MCSS Schedule of Dental Hygiene Services and Fees
January 2018

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Ministry of Community and Social Services Schedule of Dental Hygiene Services and Fees
For adults under the Ontario Disability Support Program and children under the Ontario Works Program residing in a First Nation community

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MCSS Schedule of Dental Hygiene Services and Fees

SOCIAL ASSISTANCE LEGISLATION

Dental benefits under this schedule are available under the following two programs:

- **Ontario Disability Support Program** (ODSP)
- **Ontario Works** (solely for children 17 years of age or younger residing in a First Nation community)*

***Please refer to page 5 of this Schedule for more information.**

THE SCHEDULE EXPLAINED

This schedule is for dental hygienists who have been approved by the College of Dental Hygienists of Ontario to self-initiate dental hygiene services.

This schedule lists services for both the **Mandatory Basic Dental Care Plan** and the **Dental Special Care Plan (DSCP).** The Mandatory Basic Dental Care Plan covers ODSP recipients and their adult spouses as well as children 17 years of age or younger on Ontario Works, residing in a First Nation community.

The Dental Special Care Plan is intended to augment the Mandatory Basic Dental Care Plan for ODSP recipients and adult spouses, whose:

- Disability, prescribed medications or prescribed medical treatment directly impacts their oral health.

DSCP services are highlighted in the schedule as follows:

Dental Special Care Plan (DSCP)	**EXAMINATION AND ASSESSMENT** Additional coverage beyond the limits listed above is available through the Dental Special Care Plan (DSCP) for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP.			
	00121	Examination and Assessment, Previous Client, Routine Recall	14.97	**DSCP Limit**: Maximum, 4 per 12 months, per client, per hygienist, per address (MCSS and DSCP combined). Pre-determination required for additional coverage beyond the MCSS limit.

All DSCP services require predetermination. Instructions for pre-determining DSCP services are available in the section "Pre-determination of Benefits" starting on page 8.

The services covered under DSCP are:

- Additional Recall Examinations (00121)
- Additional Stain Removal (00537)
- Additional Periodontal Debridement / Root Planing (00511 – 00519, 00521 – 00529)
- Additional Fluoride Application (00611)
- Custom Fluoride Application (00613 – 00615)

Specific limits for dental hygiene services under the Mandatory Basic Dental Care Plan and the Dental Special Care Plan are noted in the 'Limit' column where applicable. Some services require a note or specific criteria on the dental claim form to be considered for payment. These requirements are listed in the 'Limit' column beside the associated procedure codes.

ELIGIBILITY INFORMATION

Who is eligible?

Those eligible for Mandatory Basic Dental Care under this schedule are:

ODSP

- ODSP recipients
- The spouse of an ODSP recipient if the spouse is 18 years of age or older

Ontario Works

- Ontario Works children 17 years of age or younger, **whose families are residing in a First Nation community**
- Ontario Works children 17 years of age or younger **residing in a First Nation community** whose guardian receives Temporary Care Assistance on their behalf under Ontario Works
- Ontario Works recipients 17 years of age or younger and spouses 17 years of age or younger **residing in a First Nation community**

Dental Special Care Plan

Those eligible for the Dental Special Care Plan (DSCP) under this schedule are:

- ODSP recipients and their spouse (if the spouse is 18 years of age or older) whose disability, prescribed medications or prescribed medical treatment directly impacts their oral health

Who is not eligible for benefits under this schedule?

- Members of an ODSP benefit unit who are 17 years of age and younger
- Dependents (18 years of age or older) of ODSP recipients who are not the recipient's spouse
- Children on whose behalf Assistance for Children with Severe Disabilities (ACSD) is provided
- Members of an Ontario Works benefit unit 17 years of age and younger **(except for children aged 17 and younger residing in a First Nation community,**
- Children whose guardian receives Temporary Care Assistance under Ontario Works **(except for children aged 17 or younger residing in a First Nation community**
- Adult Ontario Works participants

Dental coverage for those not eligible for benefits under this schedule

Members of a benefit unit 17 years of age and younger

- Healthy Smiles Ontario provides dental coverage for:
  - Members of an Ontario Works and ODSP benefit unit 17 years of age and younger
  - Children on whose behalf Temporary Care Assistance is provided under Ontario Works
  - Children on whose behalf ACSD is provided

Adult Ontario Works participants

- Municipalities may provide dental coverage for adult Ontario Works participants as a discretionary benefit (usually emergency and/or denture benefits).

