PACIFIC BLUE CROSS®

DENTAL FEE SCHEDULE

Effective
February 1, 2025

Appendent to Group and Individual Dental Plan Agreements and Contracts

Visit providernet.ca for a copy of the Pacific Blue Cross Dental Fee Schedule:

1. **Sign in with your email address and password**
2. **Click *Resources & References*.**

Paper copies are no longer available.

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Preface

1.0 Introduction

It is important that you read this fee schedule and become familiar with its contents. Every time a claim is submitted to Pacific Blue Cross, it indicates your understanding of and agreement with the terms, conditions and guidelines set out in this fee schedule.

1.1 Icons

Throughout this document, a few icons have been added to either clarify or add important information to the content. They are:

	**New Icon**	Information has been added/updated.
	**Important Icon**	Information that is crucial to benefits or submission requirements.

2.0 Plan Design

2.1 Basic, Major, and Orthodontic

Benefits provided under standard Pacific Blue Cross Dental Care plans are separated into three categories: Our clients may have various plan designs with varying levels of benefits. For example, some plans may cover basic services only while others include all three. Pacific Blue Cross reserves the right to request supporting documentation (such as pre/post-treatment radiographs, study models, photographs, periodontal charting, and clinical descriptions).

Basic- Diagnostic, Preventive and Restorative Services

Includes services for the basic care and maintenance of teeth, including procedures to restore teeth to natural or normal function.

Major - Restorative Services

Includes major restorations or replacement of missing teeth, or for reconstruction of teeth where basic restorative methods cannot be used satisfactorily (including crowns, bridges and dentures). Before proceeding with treatment, Pacific Blue Cross recommends that your office submit a request for prior approval.

Orthodontics

Includes orthodontic services performed to maintain, restore or establish normal functioning occlusion of the teeth. Treatment performed solely for splinting and those services listed as contract exclusions are not eligible.

2.2 Schedules 1, 2, and 3

This fee schedule outlines frequency and financial limits for standard Pacific Blue Cross Dental Care plans. The different limits are identified as schedules 1, 2 and 3 and are indicated in this fee schedule where applicable. If a limit for a fee item number is the same in all three schedules, no schedule designation is shown.

Individual Dental Care plans, non-standard dental care plans, and national Blue Cross plans each have unique limitations that may differ from schedules 1, 2 and 3.

See Commonly Asked Schedule 1, 2, 3 Frequencies

2.3 Individual Dental Plans

To meet the needs of British Columbians not covered by a group plan, Pacific Blue Cross offers Individual Dental Plans (individual health benefit plans with dental coverage). Check the patient's eligibility online on PROVIDERnet or refer to the patient's Individual Dental Care Plan contract for the list of eligible services and applicable limitations.

Note: The coverage and fee restrictions that apply to these plans are different from the limitations for other Pacific Blue Cross Dental Care plans.

3.0 General Claims Information

3.1 Frequency Limits

All frequency limitations in this fee schedule include services performed by dentists, denturists and hygienists.

3.2 Claiming Deadline

Submit your claims as soon as reasonably possible. In no event will payment be made on any claim received later than one year from the date of service (excludes non-standard plans with different claiming deadlines).

3.3 Claim Form

Pacific Blue Cross provides a PDF Pacific Blue Cross claim form for your dental office if you do not use the Standard Dental Claim Form. It is available for download at **pac.bluecross.ca**. To ensure prompt and accurate claims processing, you must accurately identify the claimant. Pacific Blue Cross requires the plan member's policy and identification number, the patient's signature, the patient's relationship to the plan member (self, spouse, child), the patient's date of birth, the patient's name and current address. Payment may be delayed or rejected if incorrect numbers and information are indicated on the claim.

3.4 Provider ID Numbers

All submissions, including paper, must show both of the following ID numbers of the practitioner performing the services:

1) CDAnet UIN or 9 digit Pacific Blue Cross assigned ID number and
2) CDAnet office number or 4 digit Pacific Blue Cross assigned office number.

3.5 Signatures

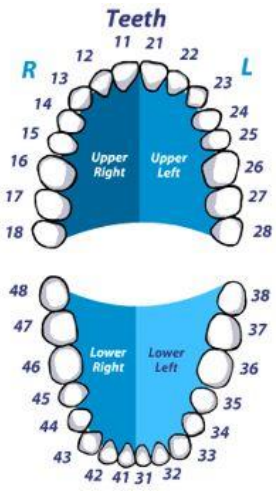
A patient (parent/guardian for minors) signature is required on all claim forms in the section that acknowledges services rendered and release of information. Do not obtain patient signatures on blank or incomplete claim forms. Pacific Blue Cross is unable to accept "signature on file" as an alternative for the patient's signature; however, this will be accepted in the other employee/plan member/subscriber sections. This requirement does not apply to Ministry of Children and Family Development (MCFD) or Ministry of Social Development and Poverty Reduction (MSDPR). The patient's signature is not required on adjustments or resubmissions as long as the claim originally submitted was signed, or was submitted via CDAnet. For CDAnet claims, dental offices should ensure they have the patient and member signatures on file as per the CDAnet Subscription Agreement.

3.6 Date of Service

The date of service indicated on the claim must be the actual date services are rendered for procedures that require only a single office visit. For procedures which require more than one office visit, the final completion date or the actual insertion date must be used for the date of service. Services and procedures must be completed and considered successful before submitting a claim for payment. Temporary procedures are the responsibility of the patient.

3.7 Site, Arch number, Tooth Number

The appropriate site must be submitted with the appropriate fee code as indicated in the PBC Fee Schedule. A site is an area that lends itself to one or more procedures. It is considered to include a full quadrant, sextant, or a group of teeth, or in some cases, a single tooth. Please ensure these instructions are followed to avoid delays when processing your claim or pre-determination submission. Pacific Blue Cross follows the International Tooth Code for identifying the site of work.



When identifying teeth, sextants can be used to divide the dental arches. This table illustrates the tooth numbers that correspond to sextants, that correspond with the arches.

Note: When submitting Arch, it must be submitted with the appropriate arch ID e.g. 01 or 02.

Arch		Sextant	Tooth Numbers
00 Both	01 Upper	03	18 - 14
		04	13 - 23
		05	24 - 28
	02 Lower	06	38 - 34
		07	33 - 43
		08	44 - 48

Periodontal Surgery

Codes for periodontal surgical procedures apply to sites. A surgical site may be a single tooth or a group of teeth up to a sextant. Where surgery is performed at the same sitting in contiguous sextants, but involving less than two sextants, the fee should be adjusted accordingly. Similarly, where multiple procedures are performed in the same sitting, an adjustment should be made for the procedure involving the lesser fee. *Where frenectomy/frenoplasty or vestibular deepening are involved during preparation of a graft site, then these procedures are considered part of the graft preparation and fee and should not be billed as independent fees.*

3.8 Lab Fees

Lab fees must be separated from the professional fee on each claim line. Pacific Blue Cross determines and applies reasonable and customary fees and limits to services listed in this fee schedule. This includes but is not limited to fees listed as “I.C.” or “+L”. The “+L” may include Commercial Laboratory charges, In-house Laboratory charges, parts and components and/or service charges. In order to obtain amounts eligible under the plan, a predetermination must be submitted with your estimated fees. Claim paid amounts may differ from the predetermination based on actual lab fees submitted.

3.9 Practitioner Signature on Adjustments/Resubmissions

Resubmissions and adjustment requests do not require an authorized signature if the original claim submitted was signed or the claim was transmitted via CDAnet®/DACnet™/CDHAnet. Similarly, we do not require the patient’s signature on adjustments or resubmissions provided the original claim submitted was signed, or the claim was transmitted via CDAnet®/DACnet™/CDHAnet.

The original claims must include the authorized signature of the dental office as this confirms that the work was completed and accurately billed. The dental practitioner remains solely responsible for all claims submitted.

3.10 Receipts

Pacific Blue Cross does not require receipts except for orthodontic claims and special requests. Photocopies of receipts are only accepted for coordination of benefits claims where Pacific Blue Cross is not the primary plan. Receipts are not returned. Information on how to submit orthodontic claims is available in the Orthodontic section of this fee schedule and on our website: **pac.bluecross.ca** under the Dental Claim Forms section.

3.11 Co-pay Collection / Discounting

Pacific Blue Cross reimburses claims at the applicable plan percentages of either the provider’s usual and customary fee or the Pacific Blue Cross Fee Schedule amount (whichever is less). If a discount is given to the patient, bill the actual discounted amount charged. The provider is responsible to collect any copayment amount from the patient; the copayment must be collected whether the fee is discounted or not. If discounting to non-insured patients, the same fee should be extended to insured patients.

Usual and customary fees should not change based on the existence of dental benefits. There should be no formal linkage between the fees charged by a dentist and the reimbursement provided by a dental care plan.

3.12 Bill the Fee Item of the Service Performed

The provider must bill the actual procedures performed in accordance with:

1) The industry's standard of care and,
2) The guidelines, fee item numbers and descriptors of procedures in their provincial association fee guide and,
3) The criteria and limitations listed in this fee schedule.

