hospital visits except for insured specific examinations,
   (ii) two office visits subsequent to discharge from hospital, if necessary.

The normal post-operative period is deemed to be 42 days for all surgical procedures.

8.2 Unless otherwise stated

(a) When more than one operative procedure is performed by the same surgeon at the same time under the same anesthetic, the fee shall be the full fee for the major procedure: all other procedures shall be paid at the rate of eighty-five (85) percent of the listed fee for each procedure (exception Independent Operative Procedures, IOP's).

(b) When a subsequent operation becomes necessary for the same condition because of a complication during the same hospitalization, the full fee will apply for each procedure.

(c) When a subsequent operation becomes necessary for a new condition developing during the same hospitalization, the full fee will apply for each procedure.

(d) When a surgical procedure must be repeated for the same condition during the same hospitalization or within normal convalescence, the tariff shall be the full fee for the initial procedure and half the usual fee for repeat procedure(s). This will not apply in cases where the subsequent operations are done by another surgeon.

(e) When different operative procedures are done by two different surgeons under the same anesthetic for different conditions, the fee will be 100% of the listed fee for each condition.

(f) Where a Specialist requires the expertise of another Certified Specialist, or a General Surgeon, the fee for the procedures performed shall be 150% of the listed fee and shall be divided equally between the two surgeons.

8.3 Soft Tissue Grafts

For the purpose of this Schedule, cranial bone grafts are deemed not to be from intraoral but rather extra oral sites.

Bone shavings or alloplasts placed simultaneously around dental implants as the sole grafting procedure are not insured services.

8.4 Reconstruction

For the purpose of this Schedule, bone or alloplastic reconstruction do not include surgical resection or tissue harvest

Nasal reconstruction done for cosmetic purposes is not an insured service.

8.5 Orthognathic Surgery

For the purpose of this Schedule rigid fixation includes bone plates, bicortical screws and K-wires. The fee payable for rigid fixation is for one application per side per arch.

8.6 Temporomandibular Joint

For the purposes of this Schedule, temporomandibular joint procedures are unilateral. If both joints are operated as the same surgery, the fee(s) for service(s) relating to the second joint is payable at 85% of the listed fee(s).

9. FRACTURES

9.1 Open reduction

Open reduction shall mean the reduction of a fracture by an operative procedure to include the exposure of the fracture, or internal skeletal wiring of the fracture, or placement of extraskeletal pin fixation, such as the Roger Anderson type of apparatus.

9.2 Closed reduction

Closed reduction shall mean the reduction of a fracture by a simple application of arch bars and/or intermaxilliary fixation such as used in a mandibular condylar fracture.

9.3 No reduction

No reduction shall mean the treatment of a fracture by any method other than that designated in 1 or 2 above.

9.4 The stated fee covers full treatment including necessary after care up to 42 days by the Dentist or Specialist of same specialty. This includes the removal of a wire or other device when used for traction or external fixation in the treatment of a fracture.

9.5 Multiple fractures or dislocations

In multiple fractures or dislocations, the fee for the major procedure shall be the full fee and the other fractures or dislocations shall be at eighty-five (85) percent of the listed fees.

9.6 Compound fractures

Compound fractures requiring extensive debridement should be billed IC at 150% of the listed fee for the closed reduction.

9.7 Open reduction of compound facial bone fractures requiring extensive debridement or reconstructive procedures to be assessed at double the operative fee. An IC form is required.

9.8 Where a patient is transferred to another surgeon for after-care of a fracture, the surgeon rendering the initial care shall receive 75% of the listed fee and the surgeon rendering the subsequent care 50% except where otherwise specified.

10. After Hours

10.1 Call Program (OMFS)

10.1.1 On-Call

(a) An Oral Surgeon will receive $174.00 per 24 hour call period.

(b) On-call Oral Surgeons will be available to respond to urgent and emergent requests to attend either the Health Sciences Center, St. Clare's Mercy Hospital or the Janeway in St. John's for the purpose of examining, treating or providing diagnostic services to discharged or unattached patients:

i. Who present from the community to an emergency department; or

ii. Who are referred by physicians from other facilities; and/or

iii. Who are in-patients admitted by physicians in another specialty.

(c) Approved on-call rotations must follow a defined call schedule which provides coverage 24 hours per day 365 days per year.

(d) Implementation of an on-call rotation requires participation of more than one Oral Surgeon.

10.1.2 Call back

(a) If there is only one OMFS he/she may opt to receive call back but in no case will he/she receive both on-call and call-back compensation

(b) An Oral Surgeon will receive $375.00 per call back.

10.2 Surgical Fees

10.2.1 Oral Surgeons who participate in procedures that are non-elective, unscheduled and which require the services of an Anesthesiologist are eligible for payment of a premium as follows:

(a) If a procedure commences between 6pm and midnight or on Sunday or a Statutory Holiday, then a 30% premium per procedure can be billed.

(b) If a procedure commences between 7am and 6pm on Saturday, then a 30% premium per procedure can be billed.

(c) If a procedure commences between 12am and 7am any day of the week, then a 50% premium per procedure can be billed.

(d) There shall be no pyramiding of the premiums outlined in 10.2.1(a), (b) and (c). For further clarity, an Oral Surgeon can only claim one premium per procedure.

10.3 Consultation after Hours

(a) If a consultation is rendered after hours (see fee code definition), a higher fee amount may be claimed as indicated by the rate listed for the appropriate fee codes (84012, 84014, 84016, 84032 or 84034).

(b) Where an after-hours fee code is applicable based on the time the consultation service is rendered, a starting time indicator for that consultation must appear in the patient's record.

(c) Statutory Holidays are as listed in the appropriate MCP Newsletter for that year and do not include additional Civic Holidays (e.g. Regatta Day). Premiums may be claimed for consultation services provided on the ACTUAL Statutory Holiday but not on a day held in lieu of the holiday.

11. SEDATION

(a) restricted to office of an Oral Surgeon,

(b) can be claimed once per office visit,

(c) can be claimed only when services being provided are insured under the Surgical Dental Program,

(d) does not apply to services provided under the Provincial Dental Health Plan,

(e) provider's remarks not required but a record of services performed must be maintained for audit purposes.

12. SURGICAL ASSISTANT'S SERVICES

12.1 Assistant's fees are payable by MCP only when the complexity of the procedure requires the presence of an assistant.

12.2 In surgical procedures requiring the presence of a Dentist as an assistant, the fee for the assistant shall be at 30% of the fee payable to the Oral Surgeon for the procedures performed.

12.3 Where the presence of a Specialist is required as an assistant because of the difficulty or complexity of a case, the fee payable will be 150% of the listed fee and shall be divided equally between the two providers.

12.4 When multiple or bilateral surgical procedures are done during the same anesthetic, the assistant's fee shall be based on the total fees payable for the procedures performed at which he/she assisted. When bilateral procedures or surgical revisions are carried out at separate times with separate anesthetic, the assistant shall be entitled to receive a full assistant's fee for each procedure.

12.5 In surgical procedures requiring more than one assistant, the second assistant shall compute his/her fees on the same basis as the first assistant.

Note: The time factor applicable to assistants in the Medical-Surgical Payment Schedule does not apply when fee code numbers in the Surgical-Dental Schedule are claimed.