ODSP dependent adults (i.e. dependents 18 years of age and older, other than a spouse)

- Municipalities may provide dental coverage for ODSP dependent adults 18 years of age and older, as a discretionary benefit (usually emergency and/or denture benefits).

How does the dental office verify eligibility for clients?

Eligible adults under ODSP receive a dental card that indicates the program name and the valid benefit month. Ensure you ask for this card and keep a copy in the patient's file.

See page 6 for further information about eligible Ontario Works children residing in a First Nation community.

ONTARIO WORKS CLIENTS IN FIRST NATION COMMUNITIES

ELIGIBILITY INFORMATION

Who is eligible?

Children aged 17 years and under whose families are in receipt of Ontario Works AND are residing in a First Nation community are eligible for Mandatory Basic Dental Care under this schedule**.**

Dental hygienists should continue their current procedures to bill for Ontario Works dental benefits for these clients.

Please note that if an Ontario Works family residing in a First Nation community enrolls in the Healthy Smiles Ontario (HSO) Program through the Ministry of Health and Long-Term Care, dental claims should be billed to the HSO Program.

How does the dental office verify eligibility for Ontario Works clients residing in a First Nation community?

Children who are 17 years of age and under may receive a dental card that indicates the program name, eligibility for 'basic' dental care and the valid benefit month. Ensure you ask for this card and keep a copy in the patient's file.

For children who are 17 years of age and under and not in receipt of a dental card, municipal documentation will indicate:

- the program name
- eligibility for basic dental care
- valid benefit month

ONTARIO WORKS CLIENTS IN FIRST NATION COMMUNITIES cont'd

For more information on how to verify eligibility for Ontario Works clients residing in First Nation communities, please contact the local Ontario Works office or Ontario Works dental plan administrator.

SUBMISSION OF DENTAL CLAIMS FOR ONTARIO WORKS CLIENTS IN FIRST NATION COMMUNITIES

Where do I send my claims?

For members of a benefit unit 17 years of age and under in receipt of Ontario Works (including Temporary Care Assistance) AND who are residing in a First Nation community, claim forms should be sent to the local Ontario Works dental plan administrator. Please contact the local Ontario Works office if this information is not available.

PRE-DETERMINATION OF BENEFITS

With the exception of the Dental Special Care Plan, there is no pre-determination requirement.

When to pre-determine services

A pre-determination of benefits is only required for services listed under the Dental Special Care Plan (DSCP). The purpose of pre-determining benefits is to allow dental hygienists to confirm that services covered under the DSCP are eligible. Pre-determination cannot be used to question a dental hygienist's clinical findings or judgment. The DSCP provides coverage for additional services for ODSP clients whose disabilities, prescribed medication or medical treatment directly impacts their oral health necessitating one or more of the services listed in DSCP. The DSCP also provides coverage for periodontal debridement and/or root planing (00511 – 00519, 00521 – 00529) once only prior to major cardiac, transplant or other surgery where dental cleaning is requested by the client's medical/dental practitioner. The dental hygienist must indicate the specific condition being treated (for additional information, refer to the 'DSCP Limit:' in the 'Limit' column of this schedule).

A pre-determination for services beyond the schedule may be submitted for approval by the plan administrator for persons with severe disabilities.

Do topical fluorides and panoramic radiographs, have to be pre-determined?

No.

However, the eligibility requirements remain in place. Many services in this schedule are covered only under specific circumstances (e.g. fluoride, panoramic radiographs). This schedule lists the criteria or limits that apply to each service in the 'Limit' column. In order for the plan administrator to determine eligibility for these services, the dental hygienist must indicate the specific eligibility criteria that is/are applicable to the claim. This information must be provided in the 'Registered Dental Hygienist Use (Additional Information only)' box on the National Dental Hygiene Claim Form.