Bill for treatment provided. For example, do not bill for services that were predetermined but not provided, or the time the patient was booked for, or for a similar procedure to what was actually performed because it was covered under the patient's dental plan. **In other words, always bill for actual services rendered and do not substitute and/or separate the service(s) with alternate fee item numbers.**

For standard dental care plans, if the service performed is not listed in this fee schedule Pacific Blue Cross may allow a lower cost alternative based on the applicable basic rate determined by Pacific Blue Cross’ criteria (i.e., composite restorations on permanent molars are paid at the bonded amalgam equivalent). This does not apply to non-standard Pacific Blue Cross plans, Ministry of Children and Family Development (MCFD) or Ministry of Social Development and Poverty Reduction (MSDPR) claims.

Existence of dental benefits should not impact care provided.

Treatment plans must be driven by clinical needs (although patient choice of options may be influenced by benefits).

3.13 Overpayments

In the event that there is an overpayment, Pacific Blue Cross may adjust the balance owing on a future statement. An overpayment may result from claim adjustment requests from the dental office or a case where Pacific Blue Cross identified a claim that needed to be adjusted. Pacific Blue Cross’ system cannot accept a dental office’s cheque to refund Pacific Blue Cross for an overpayment or adjustment while ongoing claims are being processed for the dental office.

Continue to notify Pacific Blue Cross of adjustments by mail, on a paper claim or on a copy of your statement. Adjustments may be requested also by calling 604 419-2000 or 1 877 PAC-BLUE. Once the error is adjusted, the correction will show on the next dental statement.

In situations when an overpayment is not recovered from the next dental payment, Pacific Blue Cross will invoice the dental office. In this case, please send Pacific Blue Cross a personal cheque or return the computer generated cheque. In summary, Pacific Blue Cross kindly requests your cooperation to only send Pacific Blue Cross cheques if the dental office receives an invoice from Pacific Blue Cross indicating an amount is owed.

4.0 Duly Registered

The dental practitioner verifies that he/she is duly registered under the laws of their province or territory to practice. The dental practitioner agrees to advise Pacific Blue Cross as soon as reasonably possible if he/she is no longer able to practice with their regulatory college, or has limits or conditions placed on their registration. Pacific Blue Cross will not pay for services rendered by a dental practitioner who is not registered to practice, or provides services outside of their scope of practice, or outside of limits and conditions on their practice.

5.0 Privacy

Pacific Blue Cross protects the confidentiality and security of members' personal information. Under the Personal Information Protection Act, consent is required for the disclosure of Pacific Blue Cross members' personal information. Member consent can be given verbally or in writing at the initial point of contact. For this reason, Pacific Blue Cross asks that your customer give you consent to contact Pacific Blue Cross.

6.0 New or Referred Patients

Pacific Blue Cross strongly suggests that you request picture identification from new and referred patients. You should maintain the patient's current address and telephone number, as well as the name and telephone number of the plan administrator (due to privacy laws, Pacific Blue Cross is unable to release this information). This will help to prevent fraudulent claims.

You can anonymously report incidents of fraud and unethical behaviour (e.g. non-collection of copayment) to an independent third party Whistleblower Hotline. Visit **pbc-ethics.com** or call ConfidenceLine™ at 1-800-661-9675 (24/7 availability).

7.0 Services Not Eligible

Services not listed in this fee schedule are not eligible for reimbursement, except as noted in 3.11 of this fee schedule (excludes non-standard plans which may explicitly cover some expenses). The following are some of the exclusions:

a) Recent duplication of services by the same or a different dentist, dental specialist, denturist or hygienist.
b) Procedures performed for congenital malformations or for purely cosmetic reasons.
c) Charges in excess of those listed in this fee schedule.
d) Charges for drugs (i.e. Botox), pantographic tracings and grafts.
e) Charges for implants or services performed in conjunction with implants, except as indicated in this fee schedule.
f) Charges for services solely for the functioning or structure of the jaw, jaw muscles or temporomandibular joint (e.g., temporomandibular joint dysfunction or pain, myofacial pain dysfunction, etc.).
g) Charges for TENS treatment.
h) Charges for services related to orthognathic surgery.
i) Anesthesia not done in conjunction with surgery and charges for facilities, equipment and supplies.
j) Incomplete, unsuccessful or temporary procedures.
k) Any extra procedure that is normally included with the service performed.
l) Services or items that would not normally be performed for a patient without dental benefit coverage.
m) Services or items which are free for patients with or without dental benefit coverage.
n) Oral hygiene or nutritional instruction, completion of forms, written reports, communication costs, or charges for translating documents into English.
o) Late or financing charges, interest or insurance charges and charges for broken appointments.
p) Replacement of lost, stolen or broken removable dental appliances

Some Fee Items in this guide may have specific services that are not eligible for reimbursement. Please refer to the specific fee item in the guide to determine services not eligible.

8.0 Predetermination

8.1 Submit a Predetermination

Before proceeding with treatment, Pacific Blue Cross recommends that your office submit a predetermination. If the course of treatment changes after the services are predetermined, submit a revised treatment plan for approval. *Note: Claim paid amounts may differ from the predetermination based on actual fees submitted.*

Claims for services submitted without a predetermination may be subject to review and require additional supporting documentation. Services and procedures that were predetermined must be completed and considered successful before submitting a claim for payment.

8.2 Supporting Documentation Requirements

Radiographs submitted with a predetermination must be clear, original, diagnostic quality radiographs. Panoramic radiographs or copies of radiographs are not acceptable. Pacific Blue Cross returns original radiographs, study models and clinical photos (that are printed on photo quality paper).

Onlays are subject to the criteria outlined in the Restorative section of this fee schedule. Predeterminations for onlays are required and must be accompanied by clear, original, diagnostic quality radiographs and either a clear photograph or study model. Documentation must include a clinical description. A working model or cerec printout of the completed onlay must be available upon request. Claims received without predetermination may be reimbursed at a lower cost alternative.

9.0 Eligibility Information

Confirmation of eligibility is not a guarantee of payment or coverage. A member's status can change at any time. The patient should contact their plan administrator when in doubt.

a) Access PROVIDERnet at **providernet.ca.** Use PROVIDERnet to review if your patient has active coverage, get a plan breakdown, look up limits and rules for specific procedures, find out the next date a procedure is eligible and the remaining balance for a patient's specific maximum. You can also download forms from the website. For Ministry of Social Development and Poverty Reduction patients, you can confirm if your patient has active coverage and look up plan limits available for services.

b) Pacific Blue Cross underwrites many non-standard plans. You can access PROVIDERnet for the plan percentages and type of coverage before proceeding with treatment. Some plans contain unique financial or procedural limits. Patients should check with their plan administrator for complete details or can visit their Member Profile to view their own information. You can also submit a predetermination through CDAnet/DACnet/CDHAnet or submit a manual predetermination on a standard dental claim form. Some predeterminations/dental claims require photographs, clinical description, x-rays, and/or study models to be submitted to Pacific Blue Cross.

c) All benefits are subject to the terms and conditions of your patient's Dental Care plan contract.

10.0 Coordination of Benefits (COB)

Save time and mailing expenses by sending your Coordination of Benefits (COB) claims electronically to Pacific Blue Cross (PBC). Ensure that the COB 07 transaction is enabled in your practice management software or call your vendor to have them configure the COB 07 transaction for you.

10.1 PBC is Primary Payer

For electronic and paper claims submit one claim to PBC

10.2 Dual Pacific Blue Cross Coverage

For electronic claims, when there are two PBC plans, or whose additional coverage is with a national Blue Cross plan, PBC will use the Embedded EOB transaction to process claims where they are the primary and secondary ('blue on blue' claims). These claims will be processed automatically.

For paper claims submit only one claim form or predetermination. Indicate the coverage information for the second plan in the appropriate area on the claim form or predetermination.

10.3 When PBC is the Secondary Payer

For electronic claims where PBC is the secondary carrier and different from the primary, the dental office will be able to use the COB 07 claim transaction (both version 2 and 4 EOB can be included).

For paper claims, a copy of the Explanation of Benefits from the primary plan is always required along with your claim form when submitting a COB claim where Pacific Blue Cross is the secondary plan.

To prevent the delay of assessment please provide any pertinent information that will assist Pacific Blue Cross in determining the order of payment. It is a requirement to include proof of payment (copy of the Explanation of Benefits) when another carrier is involved. This assists with the processing of a claim when deductibles or limitations are reached under the primary plan. If the primary plan is no longer in effect, please provide the termination date.