13 MCP REGISTRATION

13.1 All Dentists and Specialists receiving funding from MCP for clinical services provided must be registered with MCP through completion of a Provider Registration Form.

13.2 Changes in practice (e.g. address, licensure status, banking information, method of remuneration, etc.) require notification to MCP prior to the changes being effective for billing purposes.

14 LOCUM COVERAGE

Written documentation of locum practice/services is required for all Dentists and Specialists. Contact MCP for current policy and forms.

Appendix A

EXTRACTION OF ERUPTED TEETH

The extraction of erupted teeth is not an insured benefit of the Surgical Dental Program of MCP except in the following situations:

1. Teeth in the line of an osseous fracture, removed at the time of treatment of the fracture(s).

2. Teeth involved in acute trauma, removed at the time of the initial presentation of the patient for treatment.

3. Teeth specifically associated with the treatment of tumors.

4. Teeth which are the direct or potential source of an infection which may compromise medical treatment for either of:

    (a) diabetes mellitus
    (b) bleeding dyscrasia
    (c) steroid therapy
    (d) immunosuppression
    (e) organ transplant
    (f) cardiac surgery (bypass, transplant, valves or septum)
    (g) chemotherapy/radiation therapy
    (h) psychiatric illness when the patient is hospitalized for treatment by a psychiatrist

Numbers 1-4 above require a form to be signed by a medical or dental practitioner in which a request is made for the extraction of teeth and which clearly identifies the medical condition being treated.

5. Teeth which are the direct source of an acute dental infection which places the patient in immediate medical distress involving uncontrolled septicaemia or airway occlusion.

    This presupposes an emergency situation. Documentation by IC Form or hospital record may be required.

Appendix B

EXTRACTION OF IMPACTED TEETH

The extraction of impacted teeth is not an insured benefit of the Surgical Dental Program of MCP except in cases where such removal of partially erupted, or of completely bone covered, impacted teeth is associated with one or more of the following situations:

1. There is a history of persistent or recurring infection associated with the impacted tooth. Treatment would indicate two or more courses of antibiotics.

2. Extraction is requested by a physician to prevent complications in medically compromised patients who are being treated by the physician for either of:

    (a) Cardiac valvular disease
    (b) Renal disease
    (c) Haematological disorder
    (d) Immunosuppressive disease
    (e) Malignancies
    (f) Insulin dependent diabetes, or
    (g) Any other medical condition requiring in-hospital monitoring.

3. Extraction is surgically indicated to treat a cystic and/or neoplastic process which is evident on radiographic examination

4. Extraction of the mandibular contralateral, partially erupted or completely bone covered, impacted tooth, potentially eligible for payment as described above, and as evidenced by clinical and radiographic data, is completed at the same appointment.

Copy of Hospital Operative Report of procedure is required.

Surgical Dental Payment Schedule

April 1, 2015 to March 31, 2016

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
	FOR GENERAL DENTISTS *Services listed with no corresponding fees will require prior approval*		
	EXTRACTION OF ERUPTED TEETH (See Appendix A)		
84040	Removal of erupted tooth, uncomplicated procedure	41.45	44.43
84042	Multiple removal, additional teeth, per tooth	18.38	22.97
84044	Surgical removal of erupted tooth, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of	88.90	104.59
84046	Removal of residual roots, covered by soft tissue, single	72.20	90.25
84048	- each additional tooth, same quadrant	36.10	45.13
84050	Removal residual roots, covered by bone, single	116.57	135.38
84052	- each additional tooth, same quadrant	54.15	67.69
	EXTRACTION OF IMPACTED TEETH (See Appendix B)		
84060	Impaction, requires incision of overlying soft tissue and removal of tooth, per tooth, IOP (I.C. form required)	88.91	104.59
84062	Impaction, requires incision of overlying soft tissue, elevation of flap and either removal of bone or sectioning and removal of tooth, per tooth, IOP (I.C. form required)	141.93	157.70
84064	Impaction, requires incision of overlying soft tissue, elevation of flap and removal of completely bone covered tooth, per tooth, IOP, (I.C. form required)	178.83	210.38
84066	Impaction, requires incision of overlying soft tissue, elevation of flap, removal of bone and/or sectioning of tooth for removal and/or presents unusual circumstances or difficulties. Operative report is required. IOP (I.C. form required)	194.56	239.45
	NOTE: For all following services, claims will be reviewed prior to payment whenever, in a category, more than one service is provided per patient at the same operation. Operative reports or I.C. forms may be required for such reviews.		
	SURGICAL EXPOSURE OF TEETH		
84070	Surgical exposure, uncomplicated, soft tissue coverage, per tooth	93.51	116.89
84072	Surgical exposure, complex hard tissue, coverage, per tooth	128.56	151.94
84074	Surgical exposure, unerupted tooth with orthodontic attachment	251.19	313.99
	SURGICAL MOVEMENT OF TEETH		
84080	Repositioning, surgical, per tooth	151.94	187.00
84082	Transplantation, erupted tooth		280.52
84084	Transplantation, unerupted tooth		350.64
	REMODELLING AND RECONTOURING ORAL TISSUES		

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
	ALVEOLOPLASTY: When teeth are extracted, trimming of bone and suturing are considered as part of the procedure. Should an Alveoloplasty be claimed together with fee codes for extractions, an OR report or I.C. form must accompany the claim.		
84100	Alveoloplasty, in conjunction with extractions, per sextant, OR report or I.C. form required	56.10	70.13
84102	Alveoloplasty, not in conjunction with extractions, per sextant	87.66	109.57
	Remodelling of Bone		
84104	Mylohyoid ridge, remodelling		257.14
84106	Genial tubercles, remodelling		175.31
	Excision of Bone		
84108	Nasal bone		187.00
84110	Torus palatinus		268.82
88412	Torus mandibularis, per quadrant		175.31
	Removal of Bone Exostosis Multiple		
84114	Quadrant		293.18
	Reduction of Bone, Tuberosity		
84116	Unilateral	109.57	136.97
	Gingivoplasty and/or Stomatoplasty		
84120	Gingivoplasty, per sextant	87.66	109.57
84122	Gingivectomy, per sextant	128.58	160.72
84124	Excision of vestibular hyperplastic tissue, per sextant		109.57
84126	Surgical shaving of papillary hyperplasia of the palate		186.16
84128	Excision of pericoronal gingiva (for retained tooth/implant), per tooth/implant		40.90
	Remodelling Floor of Mouth		
84130	Full arch lowering of the floor of the mouth, (excludes splint and model)		730.51
	Vestibuloplasty		
84132	Submucosal, per arch, uncomplicated (includes splint)		243.36
84134	Secondary epithelialization, uncomplicated, per arch		321.36
84136	Vestibuloplasty, with labial inverted flap, (secondary epithelialization, complicated)		643.45
84138	Vestibuloplasty, with skin graft		584.41
84140	Vestibuloplasty, with mucosal graft		643.45