The services that require additional information are:

Procedure Code	Description	Requirement	Page number
00241	Radiographs, Panoramic, Single film	List one criteria on dental hygiene claim form	16
00611	Fluoride Application – Topical – in office	List two criteria on dental hygiene claim form	18

How long is the pre-determination of benefits valid?

The pre-determination of benefits for DSCP services, issued by the dental plan administrator, is valid for five years from the date of issue. Note: the client must be eligible for coverage in the month that treatment is rendered.

Can pre-determination of benefits be appealed?

Yes. Dental hygienists may appeal the plan administrator's decision respecting the pre-determination of benefits. Appeals are to be made to the plan administrator. Details about the appeal process will be available from the dental plan administrator at the request of the dental hygienist.

How to pre-determine services:

How to determine when to submit a pre-treatment form

A pre-treatment form must be submitted for those DSCP services indicated in the schedule. Example:

Dental Special Care Plan (DSCP)

EXAMINATION AND ASSESSMENT Additional coverage beyond the limits listed above is available through the Dental Special Care Plan (DSCP) for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP.			
00121	Examination and Assessment, Previous Client, Routine Recall	14.97	**DSCP Limit**: Maximum, 4 per 12 months, per client, per hygienist, per address (MCSS and DSCP combined). Pre-determination required for additional coverage beyond the MCSS limit.

What pre-treatment form can be submitted?

The Standard Dental Pre-treatment form may be used for all clients.

What vital information is required on a pre-treatment form?

- Dental Hygienist signature
- Dental Hygienist name, address and unique identification number
- Client/patient signature to authorize the release of personal information to the plan administrator for pre-determination purposes
- Cardholder name and case identification number
- Name of plan: ODSP
- Client/patient name and identification number
- The DSCP services that are recommended
- Confirmation that disability, medical condition or medication will have a direct impact on their oral health. For DSCP requests place DSCP on the pre-treatment form
- The specific applicable criteria as listed in this schedule

Will X-rays and/or study models be required?

No. There is no requirement for a dental hygienist to provide radiographs, study models or any other diagnostic material for dental treatment (planned or performed) under this schedule.

Where should pre-treatment forms be mailed?

Pre-treatment forms for adults under ODSP are to be submitted to AccertaClaim Servicorp Inc. (Accerta).

When should a reply to a pre-treatment form be expected?

The dental plan administrator is expected to reply within 5 working days from the date it received the pre-treatment form request.

SUBMISSION OF DENTAL CLAIMS

Where do I send my claims?

For adults under ODSP dental claims should be sent to:
Accerta
Toronto 'P"
P.O. Box 310
Toronto, ON M5S 2S8

Which forms are required when submitting to Accerta?

Accerta can accept National Dental Hygiene Claim Forms only. This includes pre-printed or computer generated claim forms.

Can I use EDI to submit claims?

Accerta accepts EDI transmissions for ODSP dental claims. Transmission types include:

- Dental Claims Submission
- Dental Claim Reversal

EDI responses include:

1. Explanation of Benefit (EOB)
   - Results of adjudication

- Partial or full reimbursement notices

2. Acknowledgement (ACK)
  - Response status message indicates the reason for the response
  - Claim is rejected because of errors (please call Accerta for assistance)
  - Claim is received successfully by the carrier and is held for further processing The Primary Policy/Plan Number for ODSP is MCS.

Please use Accerta's carrier code (BIN 311140) by adding it under instream.

When should claims be submitted?

Claims are to be sent in as **treatment occurs**.

Deadline for claims submissions

Claims must be received by Accerta for initial processing within 12 months of the date the services were provided.

CLAIMS PROCESSING AND ADJUDICATION

What happens when a client visits more than one dental hygienist?

Dental hygienists will be reimbursed for treatment provided when a client exceeds frequency limitations by attending more than one dental hygienist in a different office.

Is Extra or Balance Billing acceptable?

No. Extra billing or balance billing is not permitted for services covered and paid for under this schedule. A dental hygienist may bill the client for services not covered and not paid for under this schedule.

How to avoid reimbursement delays

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

- The treating dental hygienist's name
- The treating dental hygienist's unique identification number (UIN), and
- The treating dental hygienist's address

How is the frequency of services calculated?

