

Schedule of Benefits

**Dental Services
Under the
Health Insurance Act
(July 27, 2026
(effective October 1, 2026))**

Ministry of Health

[Commentary:

“The Schedule of Dental Benefits is defined under Regulation 552 of the *Health Insurance Act* but does not include the commentary and the column titled INTL.”]

SERVICES OF DENTISTS

GENERAL PREAMBLE

The following apply to Parts I, II and III

1. A service described in this Schedule includes all in-hospital visits, the in-hospital operative procedure, the usual postoperative care and one post discharge follow-up visit.
2. The services rendered by dentists that are prescribed as insured services are the services set out in Parts I, II and III of the Schedule of Dental Benefits.
3. "Specialist" means,
 - a. with respect to dental services rendered in Ontario, a dental surgeon who holds a specialty certificate of registration from the Royal College of Dental Surgeons of Ontario.
 - b. with respect to dental services rendered elsewhere in Canada, a dental surgeon who holds a designation from a professional regulatory body in the Canadian province or territory outside of Ontario where the services are rendered that, in the opinion of the General Manager, is equivalent to the designation referred to in clause (a),

or
 - c. with respect to dental services rendered outside Canada, a dental surgeon who holds a designation in the jurisdiction outside Canada where the services are rendered that, in the opinion of the General Manager, is equivalent to the designation referred to in clause (a).

4. Subsequent Operative Procedures

When complications occur following a procedure and a subsequent procedure becomes necessary for the same condition, or for a new condition, the full listed fee shall be payable for each procedure.

5. Premiums

Non-elective dental surgical procedures and oral and maxillofacial surgical procedures

When such services commence after 5:00 p.m. and before midnight, or on a Saturday, Sunday or Holiday, the amount payable for the service(s) is increased by 30% (T809).

When such services commence between midnight and 7:00 a.m. any night of the week, the amount payable for the service is increased by 50% (T810).

[Commentary:

1. It is a condition for the performance and for payment of the insured services prescribed under the regulation subsection (6); that hospitalization in a public hospital graded under the *Public Hospitals Act* as Groups A, B, C or D (i.e. an acute care hospital) is medically necessary, and that these services be performed by a dentist who has been appointed to the dental/medical staff of the respective hospital.
2. Six (6) new codes identified by an asterisk (*), listed in this schedule (3 codes in the Salivary Glands section and 3 codes in the Premiums and Unlisted procedures section), do not become effective until March 1, 2007.]

SERVICES OF DENTISTS

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PART I

PREAMBLE

1. Multiple Operative Procedures

When more than one procedure is performed at the same time, the major procedure is payable at the listed fee, and subsequent procedures performed at the same time are payable at 85% of the listed fee, except where multiple procedures are identified in this Schedule by a specific add-on code. An operative report or explanation should be submitted with the claim for independent consideration, upon request by the medical/dental consultant.

2. Consultation, Visits

Patient Consultations:

A consultation is an insured service only when rendered in a hospital. A private dental office situated in a hospital is not considered to be "in a hospital" for the purpose of a consultation.

A consultation is a service provided upon a written request from a referring physician or dentist who, in light of his/her professional knowledge of the patient, requires the opinion of another dentist ("the consultant") competent to give advice in this field, because of the complexity, obscurity or seriousness of the case or because another opinion is requested by the patient or an authorized person acting on his/her behalf. Except where otherwise specified, the consultant's service is insured only when the consultant renders an assessment "including the review of all relevant data". An assessment is defined as requiring a direct physical encounter with the patient including any appropriate physical examination.

A consultation is also insured when rendered by a dentist(s) (in addition to the first consultant) whose expertise is (are) also required provided that the additional dentist(s) also render(s) an assessment of the patient at the same time for the same condition and records a separate consultation report on the chart.

Consultations are limited to one consultation per year, per patient, by any one dentist, except where the same patient is referred to the same consultant a second time within the year with a clearly defined, unrelated diagnosis, where an additional consultation is then payable.

Benefits are payable for follow up assessments carried out in hospital when claimed under T651. Additional dentists whose expertise is (are) also required and who examine the patient at the same time for the same condition and who also record a separate consultation report on the chart may bill for a consultation fee.

Any T650 or T651 billings submitted in excess of one per patient per day per dentist are payable at zero.

When billing code T650 in conjunction with odontectomy codes, in order to remunerate the provision of T650 on the same day as an extraction, an emergency consultation report or prior approval form indicating either the nature of the emergency, or the exceptional circumstance/ medical rationale for same-day consultation must be submitted for manual review in support of the claim. Failure to do so will result in the claim not being paid.

Diagnostic Consultations:

A diagnostic consultation requires the review of a patient's history and any clinical findings, the analysis of submitted material and the submission of a written report.

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An in-hospital diagnostic consultation fee is payable when an oral pathologist provides a consultation with respect to tissue, histology slides, and/or laboratory test results of the patient of another dentist or physician.

An in-hospital diagnostic consultation fee is also payable when an oral radiologist or a dentist appointed as a consultant to Cancer Care Ontario provides a consultation with respect to diagnostic images of the patient of another dentist or physician.

A hospital consultation fee (T650) is payable in addition to the listed surgical procedure fee when a prior elective assessment has not been performed out of hospital.

Visits:

A visit fee (T652) is payable for a visit by a dentist to an admitted bed patient, and that visit is for the purpose of observing, assessing or evaluating the patient with respect to whom the dentist rendered a prior consultation or has undertaken a surgical procedure during a previous hospital admission and where the patient has been readmitted for management of a dental condition. One visit per patient, per day is payable commencing the day after the day of the initial consultation. The dentist must attend at the visit and record a progress note on the patient's medical chart.

Complex Consultations and Complex Follow-up Assessments:

A complex consultation (T050) is a consultation payable when the dentist devotes at least fifty (50) minutes exclusively to the patient who has had or is planning to have one of the listed “eligible medical procedures or treatments”.

A complex follow-up assessment (T051) is an assessment payable when the dentist devotes at least thirty (30) minutes exclusively to the patient who has had or is planning to have one of the listed “eligible medical procedures or treatments”.

The “eligible medical procedures or treatments” for the complex services (T050, T051) are:

- Organ transplant;
- Hematopoietic stem cell or bone marrow transplant;
- Cardiac valve replacement or valvuloplasty procedure;
- Chemotherapy;
- Chimeric antigen receptor (CAR) T-cell therapy;
- High-dose bone modifying agents (anti resorptive therapy) when used to treat cancer;
- Treatment of head and neck cancer; and
- Major reconstructive and ablative surgery of the head and neck.

3. Surgical Assistant

Assistants' fees are payable by the Plan only when the complexity of the procedure requires the assistance of a second surgeon. The fee payable for assisting a physician (T644) at a surgical procedure listed in the Schedule of Benefits Physician Services under the *Health Insurance Act* is 30% of the surgical fee set out in the Schedule of Benefits Physicians Services under the *Health Insurance Act*.