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
	Alveolar Ridge Reconstruction		
84142	Alveolar ridge reconstruction, with autogenous bone/arch, per arch		873.16
84144	Ceramic grafting, per sextant		292.20
	TESTS, HISTOLOGICAL		
84150	Biopsy, soft oral tissue, by incision, IOP	87.66	109.57
84152	Biopsy, hard oral tissue, by incision, IOP		233.63
	SURGICAL EXCISIONS		
	Surgical Excision, Tumours, Benign		
84160	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, less than 2 cm.	143.21	179.02
84162	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, over 2 cm.	243.80	304.75
84164	Tumours, benign, bone tissue, less than 2 cm.	187.01	233.76
84166	Tumours, benign, bone tissue, over 2 cm.	280.51	350.64
84168	Extra large lesions over 3 cm. or complicated		696.55
	Surgical Excisions, Tumours, Malignant		
84170	Tumours, malignant, soft tissue, less than 2 cm		204.54
84172	Tumours, malignant, soft tissue, over 2 cm.		350.64
84174	Tumours, malignant, bone tissue, less than 3 cm.		350.64
84176	Tumours, malignant, bone tissue, 3 - 6 cm.		584.41
84178	Large lesions over 6 cm. or complicated, (minimum value $625.00)		I.C.
	Cheiloplasty (lip shave)		
84180	Cheiloplasty, partial		262.98
84182	Cheiloplasty, total		429.47
	Grafts, bone, to the jaw		
84190	Per graft		730.51
	Augmentations, Prosthetic, of the Jaw		
84200	Implantation of intraosseous prosthesis(continuity defect)		730.51
84202	Removal of intraosseous prosthesis		321.41
84204	Augmentation of the chin		365.25
	Surgical Excision of Cysts/Granulomas		
84210	Less than 2 cm.	163.99	204.98

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
84212	Over 2 cm.	513.68	642.10
84214	Cyst, complicated (over 6 cm.)		540.57
84216	Marsupialization		378.29
	SURGICAL INCISIONS		
	Surgical Incision and Drainage and/or Exploration, Intraoral		
84220	Intraoral surgical exploration, soft tissue, IOP	91.09	113.87
84222	Intraoral abscess, soft tissue, IOP	46.74	58.43
84224	Intraoral abscess in major anatomical area with drain	181.17	226.46
	Surgical incision and drainage and/or exploration, extraoral		
84230	Extraoral abscess, superficial, soft tissue	75.97	94.96
84232	Extraoral abscess, deep soft tissue, with drain	181.17	226.46
	Surgical incision for Removal of Foreign Bodies		
84240	From skin or subcutaneous alveolar tissue	70.14	87.67
84242	Of reaction-producing foreign bodies		201.22
84244	Of needle from musculoskeletal system		201.22
	Sequestrectomy (for Osteomyelitis)		
84250	Sequestrectomy, for osteomyelitis		219.15
84252	Sequestrectomy and saucerization		321.41
84254	Extraoral sequestrectomy (complicated) (minimum value $343.75)		I.C.
	Mandibulectomy		
84260	Partial (3 - 6 cm.)		640.22
84262	Hemi (6 - 12 cm.)		960.54
84264	Total (more than 12 cm.) (minimum value $545.00)		I.C.
	Maxillectomy		
84270	Partial (3 - 6 cm.)		314.12
84272	Hemi (6 - 12 cm.)		401.77
84274	Total (more than 12 cm.) (minimum value $545.00)		I.C.
	Apicoectomy		
84280	Apicoectomy and/or apical curettage, one root	140.25	175.31
84282	Apicoectomy and/or apical curettage, two roots	216.24	270.30

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
84284	Apicoectomy and/or apical curettage, three roots or more	292.20	365.25
	TREATMENT OF FRACTURES		
84300	Intermaxillary fixation, per arch	181.17	226.46
84302	Intramaxillary suspension (wiring)	181.17	226.46
84304	Circumzygomatic wiring, unilateral	105.19	131.49
84306	Removal of wire, plate and screw	-	321.41
84308	Removal of intermaxillary fixation, IOP	105.19	131.49
84310	Occlusal equilibration per arch, IOP		73.05
	Fractures, Reduction, Mandible		
84330	Closed (simple)	392.68	490.86
84332	Open (simple)	521.66	652.08
84334	Open (multiple)	1,092.43	1,365.53
	Fractures, Reduction, Maxilla		
	Horizontal, LeFort I		
84340	Closed (simple)	392.68	490.86
84342	Open (simple)	521.66	652.08
84344	Open (multiple)	1,092.42	1,365.53
84346	Compound fracture of maxilla (requiring reduction and soft tissue repair)	555.18	693.98
		-	-
	Pyramidal, LeFort II	-	-
84350	Closed (simple)	392.69	490.86
84352	Open (unilateral)	555.18	693.98
84354	Open (bilateral)	1,092.42	1,365.53
	Fractures, Reduction, Naso-orbital		
84360	Closed (simple)	350.64	438.30
84362	Open (single)	438.30	547.87
84364	Open (multiple)	555.18	693.98
	Fractures, Reduction, Malar Bone		
84370	Closed (simple)	441.94	552.42
84372	Open (simple)	445.23	556.54
84374	Open, complicated orbit involved	701.29	876.61
	Fractures, Reduction, Zygomatic Arch		

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
84380	Closed	220.84	276.05
84382	Open	441.94	552.42
	Fractures, Reduction, Craniofacial Dysfunction, LeFort III Transverse		
84390	Closed	438.30	547.87
84392	Open	1,046.07	1,307.59
	Fractures, Reduction, Alveolar		
84400	Fracture, alveolar, debride, teeth removed - no fixation	105.19	131.49
84402	Reduction, alveolar, closed, with teeth	447.21	559.01
84404	Reduction, alveolar, open, with teeth	181.17	226.46
84406	Replantation, avulsed tooth (including splinting), single	262.98	328.72
84408	Replantation, avulsed teeth (including splinting), each additional	126.23	157.79
84410	Repositioning of traumatically displaced teeth (including splinting)	181.17	226.46
84412	Repairs, lacerations, uncomplicated, 5 cm. or less	81.81	102.26
84414	Repairs, lacerations, complicated, up to 5 cm.	105.19	131.49
84416	Repairs, lacerations, complicated, over 5 cm (minimum value $170.00)		I.C.
	TREATMENT OF MAXILLOFACIAL DEFORMITIES		
	Osteotomy, Ostectomy, Ramus of Mandible		
84426	Osteotomy, unilateral		1,081.13
84428	Osteotomy, subcondylar, closed		1,307.59
84430	Osteotomy, subcondylar, open		1,374.03
84432	Osteotomy, ramus, oblique, extraoral		1,374.03
84434	Osteotomy, ramus, oblique, intraoral		1,374.03
84436	Osteotomy/ostectomy body of mandible		1,374.03
84438	Osteotomy, coronoidectomy		587.43
84440	Osteotomy, condylar neck		1,307.59
84442	Osteotomy, saggital split		1,374.03
	Osteotomy, Miscellaneous		
84444	Osteotomy, oblique with bone graft		1,679.56
84446	Osteotomy, inverted "L"		1,307.59
84448	Osteotomy, "C"		1,307.59