Here is a quick reference to note which PBC plan is secondary when there is COB involving these PBC plan sponsors :

External Insurance	Pacific Blue Cross Insurance				Which Plan is Secondary Payer
	General Block of Business	MSDPR	MCFD	FNHA	
✓	✗	✗	✗	✓	FNHA
✓	✗	✓	✗	✗	MSDPR
✓	✗	✗	✓	✗	MCFD
✗	✓	✗	✗	✓	FNHA
✗	✓	✓	✗	✗	MSDPR
✗	✓	✗	✓	✗	MCFD
✗	✗	✓	✗	✓	FNHA
✗	✓	✓	✗	✓	Secondary MSDPR, Tertiary FNHA
✗	✗	Any client with possible overlapping coverage			Submit all documentation with COB information to PBC for review
CDCP	✗	✗	✗	✓	Canadian Dental Care Plan (CDCP)
CDCP	✗	✓	✗	✗	MSDPR
CDCP	✗	✗	✓	✓	MCFD
CDCP	✗	✓	✓	✓	Secondary CDCP, Tertiary MSDPR, Fourth MCFD

Note: Claims for patients with COB coverage under PBC's **General Block of Business, MCFD and FNHA** require *only one claim submission to PBC* and will automatically process under these three PBC plan sponsor types.

Claims for patients with coverage under **MSDPR** *always require a separate claim submission* under the MSDPR coverage from the other three PBC plan sponsor types.

10.4 COB Scenario Summary

Which carrier to submit to first based on whether the coverage is with PBC, MyPBCBenefits or another carrier?

Scenario	Primary Coverage	Secondary Coverage	Description
1	PBC	None	Submit PBC claim to PBC
2	PBC	PBC	Submit PBC claim to PBC. When there is more than one PBC coverage, the claim will be automatically processed under all coverages.
3	PBC	MyPBCBenefits	Primary Coverage for PBC – Submit claim to PBC Secondary Coverage for MyPBCBenefits • Submit electronic claims to TELUS Adjudicare • Submit paper claims to PBC
4	PBC	Other Carrier	Primary Coverage for PBC – Submit claim to PBC
5	MyPBCBenefits	None	• Submit electronic MyPBCBenefits claims to TELUS Adjudicare • Submit paper MyPBCBenefits claims to PBC
6	MyPBCBenefits	PBC	Primary Coverage for MyPBCBenefits • Submit electronic claims to TELUS Adjudicare • Submit paper claims to PBC Secondary Coverage for PBC – Submit claim to PBC
7	MyPBCBenefits	MyPBCBenefits	• Submit separate electronic claims for each MyPBCBenefits plan to TELUS Adjudicare • Submit paper MyPBCBenefits claim to PBC
8	MyPBCBenefits	Other Carrier	Primary Coverage for MyPBCBenefits • Submit electronic claims to TELUS Adjudicare • Submit paper claims sent to PBC

10.5 COB Guidelines

Whose coverage to submit to first based on whether the patient is the Member, Spouse or Children?

Pacific Blue Cross bases COB rules on the Canadian Life and Health Insurance Association (www.clhia.ca) guidelines.

They are:

1) The plan where the person is covered as a member.
2) The plan where the person is covered as a dependent spouse.
3) If a person is a member (cardholder) of two plans, priority goes to:
    a. the plan where the member is an active full-time employee
    b. the plan where the member is an active part-time employee
    c. the plan where the member is a retiree
4) Primary coverage for dependent children is determined by:
    a. the plan of the parent with the earlier birth date (MM/DD) in the calendar year.
    b. the plan of the parent whose first name begins with the earlier letter in the alphabet when the parents have the same birth date.
5) In situations of separation or divorce, where there is single custody, the following order applies:
    a. the plan of the parent with custody of the child
    b. the plan of the spouse of the parent with custody of the child
    c. the plan of the parent not having custody of the child
    d. the plan of the spouse to the parent not having custody of the child
6) In situations of separation or divorce where there is joint custody, the following order applies:
    a. the plan of the parent with earlier birth date (MM/DD) in the calendar year
    b. the plan of the parent with later birth date (MM/DD) in the calendar year
    c. the plan of the spouse of the parent with earlier birth date (MM/DD) in the calendar year
    d. the plan of the spouse of the parent with later birth date (MM/DD) in the calendar year

Total reimbursement will never exceed 100 percent of the eligible amount (excludes non-standard plans who allow for different eligible amounts).

10.6 Some Plans may not Allow COB

The patient should verify eligibility with the plan administrator as some plans do not allow duplicate coverage. If the dental care plan provisions do not allow duplicate coverage, you must check the validity of any predetermination before starting treatment.

10.7 Some Plans are Always Primary

A plan that does not have a COB provision is always primary and pays before a plan that does have a COB provision.

11.0 Supernumerary & Retained Primary 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 in the description of service column on the claim form.

Use the respective primary tooth number for retained primary teeth and indicate that it is a retained primary tooth in the notes section of the claim form.

12.0 Unit of Time

One unit of time = 15 minutes.

It is a misuse of the fee guide to bill for more units of time during an appointment than the total time the patient was seated and attended by a caregiver. It is appropriate to bill for all the time that caregivers attend to the patient. If, during the appointment, a procedure such as a recall exam (which is billed on a procedural basis) is performed, the maximum number of time units to be billed should be reduced to recognize the time required to perform the billed procedure. The procedures to be billed on a per unit of time basis should reflect the predominant service performed during the unit (or ½ unit) of time.

13.0 Fee Item Number: Additions and Deletions

14.0 Version Control

Version	Description	
Version 1	Issued on February 1, 2025	
	Deletion	***Addition***
	05201	*92332*
	05202	*92333*
	05209	*92334*
	92301	*92339*
	92302	
	92303	
	92304	
	92309	
Version 2	Issued on March 28, 2025	
	Deletion	***Addition***
		05201
		05202
		05209

Commonly Asked Schedule 1, 2, 3 Frequencies*

	Complete Exams	New Patient and Recall Exams	Recall Exams	Complete Series (X-rays)	Panorex X-ray	Scaling & Root Planing	Polish, Fluoride	Pit and Fissure Sealants	Bruxism Guard	Root Canals	Dentures — Complete & Partial	Crowns, abutments and pontics	Tooth coloured restorations
Schedule 1	One in a three-year period, combined for all periodontists. One in a three-year period, combined for all other specialists and or GPs.	Combined limit of two per calendar year	Two per calendar year	One every 36 months	One every 36 months	Reasonable & Customary	Two per calendar year	One per tooth in a two-year period (covered for dependent children and adults)	Plan A Basic Service - Two every five years	One per tooth in a five-year period	Limited to one upper and one lower denture (complete or partial) in a five-year period	On tooth numbers seven and eight will be paid as gold	Paid at the bonded amalgam equivalent on primary and molar teeth
Schedule 2					One every 24 months				Plan B Major Service - Two every five years				
Schedule 3	Two per lifetime (one by a GP & one by a specialist)				One every 60 months	The contract % of the contract maximum of $764.40 per calendar year			Plan A Basic Service - Two every five years	Once per tooth per lifetime		n/a	

** Refer to information in this fee schedule for details, outlining frequency and financial limits for Schedule 1, 2 and 3 Pacific Blue Cross Dental Plans*

Diagnostic 01000-09999

Clinical Oral Examinations

Complete Oral, Examination and Diagnosis, permanent dentition

Note: Exam and Diagnosis must be performed by dentist. However, charting and measurements may be delegated to qualified staff.

To Include:

a) History, Medical and Dental
b) Clinical examination and diagnosis of hard and soft tissues, including carious lesions, missing teeth, determination of sulcular depth and location of periodontal pockets, gingival contours, mobility of teeth, recession, interproximal tooth contact relationships, occlusic of teeth, TMJ, pulp vitality tests, where necessary, and any other pertinent factors
c) Radiographs extra, as required

Schedules 1 and 2: **Limited to one in a three-year period, combined for all periodontists.**
Limited to one in a three-year period, combined for all other specialists and or general practitioners.
Schedule 3: **Limited to two per lifetime (one by a general practitioner and one by a specialist).**

Extended examination and diagnosis on permanent dentition, recording history, charting, treatment planning and case presentation, including description as per Complete Oral, Examination and Diagnosis, permanent dentition (above).

01103	Permanent Dentition	146.00

New Patient and Recall

Examination of hard and soft tissues including checking of occlusion and appliances, but not including specific tests/analysis as for Examination and Diagnosis, Complete Oral (above).

New patient and recall exams have a combined limit of two per calendar year.

01201	New Patient (once per dentist - may include PSR - periodontal screening and recording)	67.20
01202	Previous Patient (recall)	41.60

Specific Exams

Not to be used as a substitute for limited exam codes (01201, 01202)

Specific exams are limited to a combination of two per calendar year.

01204	Specific – Examination and evaluation of a specific situation	61.00
01205	Emergency – Examination and diagnosis for the investigation of discomfort and/or infection in a localized area.	74.90
01702	Prosthodontic, Specific, Note and Record	55.30

Prosthodontic – General

To include: Extended examination of the Edentulous Mouth, including detailed Medical and Dental (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 lymph nodes, and including evaluation for implant-supported or retained prosthesis

Limited to one in a five-year period.

01701	Edentulous	120.00

Orthodontic Examination and Diagnosis

01901	See Orthodontics Services	940.00

Diagnostic 01000-09999

Radiographs (Radiographic Examination, Diagnosis and Interpretation by Dentist)

All radiographs (including complete series and panoramic films) are limited to the contract percentage of $126.00 per patient, per calendar year, excluding radiographs performed for orthodontic purposes.