Code T643 when rendered with the following procedures is payable at zero:

T650, T651, T652, T653, T654, T330, T331, T332, T333, T334, T335, T336, T337, T338, T339, T341, T342, T343, T344, T348, T349, T350, T660, T662, T663, T665, T667, T668, T669, T396,

SERVICES OF DENTISTS

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T401, T395, T387, T402, T388, T403, T404, T406, T390, T391, T394, T370, T371, T760, T761, T601, T602, T580, T581, T620, T622, T623, T624, T628, T629, T701, T709, T710, T711, T712, T901, T902, T903, T904, T905, T906, T907, T908, T909, T910, T911, T912, T925, T926, T927, T928, T936

If a procedure falls into the above category of services, a letter from the surgeon explaining the necessity for an assistant must accompany all such claims for independent consideration, or they will be paid at zero.

Claims will only be paid for surgery that is related to the scope of practice of the oral and maxillofacial surgeon.

4. Soft Tissue Graft (skin, mucosa, fat, muscle and nerve/Bone and Cartilage Harvesting)

When harvested by the primary or second surgeon during the same surgery, the fee payable for the initial harvest from a maxillofacial site by each surgeon is payable at 100% of the listed fee. Each subsequent harvest during the same surgery from a separate maxillofacial site is payable at 85% of the listed fee.

When harvested by the primary or second surgeon during the same surgery, the fee payable for the initial harvesting from a non maxillofacial (remote donor site) is payable at 100% of the listed fee. Each subsequent harvest during the same surgery from a separate non-maxillofacial donor site is payable at 85% of the listed fee.

For the purpose of this Schedule, cranial bone grafts are deemed not to be maxillofacial but rather remote sites.

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

Arch reconstruction procedures are insured at the listed fee when performed simultaneously with implant placement.

5. Reconstruction

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

Nasal reconstruction (T363) done for cosmetic purposes is not an insured service.

6. Fractures and Dislocation

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

For the purpose of this Schedule, procedures that are incidental to the primary procedure, such as the placement of arch bars or the wiring of dentures or splints are payable at 85% of the listed fee except where such placement(s) or wiring is or are identified in this Schedule by a specific add-on code.

Where, as part of a fracture and/or dislocation, it is necessary to remove diseased or fractured teeth, the fee for the removal of such diseased or fractured teeth is payable at 85% of the listed fee. Prior approval for payment for removal of teeth is not required in these circumstances.

Maxillomandibular fixation is included in the reduction benefit.

7. Orthognathic Surgery

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

Passive placement of occlusal index splint(s) is included in intermaxillary fixation except where the splint is directly wired to a jaw or teeth. In such circumstances, the placement is a separate insured service not included in the intermaxillary fixation.

When performed in conjunction with an osteotomy, application of arch bars, splints and intermaxillary fixation is or are payable at 85% of the appropriate listed fixation fee except where such application(s) or fixation is or are identified in this Schedule by a specific add-on code.

Genioplasty (T565) done for cosmetic reasons is not an insured service.

8. Temporomandibular Joint

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

9. Unlisted Procedures

Independent consideration will be given to claims (T800) for other dental and oral and maxillofacial surgery procedures not listed in this Schedule.

Benefits for unlisted procedures will be assessed by comparing the fee claimed to procedures listed in the Schedule which require comparable responsibility and skill. Supporting information must be submitted with the claim.

Despite the above, dental implants are not insured services under any circumstances.

10. Virtual Care Services

SERVICES BY TELEPHONE OR VIDEO

OHIP	INTL		D.D.S	Spec
T655		Consultation	70.15	84.15
T656		Follow-up assessments within 12 months of initial consultation same diagnosis.....	57.00	65.10
T814		Premium for a consultation or visit between 5:00 p.m. and midnight, or on a Saturday, Sunday or holiday	30% of amt payable	30% of amt payable
T815		Premium for any consultation or visit to a patient in an intensive care facility (e.g., ICU or CCU)	30% of amt payable	30% of amt payable
T816		Premium for a consultation or visit between midnight and 7:00 a.m.	50% of amt payable	50% of amt payable

Note:

1.Despite any requirement in the Schedule of Dental Benefits or Regulation 552 under the Health Insurance Act that a direct physical encounter occur between the dental surgeon and the patient the services described above as T655, T656, T814, T815 and T816 are insured when the following conditions are met:

a.The service is personally rendered by the dental surgeon.

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SERVICES BY TELEPHONE OR VIDEO

- b. Other than a direct physical encounter, all the conditions for the appropriate consultation, assessment or visit as described in the Schedule of Dental Benefits have been met.
- 2. T655 and T656 require the dental surgeon to be located in a public hospital graded under the Public Hospitals Act as Group A, B, C or D when the service is rendered; the patient may be at the location of their choice.
- 3. T655 is limited to one consultation per year, per patient, by any one dentist, except where the same patient is referred to the same consultant a second time within the year with a clearly defined, unrelated diagnosis, where an additional consultation is then payable.
- 4. T656 is limited to one service per patient, per day by any one dentist.
- 5. Should an in-person encounter be required to complete the service, the in-person encounter is included as part of the Service by Telephone or Video (T655 or T656) and is not separately payable.
- 6. T655 or T656 include the provision of a new prescription or prescription renewal if rendered.
- 7. Dental surgeons are eligible for applicable premiums listed in the table above only related to the provision of the virtual care services (T655, T656).

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8. The services must be documented on the patient's medical record (including the start and stop times) or the service is not eligible for payment.

[Commentary:

1. See Part 1 Preamble of the Schedule of Dental Benefits for further requirements for billing of services.
2. T656 is payable for telephone or video follow-up assessments of either an in-person, telephone or video consultation.
3. T655, T656 should follow the Standard of Practice on Virtual Care from the Royal College of Dental Surgeons of Ontario (RCDSO).]