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
	Osteotomy, Maxilla		
84450	Osteotomy, maxilla, LeFort II.		1,374.03
84452	Osteotomy, maxilla, LeFort III.		1,684.48
84454	Osteotomy, maxilla, LeFort IIII.		2,323.18
84456	Additional to above requiring two segments		291.83
84458	Additional to above requiring three segments		583.76
84460	Additional to above requiring four segments		583.76
84462	Additional to above requiring a cranial flap		488.33
84464	Closure of cleft fistula, alveolar		270.30
84466	Closure of cleft fistula, palatal		401.77
84468	Pharyngoplasty		401.77
84470	Submucous resection		263.99
	Osteotomy, Maxilla/Mandible, Segmental		
	Maxilla		
84480	Osteotomy, segmental, anterior		1,225.94
84482	Osteotomy, segmental, posterior		1,374.03
84484	Osteotomy, midpalate split, anterior		1,307.59
84486	Osteotomy, midpalate split, complete		1,307.59
	Mandible		
84488	Osteotomy, segmental, anterior with transfer of mental eminence		1,081.13
84490	Osteotomy, segmental, anterior without transfer of mental eminence		1,081.13
84492	Osteotomy, segmental, posterior		1,351.43
84494	Osteotomy, lower border, mandible		1,351.43
84496	Osteotomy, total dento-alveolar		1,374.03
	Osteotomy, with "Interpositional Graft"		
84500	Using bone		1,679.56
84502	Using alloplast		1,679.56
84504	Using cartilage		1,679.56
	Genioplasty		
84510	Genioplasty, sliding		365.25
84512	Genioplasty, reduction		314.12

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
84514	Genioplasty, augmentation with graft		574.66
84516	Myotomy, suprahyoid		365.25
	Miscellaneous Treatment of Maxillofacial Deformities		
84520	Corticotomy, per 9 cuts (maximum $1118.75)		I.C.
84522	Interdental septotomy	128.58	160.72
84524	Surgical expansion of the palate		564.10
	Palatorraphy		
84530	Palatorraphy, anterior (closure of palatine fissure)		365.25
84532	Palatorraphy, posterior		365.25
84534	Palatorraphy, total		675.57
84536	Palotorraphy, with bone graft separate		814.32
84538	Palatorraphy, with bone graft to anterior alveolar ridge separate		631.80
	Frenectomy		
84540	Frenectomy	108.11	135.14
84542	Frenoplasty	108.11	135.14
	Glossectomy		
84550	Glossectomy, partial, anterior wedge		270.30
84552	Glossectomy, full postero-anterior wedge (minimum $408.75)		I.C.
	Cleft Surgery		
84560	Primary unilateral cleft lip repair (minimum $170.00)		I.C.
84562	Secondary unilateral cleft lip repair (minimum $170.00)		I.C.
84564	Primary bilateral cleft lip repair (minimum $170.00)		I.C.
84566	Secondary bilateral cleft lip repair (minimum $170.00)		I.C.
84568	Reconstruction of cleft lip with lip switch flap (minimum $170.00)		I.C.
84570	Complex reconstruction or revision of cleft lip (minimum $170.00)		I.C.
84572	Closure of alveolar cleft (see grafting codes)		452.91
	Oronasal Fistula		
84580	Primary closure at time of initial surgery	216.24	270.30
84582	Secondary closure with palatal flap		365.25
84584	Secondary closure with pharyngeal flap		365.25
84586	Secondary closure with tongue flap		365.25

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
84588	Secondary closure with buccal flap		814.32
	TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTIONS		
	TMJ, Dislocation, Management		
84600	TMJ, dislocation, open reduction, (exposure of joint)		584.41
84602	TMJ, dislocation, closed reduction, uncomplicated	87.66	109.57
84604	TMJ, dislocation, closed reduction, under G.A.	146.10	182.62
84606	TMJ, luxation reduction, without anaesthesia	87.66	109.57
84608	TMJ, luxation reduction, under G.A.	146.10	182.62
84610	TMJ, manipulation under anaesthesia	146.10	182.62
84612	TMJ, fixation (arch bars)		314.12
	TMJ, Capsule, Management of		
84616	Menisectomy		510.82
84618	Capsulorraphy		584.41
84620	Myotomy, lateral pterygoid muscle		584.41
84622	Plication, posterior attachment of the disk of the TMJ, in cases of internal derangement		1,050.84
	TMJ, Condylar, Surgical		
84626	Condylectomy		510.82
84628	Condylotomy		496.74
84630	Osteotomy, oblique, with silastic interposition for ankylosis (graft)		1,307.59
	TMJ, Articular Eminence, management of		
84634	Reconstruction of the glenoid fossa zygomatic arch and temporal bone (Obwegeser technique)		1,624.69
84636	Articular eminence, arthroplasty		584.41
	TMJ, Arthrocentesis		
84640	Puncture and aspiration		73.05
	TMJ, Management by Injection		
84644	Anti-imflammatory drugs		73.05
84646	With sclerosing agent		I.C.
	TMJ, Appliance Splints for use ONLY in post surgical cases		
84650	Maxillary, IOP	108.11	135.14

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
84652	Mandibular, IOP	108.11	135.14
84654	Occlusal adjustment, per arch, IOP		73.05
	Arthrography of TMJ		
84660	Performing the Arthrographic procedure		151.61
	TREATMENT OF SALIVA GLANDS		
84670	Salivary duct, dilation, IOP		77.22
84672	Salivary duct, insertion of polyethylene tube		77.22
84674	Salivary duct, sialodochoplasty		246.27
84676	Salivary duct, reconstruction		226.46
84678	Salivary duct, sialolithotomy anterior 1/3 of canal		226.46
84680	Salivary duct, sialolithotomy posterior 2/3 of canal		314.12
84682	Salivary duct, external approach (minimum $268.75)		I.C.
84684	Excision of submandibular gland		550.63
84686	Excision of sublingual gland		345.03
84688	Excision of mucocele		160.72
84690	Excision of ranula		262.98
84692	Marsupialization of ranula		123.19
84694	Salivary gland removal, parotid		1,284.59
	NEUROLOGICAL DISTURBANCES, TREATMENT OF		
	Neurological Disturbances, Trigeminal Nerve		
84700	Injection for destruction, IOP		158.50
84702	Avulsion at periphery		340.50
84704	Alcoholization of a branch, IOP		73.05
84706	Infiltration of a branch for diagnosis		36.52
	Neurological Disturbances, Mental Nerve		
84710	Transposition of		500.92
84712	Decompression of canal		407.89
	Neurological Disturbances, Inferior Dental Nerve		
84716	Complete avulsion		401.77
	Neurological Disturbances Surgery		

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
84720	Injured nerve repair, primary		326.57
84722	Injured nerve repair, secondary		768.73
84724	Neural transposition and decompression		461.76
84726	Implantation of electrode for peripheral nerve stimulation		299.20
84728	Excision of tumour or neuroma		270.30
84730	Add 40% to basic fee when using operating microscope		I.C.
84732	Nerve repair with graft		394.71
	ANTRAL SURGERY		
	Antral Surgery, Recovering Foreign Bodies		
84740	Immediate recovery of dental root or foreign body from the antrum	216.24	270.30
84742	Immediate closure of antrum by another dental surgeon	216.24	270.30
84744	Delayed recovery of a dental root with oral antrostomy		365.25
84746	Antral surgery with nasal antrostomy		365.25
	Antral Surgery, Lavage		
84750	Lavage, oral approach	56.74	70.93
84752	Lavage, nasal approach	56.74	70.93
	Antral Surgery, Oro-antral Fistula Closure (same session)		
84758	Closure with buccal flap	216.24	270.30
84760	Closure with gold plate	216.24	270.30
84762	Closure with palatal flap	216.24	270.30
	Antral surgery Oro-antral Fistula Closure (subsequent session)		
84766	Closure with buccal flap		814.32
84768	Closure with gold plate		365.25
84770	Closure with palatal flap		365.25
	HAEMORRHAGE CONTROL		
84780	Secondary haemorrhage control, IOP	70.14	87.67
84782	Haemorrhage control using compression and haemostatic agent, IOP	70.14	87.67
84784	Haemorrhage control using haemostatic substances and sutures (includes removal of bony tissues if necessary), IOP (minimum		I.C.
	GRAFTS, SURGICAL		