Frequency and annual maximums will be calculated based on a 12 month rolling period.

How will radiographs be reimbursed?

Periapical films are paid cumulatively up to the maximum payable per client, per dental hygienist, per 12 month period. For example:

If 00222 is claimed, the amount payable is $11.52.

If 00221 is subsequently claimed, the amount payable is $1.53.

The represents the difference between the amount previously paid $11.52 and the maximum for 3 periapical films which is $13.05.

Co-ordination of Benefits

Claims for services performed for clients who have dental benefits under a private dental plan contract or insurance policy, must be submitted through the private plan first. If the private insurance pays less than the full amount of the dental hygienist's fee, benefits may be coordinated through this plan. This plan will top up the payment to the amount billed by the dental hygienist, as long as the top up is equal to or less than, the fee shown in this schedule:

If 00121 is claimed, the amount billed by the provider, e.g. $28.34.

According to this schedule, the amount payable is $14.97.

If the private insurance covers 80% of the amount billed, the private insurance would pay $22.67 (80% of $28.34) leaving a balance of $5.67. This plan would pay the balance of $5.67 as the balance is less than the fee in MCSS schedule ($14.97), so the provider's fee would be paid in full.

Please complete a duplicate dental claim form and attach the Explanation of Benefits from the first payer.

Please note, First Nations Inuit Health Branch (FNIHB) staff have advised that where a client is eligible for coverage under the Non-Insured Health Benefits (NIHB) program and OW or ODSP, the NIHB program is second payer.

Please contact Accerta if you require further details.

OTHER INFORMATION

For questions about completing pre-treatment forms and/or claim forms, or questions about claims processing or payments, please contact Accerta:

In Toronto call: 416-922-6565
Outside Toronto call: 1-800-505-7430
Or email: info@accerta.ca
Copies of this schedule are available on AccertaWorX or visit Accerta's website at www.accerta.ca.

Code	Description		Hygienist Fee	Limit

ASSESSMENT SERVICES

EXAMINATION AND ASSESSMENT			All clients are covered for any **TWO examinations, from the list below, in any 12 month period** provided these examinations are within the frequency limitations described below. Please note that while all emergency exams are covered, they count toward the two exam limitation in any 12 month period. Consequently, if a patient has two or more emergency exams in a 12 month period, they would not be covered for any routine or non-emergency exams in that period. A recall exam or a new client exam is payable when 9 months have elapsed between these services.
Examination and Assessment, New Client			1 per 60 months, per client, per hygienist, per address.
00111	Examination and Assessment, New Client, Primary	19.29	
00112	Examination and Assessment, New Client, Mixed	28.94	
00113	Examination and Assessment, New Client, Permanent	38.58	

EXAMINATION AND ASSESSMENT			A recall exam or a new client exam is payable when 9 months have elapsed between these services.
00121	Examination and Assessment, Previous Client, Routine Recall	14.97	1 per 9 months, per client, per hygienist, per address.
00122	**Examination and Assessment, Previous Client, Specific**	13.93	1 per 12 months, per client, per hygienist, per address.
00123	**Examination and Assessment, Previous Client, Emergency**	13.93	All emergency exams will be covered. There is no limit on the number of emergency exams that will be covered.

Dental Special Care Plan (DSCP)

EXAMINATION AND ASSESSMENT			
00121	Examination and Assessment, Previous Client, Routine Recall	14.97	**DSCP Limit**: Maximum, 4 per 12 months, per client, per hygienist, per address (MCSS and DSCP combined). Pre-determination required for additional coverage beyond the MCSS limit.

