	Column	Title
2.	IND	(Indicator) Lists symbols used to refer provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used. Explanation of indicators used in this column is given below: i. An asterisk (*) denotes those procedures which normally require prior authorization

in order to be eligible for reimbursement under the New Jersey Medicaid program.

ii. A double asterisk (**) denotes those procedures which may be treated in an emergency situation when prior authorization is not feasible. These procedures must receive authorization prior to payment.

iii. The letter (d) denotes those procedures which require that a diagnosis be entered in the appropriate item on the Dental Services Claim form (MC-10) in order to be eligible for reimbursement.

iv. The cross-hatch (#) denotes those procedures for which special prior authorization requirements exist. Those requirements are listed with the procedure codes involved or in N.J.A.C. 10:56-2.

3. HCPCS Codes — Lists the HCPCS procedure code numbers.

4. MOD — (Modifier) Lists alphabetic or numeric characters. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic or numeric characters at the end of the code. The New Jersey Medicaid/FamilyCare fee-for-service programs recognized modifier codes are listed with appropriate procedure codes in this subchapter. The modifiers "22," "52" and "76" are designated for use in the New Jersey Manual for Dental Services as follows:

i. 22— Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure number. A report may also be appropriate.

(1) This modifier may also be applied when a dental laboratory procedure is used in conjunction with specified chairside procedures or where an adjunctive service is rendered in addition to the basic service.

ii. 52— Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier "52", signifying that the service is reduced.

iii. 76— Repeat Procedure by Same Practitioner: The practitioner may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier "76" to the procedure code of the repeated service.

iv. YL Mandibular—Lower.

v. YU Maxillary—Upper.

(1) When it is necessary for the New Jersey Medicaid/FamilyCare fee-for-service programs to distinguish between services rendered in the mandibular arch as opposed to the maxillary arch and the basic codes do not make the differentiation, the modifiers "YL" and "YU" have been assigned to make this distinction.

vi. The appropriate quadrant codes shall be entered on the Dental Claim Form, MC–10, for the dental procedures listed below. Acceptable quadrant values are as follows:
UL—Upper Left
UR—Upper Right
LL—Lower Left
LR—Lower Right
The codes requiring the quadrant values are:
D4210 Gingivectomy or Gingivoplasty
D4220 Gingival Curettage
D4260 Osseous Surgery
D4341 Periodontal Scaling and Root Planing
D4272 Apically Repositioning Flap Procedure
D7310 Alveoloplasty in Conjunction with Extraction
D7320 Alveoloplasty not in Conjunction with Extraction
D7340 Vestibuloplasty—Ridge Extension—Secondary Epithelialization
D7350 Vestibuloplasty—Ridge Extension
D7471 Removal of Exostosis

5. Description — Lists the code narrative.

6. Maximum Fee lists the New Jersey Medicaid/FamilyCare fee-for-service programs' maximum reimbursement allowance schedule for Specialist and Non–Specialist.
   i. S— Denotes Specialist fee.
   ii. NS— Denotes Non-Specialist fee.
   iii. BR—Denotes By Report (Individual Consideration of Procedure and Fee).
   (1) This means that additional information will be required in order to properly evaluate the service and determine an appropriate fee. A copy of this report must be attached to the Dental Services Prior Authorization Form MC-10A part 1 of 2 and Dental Claim Form MC–10 part 2 of 2.