		2015-2016 Eff: April 1, 2015 Revised for 0.00% Dentist	Oral Surg
	Harvesting of Intraoral Tissue for Grafting to Operative Site		
84800	Bone		233.76
84802	Cartilage		233.76
84804	Skin		88.63
84806	Mucosa		I.C.
84808	Muscle		I.C.
84810	Dermis		I.C.
	Harvesting of Extraoral Tissue for Grafting to Operative Site (to include ilium, rib, etc.)		
84820	Bone		438.30
84822	Cartilage		438.30
84824	Costochondral		245.42
84826	Skin		88.63
84828	Mucosa		88.63
84830	Fascia		133.66
84832	Muscle		133.66
84834	Dermis		133.66
84836	Nerve		279.26
	Vascularized Tissue Flaps		
84840	Free		71.47
84842	Attached		71.47
	EMERGENCY PROCEDURES		
84850	Tracheotomy	216.24	270.30
84852	Crico-thyroidotomy	216.24	270.30
	APPLICATION OF SURGICAL SPLINTS		
84860	Study model, IOP	35.04	39.81
84862	Surgical template, IOP	58.44	73.05
84864	Surgical template with fixation clasp, IOP	146.10	182.62
84866	Surgical obturator, surgical or gunning splint, IOP	259.26	294.60

Surgical Dental Payment Schedule

April 1, 2016 to March 31, 2017

	Hospital In-Patient Consultation	Rate
84002	Dentist	**60.74**
84004	Specialist	**72.86**

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Hospital In-Patient Consultation (after hours)

Service rendered on Sundays and Statutory Holidays or between 6:00 p.m. and 8:00 a.m. Monday through Saturday

84012	Dentist	**72.49**
84014	Specialist	**89.42**

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Hospital In-Patient

Specific Examination (ie. for hospital visits by a Dentist or Specialist for the management of severe oral infection, not related to the provision of post-operative care)

84018	Dentist	**23.51**
84020	Specialist	**28.18**

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Hospital Out-Patient Consultation

84022	Dentist	**60.74**
84024	Specialist	**72.86**

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Hospital Out-Patient Consultation (after hours)

84032	Dentist	**72.49**
84034	Specialist	**89.42**

SURGICAL DENTAL PROCEDURES

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
	FOR GENERAL DENTISTS *Services listed with no corresponding fees will require prior*		
	EXTRACTION OF ERUPTED TEETH (See Appendix A)		
84040	Removal of erupted tooth, uncomplicated procedure	42.28	45.32
84042	Multiple removal, additional teeth, per tooth	18.74	23.43
84044	Surgical removal of erupted tooth, requires elevation of mucoperiosteal flap, and removal of bone and/or sectioning of	90.68	106.68
84045	Each additional tooth removed, same appointment, same quadrant	65.39	76.94
84046	Removal of residual roots, covered by soft tissue, single	73.64	92.06
84048	- each additional tooth, same quadrant	36.83	46.03
84050	Removal residual roots, covered by bone, single	118.91	138.09
84052	- each additional tooth, same quadrant	55.24	69.04
	EXTRACTION OF IMPACTED TEETH (See Appendix B)		
84060	Impaction, requires incision of overlying soft tissue and removal of tooth, per tooth, IOP (I.C. form required)	90.69	106.68
84062	Impaction, requires incision of overlying soft tissue, elevation of flap and either removal of bone or sectioning and removal of tooth, per tooth, IOP (I.C. form required)	144.77	160.85
84064	Impaction, requires incision of overlying soft tissue, elevation of flap and removal of completely bone covered tooth, per tooth, IOP, (I.C. form required)	182.40	214.59
84066	Impaction, requires incision of overlying soft tissue, elevation of flap, removal of bone and/or sectioning of tooth for removal and/or presents unusual circumstances or difficulties. Operative report is required. IOP (I.C. form required)	198.45	244.24
	NOTE: For all following services, claims will be reviewed prior to payment whenever, in a category, more than one service is provided per patient at the same operation. Operative reports or I.C. forms may be required for such reviews.		
	SURGICAL EXPOSURE OF TEETH		
84070	Surgical exposure, uncomplicated, soft tissue coverage, per tooth	95.38	119.23
84072	Surgical exposure, complex hard tissue, coverage, per tooth	131.14	154.98
84074	Surgical exposure, unerupted tooth with orthodontic attachment	256.22	320.27
	SURGICAL MOVEMENT OF TEETH		
84080	Repositioning, surgical, per tooth	154.98	190.74
84082	Transplantation, erupted tooth		286.13

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84084	Transplantation, unerupted tooth		357.65
	REMODELLING AND RECONTOURING ORAL TISSUES		
	ALVEOLOPLASTY: When teeth are extracted, trimming of bone and suturing are considered as part of the procedure. Should an Alveoloplasty be claimed together with fee codes for extractions, an OR report or I.C. form must accompany the claim.		
84100	Alveoloplasty, in conjunction with extractions, per sextant, OR report or I.C. form required	57.23	71.53
84102	Alveoloplasty, not in conjunction with extractions, per sextant	89.41	111.76
	Remodelling of Bone		
84104	Mylohyoid ridge, remodelling		262.28
84106	Genial tubercles, remodelling		178.82
	Excision of Bone		
84108	Nasal bone		190.74
84110	Torus palatinus		274.20
884112	Torus mandibularis, per quadrant		178.82
	Removal of Bone Exostosis Multiple		
84114	Quadrant		299.04
	Reduction of Bone, Tuberosity		
84116	Unilateral	111.77	139.71
	Gingivoplasty and/or Stomatoplasty		
84120	Gingivoplasty, per sextant	89.41	111.76
84122	Gingivectomy, per sextant	131.15	163.93
84124	Excision of vestibular hyperplastic tissue, per sextant		111.76
84126	Surgical shaving of papillary hyperplasia of the palate		189.88
84128	Excision of pericoronal gingiva (for retained tooth/implant), per tooth/implant		41.72