Predeterminations for major restorative treatment must be submitted with clear, original, diagnostic quality printed digital images or mounted periapical/bitewing radiographs. Panoramic radiographs or copies of radiographs are not acceptable. Panoramic radiographs are only acceptable for oral surgery and/or periodontic review

Complete Series

Limited to one in a 36-month period. Complete series is also included in radiograph limit (above).

02101	Minimum of twelve images including bitewings	117.00
02102	Minimum of sixteen images including bitewings	126.00

Periapical

02111	Single image	23.00
02112	Two images	31.50
02113	Three images	40.00
02114	Four images	48.70
02115	Five images	57.40
02116	Six images	66.00
02117	Seven images	74.30
02118	Eight images	83.10
02119	Nine images	91.70
02120	Ten images	100.00
02121	Eleven images	109.00
02122	Twelve images	117.00
02123	Thirteen images	126.00
02124	Fourteen images	126.00
02125	Fifteen images	126.00

Occlusal

02131	Single image	32.80
02132	Two images	45.30
02133	Three images	60.20

Bitewing

02141	Single image	23.00
02142	Two images	31.50
02143	Three images	40.00
02144	Four images	48.70

Regional/Localized, Other

02151	Single image	56.50
02152	Two images	82.40
02153	Three images	108.00
02154	Four images	135.00
02159	Each additional image over four	25.90

Panoramic

Panoramic Image is also included in radiograph limit (above).

Schedule 1: **Limited to one in a 36-month period.**
Schedule 2: **Limited to one in a 24-month period.**
Schedule 3: **Limited to one in a 60-month period.**

02601	Single image	87.00

Diagnostic 01000-09999

Tests

Histopathological Tests/Analysis (technical procedure only)

Detailed lab invoices must be available on request.

Soft Tissue

04311	Biopsy, Soft Oral Tissue - By puncture	167.00	+ L
04312	Biopsy, Soft Oral Tissue - By incision	269.00	+ L

Hard Tissue

04322	Biopsy, Hard Oral Tissue - By Incision	539.00	+ L

Pulp Vitality Test/Analysis & Interpretation

Limited to one unit per quadrant in a six-month period.

04501	One unit	138.00
04507	One half unit	69.00

Diagnostic Visual Imaging (technical procedure only)

Diagnostic visual imaging are limited to the contract percentage of the maximum of $70.00, per patient, per calendar year.

Note: This limit will be represented on PROVIDERnet as 0480E.

04811	Single photo	30.10
04812	Two photos	39.90
04813	Three photos	50.20
04819	Each additional photo over three	9.80

Diagnostic Models (including interpretation and laboratory costs)

Limited to one set in a calendar year.

Diagnostic models (required for predeterminations) which are chipped, cut or badly broken are not acceptable, and new models will be requested.

04911	Unmounted, Trimmed	138.00

Case Presentation/Treatment Planning

Case presentation/treatment planning are limited to the contract percentage of the maximum of $187.30, per patient, per calendar year.

Note: This limit will be represented on PROVIDERnet as 0520E.

Eligible only for consultation with patient for comprehensive major restorative cases when used to discuss treatment proposal and alternatives with the patient after a complete exam has been done.

Not Eligible: Case Presentation/Treatment Planning in conjunction with any examinations.

05201	One Unit of time	62.30
05202	Two units	125.00
05209	Each additional unit over two	62.30

Remote Assessment, of Chief Complaint

May be used for consultations with patients, exceeding 7.5 minutes, utilizing a telehealth platform. (Includes medical history, assessment of the clinical situation, interim diagnosis, remote management (e.g. calling in a prescription, referral etc.), appropriate documentation and subsequent follow-up calls).

Limited to two units per patient per calendar year.

Procedure Code 01204, 01205, 01702 are ineligible within the week following a billing of 08011/8012.

08011	One unit of time	62.30
08012	Two units	125.00

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.

Limited to two per calendar year.

11101		47.60

Scaling

Schedule 3: **Scaling, root planing and gingival curettage are limited to the contract percentage of the combined dollar maximum of $764.40 per patient, per calendar year.**

Scaling refers to removal of supragingival and accessible subgingival bacterial plaque and calculus from tooth surfaces. Where scaling and root planing are incorporated in periodontal surgical treatment, Pacific Blue Cross considers these services to be included in the surgical fee.

11111	One unit	58.80
11112	Two units	117.60
11113	Three units	176.40
11114	Four units	235.20
11115	Five units	294.00
11116	Six units	352.80
11117	One half unit	29.40
11119	Each additional unit over six	58.80

Fluoride Treatment

Limited to two per calendar year.

12111	Fluoride Treatment, Rinse	14.60
12112	Fluoride Treatment, Gel or Foam	20.10
12113	Fluoride Treatment, Varnish	24.10
12114	Fluoride Treatment, Supervised, Self-Administered Brush-In	14.60

Pit and Fissure Sealants/Preventive Restorative Resin

Limited to one per tooth in a two-year period.

Pit and Fissure Sealants *(mechanical and/or chemical preparation included)*

13401 🦷	First tooth	32.90
13409 🦷	Each additional tooth, same quadrant	18.00

Preventive Restorative Resin

Preventive Restorative Resin involves some preparation of the pits and/or fissures in tooth enamel and may extend into dentin in limited areas

13411 🦷		80.50

Periodontal Appliances - *bruxism appliance*

Including impression, insertion and adjustments (no post-insertion adjustments).

Limited to two appliances in a five-year period.

Schedules 1 and 3: **Paid under Basic.**

Schedule 2: **Paid under Major (plans with prosthetic coverage only).**

Not Eligible: Spare appliances, treatment of obstructive airway disorders (snoring devices), mouth guards (sports guards) and control of oral habits.

14611	Maxillary	335.00	+ L
14612	Mandibular	335.00	+ L

Preventative 10000-19999

Space Maintainers

Includes the design, separation, fabrication, insertion and, where applicable, initial cementation and removal.

Space maintainers are covered under all plans when used to maintain space not to obtain more space includes observation for three months.

Band Type, Fixed

15101	Unilateral	219.00	+ L
15102	Unilateral with intra-alveolar attachment	241.00	+ L
15103	Bilateral, soldered lingual arch	285.00	+ L

Acrylic, Removable

15403	No Clasps	209.00	+ L

Maintenance of Space Maintainers

15601	To include: Adjustment and/or recementation after 30 days from insertion	73.90	
15602	Addition of clasps and/or activating wires	73.90	+ L
15603	Repairs (includes recementation)	73.90	+ L
15604	Removal of fixed appliances by second dentist	73.90	

Disking of Teeth (interproximal)

Limited to one unit per tooth per lifetime.

16201	One unit	90.70

Recontouring of Teeth for Functional Reasons/ Occlusion

Recontouring and occlusal adjustments are limited to the contract percentage of the combined maximum of $976.00, per patient, per calendar year.

Recontouring (not associated with delivery of a single or multiple prosthesis)

16401	One unit	78.00
16409	Each additional unit	78.00

Occlusion - Occlusal Adjustment/Equilibration

a) May require several sessions
b) May be used in conjunction with basic restorative treatment only when occlusal adjustment/equilibration is not required as a result of that restoration
c) Not to be used in conjunction with the delivery and post-insertion care of fixed and removable prosthesis (50000 + 60000 code series) by the same dentist for a period of three months

A clinical description is required for 3 or more units in one visit.

16511	One unit	122.00
16512	Two units	244.00
16513	Three units	366.00
16514	Four units	488.00
16517	One half unit	61.00
16519	Each additional unit over four	122.00

Caries, Trauma and Pain Control

Caries, Trauma and Pain Control

Removal of carious lesion or existing restorations or gingivally attached tooth fragment and placement of sedative/protective dressings includes pulp caps when necessary, as a separate procedure (using code 20141).

Limited to one per tooth per lifetime.

Not Eligible: When performed in conjunction with a restoration.

20111	First tooth	146.00
20119	Each additional tooth, same quadrant	72.70

Trauma Control, Smoothing of Fractured Surfaces, per tooth

20131	First tooth	47.00
20139	Each additional tooth, same quadrant	21.60

Pulp Cap, Direct Performed in Conjunction with Permanent Restorations

Performed at the same appointment as the permanent/temporary restoration, it is to include placement of an appropriate pulp capping material. This base material procedure is to be used where pulp exposure is evident or when pulpal tissue is visible (blushing pulp) through the dentin. It is not to be used for routine liner placement where decay removal is slightly below ideal preparation depths.

Not Eligible: When performed in conjunction with a pulpotomy.

20141	First tooth	49.50

Amalgam and Tooth Coloured Restorations

Where, at the same sitting, in order to conserve tooth structure, separate amalgam restorations are performed on the same tooth, the fee should be determined by counting the total number of surfaces restored.

Pacific Blue Cross does not pay an additional amount for difficult procedures. Surface names must be indicated, and tooth numbers are required for all restorative treatment. Restorations billed for veneer applications or diastema closures are not eligible. Restorations solely for correction of vertical dimension, wear or restoring occlusion are not eligible. Clear, original, diagnostic quality radiographs must be provided on request.