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OHIP INTL

D.D.S

Spec

CONSULTATIONS AND VISITS

See point 2 of Part I Preamble to this Schedule (page D2)

T650	93100	Consultation in hospital	70.15	84.15
T050		Complex consultation in hospital	136.10	163.20
T651		Follow-up assessments within 12 months of initial consultation same diagnosis, in hospital, emergency or outpatient department	57.00	65.10
T051		Complex follow-up assessments within 12 months of initial consultation same diagnosis, in hospital, emergency or outpatient department	108.95	124.50
T652		Hospital visit, admitted bed patient.....	38.10	47.55
T653		Examination under general anesthesia (sole procedure)	38.10	47.55
T654		- with diagnostic imaging (may be billed in addition to T653) add	32.55	40.70

EMERGENCY PROCEDURES

T630	79401	Control of bleeding secondary to dental extraction	78.40	93.95
T631	79603	Post-surgical care, minor	17.40	20.85
T632	79604	Post-surgical care, major	38.55	46.25

SURGICAL ASSISTING

T643		Assisting at major oral and maxillofacial surgical procedure	30% of surgical fee	30% of surgical fee
T644		Assisting at physician's surgery	30% of surgical fee [†]	30% of surgical fee [†]

GINGIVOPLASTY AND VESTIBULOPLASTY

T330	73119	Gingivoplasty independent of tooth extraction, per quadrant	35.90	43.20
T331	73121	Excision of vestibular hyperplastic tissue, per quadrant	—	129.30
T332	73123	Surgical shaving of papillary hyperplasia of the palate	—	185.85
T333	73130	Remodelling of the mylohyoid ridge	—	131.25
T334	73131	Remodelling of the genial tubercles	—	168.00
T335	73132	Excision of nasal spine	—	131.25
T336	73133	Excision of torus palatinus	243.90	292.70
T337	73134	Excision of torus mandibularis, unilateral	243.90	292.70
T338	73135	Excision of torus mandibularis, bilateral	243.90	292.70
T339	73140	Excision of multiple exostoses, per quadrant	243.90	292.70

Reduction tuberoplasty

T341	73150	- unilateral	—	136.75
T342	73151	- bilateral	—	273.40

Augmentation pterygomaxillary tuberoplasty

T343	73160	- unilateral	—	136.75
T344	73161	- bilateral	—	273.40

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T345	73200	Full arch lowering of floor of mouth	—	410.35
T346	73201	Partial arch lowering of floor of mouth	—	242.95

Submucous vestibuloplasty

T347	73300	- maxilla	—	242.95
T348	73301	- mandible.....	—	242.95

Vestibuloplasty

T349	73310	- with secondary epithelialization, maxilla	—	321.05
T350	73311	- with secondary epithelialization, mandible	—	321.05
T351	73330	- with skin graft, maxilla	—	573.95
T352	73331	- with skin graft, mandible.....	—	573.95
T353	73340	- with mucosal graft, maxilla	—	642.40
T354	73341	- with mucosal graft, mandible.....	—	642.40

[Commentary:

‡As per the Schedule of benefits - Physician Services

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Spec

BIOPSY AND CYTOLOGY

T660	04300	Biopsy of oral tissue – soft	78.40	93.95
T662	04330	Cytological or bacteriological smear.....	26.10	28.55
T663		Biopsy of oral tissue - bone and/or cartilage	241.50	298.55
T665	04315	Aspiration of oral tissue – soft	—	33.60
T667	04316	Aspiration of oral tissue – bone and/or cartilage	—	50.30
T668		Needle aspiration, extraoral lesion - soft	—	99.65
T669		Needle aspiration, extraoral lesion - bone and/or cartilage	—	126.25

SURGICAL EXPOLARATION, INCISION AND SEQUESTRECTOMY

T396		Exploration of soft tissue (as sole surgical procedure) per quadrant – intraoral	—	145.50
T401	75100	Incision and drainage of soft tissue – intraoral	38.55	46.25
T395		Incision and drainage of major anatomical spaces, other than vestibular or palatal space – intraoral	—	237.05
T387		Exploration of bone or cartilage (as sole surgical procedure) per quadrant – intraoral	—	294.45
T402	75110	Trephination and drainage of bone and/or cartilage tissue – intraoral	90.75	108.90
T388		Exploration of soft tissue (as sole surgical procedure) per quadrant – extraoral	—	354.70
T403	75200	Incision and drainage of soft tissue – extraoral	—	193.50
T393		Incision and drainage of major anatomical spaces(s), other than vestibular space – extraoral	—	511.70
T389		Exploration of bone or cartilage (as sole surgical procedure) per quadrant - extraoral.....	—	563.90
T404	75500	Sequestrectomy for osteomyelitis – intraoral	—	165.85
T405	75501	Sequestrectomy for osteomyelitis – extraoral	—	373.70
T406	75510	Sequestrectomy and saucerization	—	401.05

CYSTS AND TUMOURS

Note:

Includes biopsy unless separate quick section is performed at same operation.

Excision of cyst

T390	74408	- under 1 cm	178.90	214.60
T391	74401	- 1 cm to 3 cm	—	228.75
T392	74411	- over 3 cm	—	389.45
T394	74410	Marsupialization of cyst (includes 12 post surgical visits)	—	483.40

Resection of benign soft tissue lesion

T370	74108	- under 1 cm	178.90	214.60
T371	74109	- 1 cm to 3 cm	—	261.95
T368		- greater than 3 cm	—	820.50

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Excision of benign tumour of bone

T369	- less than 1 cm	—	214.40
T372 74110	- 1 cm to 3 cm	—	228.75
T373 74118	- over 3 cm	—	389.45
T374 74200	- oral cavity or lip – under 3 cm	—	228.75

Excision malignant tumour, soft tissue oral cavity

T375	- over 3 cm	—	389.45
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Excision malignant tumour of bone

T376 74210	- under 3 cm	—	228.75
T377 74218	- over 3 cm	—	389.45
T378 74220	Cheiloplasty (lip shave)	—	548.80

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MAXILLECTOMY/MANDIBULECTOMY

Partial mandibulectomy

T407	75531	- up to 3 cm	—	818.15
T408	75532	- over 3 cm	—	1227.45
T409	75540	Total mandibulectomy	—	1840.95

Partial maxillectomy

T427	75551	- up to 3 cm	—	818.15
T428	75552	- over 3 cm	—	1227.45
T429	75560	Total maxillectomy	—	1840.95
T445		- interim stabilization with bone plate – per side add	—	309.30

RECONSTRUCTION

Reconstruction of mandible

T382		- unilateral, partial	—	1220.95
T383		- complete (including condyle) – unilateral	—	1505.30
T384		- bilateral, partial	—	1667.45
T385		- bilateral	—	2629.60
T386		Construction of developmentally absent condyle and vertical ramus – unilateral	—	2141.00

Reconstruction of maxilla

T361		- unilateral	—	1220.95
T362		- bilateral	—	1667.45
T363		Nasal reconstruction not for cosmetic purposes	—	2126.40
T364		- stabilization with plating or crib – per side add	—	252.50

Alveolar ridge reconstruction: with autogenous bone and/or alloplastic material per arch

T359		- maxilla	—	1115.80
T360		- mandible	—	1115.80

ONLAY BONE GRAFTS AND/OR ALLOGRAFTS FOR RECONSTRUCTION (not for cosmetic purposes)