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
	Remodelling Floor of Mouth		
84130	Full arch lowering of the floor of the mouth, (excludes splint and model)		745.12
	Vestibuloplasty		
84132	Submucosal, per arch, uncomplicated (includes splint)		248.23
84134	Secondary epithelialization, uncomplicated, per arch		327.79
84136	Vestibuloplasty, with labial inverted flap, (secondary epithelialization, complicated)		656.32
84138	Vestibuloplasty, with skin graft		596.10
84140	Vestibuloplasty, with mucosal graft		656.32
	Alveolar Ridge Reconstruction		
84142	Alveolar ridge reconstruction, with autogenous bone/arch, per arch		890.62
84144	Ceramic grafting, per sextant		298.04
	TESTS, HISTOLOGICAL		
84150	Biopsy, soft oral tissue, by incision, IOP		111.76
84152	Biopsy, hard oral tissue, by incision, IOP		238.30
	SURGICAL EXCISIONS		
	Surgical Excision, Tumours, Benign		
84160	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, less than 2 cm.	146.07	182.60
84162	Tumours, benign, scar tissue, inflammatory or congenital lesions of soft tissue, over 2 cm.	248.67	310.85
84164	Tumours, benign, bone tissue, less than 2 cm.	190.75	238.44
84166	Tumours, benign, bone tissue, over 2 cm.	286.12	357.65
84168	Extra large lesions over 3 cm. or complicated		710.48
	Surgical Excisions, Tumours, Malignant		
84170	Tumours, malignant, soft tissue, less than 2 cm		208.63
84172	Tumours, malignant, soft tissue, over 2 cm.		357.65
84174	Tumours, malignant, bone tissue, less than 3 cm.		357.65
84176	Tumours, malignant, bone tissue, 3 - 6 cm.		596.10
84178	Large lesions over 6 cm. or complicated, (minimum value $637.50)		I.C.

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
	Cheiloplasty (lip shave)		
84180	Cheiloplasty, partial		268.24
84182	Cheiloplasty, total		438.06
	Grafts, bone, to the jaw		
84190	Per graft		745.12
	Augmentations, Prosthetic, of the Jaw		
84200	Implantation of intraosseous prosthesis(continuity defect)		745.12
84202	Removal of intraosseous prosthesis		327.84
84204	Augmentation of the chin		372.56
	Surgical Excision of Cysts/Granulomas		
84210	Less than 2 cm.	167.27	209.08
84212	Over 2 cm.	523.95	654.94
84214	Cyst, complicated (over 6 cm.)		551.38
84216	Marsupialization		385.86
	SURGICAL INCISIONS		
	Surgical Incision and Drainage and/or Exploration, Intraoral		
84220	Intraoral surgical exploration, soft tissue, IOP	92.92	116.15
84222	Intraoral abscess, soft tissue, IOP	47.68	59.60
84224	Intraoral abscess in major anatomical area with drain	184.79	230.99
	Surgical incision and drainage and/or exploration, extraoral		
84230	Extraoral abscess, superficial, soft tissue	77.49	96.86
84232	Extraoral abscess, deep soft tissue, with drain	184.79	230.99
	Surgical Incision for Removal of Foreign Bodies		
84240	From skin or subcutaneous alveolar tissue	71.54	89.42
84242	Of reaction-producing foreign bodies		205.24
84244	Of needle from musculoskeletal system		205.24
	Sequestrectomy (for Osteomyelitis)		

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84250	Sequestrectomy, for osteomyelitis		223.53
84252	Sequestrectomy and saucerization		327.84
84254	Extraoral sequestrectomy (complicated) (minimum value $350.63)		I.C.
	Mandibulectomy		
84260	Partial (3 - 6 cm.)		653.02
84262	Hemi (6 - 12 cm.)		979.75
84264	Total (more than 12 cm.) (minimum value $555.90)		I.C.
	Maxillectomy		
84270	Partial (3 - 6 cm.)		320.40
84272	Hemi (6 - 12 cm.)		409.81
84274	Total (more than 12 cm.) (minimum value $555.90)		I.C.
	Apicoectomy		
84280	Apicoectomy and/or apical curettage, one root	143.05	178.82
84282	Apicoectomy and/or apical curettage, two roots	220.56	275.71
84284	Apicoectomy and/or apical curettage, three roots or more	298.04	372.56
	TREATMENT OF FRACTURES		
84300	Intermaxillary fixation, per arch	184.79	230.99
84302	Intramaxillary suspension (wiring)	184.79	230.99
84304	Circumzygomatic wiring, unilateral	107.30	134.12
84306	Removal of wire, plate and screw		327.84
84308	Removal of intermaxillary fixation, IOP	107.30	134.12
84310	Occlusal equilibration per arch, IOP		74.51
	Fractures, Reduction, Mandible		
84330	Closed (simple)	400.54	500.68
84332	Open (simple)	532.10	665.12
84334	Open (multiple)	1,114.27	1,392.84
	Fractures, Reduction, Maxilla Horizontal, LeFort I		

SURGICAL DENTAL PROCEDURES

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84340	Closed (simple)	400.54	500.68
84342	Open (simple)	532.10	665.12
84344	Open (multiple)	1,114.27	1,392.84
84346	Compound fracture of maxilla (requiring reduction and soft tissue repair)	566.29	707.86
	Pyramidal, LeFort II		
84350	Closed (simple)	400.54	500.68
84352	Open (unilateral)	566.29	707.86
84354	Open (bilateral)	1,114.27	1,392.84
	Fractures, Reduction, Naso-orbital		
84360	Closed (simple)	357.65	447.07
84362	Open (single)	447.06	558.83
84364	Open (multiple)	566.29	707.86
	Fractures, Reduction, Malar Bone		
84370	Closed (simple)	450.77	563.47
84372	Open (simple)	454.14	567.67
84374	Open, complicated orbit involved	715.31	894.14
	Fractures, Reduction, Zygomatic Arch		
84380	Closed	225.26	281.57
84382	Open	450.77	563.47
	Fractures, Reduction, Craniofacial Dysfunction, LeFort III Transverse		
84390	Closed	447.06	558.83
84392	Open	1,066.99	1,333.74
	Fractures, Reduction, Alveolar		
84400	Fracture, alveolar, debride, teeth removed - no fixation	107.30	134.12
84402	Reduction, alveolar, closed, with teeth	456.15	570.19
84404	Reduction, alveolar, open, with teeth	184.79	230.99
84406	Replantation, avulsed tooth (including splinting), single	268.24	335.29
84408	Replantation, avulsed teeth (including splinting), each additional	128.76	160.95

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84410	Repositioning of traumatically displaced teeth (including splinting)	184.79	230.99
84412	Repairs, lacerations, uncomplicated, 5 cm. or less	83.44	104.31
84414	Repairs, lacerations, complicated, up to 5 cm.	107.30	134.12
84416	Repairs, lacerations, complicated, over 5 cm (minimum value $173.40)		I.C.
	TREATMENT OF MAXILLOFACIAL DEFORMITIES		
	Osteotomy, Ostectomy, Ramus of Mandible		
84426	Osteotomy, unilateral		1,102.75
84428	Osteotomy, subcondylar, closed		1,333.74
84430	Osteotomy, subcondylar, open		1,401.51
84432	Osteotomy, ramus, oblique, extraoral		1,401.51
84434	Osteotomy, ramus, oblique, intraoral		1,401.51
84436	Osteotomy/ostectomy body of mandible		1,401.51
84438	Osteotomy, coronoidectomy		599.18
84440	Osteotomy, condylar neck		1,333.74
84442	Osteotomy, saggital split		1,401.51
	Osteotomy, Miscellaneous		
84444	Osteotomy, oblique with bone graft		1,713.15
84446	Osteotomy, inverted "L"		1,333.74
84448	Osteotomy, "C"		1,333.74
	Osteotomy, Maxilla		
84450	Osteotomy, maxilla, LeFort II.		1,401.51
84452	Osteotomy, maxilla, LeFort III.		1,718.17
84454	Osteotomy, maxilla, LeFort IIII.		2,369.64
84456	Additional to above requiring two segments		297.67
84458	Additional to above requiring three segments		595.44
84460	Additional to above requiring four segments		595.44
84462	Additional to above requiring a cranial flap		498.10