All restorations are limited to the contract percentage of the dollar equivalent of a five-surface filling per tooth in a two-year period.

Amalgam – Primary

Non-bonded

21111	One surface	151.00
21112	Two surfaces	190.00
21113	Three surfaces	218.00
21114	Four surfaces	251.00
21115	Five surfaces (maximum per tooth)	289.00

Bonded

21121	One surface	151.00
21122	Two surfaces	190.00
21123	Three surfaces	218.00
21124	Four surfaces	251.00
21125	Five surfaces (maximum per tooth)	289.00

Restorative 20000-29999

Amalgam – Permanent

Non-Bonded

Bicuspids and Anteriors

21211	One surface	179.00
21212	Two surfaces	246.00
21213	Three surfaces	301.00
21214	Four surfaces	367.00
21215	Five surfaces (maximum per tooth)	447.00

Molars

21221	One surface	194.00
21222	Two surfaces	291.00
21223	Three surfaces	357.00
21224	Four surfaces	440.00
21225	Five surfaces (maximum per tooth)	541.00

Bonded

Bicuspids and Anteriors

21231	One surface	179.00
21232	Two surfaces	246.00
21233	Three surfaces	301.00
21234	Four surfaces	367.00
21235	Five surfaces (maximum per tooth)	447.00

Molars

21241	One surface	194.00
21242	Two surfaces	291.00
21243	Three surfaces	357.00
21244	Four surfaces	440.00
21245	Five surfaces (maximum per tooth)	541.00

Buildups/Cores

21301	See Major Restorative Services	156.00

Retentive Pins, per restoration (for amalgam and tooth coloured restorations)

Limited to the contract percentage of the dollar equivalent of five pins per tooth in a two-year period.

21401	One pin	43.60
21402	Two pins	65.50
21403	Three pins	82.70
21404	Four pins	100.00
21405	Five or more pins	117.00

Restorative 20000-29999

Metal Prefabricated Restorations, Full Coverage

22201	Primary anterior	299.00
22211	Primary posterior	289.00
22301	Permanent anterior	298.00
22311	Permanent posterior	298.00

Tooth Coloured Restorations – Permanent

All restorations are limited to the contract percentage of the dollar equivalent of a five-surface filling per tooth in a two-year period.

Permanent anteriors and bicuspids only. Primary and molar teeth are paid at the bonded amalgam equivalent.

Anteriors

Bonded Technique (not to be used for veneer applications or diastema closures.)

23111	One surface	172.00
23112	Two surfaces	209.00
23113	Three surfaces	259.00
23114	Four surfaces	319.00
23115	Five surfaces (maximum per tooth)	394.00

Bicuspids

Bonded Technique

23311	One surface	198.00
23312	Two surfaces	274.00
23313	Three surfaces	334.00
23314	Four surfaces	408.00
23315	Five surfaces (maximum per tooth)	497.00

Buildups/Cores

23602	See Major Restorative Services	226.00

Restorative 20000-29999

Major Restorative Services

Items under this section are covered if no other material could be used that would conform to the general principles of basic Dentistry. Major reconstruction of decayed teeth is eligible only when basic restorative materials cannot be used satisfactorily.
Patients choosing to have gold, porcelain or ceramic, where other material would suffice, should be advised that they will be responsible for the difference in the cost of gold, porcelain or ceramic, and the cost of alternative adequate material. The allowance for all crown and bridgework includes all provisional crowns or units used. Application failure does not meet our criteria to be eligible for major restorative services.
The replacement of existing services are eligible only when they are no longer functional, repairable or if a major restoration is serviceable. Pacific Blue Cross will not pay for extensive restorations until inserted in the patient's mouth.
Prior approval is recommended to avoid misunderstandings. Clear, original, diagnostic quality radiographs, photographs, clinical descriptions, diagnostic and/or working models may be required for review.
Not Eligible:

- ***Dentistry for congenital malformations or purely cosmetic purposes.***
- ***Restorations necessary for restoring vertical dimension and/or restoring occlusion.***
- ***In all crown and bridgework, a buildup of a tooth by use of amalgams or pins or other such material, other than that provided in the schedule.***
- ***Gingival troughing or limited recontouring is considered included in the cost of the total restoration.***

All major restorative services (crowns, inlays, onlays, veneers and fixed bridge restorations) are limited to once every five years, from the original insertion date, when the same tooth is involved.
Schedules 1 and 2: Crowns, abutments and pontics on tooth numbers seven and eight will be paid as gold.

Buildups/Cores (in conjunction with crown or fixed bridge retainer)

Limited to one per tooth in a five-year period.
Buildups/cores are eligible only for the purpose of retention and preservation of a tooth when performed with major restorative treatment. Necessity must be evident on clear, original, diagnostic quality radiographs and/or photographs. Where necessity is not clearly evident, a detailed/concise clinical description and/or working photographs may also be required.

Not Eligible:

- ***Transitional buildups/cores to facilitate impression taking and/or block out undercuts are considered included in the cost of the total restoration.***
- ***Buildups/cores when performed with inlays, onlays or veneers.***

21301	🦷	Non-bonded	156.00
23602	🦷	Bonded, Tooth Coloured, Plastic with/without Silver fillings	226.00

Inlays

Eligible only on Anteriors (MI or DI) – Tooth surface names must be indicated on all submissions.
Schedules 1 and 3: Paid under Major
Schedule 2: Paid under Basic
An Inlay is a fixed intracoronal restoration; a dental restoration made outside of a tooth to correspond to the form of the prepared cavity, which is then luted into the tooth.
Not Eligible: Buildups/cores when performed with inlays.

Metal

25112	🦷	Two surfaces	881.00	+ L

Porcelain/Ceramic/Polymer Glass (Bonded)

25142	🦷	Two surfaces	889.00	+ L

Restorative 20000-29999

Onlays

An onlay is a restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means. The principal difference between a crown and an onlay is that an onlay does not extend beyond the height of contour on more than two adjacent walls.

Requirements: 1) Internally retained or bonded. 2) Proximal box. 3) At least one entire cusp requires restoring. Tooth surface names must be indicated on all submissions.

Eligible only on Posteriors and Bicuspids.

Schedules 1 and 3: Paid under Major.

Schedule 2: Paid under Basic.

Predeterminations for onlays are required and must be accompanied by clear, original, diagnostic quality radiographs and either a clear photograph or study model. Documentation must indicate the designated surfaces to be restored and include a clinical description. Pacific Blue Cross may request a working model or cerec printout of the completed onlay. Claims received without predetermination may be reimbursed at a lower cost alternative.

Not Eligible: Buildups/cores when performed with onlays.

25511	Cast Metal, Indirect	1070.00	+ L
25521	Composite/compomer, Indirect, Bonded	992.00	+ L
25531	Porcelain/ceramic/polymer, glass, Bonded	1095.00	+ L

Posts

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

Cast Metal

As a separate procedure (including core)

25711	Single section	451.00	+ L

Concurrent with impression for crown (including core)

25721	Single section	180.00	+ L
25722	Two sections	264.00	+ L

Prefabricated Retentive

25731	One post	236.00	+ E
25732	Two posts	377.00	+ E
25733	Three posts	519.00	+ E

Crowns

All major restorative services (crowns, inlays, onlays, veneers and fixed bridge restorations) are limited to once every five years, from the original insertion date, when the same tooth is involved.

Schedules 1 and 2:

Crowns, abutments and pontics on tooth numbers seven and eight will be paid as gold.

A crown is an artificial replacement that restores missing tooth structure by surrounding part or all the remaining structure with a material such as cast metal, porcelain, or a combination of materials such as metal and porcelain.

27111	Acrylic / composite / compomer, indirect	885.00	+ L
27201	Porcelain / ceramic / polymer glass	1070.00	+ L
27211	Porcelain / ceramic / polymer glass, fused to metal base	1070.00	+ L
27213	Porcelain / ceramic / polymer glass, fused to metal base, with porcelain margin	1070.00	+ L
27221	¾, Porcelain / ceramic / polymer glass,	1070.00	+ L
27301	Cast metal	999.00	+ L
27311	¾, Cast metal	1070.00	+ L

Restorative 20000-29999

Crown Made to an Existing Partial Denture Clasp (additional to crown)

27401	One crown	114.00	+ L
27409	Each additional crown	114.00	+ L

Copings, Metal/Acrylic, Transfer (thimble type)

27511	As a separate procedure	249.00	+ L
27519	Each additional coping as a separate procedure	186.00	+ L

Veneers

All major restorative services (crowns, inlays, onlays, veneers and fixed bridge restorations) are limited to once every five years, from the original insertion date, when the same tooth is involved.

Eligible only on Anteriors and Bicuspids. Models or photograph(s) must be provided in addition to clear, original, diagnostic quality radiographs and a clinical description.

Not Eligible: Buildups/cores when performed with veneers.

27602	Porcelain/ceramic/polymer glass, bonded	1070.00	+ L

Repairs of Inlays, Onlays, Crowns, Porcelain/ceramic/polymer glass (single units only, does not include removal and recementation)

Not Eligible: When billed with fee item numbers 29101 and 29102 on the same prosthesis, when a new prosthesis is constructed or in conjunction with metal prefabricated restorations on primary teeth.