Mandible

T101		- unilateral	—	318.95
T102		- bilateral	—	410.00

Maxilla

T105		- unilateral	—	318.95
T106		- bilateral	—	410.00

Zygoma

T109		- unilateral	—	273.05
T110		- bilateral	—	364.00

Temporal

T113		- unilateral	—	364.00
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OHIP	INTL	D.D.S	Spec
T114	- bilateral	—	455.05
Frontal			
T117	- unilateral	—	364.00
T118	- bilateral	—	455.05
T111	Nasal bones	—	364.00
T112	Nasal cartilage	—	364.00
T210	Bone graft to standard osteotomy site, unless included in the description of the surgery – per site	—	215.95
T211	Membrane guided bone regeneration – per site	—	77.85

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HARVESTING OF TISSUE

Bone

T260	- intraoral	—	174.80
T261	- extraoral maxillofacial	—	257.00
T262	- rib	—	284.85
T263	- iliac crest	—	284.85
T264	- calvarial	—	284.85
T265	- tibia	—	284.85
T266	Cartilage	—	257.00
T267	Skin	—	81.55
T268	Mucosa	—	81.55
T269	Fascia	—	123.00
T270	Muscle	—	123.00
T271	Dermis	—	123.00
T272	Fat	—	123.00
T273	Nerve – intraoral	—	202.65
T274	Nerve – extraoral	—	257.00

FRACTURES

Note:

For cranial flap approach to treat upper or midface fractures, add code T201 or T202.

Mandible

T430	76210	Closed reduction (will not be paid with T431 – T433)	502.10	627.25
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Open reduction

T431	76220	- single	—	833.30
T432	76230	- double	—	1137.10
T433	76240	- multiple	—	1745.00
T426		- with rigid internal fixation –per side add	—	146.35

Maxilla LeFort I

T440	76310	Closed reduction (will not be paid with T441 – T443)	502.10	627.25
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Open reduction

T441	76320	- single	—	833.30
T442	76330	- double	—	1137.10
T443	76340	- multiple	—	1745.00
T426		- with rigid internal fixation – per side add	—	146.35

Maxilla LeFort II

T450	76410	Closed reduction (will not be paid with T451 or T452)	—	627.25
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Open reduction

T451	76420	- unilateral	—	833.30
T452	76430	- bilateral	—	1745.00

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T426	- with rigid internal fixation - per side	add	—	146.35
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Cranofacial Dysjunction LeFort III

T425	Closed reduction		—	1745.00
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T424 76820	Open reduction		—	2585.80
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T426	- with rigid internal fixation – per side	add	—	146.35
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Spec

Nasal Ethmoid

Nasal Bones

T463	Closed reduction	—	302.00
T464	Open reduction (including nasal septum)	—	645.35

Nasal-ethmoid Complex

T465	Open reduction (including canthal ligament repair)	—	1039.50
T426	- with rigid internal fixation – per sid add	—	146.35

Orbital Rim

Open reduction

T460 76510	- transcutaneous approach	—	931.35
T461 76520	- transoral approach	—	705.95
T462 76530	Orbital blowout – isolated injury	—	1039.05
T426	- with rigid internal fixation – per side add	—	146.35
T468	- with antral packing add	—	146.35

Malar

T470 76620	Reduction – transoral approach	—	705.95
T471	Reduction – transcutaneous approach	—	711.20
T426	- with rigid internal fixation – per side add	—	146.35

Zygomatic Arch

T480 76710	Open reduction – transoral approach	—	352.75
T481 76720	Transcutaneous approach	—	705.95
T426	- with rigid internal fixation - per side add	—	146.35

Alveolus

Fracture of alveolus

T488	- closed	595.50	714.35
T489	- open	812.60	931.45
T491 76940	Reimplantation of avulsed or subluxated tooth (including root canal therapy and surgery)	294.45	353.40
T426	- with rigid internal fixation – per side add	—	146.35

Frontal Sinus

T493	Anterior table and/or posterior table repair – local access	—	771.90
T494	- with coronal incision and pericranial flap to obliterate sinus and nasal frontal duct to include cranialization – per side add	—	643.25
T495	- with fat to obliterate sinus and nasal frontal duct.....add	—	192.95
T496	- nasal frontal duct reconstruction with stent or creating opening into ethmoid sinuses.....add	—	128.80
T426	- with rigid internal fixation – per side add	—	146.35

SERVICES OF DENTISTS

PART 1

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D.D.S

Spec

LACERATIONS, SCAR REVISION, CLEFT LIP, ORO-NASAL FISTULAS

Repair of uncomplicated laceration, intraoral or extraoral

T501	76950	- under 2 cm	59.30	71.25
T507		- 2 cm to 5 cm	117.00	140.40
T508		- over 5 cm	—	180.65

Involving both skin and mucosa

T504	76960	- under 2 cm	—	136.55
T505	76961	- over 2 cm	—	303.40

Repair of complicated laceration and/or scar revision (including local tissue shifts) - intraoral and extraoral

T520	76970	- under 2.5 cm	—	93.55
T521	76971	- 2.6 cm to 5 cm	—	149.75
T522	76972	- over 5 cm	—	299.30
T530		Split thickness skin graft to face	—	363.40

Cleft Lip

T523	77630	Unilateral repair	—	533.30
T524	77640	Reconstruction with lip switch flap	—	652.65

Complex reconstruction or revision

T525	77645	- unilateral	—	614.25
T526		- bilateral	—	1233.50

Oral Nasal Fistula (not to include alveolar bone graft)

T510		Primary closure at time of initial surgery	—	248.00
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Secondary closure

T511		- with palatal flap	—	812.95
T512		- with pharyngeal flap	—	1247.50
T513		- with tongue flap	—	1247.50
T514		- with buccal flap	—	812.95

Cleft Palate

Palatorrhaphy

T568	77700	- anterior	—	630.75
T569	77710	- posterior	—	770.90
T570	77720	- total	—	1247.50

SERVICES OF DENTISTS

PART 1				
OHIP	INTL		D.D.S	Spec
FIXATION				
T410	76100	Maxillomandibular fixation	—	145.15
T121		- application of arch bar, and/or splint and/or wiring of dentures – one		
		add	156.70	195.90
T122		- application of arch bar(s), and/or splint(s) and/or wiring of dentures – two		
		add	251.65	314.50
T126		Rigid internal fixation – per side – per facial bone	—	133.45
T412	76120	- circumzygomatic wiring – each	—	50.75
T413	76130	- peralveolar or transpalatal wiring – each	—	50.75
T414	76140	- nasal spine wiring – each	—	50.75
T415	76150	- piriform aperture wiring – each	—	50.75
T416	76160	- circummandibular wiring - (payment limited to a maximum of three) – each	—	50.75
		add	—	211.60
T419	76191	- orbital suspension – each	—	285.85
T420	76192	Extrasketal suspension (e.g. Head Frame)	—	252.50
T437		- metal or allogeneic crib for particulate bone graft	—	97.30
		add	—	134.55
T422	76196	Removal of arch splint(s)	—	223.40
T439		Removal of transosseous wire(s) - per operative site	111.70	156.55
T423	76197	Removal of fixation screw(s) and/or plate(s) – per operative site	—	154.65
T435		Removal of maxillomandibular fixation devices	—	926.85
T436		Removal of extrasketal suspension	—	926.85
T589	74303	Removal of intraosseous prosthesis (not to include dental implants)	—	
T438		Removal of TMJ Fossa Prosthesis or Condylar Prosthesis or major reconstruction plate - per device	—	

SERVICES OF DENTISTS

PART 1

OHIP INTL

D.D.S

Spec

ORTHOGNATHIC SURGERY

Note:

Osteotomies are considered bilateral unless otherwise stated.