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84464	Closure of cleft fistula, alveolar		275.71
84466	Closure of cleft fistula, palatal		409.81
84468	Pharyngoplasty		409.81
84470	Submucous resection		269.27
	Osteotomy, Maxilla/Mandible, Segmental Maxilla		
84480	Osteotomy, segmental, anterior		1,250.46
84482	Osteotomy, segmental, posterior		1,401.51
84484	Osteotomy, midpalate split, anterior		1,333.74
84486	Osteotomy, midpalate split, complete		1,333.74
	Mandible		
84488	Osteotomy, segmental, anterior with transfer of mental eminence		1,102.75
84490	Osteotomy, segmental, anterior without transfer of mental eminence		1,102.75
84492	Osteotomy, segmental, posterior		1,378.46
84494	Osteotomy, lower border, mandible		1,378.46
84496	Osteotomy, total dento-alveolar		1,401.51
	Osteotomy, with "Interpositional Graft"		
84500	Using bone		1,713.15
84502	Using alloplast		1,713.15
84504	Using cartilage		1,713.15
	Genioplasty		
84510	Genioplasty, sliding		372.56
84512	Genioplasty, reduction		320.40
84514	Genioplasty, augmentation with graft		586.15
84516	Myotomy, suprahyoid		372.56

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
	Miscellaneous Treatment of Maxillofacial Deformities		
84520	Corticotomy, per 9 cuts (maximum $1,141.13)		I.C.
84522	Interdental septotomy	131.15	163.93
84524	Surgical expansion of the palate		575.38
	Palatorraphy		
84530	Palatorraphy, anterior (closure of palatine fissure)		372.56
84532	Palatorraphy, posterior		372.56
84534	Palatorraphy, total		689.08
84536	Palotorraphy, with bone graft separate		830.61
84538	Palatorraphy, with bone graft to anterior alveolar ridge separate		644.44
	Frenectomy		
84540	Frenectomy	110.27	137.84
84542	Frenoplasty	110.27	137.84
	Glossectomy		
84550	Glossectomy, partial, anterior wedge		275.71
84552	Glossectomy, full postero-anterior wedge (minimum $416.93)		I.C.
	Cleft Surgery		
84560	Primary unilateral cleft lip repair (minimum $173.40)		I.C.
84562	Secondary unilateral cleft lip repair (minimum $173.40)		I.C.
84564	Primary bilateral cleft lip repair (minimum $173.40)		I.C.
84566	Secondary bilateral cleft lip repair (minimum $173.40)		I.C.
84568	Reconstruction of cleft lip with lip switch flap (minimum $173.40)		I.C.
84570	Complex reconstruction or revision of cleft lip (minimum $173.40)		I.C.
84572	Closure of alveolar cleft (see grafting codes)		461.97
	Oronasal Fistula		
84580	Primary closure at time of initial surgery	220.56	275.71
84582	Secondary closure with palatal flap		372.56
84584	Secondary closure with pharyngeal flap		372.56

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84586	Secondary closure with tongue flap		372.56
84588	Secondary closure with buccal flap		830.61
	TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTIONS		
	TMJ, Dislocation, Management		
84600	TMJ, dislocation, open reduction, (exposure of joint)		596.10
84602	TMJ, dislocation, closed reduction, uncomplicated	89.41	111.76
84604	TMJ, dislocation, closed reduction, under G.A.	149.02	186.27
84606	TMJ, luxation reduction, without anaesthesia	89.41	111.76
84608	TMJ, luxation reduction, under G.A.	149.02	186.27
84610	TMJ, manipulation under anaesthesia	149.02	186.27
84612	TMJ, fixation (arch bars)		320.40
	TMJ, Capsule, Management of		
84616	Menisectomy		521.04
84618	Capsulorraphy		596.10
84620	Myotomy, lateral pterygoid muscle		596.10
84622	Plication, posterior attachment of the disk of the TMJ, in cases of internal derangement		1,071.86
	TMJ, Condylar, Surgical		
84626	Condylectomy		521.04
84628	Condylotomy		506.67
84630	Osteotomy, oblique, with silastic interposition for ankylosis (graft)		1,333.74
	TMJ, Articular Eminence, management of		
84634	Reconstruction of the glenoid fossa zygomatic arch and temporal bone (Obwegeser technique)		1,657.18
84636	Articular eminence, arthroplasty		596.10
	TMJ, Arthrocentesis		
84640	Puncture and aspiration		74.51
	TMJ, Management by Injection		
84644	Anti-imflammatory drugs		74.51

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84646	With sclerosing agent		I.C.
	TMJ, Appliance Splints for use ONLY in post surgical cases		
84650	Maxillary, IOP	110.27	137.84
84652	Mandibular, IOP	110.27	137.84
84654	Occlusal adjustment, per arch, IOP		74.51
	Arthrography of TMJ		
84660	Performing the Arthrographic procedure		154.64
	TREATMENT OF SALIVA GLANDS		
84670	Salivary duct, dilation, IOP		78.76
84672	Salivary duct, insertion of polyethylene tube		78.76
84674	Salivary duct, sialodochoplasty		251.20
84676	Salivary duct, reconstruction		230.99
84678	Salivary duct, sialolithotomy anterior 1/3 of canal		230.99
84680	Salivary duct, sialolithotomy posterior 2/3 of canal		320.40
84682	Salivary duct, external approach (minimum $274.13)		I.C.
84684	Excision of submandibular gland		561.64
84686	Excision of sublingual gland		351.93
84688	Excision of mucocele		163.93
84690	Excision of ranula		268.24
84692	Marsupialization of ranula		125.65
84694	Salivary gland removal, parotid		1,310.28
	NEUROLOGICAL DISTURBANCES, TREATMENT OF		
	Neurological Disturbances, Trigeminal Nerve		
84700	Injection for destruction, IOP		161.67
84702	Avulsion at periphery		347.31
84704	Alcoholization of a branch, IOP		74.51
84706	Infiltration of a branch for diagnosis	29.80	37.25