29201	Direct	199.00	

Coping Crowns, Metal Cast Indirect

28211	No attachment	375.00	+ L
28221	With attachments	374.00	+ L +E

Recementation/Rebonding/Removal

Limited to two units per prosthesis per sitting for recementation and/or removal.

Not Eligible: Recementation, repairs, and removals of metal prefabricated restorations on primary teeth or when a new prosthesis is constructed.

Recementation/Rebonding, Inlays, Onlays, Crowns, Veneers, Posts, Natural Tooth Fragments (single units only) (+L where laboratory charges are incurred during the repair of the unit)

29101	One unit	104.00	+L+E
29102	Two units	208.00	+L+E

Removal, Inlays, Onlays, Crowns, Veneers (single units only)

29301	One unit	103.00	
29302	Two units	206.00	

Pulpotomy

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

Permanent (as a separate emergency procedure)

32221	Anterior and bicuspid	168.00
32222	Molar	167.00

Primary

32231	As a separate procedure	123.00
32232	Concurrent with restorations (but excluding final restoration)	105.00

Pulpectomy (an emergency procedure and/or as a pre-emptive phase to the preparation of the root canal system for obturation). In any event, the fee for the completed endodontic procedure is reduced by the fee charged for the Emergency Pulpectomy.

Permanent/Retained Primary

32311	One canal	220.00
32312	Two canals	263.00
32313	Three canals	429.00
32314	Four or more canals	469.00

Primary

32321	Anterior	220.00
32322	Posterior	346.00

Root Canal Therapy

Schedules 1 and 2: **Limited to one per tooth in a five-year period.**
Schedule 3: **Limited to one per tooth per lifetime.**

To include: treatment plan, clinical procedures (i.e., pulpectomy, biomechanical preparation, chemotherapeutic treatment and obturation), with appropriate radiographs, including temporary restoration but excluding final restoration.
In any event, the fee for the completed endodontic procedure is reduced by the fee charged for the Emergency Pulpectomy.
Payment for primary teeth is made under fee item number 32231. Root canal therapy for difficult access and exceptional anatomy are paid at the basic rate.

33111	One canal	642.00
33121	Two canals	820.00
33131	Three canals	1154.00
33141	Four or more canals	1276.00

Calcified Canals

Unable to penetrate with size #10 file and not clearly discernible on a radiograph.

33114	One canal	684.00
33124	Two canals	996.00
33134	Three canals	1380.00
33144	Four or more canals	1500.00

Endodontics 30000-39999

Apexification/Apexogensis/Induction of Hard Tissue Repair

Eligible only on permanent teeth (first visit including pulpectomy).

33601	One canal	208.00
33602	Two canals	291.00
33603	Three canals	381.00
33604	Four or more canals	391.00

Re-insertion of Dentogenic Media, Per Visit

33611	One canal	69.90
33612	Two canals	97.00
33613	Three canals	138.00
33614	Four or more canals	154.00

Apicoectomy/Apical Curettage

Maxillary

Anterior

34111	One root	541.00
34112	Two roots	635.00

Bicuspid

34121	One root	545.00
34122	Two roots	665.00
34123	Three roots	750.00

Molar

34131	One root	633.00
34132	Two roots	746.00
34133	Three roots	843.00
34134	Four or more roots	948.00

Mandibular

Anterior

34141	One root	554.00
34142	Two or more roots	657.00

Bicuspid

34151	One root	544.00
34152	Two roots	645.00
34153	Three or more roots	750.00

Molar

34161	One root	631.00
34162	Two roots	743.00
34163	Three roots	838.00
34164	Four or more roots	943.00

Retrofilling

Maxillary

Anterior

34211	One canal	98.00
34212	Two or more canals	195.00

Endodontics 30000-39999

Bicuspid

34221	One canal	101.00
34222	Two canals	214.00
34223	Three canals	308.00
34224	Four or more canals	402.00

Molar

34231	One canal	101.00
34232	Two canals	214.00
34233	Three canals	308.00
34234	Four or more canals	402.00

Mandibular

Anterior

34241	One canal	101.00
34242	Two or more canals	214.00

Bicuspid

34251	One canal	101.00
34252	Two canals	214.00
34253	Three canals	308.00
34254	Four or more canals	402.00

Molar

34261	One canal	101.00
34262	Two canals	214.00
34263	Three canals	308.00
34264	Four or more canals	402.00

Root Amputations (includes recontouring tooth and furca)

When root amputation and osseous surgery (42411, 42421) are performed in the same quadrant on the same day, root amputation is paid at 50%.

34411	One root	473.00
34412	Two roots	566.00

Hemisections

34422	Maxillary Molar	I.C
34423	Mandibular Molar	256.00

Perforations/Resorptive Defects, Pulp Chamber or Root Repair

Non-surgical

34511	Per tooth	293.00

Surgical

34521	Anterior	571.00
34522	Bicuspid	675.00
34523	Molar	692.00

Open and Drain (separate emergency procedures)

39201	Anteriors and bicuspids	116.00
39202	Molars	116.00

Opening Through artificial Crown (in addition to procedures)

39501	Anteriors and bicuspids	71.00

Management of Oral Disease

A clinical description indicating the necessity of treatment may be requested.

Oral Manifestations, Oral Mucosal Disorders

Oral Manifestations, Oral Mucosal Disorders, mucocutaneous disorders and diseases of localized mucosal conditions, (e.g. lichen planus, aphthous stomatitis, benign mucous membrane pemphigoid, pemphigus, salivary gland tumours, leukoplakia with and without dysplasia, neoplasms, hairy leukoplakia, polyps, verrucae, fibroma, etc.).

Not Eligible: Billing of diagnostic services (such as: direct fluorescence visualization e.g., VELscope)

41211	One unit	119.00
41212	Two units	238.00
41213	Three units	357.00
41214	Four units	476.00
41219	Each additional unit over four	119.00

Nervous and Muscular Disorders

Nervous and Muscular Disorders, disorders of facial sensation and motor dysfunction of the jaw, (e.g. trigeminal neuralgia, atypical facial pain, atypical odontologia, burning mouth syndrome, dyskinesia, post injection trismus, muscular and joint pain syndromes).

Not Eligible:

- ***Services solely for the functioning or structure of the jaw, jaw muscles or temporomandibular joint (e.g., temporomandibular joint dysfunction or pain, myofacial pain dysfunction, etc.)***
- ***Administration of Botox or in conjunction with the administration of Botox***
- ***TENS treatment***

41221	One unit	95.70
41222	Two units	191.40
41223	Three units	287.10
41224	Four units	382.80
41229	Each additional unit over four	95.70

Oral Manifestations of Systemic Disease

Oral Manifestations of Systemic Disease, oral manifestations of systemic diseases or complications of medical therapy, e.g. complications of chemotherapy, radiation therapy, post-operative neuropathic, post-surgical or radiation therapy, dysfunction, oral manifestation of lupus erythematoses and systemic diseases including, leukaemia, diabetes and bleeding disorders (e.g. haemophilia)

41231	One units	93.30
41232	Two units	187.00
41233	Three units	280.00
41234	Four units	373.00
41239	Each additional unit over four	93.30

Periodontics 40000-49999

PERIODONTAL SERVICES, SURGICAL

Includes local anaesthetic, suturing and the placement and removal of initial surgical dressing. A surgical site is an area that leads itself to one or more procedures. It is considered to include a full quadrant, sextant, or a group of teeth or, in some cases, a single tooth. *Where frenectomy/frenoplasty or vestibular deepening are involved during preparation of a graft site, then these procedures are considered part of the graft preparation and fee and should not be billed as independent fees.*

Gingival Curettage

Schedules 1 and 2: Limited to one per sextant in a five-year period.

Schedule 3: **Scaling, root planing and gingival curettage are limited to the contract percentage of the combined dollar maximum of $764.40, per patient, per calendar year.**

Sextant ID must be indicated e.g., 03, 04, 05, 06, 07 or 08.

42111	Surgical curettage, to include definitive root planing Per sextant	341.00

Gingivectomy

The procedure by which gingival deformities are reduced and reshaped to create normal and functional form, when the pocket is uncomplicated by extension into the underlying bone; does not include limited recontouring to facilitate restorative services.

Limited to one per sextant in a five-year period. Sextant ID must be indicated e.g., 03, 04, 05, 06, 07 or 08.

Not Eligible: Gingival troughing or in conjunction with crown and bridgework.

42311	Per sextant	345.00

Gingival Fiber Incision (supra crestal fibrotomy)

Eligible only on permanent maxillary anteriors.

42331	First tooth	163.00
42339	Each additional tooth	41.40

Osseous Surgery/Crown Lengthening

Osseous surgery and crown lengthening are limited to the contract percentage of the combined maximum of $1,391.00 per sextant, in a five-year period. Sextant ID must be indicated e.g., 03, 04, 05, 06, 07 or 08.

Osseous Surgery

Not Eligible: Gingival troughing or limited recontouring.