Code	Description		Hygienist Fee	Limit
RADIOGRAPHS + Radiographs, Intraoral, Periapical				Maximum of 8 periapical films per 12 months, per client, per hygienist, per address (except when required in an emergency situation) are paid cumulatively. Maximum payable for periapical and occlusal films combined is $16.40.
00221	Single film		9.83	
00222	Two films		11.52	
00223	Three films		13.05	
00224	Four films		14.64	
00225	Five films		16.73	
00226	Six Films		16.73	
00227	Seven Films		16.73	
00228	Eight Films		16.73	
Radiographs, Intraoral, Bitewing				Maximum payable for 2 bitewing films, per client, per hygienist, per 9 months is $11.29
00211	Single film		9.83	
00212	Two films		11.52	
Radiographs, Panoramic				1 per 24 months, per client, per hygienist. **Except in an emergency when criteria 1, 2, 5 or 6 applies**. Maximum payable is $28.90. These radiographs are covered when required due to: 1. facial trauma with symptoms of possible jaw fracture; 2. facial swelling of unknown etiology, 3. significant delayed eruption pattern; 4. severe gag reflex with multiple carious lesions; 5. diagnosis cannot be made using periapical film; 6. and special circumstances clearly substantiated by the practitioner. One of the above criteria **(listing the number is acceptable)** must appear on the dental claim form for consideration of payment.
00241	Single film		29.48	

Code	Description		Hygienist Fee	Limit

PREVENTIVE SERVICES

MAINTENANCE CARE SERVICES (RECALL)

STAIN REMOVAL			1 per 9 months when performed in conjunction with a recall exam and stain removal.
00537	One half unit	7.58	

Dental Special Care Plan (DSCP)

STAIN REMOVAL Additional frequency/units of time beyond the limits listed above are available through the Dental Special Care Plan (DSCP) for those clients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of any additional coverage under DSCP.			**DSCP Limit**: Maximum, 4 occurrences per 12 months, per client, per hygienist, per address (MCSS and DSCP combined) when performed in conjunction with a recall exam and stain removal. Pre-determination required for additional coverage beyond the MCSS limit.
00537	One half unit	7.58	

PERIODONTAL DEBRIDEMENT			A combined maximum (Scaling/Root Planing) 4 units per 12 months, per client, per hygienist.
00511	One unit of time	33.28	
00512	Two units	66.57	
00513	Three units	99.85	
00514	Four units	133.12	
00517	One half unit	16.64	

Dental Special Care Plan (DSCP)

PERIODONTAL DEBRIDEMENT			**DSCP Limit:** Coverage is available for an additional 8 units of scaling and/or root planing per 12 months, per client, per hygienist. (Maximum of 12 units of scaling and/or root planing under MCSS and DSCP combined, per 12 months, per client, per hygienist). Pre-determination is required for the additional 8 units of scaling and/or root planing only.
00511	One unit of time	33.28	
00512	Two units of time	66.57	
00513	Three units of time	99.85	
00514	Four units of time	133.12	Covered on a periodic or ongoing basis as a result of increased susceptibility to periodontal disease as a result of the disability, prescribed medication or prescribed medical treatment **OR** once only prior to major cardiac, transplant or other surgery where dental cleaning is requested by the patient's medical/dental practitioner.
00515	Five units of time	166.04	
00516	Six units of time	199.69	
00517	One half unit of time	16.64	
00519	Each additional unit of time over six	33.28	

Code	Description		Hygienist Fee	Limit
	FLUORIDE APPLICATION			Coverage is limited to situations where **two or more** of the following criteria apply: 1. Water fluoride content is less than 0.3 ppm, 2. Past history of smooth surface decay in the last three years 3. Present smooth surface decay 4. Evidence of long standing poor oral hygiene 5. A severe medically compromised patient 6. Xerostomia – radiation or drug induced **Two** of the above criteria (listing numbers are acceptable) must appear on the dental claim form for consideration of payment.
00611	Fluoride Application, Topical, in office		8.35	

Dental Special Care Plan (DSCP)	FLUORIDE APPLICATION			**DSCP Limit:** As required, to address high risk of caries for patients who are at high risk as a direct result of their disability, prescribed medication or prescribed medical treatment.
	00611	Fluoride Application, Topical, in office	8.35	