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
	Neurological Disturbances, Mental Nerve		
84710	Transposition of		510.94
84712	Decompression of canal		416.05
	Neurological Disturbances, Inferior Dental Nerve		
84716	Complete avulsion		409.81
	Neurological Disturbances Surgery		
84720	Injured nerve repair, primary		333.10
84722	Injured nerve repair, secondary		784.10
84724	Neural transposition and decompression		471.00
84726	Implantation of electrode for peripheral nerve stimulation		305.18
84728	Excision of tumour or neuroma		275.71
84730	Add 40% to basic fee when using operating microscope		I.C.
84732	Nerve repair with graft		402.60
	ANTRAL SURGERY		
	Antral Surgery, Recovering Foreign Bodies		
84740	Immediate recovery of dental root or foreign body from the antrum	220.56	275.71
84742	Immediate closure of antrum by another dental surgeon	220.56	275.71
84744	Delayed recovery of a dental root with oral antrostomy		372.56
84746	Antral surgery with nasal antrostomy		372.56
	Antral Surgery, Lavage		
84750	Lavage, oral approach	57.88	72.35
84752	Lavage, nasal approach	57.88	72.35
	Antral Surgery, Oro-antral Fistula Closure (same session)		
84758	Closure with buccal flap	220.56	275.71
84760	Closure with gold plate	220.56	275.71
84762	Closure with palatal flap	220.56	275.71
	Antral surgery Oro-antral Fistula Closure (subsequent session)		
84766	Closure with buccal flap		830.61

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
84768	Closure with gold plate		372.56
84770	Closure with palatal flap		372.56
	HAEMORRHAGE CONTROL		
84780	Secondary haemorrhage control, IOP	71.54	89.42
84782	Haemorrhage control using compression and haemostatic agent, IOP	71.54	89.42
84784	Haemorrhage control using haemostatic substances and sutures (includes removal of bony tissues if necessary), IOP (minimum $208.59)		I.C.
	GRAFTS, SURGICAL		
	Harvesting of Intraoral Tissue for Grafting to Operative Site		
84800	Bone		238.44
84802	Cartilage		238.44
84804	Skin		90.40
84806	Mucosa		I.C.
84808	Muscle		I.C.
84810	Dermis		I.C.
	Harvesting of Extraoral Tissue for Grafting to Operative Site (to include ilium, rib, etc.)		
84820	Bone		447.07
84822	Cartilage		447.07
84824	Costochondral		250.33
84826	Skin		90.40
84828	Mucosa		90.40
84830	Fascia		136.33
84832	Muscle		136.33
84834	Dermis		136.33
84836	Nerve		284.85
	Vascularized Tissue Flaps		
84840	Free		72.90
84842	Attached		72.90

SURGICAL DENTAL PROCEDURES

		Rates Effective April 1, 2016 ** Revised for 2.00% Dentist	Oral Surg
	EMERGENCY PROCEDURES		
84850	Tracheotomy	220.56	275.71
84852	Crico-thyroidotomy	220.56	275.71
	APPLICATION OF SURGICAL SPLINTS		
84860	Study model, IOP	35.74	40.61
84862	Surgical template, IOP	59.61	74.51
84864	Surgical template with fixation clasp, IOP	149.02	186.27
84866	Surgical obturator, surgical or gunning splint, IOP	264.45	300.49

Surgical Dental Procedures Provided in office by Oral Maxillo Facial Surgeons

October 14, 2015

SURGICAL DENTAL PROCEDURES
Provided in office by Oral Maxillo Facial Surgeons

The following payment schedule reflects fees that can be billed by oral surgeons for services provided in their office. The effective date will be October 14, 2015.

For comparison purposes, this payment schedule will show current rates of pay as well as the new rate. The new rate will be at 65% of the 2014 NLDA suggested fee guide for specialists. You will note that new codes have been assigned to allow these "in office" services to be addressed separately at future talks. Services provided in a publicly funded facility (hospital) will remain using pre-existing codes and fees.

It is understood by all parties that the Department of Health and Community Services will monitor the volume of work and costs relating to this new schedule. Should the volume of work increase costs to the Surgical Dental Program by more than 30% at any point in time during the fiscal year over the cost to the Surgical Dental Program of providing those six procedures in the previous fiscal year, Government will, at its sole discretion, return to paying fees listed in the payment schedule in effect for hospital based services prior to October 14, 2015. Government fiscal year is from April 1 to March 31.

This payment schedule for office based procedures expires March 31, 2016.

New Patient Exam	*New Code 840000*	*48.04*

Extractions if completed in office or Oral Surgeon

Current SD codes	*New Code for in Office Service*	*Oral Surgeon*		
		Current	*NLDA*	*New*
84040	84039	44.43	113.73	73.92
84042	84041	22.97	61.17	39.76
84044	84043	104.59	273.32	177.66
84046	84047	90.25	213.85	139.00
84048	84049	45.13	166.18	108.02
84050	84051	135.38	320.63	208.41
84052	84053	67.69	278.79	181.21

Impactions

Current SD codes	*New Code for in Office Service*	*Oral Surgeon*		
		Current	*NLDA*	*New*
84060	84061	104.59	274.44	178.39
84062	84063	157.70	390.59	253.88
84064	84065	210.38	512.29	332.99
84066	84067	239.45	623.48	405.26

X-rays (Panorex - In Office for Insured Services)

Current SD codes	*New Code for in Office Service*	*Oral Surgeon*		
		Current	*NLDA*	*New*
87020	87021	72.10	93.00	72.10*

Haemorrhage Control

Current SD codes	*New Code for in Office Service*	*Oral Surgeon*		
		Current	*NLDA*	*New*
84780	84781	87.67	191.31	124.35
84782	84783	87.67	126.50	87.67*
84784	84785	-	193.00	125.45

Biopsy

Current SD codes	*New Code for in Office Service*	*Oral Surgeon*		
		Current	*NLDA*	*New*
84150	84151	109.59	171.28	111.33
84152	84153	233.63	264.59	233.63*

Surgical Excisions

Current SD codes	*New Code for in Office Service*	*Oral Surgeon*		
		Current	*NLDA*	*New*
84160	84161	179.02	470.78	306.01
84162	84163	304.75	568.93	369.81
84164	84165	233.76	505.53	328.59
84166	84167	350.64	902.03	586.32

Oro-antral fistula closure

Current SD codes	*New Code for in Office Service*	*Oral Surgeon*		
		Current	*NLDA*	*New*
84740	84741	270.30	216.24	270.30*
84758	84759	270.30	947.74	616.03

*** Note: Current fee is higher than 65% of NLDA rate.**

Oral Surgery On Call and Call Back Schedule

Fee Code:	**658010 – Oral Surgery On-Call Payment (Regular Shift-Hourly)**
Effective Date:	October 14, 2015
Rate:	$7.25/per hour
Patient log required:	Yes, if patients seen during shift
Specialty specific:	Specialty 062
Allowable Overlaps:	No overlapping permitted

Fee Code:	**658020 – Oral Surgery On-Call Payment Call Back – not to be available during regular On-Call coverage**
Effective Date:	October 14, 2015
Rate:	$375 per call back
Units:	1 per call back
Patient log required:	Yes
Specialty specific:	Specialty 062
Allowable Overlaps:	No overlapping permitted with fee code 658010

Surgical Premiums

SURGICAL PREMIUMS

After Hours Surgical Procedure Premiums

Surgical procedures that are non-elective, unscheduled and which either require the services of an Anaesthesiologist or are performed using one of the regional nerve blocks specified for local anaesthetic purposes, qualify for premiums when commenced between 6:00 p.m. and 7 a.m. or on Saturdays, Sundays or Statutory Holidays.

Prem		**Oral**
Code		***Surgeon***
01	Procedures that qualify and commence between 6:00 p.m. and midnight or on Saturdays, Sundays or Statutory Holidays.....add	30%
03	Procedures that qualify and commence any night between midnight and 7:00 a.m.....add	50%