42411	Flap approach with osteoplasty/ostectomy; Per sextant	1391.00
42421	Flap approach with curettage of osseous defect; Per sextant	1200.00

Crown Lengthening

Limited to once per sextant in a five-year period. Site must be indicated. A surgical site is an area that lends itself to one or more procedures. It is considered to include a full quadrant, sextant, or a group of teeth or, in some cases, a single tooth.

Predetermination for crown lengthening is required and must be accompanied by a concise clinical description supporting necessity for treatment and diagnostic quality radiographs.

Not Eligible: Gingival troughing, limited recontouring and laser flapless procedures.

42451	Flap approach, with osteoplasty/ostectomy for crown lengthening; Per sextant	718.00

Periodontics 40000-49999

Proximal Wedge Procedure, with Flap Curettage (as a separate procedure)

Quadrant ID must be indicated e.g., 10, 20, 30 or 40.

42811	Per quadrant	579.00	
42819	Ostectomy/osteoplasty; Per quadrant	677.00	

Provisional Splinting or Ligation

Intra Coronal

43111	Per joint	160.00	+E

Extra Coronal

43211	Bonded joint restorations; Per joint	128.00	+E
43231	Wire ligation; Per joint	149.00	
43241	Wire ligation, restorative material covered; Per Joint	160.00	

Removal of Fixed Periodontal Splints

43281	One unit	118.00
43289	Each additional unit	118.00

Root Planing

Schedule 3: Scaling, root planing and gingival curettage are limited to the contract percentage of the combined dollar maximum of $764.40, per patient, per calendar year.

The procedure by which roughened root surfaces are smoothed by the appropriate instruments, and where there is substantial loss of attachment.

Not Eligible: Where scaling and root planing are incorporated in periodontal surgical treatment, Pacific Blue Cross considers these services to be included in the surgical fee.

43421	One unit	58.80
43422	Two units	117.60
43423	Three units	176.40
43424	Four units	235.20
43425	Five units	294.00
43426	Six units	352.80
43427	One half unit	29.40
43429	Each additional unit over six	58.80

Dentures – Complete & Partial

Limited to one upper and one lower denture (complete, partial or reset) in a five-year period.

Pacific Blue Cross does not pay for complete and/or partial dentures until inserted and accepted by the patient.

Complete Dentures

Denture services include: impressions, initial and final jaw relation records, try-in evaluation and check records, insertion and adjustments, including three months post insertion care.

Standard

51101	Maxillary	1014.00	+ L
51102	Mandibular	1106.00	+ L

Surgical, Standard, Immediate

Includes first tissue conditioner and 3 months post-insertion care, but not a processed reline.

51301	Maxillary	1240.00	+ L
51302	Mandibular	1328.00	+ L

Overdenture, Tissue Borne, Supported by Natural Teeth with or without Coping Crowns, no attachments

51711	Maxillary	1413.00	+ L
51712	Mandibular	1505.00	+ L

Partial Dentures

Partial dentures include: impressions, analysis and design, tooth preparation and master impression, bite registration, mold selection and shade, try-in, insertion and occlusal equilibration, and adjustments (up to 3 months post insertion).

Acrylic

With or Without Clasps – Provisional

Eligible only on anterior teeth and within one month of recent extraction.

52101	Maxillary	400.00	+ L
52102	Mandibular	436.00	+ L

Resilient Retainer

52201	Maxillary	1026.00	+ L
52202	Mandibular	1117.00	+ L

With Metal Wrought/Cast Clasps and/or Rests

52301	Maxillary	601.00	+ L
52302	Mandibular	655.00	+ L

With Metal Wrought Palatal/Lingual Bar and Clasps and/or Rests

52401	Maxillary	668.00	+ L
52402	Mandibular	728.00	+ L

Prosthodontics - Removable 50000-59999

Cast, With Acrylic Base

Free End, Cast Frame/Connector with Clasps, Rests

53101	Maxillary	1281.00	+ L
53102	Mandibular	1396.00	+ L

Free End, Cast Frame/Connector with Clasps, Rests – Immediate

Includes first tissue conditioner and 3 months post-insertion care, but not a processed reline.

53111	Maxillary	1344.00	+ L
53112	Mandibular	1465.00	+ L

Tooth-borne, Cast Frame/Connector, Clasps and Rests

53201	Maxillary	1102.00	+ L
53202	Mandibular	1102.00	+ L

Unilateral, One Piece Casting, Clasps and Pontics

53205	Maxillary or Mandibular	459.00	+ L

Cast, Precision Attachments

53401	Maxillary	1549.00	+ L
53402	Mandibular	1688.00	+ L

Cast, Stress Breaker Attachments (resilient)

53611	Maxillary	1549.00	+ L
53621	Mandibular	1688.00	+ L

Minor Denture Adjustments, Partial or Complete

Limited to four units per calendar year.

Arch must be submitted with the appropriate arch ID e.g., 01 or 02.

54201	One unit	91.00	+ L
54202	Two units	182.00	+ L
54209	Each additional unit over two	91.00	+ L

Denture Repairs/Additions (including tooth repair)

All denture repairs/additions require a description of the type of repair and the total lab fee charged. Indicate this information in the description of service column on the claim form. The amount charged must be billed as two amounts (provider professional fee plus lab fee). Lab slips must be available on request.

Complete Denture

No Impression Required

55101	Maxillary	117.00	+ L
55102	Mandibular	117.00	+ L

Impression Required

55201	Maxillary	229.00	+ L
55202	Mandibular	229.00	+ L

Partial Denture

No Impression Required

55301	Maxillary	117.00	+ L
55302	Mandibular	117.00	+ L

Impression Required

55401	Maxillary	229.00	+ L
55402	Mandibular	229.00	+ L

Prosthodontics - Removable 50000-59999

Denture Relines and Rebases

Relines and rebases are limited to a combined maximum of one per upper and one per lower prosthesis in a two-year period.

Direct Relines

Complete Denture

56211	Maxillary	339.00
56212	Mandibula	384.00
56221	Maxillary	271.00
56222	Mandibular	294.00

Processed Relines

Complete Denture

56231	Maxillary	339.00	+ L
56232	Mandibular	384.00	+ L

Partial Denture

56241	Maxillary	271.00	+ L
56242	Mandibular	294.00	+ L

Processed Relines – Functional impression requiring three appointments.

Complete Denture

56251	Maxillary	452.00	+ L
56252	Mandibular	497.00	+ L

Partial Denture

56261	Maxillary	384.00	+ L
56262	Mandibular	407.00	+ L

Rebases

Complete Denture

56311	Maxillary	339.00	+ L
56312	Mandibular	384.00	+ L

Partial Denture

56321	Maxillary	271.00	+ L
56322	Mandibular	294.00	+ L

Prosthodontics - Removable 50000-59999

Therapeutic Tissue Conditioning, Per Appointment

Limited to two per upper and two per lower prosthesis in a five-year period.

Complete Denture

56511	Maxillary	136.00
56512	Mandibular	136.00

Partial Denture

56521	Maxillary	136.00
56522	Mandibular	136.00

Resilient Liner (in addition to reline or rebase of denture)

Arch must be submitted with the appropriate arch ID e.g., 01 or 02.

56601	136.00	+L

Examination and Diagnosis, Prosthetic by Prescribing Dentist

Limited to one per upper and one per lower prosthesis in a five-year period.

59601	Post insertion examination of the partial prosthesis made and inserted by a denturist. Evaluation of fit of framework, acrylic saddle area(s) and occlusion	56.70

Fixed Bridge Restoration

All major restorative services (crowns, inlays, onlays, veneers and fixed bridge restorations) are limited to once every five years, from the original insertion date, when the same tooth is involved.

Schedule 1 and 2: Crowns, abutments and pontics on tooth numbers seven and eight will be paid as gold.

Pontics

62101	Cast metal	398.00	+ L
62501	Porcelain / ceramic / polymer glass fused to metal	438.00	+ L
62701	Acrylic / composite / compomer processed to metal	395.00	+ L

Recementation/Repair/Removal of Fixed Bridgework

Limited to two units per prosthesis, per sitting for recementation, removal and/or repairs.

Not Eligible: Recementation, repairs, and removals of metal prefabricated restorations on primary teeth or when a new prosthesis is constructed.

Removal

66211	One unit	118.00	
66212	Two units	236.00	

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

66301	One unit	121.00	+ L
66302	Two units	242.00	+ L

Repairs, Solder Indexing to Repair Broken Solder Joint

Not Eligible: When billed with fee item numbers 66301 and 66302 on the same prosthesis.

66721	One unit	74.10	+ L
66729	Each additional unit of time	74.10	+ L

Abutments/Retainers

67111	Acrylic, composite / compomer, indirect	814.00	+ L
67201	Porcelain / ceramic / polymer glass	971.00	+ L
67211	Porcelain / ceramic / polymer glass, fused to metal base	971.00	+ L
67251	Porcelain / ceramic / polymer glass, onlay, bonded (where one or more cusps are restored)	1001.00	+L
67301	Cast metal	906.00	+L
67311	Cast metal ¾	972.00	+L
67331	Cast metal onlay (internal retention type)	972.00	+L
67341	Cast metal onlay (bonded, external retention/partial coverage – e.g. Maryland Bridge), with or without Perforations bonded to Abutment Tooth (pontic extra)	506.00	+ L

Retentive Pins (for retainers in addition to restoration)

Limited to the contract percentage of the dollar equivalent of five pins per tooth in a five-year period.