Dental Special Care Plan (DSCP)	**FLUORIDE HOME**			**DSCP Limit***:* Lifetime maximum of one maxillary and one mandibular appliance per patient. Covered when required to address reduced salivary flow due to head and neck irradiation or to address patients with chronic dry mouth as a result of their disability, prescribed medication or prescribed medical treatment.
	Fluoride, (home application) The following procedure codes are covered under the DSCP only for those patients under ODSP/ACSD who are eligible for DSCP. A pre-determination is required for approval of coverage under DSCP.			
	00613	Fluoride Application – Home – Custom Maxillary Arch	22.38 + lab	
	00614	Fluoride Application – Home – Custom Mandibular Arch	22.38 + lab	
	00615	Fluoride Application – Custom Combined	31.97 + lab	

	PREVENTIVE SERVICES, MISCELLANEOUS			
	Sealants			Restricted to first permanent molar up to the 8th birthday only and to the second permanent molar up to the 14th birthday only.
	00602	First tooth in quadrant	11.24	

	Mouth Protector (Protective Appliance)			Ages 0 - 17 - 1 per 12 months, per patient, per hygienist, per address. Age 18 and over - 1 per 60 months, per patient, per hygienist, per address.
	00634	Mouth Protector, Processed Maxillary arch	31.04 + lab	
	00635	Mouth Protector, Processed, Mandibular arch	31.04 + lab	
	00636	Mouth Protector, Processed, Maxillary and mandibular arches	43.89+ lab	

Code	Description		Hygienist Fee	Limit

RESTORATIVE SERVICES

CARIES, TRAUMA AND PAIN CONTROL

The final restoration is payable after 7 days have elapsed.

00666	Temporary Restoration - First tooth in quadrant	26.89
00667	Temporary Restoration - Each additional tooth in quadrant	13.74

Code	Description		Hygienist Fee	Limit

PERIODONTAL SERVICES

MANAGEMENT OF ORAL DISEASE

00551	Management of oral disease	17.14	

ROOT PLANING, PERIODONTAL

Root Planing			A combined maximum (Scaling/Root Planing) 4 units per 12 months, per patient, per hygienist.
00521	Root planing - one unit of time	33.28	
00522	Root planing - two units of time	66.56	.
00523	Root planing - three units of time	99.85	
00524	Root planing - four units of time	133.12	
00527	Root planing – one half unit of time	16.64	

Dental Special Care Plan (DSCP)

ROOT PLANING			**DSCP Limit:** Coverage is available for an additional 8 units of scaling and/or root planing per 12 months, per client, per hygienist. (Maximum of 12 units of scaling and/or root planing under MCSS and DSCP combined, per 12 months, per client, per hygienist). Pre-determination is required for the additional 8 units of scaling and/or root planing only. Covered on a periodic or ongoing basis as a result of increased susceptibility to periodontal disease as a result of the disability, prescribed medication or prescribed medical treatment **OR** once only prior to major cardiac, transplant or other surgery where dental cleaning is requested by the patient's medical/dental practitioner.
00521	Root planing - one unit of time	33.28	
00522	Root planing - two units of time	66.56	
00523	Root planing - three units of time	99.85	
00524	Root planing - four units of time	133.12	
00525	Root planing - five units of time	166.04	
00526	Root planing - six units of time	199.68	
00527	Root planing - one half unit of time	16.64	
00529	Root planing - each additional unit > 6	33.28	

ANTICARIOGENICS AND/OR ANTIMICROBIAL AGENTS

Application of anticariogenics, antimicrobials			
00606	One unit of time	18.20 + exp	One unit per visit, 2 visits per 12 months, per client, per hygienist, per address.

Code	Description		Hygienist Fee	Limit
ADJUNCTIVE GENERAL SERVICES				
CONSCIOUS SEDATION				
				8 units per visit.
00741	Conscious sedation, nitrous oxide, one unit of time		14.39	
00742	Conscious sedation, nitrous oxide, two units of time		34.45	
00743	Conscious sedation, nitrous oxide, three units of time		56.11	
00744	Conscious sedation, nitrous oxide, four units of time		76.41	
LABORATORY PROCEDURES				
				The amount listed on the invoice will be paid in full. Laboratory fees must appear immediately below the procedure code(s) to which they apply. A copy of the Laboratory Invoice, or receipt of laboratory payment, must be submitted with the claim form for Commercial Laboratory Procedures (code 00991).
00991	Laboratory expenses and services		Cost	
00992	Expenses		Cost	