Mandibular Osteotomies

Subcondylar osteotomy

T540	77100	- closed	—	948.10
T740		- unilateral - closed	—	823.05
T541	77120	- extraoral	—	1371.75
T741		- unilateral - extraoral	—	823.05

Oblique osteotomy of ramus

T542	77130	- extraoral	—	1371.75
T742		- unilateral - extraoral	—	823.05
T543	77140	- intraoral	—	1371.75
T743		- unilateral - intraoral	—	823.05
T544	77150	Body osteotomy or ostectomy	—	1371.75
T744		- unilateral	—	823.05
T545	77160	Coronoidectomy - unilateral	—	586.45
T546	77170	Osteotomy of the condylar neck - unilateral	—	586.45

Sagittal split osteotomy

T547	77180	- intraoral	—	1371.75
T747		- unilateral - intraoral	—	823.05
T548	77190	- extraoral	—	1371.75
T748		- unilateral - extraoral	—	823.05
T550	77210	Inverted L osteotomy	—	1371.75
T750		- unilateral	—	823.05
T551	77220	C osteotomy	—	1371.75
T751		- unilateral	—	823.05

Anterior segmental osteotomy

T558	77440	- mandible	—	1223.90
T559	77450	- with transfer of mental eminence	—	1371.75
T560	77451	- without transfer of mental eminence	—	1371.75
T561	77460	Posterior segmental osteotomy of the mandible	—	1371.75
T579		- unilateral	—	823.05
T562	77461	Full arch dentoalveolar osteotomy of the mandible	—	1371.75
T565	77530	Genioplasty (including alloplast)	—	573.70
T567	77550	Lower border osteotomy of the mandible (unilateral)	—	684.65
T126		Rigid internal fixation – add per side per facial bone	—	133.45

Midface Osteotomies

T555	77400	Anterior segmental osteotomy maxilla	—	1223.90
T556	77410	Posterior segmental osteotomy maxilla	—	1371.75

SERVICES OF DENTISTS

PART 1

OHIP	INTL		D.D.S	Spec
T553		- unilateral	—	823.05
LeFort I Advancement				
T532 77300		- in one segment.....	—	1371.75
T022		- in two segments add	—	311.35
T023		- in three or more segments add	—	623.75
T126		- rigid internal fixation – per side per facial bone add	—	133.45

SERVICES OF DENTISTS

PART 1

OHIP INTL

D.D.S

Spec

LeFort I Intrusion

T534	- in one segment	—	1371.75
T024	- in two segments.....add	—	311.35
T025	- in three or more segments.....add	—	623.75
T030	- with SMR	—	214.90
T126	- rigid internal fixation – per side per facial bone	—	133.45

LeFort I Extrusion

T536	- in one segment	—	1453.40
T026	- In two segments	—	311.35
T027	- in three or more segments.....add	—	623.75
T126	- rigid internal fixation – per side per facial bone	—	133.45

LeFort I In Cleft Patient

T538	- in one segment	—	1600.75
T028	- in two segments.....add	—	268.60
T029	- in three or more segments.....add	—	537.25
T030	- with SMR	—	214.90
T031	- with pharyngoplasty	—	322.40
T040	- with closure alveolar fistula.....add	—	402.70
T041	- with bone graft	—	255.00
T042	- with closure hard palate fistula	—	537.25
T043	- with bone graft	—	255.00
T126	- rigid internal fixation – per side per facial bone	—	133.45

LeFort II

T554 77320	LeFort II osteotomy	—	1550.25
T126	- rigid internal fixation – per side per facial bone	—	133.45

LeFort III

T200 77330	LeFort III osteotomy	—	2138.05
T126	- rigid internal fixation – per side per facial bone	—	133.45

Craniofacial Surgery

T212	Cranioplasty	—	1432.10
T213	Cranial vault reshaping	—	1947.65
T214	Nasal reconstruction	—	1833.10

Cranial flap

T201	- unilateral	—	449.40
T202	- bilateral	—	652.85
T126	- rigid internal fixation – per side per facial bone	—	133.45

SERVICES OF DENTISTS

PART 1

OHIP INTL

D.D.S

Spec

DISTRACTION OSTEOGENESIS

Note:

Fees are for device placement and do not include the fee for the osteotomy.

Note:

Fees do not include postoperative activation visits.

Insertion Distraction Osteogenesis Device

Mandible - intraoral

T670	- unilateral	add	—	519.15
T671	- bilateral	add	—	1038.30

Mandible - extraoral

T672	- unilateral	add	—	778.70
T673	- bilateral	add	—	1297.85

Maxilla - intraoral

T674	- unilateral	add	—	519.15
T675	- bilateral	add	—	1038.30

Maxilla - extraoral

T676	- unilateral	add	—	778.70
T677	- bilateral	add	—	1297.85

Mandibular alveolus

T678	- unilateral	add	—	519.15
T679	- bilateral	add	—	1038.30

Maxillary alveolus

T680	- unilateral	add	—	519.15
T681	- bilateral	add	—	1038.30

Temporomandibular joint

T682	- unilateral	add	—	830.60
T683	- bilateral	add	—	1661.25

Cranium

T684	- unilateral	add	—	830.60
T685	- bilateral	add	—	1661.25

Orbit

T686	- unilateral	add	—	830.60
T687	- bilateral	add	—	1661.25

Zygoma

T688	- unilateral	add	—	830.60
T689	- bilateral	add	—	1661.25
T690	Removal of device - per device.....		—	259.55