69301	One pin/restoration	80.30	+ L
69302	Two pins/restoration	106.00	+ L
69303	Three pins/restoration	135.00	+ L
69304	Four pins/restoration	165.00	+ L
69305	Five or more pins/restoration	192.00	+ L

Extractions (removals)

The following surgical services include necessary local anesthetic, removal of excess gingival tissue, suturing and one post-operative treatment, when required.

Erupted Teeth

Uncomplicated

71101	Single tooth	181.00
71109	Each additional tooth, same quadrant, same appointment	154.00

Complicated (Surgical Approach)

Requiring Surgical Flap and/or Sectioning of Tooth

71201	Single tooth	306.00
71209	Each additional tooth, same quadrant	260.00

Requiring Elevation of a Flap, Removal of Bone and may include Sectioning of Tooth for Removal of Tooth.

Note: This code is intended for particularly difficult extractions that require flap/bone section.

71211	Single tooth	464.00
71219	Each additional tooth, same quadrant	394.00

Impacted Teeth

Soft Tissue Coverage

Requiring Incision of Overlying Soft Tissue and Removal of the Tooth

72111	Single tooth	303.00
72119	Each additional tooth, same quadrant	258.00

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

72211	Single tooth	467.00
72219	Each additional tooth, same quadrant	397.00

Tissue and Bone Coverage

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

72221	Single tooth	479.00
72229	Each additional tooth, same quadrant	407.00

Residual Roots (removal)

Applies only to roots not clinically visible.

Erupted Teeth

72311	Single tooth	173.00
72319	Each additional tooth, same quadrant	147.00

Soft Tissue Coverage

72321	Single tooth	340.00
72329	Each additional tooth, same quadrant	289.00

Bone Tissue Coverage

72331	Single tooth	393.00
72339	Each additional tooth, same quadrant	334.00

Oral Surgery 70000-79999

Surgical Exposure of Teeth

Unerupted, Uncomplicated, Soft Tissue Coverage (includes operculectomy)

72511	Single tooth	336.00
72519	Each additional tooth, same quadrant	168.00

Surgical Enucleation (unerupted tooth and follicle)

72711	Per tooth	336.00
72719	Each additional tooth, same quadrant	269.00

Removal of a Fractured Cusp (as a separate procedure)

Not Eligible: In Conjunction with surgical or restorative procedures on the same tooth.

72801	Single tooth	102.00
72809	Each additional tooth, same quadrant	67.50

Alveoloplasty

Sextant ID must be indicated e.g., 03, 04, 05, 06, 07 or 08.

73111	In conjunction with multiple extractions; Per sextant	177.00
73121	Not in conjunction with extractions; Per sextant	215.00

Excision of Bone

Torus Palatinus

73152		608.00

Torus Mandibularis

73153	Unilateral	385.00
73154	Bilateral	626.00

Excision of Pericoronal Gingiva (for retained tooth/implant)

Not Eligible: In conjunction with crown and bridgework.

73224	Per tooth	90.40

Removal of Hyperplastic Tissue

Includes the incision of the mucous membrane, the dissection and removal of hyperplastic tissue, the replacing and adapting of the mucous membrane.

Sextant ID must be indicated e.g., 03, 04, 05, 06, 07 or 08.

73231	Per sextant	392.00

Vestibuloplasty

Sextant ID must be indicated e.g., 03, 04, 05, 06, 07 or 08.

73421	Sulcus deepening and ridge re-construction; Per sextant	692.00

Surgical Excision of Benign Tumour,

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

74111	1 cm and under	471.00
74112	1 – 2 cm	918.00

Oral Surgery 70000-79999

Excision of Cyst

74631	1 cm and under	505.00
74632	1 – 2 cm	918.00

Surgical Incision and Drainage

Intraoral – Soft Tissue

75112 🦷	Surgical Exploration	128.00

Extraoral – Soft Tissue

75211 🦷	Abscess, Superficial	235.00

Fractures, Reductions

Mandibular, Closed

76201		1011.00

Alveolar, Debridement, Teeth Removed

76911	3 cm or less	840.00

Replantation, Avulsed Tooth/Teeth (including splinting)

76941 🦷	First tooth	599.00
76949 🦷	Each additional tooth	225.00

Repositioning of Traumatically Displaced Teeth

76951 🦷	One unit	103.00
76952 🦷	Two units	206.00
76959 🦷	Each additional unit over two	103.00

Repairs, Lacerations, Uncomplicated, Intraoral or Extraoral

Provide sextant area if not localized to a specific tooth area.

76961 🦷	2 cm or less	227.00

Frenectomy

Where frenectomy/frenoplasty or vestibular deepening are involved during preparation of a graft site, then these procedures are considered part of the graft preparation and fee and should not be billed as independent fees.

Limited to three per arch per lifetime.

77801	Upper Labial	395.00
77802	Lower Labial	395.00

Dilation of Salivary Duct

79101		94.30

Antral Surgery

Immediate Recovery of a Dental Root or Foreign Body from the Antrum

79311		227.00

Oro-antral Fistula Closure with Buccal Flap (same session)

79331		484.00

Post-Surgical Care (required by complications and unusual circumstances)

Post-surgical care is eligible only if performed four or more days after surgery.

79601	Subsequent to Initial Post-Surgical Treatment, Minor, by Treating Dentist	76.90
79602	Minor, by Other than Treating Dentist	127.00

Orthodontic Services

Benefits under this section are eligible only if the member has orthodontic coverage. Also, note that each person may have a lifetime dollar limit and/or a waiting period that must be satisfied. For this information, access PROVIDERnet at our website ***pac.bluecross.ca***

Before commencing treatment, a treatment plan with all required information must be submitted for approval. Submit a completed orthodontic treatment plan on a Certified Specialists in Orthodontics Standard Information Form or equivalent form. The treatment plan must include:

- *a complete detailed clinical description*
- *length of treatment indicating monthly or quarterly fees over the length of the estimated active treatment*
- *total cost of treatment (Note: Orthodontic retention is expected to be included in the total fee)*
- *breakdown of costs indicating: consultation fee, records fee, initial payment and monthly or quarterly fee*

Note: If billing solely for an orthodontic appliance, a clinical description may be requested.

Advise patients to submit claims as outlined in the treatment plan. Patients should not collect receipts over a year or wait until treatment is completed before submitting a claim. Claims received after one year from the date the fees were due are not eligible, and the member cannot collect payment.

If the patient pays the dental provider the full amount before treatment is complete, Pacific Blue Cross prorates the eligible expenses throughout the estimated active treatment period. Monthly payments are issued until the patient reaches the maximum dollar limit, completes the treatment or plan coverage cancels, whichever occurs first.

Not Eligible: Additional charges outside of the treatment plan for items such as missed appointments, late/financing/interest/ insurance charges. Replacement of lost, stolen or broken appliances should be clearly noted on the claim form or receipt. Payment for these additional charges is the responsibility of the patient.

To assist your patients with submitting claims, please complete dental claim forms indicating the appropriate fee item numbers. Invalid or discontinued fee item numbers will be rejected.

01901	Examination and diagnostic records		I.C.
80002	Treatment Plan		I.C.
93331	Initial Fee		I.C.
93332	Monthly Fee		I.C.
93333	Quarterly Fee		I.C.
93334	One Time Appliance		I.C.
80631	Repairs	78.10	+ L
89706	Miscellaneous *(This fee item number is not to be used for ineligible charges such as: missed appointments, late or financing charges, interest and insurance charges)*		I.C.

Anesthesia (including pre-anesthetic evaluation and post-anesthetic follow up)

Anesthesia is limited to the contract percentage of $578.00 per patient, per calendar year.
Note: This limit will be represented on PROVIDERnet as 9210E
Eligible only in conjunction with oral and periodontal surgery.

Deep Sedation

92332	Two units	I.C.	+PS
92333	Three units	I.C.	+PS
92334	Four Units	I.C.	+PS
92339	Each additional unit	I.C.	+PS

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

92441	One unit	171.00	+PS
92442	Two units	244.00	+PS
92443	Three units	318.00	+PS
92444	Four units	391.00	+PS
92445	Five units	464.00	+PS
92446	Six Units	537.00	+PS

Conscious Sedation, Combined Techniques of Inhalation plus Intravenous and/or Intramuscular Injection

92451	One unit	I.C.	+PS
92452	Two units	I.C.	+PS
92459	Each additional unit over two	I.C	PS.

Professional Communications

Consultation with Member of the Profession or other Healthcare Providers, in or out of the office

Diagnostic services provided by a dentist other than the practitioner providing treatment

93111	One unit	89.70	+E

Professional Visits – House Call

94102	Emergency Visit, when one must immediately leave home, office or hospital. (in addition to procedures performed)	114.00

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