SERVICES OF DENTISTS

PART 1

OHIP	INTL		D.D.S	Spec
TEMPOROMANDIBULAR JOINT				
T219		TMJ Arthrography	—	139.50
T220	78500	Arthrocentesis	—	100.30
T225	78600	Injection into joint – therapeutic drug	—	100.30
Dislocation				
T590	78100	- open reduction	—	509.95
T591	78110	- closed reduction	46.30	55.65
T592	78120	Manipulation under general anaesthesia (not to be billed with any other TMJ surgery)	—	110.60
T593	78200	Menisectomy	—	509.95
T594	78210	Capsulorrhaphy (not to be billed with any other TMJ surgery)	—	509.95
T595	78220	Lateral pterygoid myotomy (not to be billed with any other TMJ surgery)	—	509.95
T596	78300	Condylectomy or condyloplasty	—	509.95
T599	78400	Arthroplasty of articular eminence	—	583.70
T527	78230	Plication of disc posterior attachment (includes capsulorrhaphy) .	—	1049.10
T598	78320	Osteotomy – ramus with interpositional alloplastic material for ankylosis	—	745.50
T528	78410	Reconstruction of glenoid fossa, zygomatic arch and temporal bone autogenous tissue, graft or prosthesis	—	1622.00
T531		Repair or reconstruction of TMJ disc with tissue graft or prosthesis (includes menisectomy)	—	1170.50
T533		Reconstruction of mandibular condyle with prosthesis or tissue graft	—	1170.50
T535		Removal of temporary intra-articular implant	—	180.80
T537		- revision surgery – previous open TMJ arthrotomy.....add	—	25% to listed fee
TMJ Arthroscopic Surgery				
T231		Arthroscopy – single portal (to include diagnostic arthroscopy, indirect lysis of adhesions, lavage and manipulation).....	—	506.45
Procedures performed through additional portals (ie. Other than the first or primary arthroscopy portal)				
T232		- debridement using hinged instrument, shaver, cautery or laser (1 or 2 spaces)	—	405.15
T233		- with biopsy, or subsynovial injection steroid or removal of foreign body	—	47.25
T234		- with synovectomy and direct lysis of adhesion (1 or 2 spaces)	—	323.70
T235		- abrasion arthroplasty	—	405.15
T236		- with menisectomy (total)	—	303.85
T237		- with lateral ligament release	—	202.60
T238		- with anterior release of disc	—	270.10
T239		- with disc plication	—	506.45

SERVICES OF DENTISTS

PART 1

OHIP INTL

D.D.S

Spec

NEUROLOGICAL DISTURBANCES

T619	Physiologic monitoring (e.g., stimulation and recording evoked potentials)	—	275.35
T610 79201	Injection of nerve (lytic destruction or steroid)	—	158.25

Peripheral nerve avulsion

T611 79202	- partial	—	339.95
T612 79203	- total	—	698.95
T613 79204	Transposition of mental nerve	—	461.00
T614 79205	Decompression of inferior alveolar nerve	—	341.80
T607	Decompression of infraorbital nerve intraoral facial approach - anterior	—	702.10
T608	Decompression of infraorbital nerve transantral approach - posterior	—	1084.95
T633	Primary repair	—	300.55
T634	Secondary repair	—	707.45
T635	- neuroma excision and biopsy	—	89.95
T647	- fascicular anastomosis	—	767.10
T636	- with nerve graft (includes harvesting)	—	363.25
T637	- with conduit (up to 3 cm) (includes harvesting)	—	241.65
T638	- with conduit (over 3 cm) (includes harvesting)	—	317.95
T639	- with fibrin adhesive per anastomosis	—	69.95
T609	- with laser coagulation	—	69.95
T618 79240	- when operating microscope required for any of the above procedures	—	40% to basic fee
T605	- when injury older than eight weeks	—	30% to basic fee
T645	Trigger point injection for chronic pain	—	33.20
T646	Diagnostic or therapeutic nerve block	—	66.45

SALIVARY GLANDS

T760 79101	Dilation of salivary duct	—	77.10
T761 79102	Insertion of polyethylene tube in duct	—	77.10
T601 79103	Sialodochoplasty	—	245.85

Sialolithotomy

T602 79104	- anterior 1/3 of duct	76.50	91.90
T603 79105	- posterior 2/3 of duct	—	149.20
T454	Excision – sublingual gland	—	344.45
T455	Excision – submandibular gland	—	549.70
T456	*Excision, subtotal, parotid gland	—	800.65
T457	*Excision, total, parotid gland	—	1182.25

SERVICES OF DENTISTS

PART 1				
OHIP	INTL		D.D.S	Spec
T458		*Parotid biopsy		222.95
[Commentary:				
* effective March 1, 2007]				
T606	79109	Marsupialization of ranula	—	123.00
T230	79113	Reconstruction of salivary duct.....	—	I.C.

SERVICES OF DENTISTS

PART 1

OHIP INTL

D.D.S

Spec

FRENECTOMY/GLOSSECTOMY/MYOTOMY

T580	77840	Lingual frenectomy or Z plasty	57.20	68.90
T581	77850	Lingual frenectomy or Z plasty with genioglossus myotomy.....	—	94.50

Partial glossectomy

T582	77860	- anterior wedge.....	—	169.95
T583	77870	- anterior-posterior wedge	—	278.55
T204	77540	Suprahyoid myotomy	—	226.75

MAXILLARY SINUS

T664		Exploration of maxillary sinus via antrostomy.....	—	127.55
T666		- with fibre-optic scope..... add	—	105.15
T620	79301	Recovery of dental root or foreign body from antrum immediate..	—	118.15
T622	79303	Delayed recovery root or foreign body via antrostomy	—	174.85
T623	79304	Antrum lavage - transoral approach	—	70.80
T624	79305	Antrum lavage - transnasal approach.....	—	70.80
T625	79306	Closure of oro-antral fistula	—	200.20
T628	79309	Transnasal antrostomy	—	83.15
T629		Antral packing.....	—	115.75

TRACHEOTOMY

T310		Tracheotomy	—	150.55
T311		- with anterior cricoid split..... add	—	74.25
T312		Insertion of laryngeal or tracheal stent	—	203.50

PREMIUMS AND UNLISTED PROCEDURES

T800		Independent Consideration will be given to claims for other dental surgical procedures approved by the Ontario Dental Association but not listed specifically in this Schedule	I.C.	I.C.
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Despite the above, dental implants are not insured services under any circumstances.

T809		Premium when non-elective surgical procedures commence between 5:00 p.m. and midnight, or on a Saturday, Sunday or holiday	30% of amt payable	30% of amt payable
T810		Premium when non-elective surgical procedures commence between midnight and 7:00 a.m. any night of the week	50% of amt payable	50% of amt payable
T811		*Premium for a consultation or visit between 5:00 p.m. and midnight, or on a Saturday, Sunday or holiday.....	30% of amt payable	30% of amt payable
T812		*Premium for any consultation or visit to a patient in an intensive care facility (e.g., ICU or CCU).....	30% of amt payable	30% of amt payable

SERVICES OF DENTISTS

PART 1				
OHIP	INTL		D.D.S	Spec
T813		*Premium for a consultation or visit between midnight and 7:00 a.m.	50% of amt payable	50% of amt payable

[Commentary:
* effective March 1, 2007]

SERVICES OF DENTISTS

PART 2

PART II

PREAMBLE

1. The services listed in this section are insured only if performed in conjunction with one or more of the services listed in Part I or Part III and only when the two or more services are associated anatomically.

2. Multiple Operative Procedures

When more than one procedure is performed at the same time, the major procedure is payable at the listed fee, and subsequent procedures performed at the same time are payable at 85% of the listed fee, except where multiple procedures are identified in this Schedule by a specific add-on code.

SERVICES OF DENTISTS

PART 2

OHIP INTL

D.D.S Spec

Note:

The services listed below are insured only if performed in conjunction with one or more of the procedures listed in Part I or III and only when the 2 or more services are associated anatomically.

ROOT RESECTION AND APICAL CURETTAGE

Apical curettage and/or root resection

One root

T701	34101	- uncomplicated.....	177.85	213.35
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Root - end fillings

T709	34201	One root - uncomplicated.....	212.85	255.40
T710	34202	One root - complicated.....	284.70	341.65
T711	34212	Two roots – same tooth.....	284.70	341.65
T712	34213	Three roots – same tooth.....	338.15	405.75

Note:

Services listed under codes T709 – T712 include root-end filling, apical curettage and root resection.

SERVICES OF DENTISTS

PART 3

PART III

PREAMBLE

1. The services listed in this section are insured only when hospitalization is medically necessary and prior approval has been given by the OHIP Dental or Medical Consultant. Approved procedures must be completed within one year of the date of approval.

The request for "Prior Approval" must be provided to the Dental or Medical Consultant before the date of service except for an emergency procedure or in exceptional circumstances. Appropriate documentation or explanation must be provided to substantiate this claim.

2. The requirement for prior approval does not apply to teeth extracted from the line of fracture. The fee for such extractions is payable at 85% of the listed fee.
3. The requirement for prior approval does not apply to teeth extracted in conjunction with removal of a cyst greater than 1 cm, or in conjunction with any tumour. The fee for such extractions is payable at 85% of the listed fee.
4. When more than one procedure is performed in the same quadrant, the major procedure is payable at the listed fee, and subsequent procedures performed at the same time are payable at 85% of the listed fee, except where multiple procedures are identified by a specific add-on code. The reduction to 85% of the listed fee does not apply to procedure T902. Tooth identification numbers and corresponding procedure codes must accompany the claim.
5. If the services listed in this section are performed in conjunction with one or more services listed in Part I or Part II at the same time, the major procedure is payable at the listed fee, and subsequent procedures performed at the same time are payable at 85% of the listed fee, except where multiple procedures are identified in the Schedule as an add-on code. The reduction to 85% does not apply to procedure T902.
6. All services listed in this section include curettage of any apical lesion(s) up to 1 cm where required.
7. All services listed in this section include bone contouring and suturing, where required.

SERVICES OF DENTISTS

PART 3

OHIP INTL

D.D.S

Spec

Note:

1. The services listed in this section are insured only when hospitalization is medically necessary and prior approval has been given by the OHIP Dental or Medical Consultant.
2. The request for "Prior approval" must be provided to the OHIP Dental or Medical Consultant before the date of service except for an emergency procedure or in exceptional circumstances. Approved procedures must be completed within one year of the date of approval.
3. The amount payable for T650 is zero when it is rendered in conjunction with Part III procedures for which prior approval has been granted.

ODONTECTOMY

T901	71101	Removal of single erupted tooth - per quadrant	40.65	48.80
T902	71111	Removal of each additional erupted tooth in the same quadrant .	21.05	25.25
T903	72100	Removal of each erupted tooth – complicated	95.75	114.85
T904	72210	Removal of each tooth covered by soft tissue	95.75	114.85
T905	72220	Removal of each impacted tooth, partial bony impaction	144.35	173.15
T906	72230	Removal of each impacted tooth, complete bony impaction	191.55	229.90
T907	72240	Removal of each impacted tooth, unusual position, age factor (incl. super-numerary)	219.25	262.95

Removal of residual dental root

T908	72310	- with soft tissue coverage	82.70	99.10
T909	72320	- with bone tissue coverage	95.75	114.85

Note:

The above listed surgical services include necessary suturing. An impacted tooth is one which is prevented from its normal path or eruption by hard tissue (tooth or bone).

Surgical exposure of each unerupted tooth

T910	72410	Uncomplicated soft tissue coverage	36.95	44.35
T911	72411	Complicated hard tissue coverage	131.25	157.45
T912	72412	With orthodontic attachment	261.25	313.45

FRENECTOMY

T925	77800	Maxillary labial frenectomy	70.45	84.55
T926	77810	Mandibular labial frenectomy	70.45	84.55
T927	77820	Maxillary Z frenoplasty	70.45	84.55
T928	77830	Mandibular Z frenoplasty	70.45	84.55

ALVEOLOPLASTY

T936	73110	Alveoloplasty independent of tooth extraction - per quadrant	44.10	53.00
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SERVICES OF DENTISTS

NOT ALLOCATED

SERVICES OF DENTISTS

CODE INDEX

Code	Description	D.D.S.	Spec	Page
T022	in two segments add	—	311.35	D - 20
T023	in three or more segments add	—	623.75	D - 20
T024	in two segments add	—	311.35	D - 21
T025	in three or more segments add	—	623.75	D - 21
T026	In two segments add	—	311.35	D - 21
T027	in three or more segments add	—	623.75	D - 21
T028	in two segments add	—	268.60	D - 21
T029	in three or more segments add	—	537.25	D - 21
T030	with SMR add	—	214.90	D - 21
T031	with pharyngoplasty add	—	322.40	D - 21
T040	with closure alveolar fistula add	—	402.70	D - 21
T041	with bone graft add	—	255.00	D - 21
T042	with closure hard palate fistula add	—	537.25	D - 21
T043	with bone graft add	—	255.00	D - 21
T050	Complex consultation in hospital	136.10	163.20	D - 8
T051	Complex follow-up assessments within 12 months of initial consultation same diagnosis, in hospital, emergency or outpatient department	108.95	124.50	D - 8
T101	unilateral	—	318.95	D - 12
T102	bilateral	—	410.00	D - 12
T105	unilateral	—	318.95	D - 12
T106	bilateral	—	410.00	D - 12
T109	unilateral	—	273.05	D - 12
T110	bilateral	—	364.00	D - 12
T111	Nasal bones	—	364.00	D - 13
T112	Nasal cartilage	—	364.00	D - 13
T113	unilateral	—	364.00	D - 12
T114	bilateral	—	455.05	D - 13
T117	unilateral	—	364.00	D - 13
T118	bilateral	—	455.05	D - 13

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T121	application of arch bar, and/or splint and/or wiring of dentures – one add	156.70	195.90	D - 18
T122	application of arch bar(s), and/or splint(s) and/or wiring of dentures – two add	251.65	314.50	D - 18
T126	Rigid internal fixation – add per side per facial bone	—	133.45	D - 19
T126	Rigid internal fixation – per side – per facial bone	—	133.45	D - 18
T126	rigid internal fixation – per side per facial bone add	—	133.45	D - 20, 21
T200	LeFort III osteotomy	—	2138.05	D - 21
T201	unilateral add	—	449.40	D - 21
T202	bilateral add	—	652.85	D - 21
T204	Suprahyoid myotomy	—	226.75	D - 26
T210	Bone graft to standard osteotomy site, unless included in the description of the surgery – per site add	—	215.95	D - 13
T211	Membrane guided bone regeneration – per site add	—	77.85	D - 13
T212	Cranioplasty	—	1432.10	D - 21
T213	Cranial vault reshaping	—	1947.65	D - 21
T214	Nasal reconstruction	—	1833.10	D - 21
T219	TMJ Arthrography	—	139.50	D - 23
T220	Arthrocentesis	—	100.30	D - 23
T225	Injection into joint – therapeutic drug	—	100.30	D - 23
T230	Reconstruction of salivary duct	—	I.C.	D - 25
T231	Arthroscopy – single portal (to include diagnostic arthroscopy, indirect lysis of adhesions, lavage and manipulation)	—	506.45	D - 23
T232	debridement using hinged instrument, shaver, cautery or laser (1 or 2 spaces) add	—	405.15	D - 23
T233	with biopsy, or subsynovial injection steroid or removal of foreign body add	—	47.25	D - 23
T234	with synovectomy and direct lysis of adhesion (1 or 2 spaces) add	—	323.70	D - 23

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T235	abrasion arthroplasty add	—	405.15	D - 23
T236	with menisectomy (total) add	—	303.85	D - 23
T237	with lateral ligament release add	—	202.60	D - 23
T238	with anterior release of disc add	—	270.10	D - 23
T239	with disc plication add	—	506.45	D - 23
T260	intraoral	—	174.80	D - 14
T261	extraoral maxillofacial	—	257.00	D - 14
T262	rib	—	284.85	D - 14
T263	iliac crest	—	284.85	D - 14
T264	calvarial	—	284.85	D - 14
T265	tibia	—	284.85	D - 14
T266	Cartilage	—	257.00	D - 14
T267	Skin	—	81.55	D - 14
T268	Mucosa	—	81.55	D - 14
T269	Fascia	—	123.00	D - 14
T270	Muscle	—	123.00	D - 14
T271	Dermis	—	123.00	D - 14
T272	Fat	—	123.00	D - 14
T273	Nerve – intraoral	—	202.65	D - 14
T274	Nerve – extraoral	—	257.00	D - 14
T310	Tracheotomy	—	150.55	D - 26
T311	with anterior cricoid split add	—	74.25	D - 26
T312	Insertion of laryngeal or tracheal stent	—	203.50	D - 26
T330	Gingivoplasty independent of tooth extraction, per quadrant	35.90	43.20	D - 8
T331	Excision of vestibular hyperplastic tissue, per quadrant	—	129.30	D - 8
T332	Surgical shaving of papillary hyperplasia of the palate	—	185.85	D - 8
T333	Remodelling of the mylohyoid ridge	—	131.25	D - 8
T334	Remodelling of the genial tubercles	—	168.00	D - 8
T335	Excision of nasal spine	—	131.25	D - 8

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T336	Excision of torus palatinus	243.90	292.70	D - 8
T337	Excision of torus mandibularis, unilateral	243.90	292.70	D - 8
T338	Excision of torus mandibularis, bilateral	243.90	292.70	D - 8
T339	Excision of multiple exostoses, per quadrant	243.90	292.70	D - 8
T341	unilateral	—	136.75	D - 8
T342	bilateral	—	273.40	D - 8
T343	unilateral	—	136.75	D - 8
T344	bilateral	—	273.40	D - 9
T345	Full arch lowering of floor of mouth	—	410.35	D - 9
T346	Partial arch lowering of floor of mouth	—	242.95	D - 9
T347	maxilla	—	242.95	D - 9
T348	mandible	—	242.95	D - 9
T349	with secondary epithelialization, maxilla	—	321.05	D - 9
T350	with secondary epithelialization, mandible	—	321.05	D - 9
T351	with skin graft, maxilla	—	573.95	D - 9
T352	with skin graft, mandible	—	573.95	D - 9
T353	with mucosal graft, maxilla	—	642.40	D - 9
T354	with mucosal graft, mandible	—	642.40	D - 9
T359	maxilla	—	1115.80	D - 12
T360	mandible	—	1115.80	D - 12
T361	unilateral	—	1220.95	D - 12
T362	bilateral	—	1667.45	D - 12
T363	Nasal reconstruction not for cosmetic purposes	—	2126.40	D - 12
T364	stabilization with plating or crib – per side add	—	252.50	D - 12
T368	greater than 3 cm	—	820.50	D - 10
T369	less than 1 cm	—	214.40	D - 11
T370	under 1 cm	178.90	214.60	D - 10
T371	1 cm to 3 cm	—	261.95	D - 10
T372	1 cm to 3 cm	—	228.75	D - 11
T373	over 3 cm	—	389.45	D - 11

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T374	oral cavity or lip – under 3 cm	—	228.75	D - 11
T375	over 3 cm	—	389.45	D - 11
T376	under 3 cm	—	228.75	D - 11
T377	over 3 cm	—	389.45	D - 11
T378	Cheiloplasty (lip shave)	—	548.80	D - 11
T382	unilateral, partial	—	1220.95	D - 12
T383	complete (including condyle) – unilateral	—	1505.30	D - 12
T384	bilateral, partial	—	1667.45	D - 12
T385	bilateral	—	2629.60	D - 12
T386	Construction of developmentally absent condyle and vertical ramus – unilateral	—	2141.00	D - 12
T387	Exploration of bone or cartilage (as sole surgical procedure) per quadrant – intraoral	—	294.45	D - 10
T388	Exploration of soft tissue (as sole surgical procedure) per quadrant – extraoral	—	354.70	D - 10
T389	Exploration of bone or cartilage (as sole surgical procedure) per quadrant - extraoral	—	563.90	D - 10
T390	under 1 cm	178.90	214.60	D - 10
T391	1 cm to 3 cm	—	228.75	D - 10
T392	over 3 cm	—	389.45	D - 10
T393	Incision and drainage of major anatomical spaces(s), other than vestibular space – extraoral	—	511.70	D - 10
T394	Marsupialization of cyst (includes 12 post surgical visits)	—	483.40	D - 10
T395	Incision and drainage of major anatomical spaces, other than vestibular or palatal space – intraoral	—	237.05	D - 10
T396	Exploration of soft tissue (as sole surgical procedure) per quadrant – intraoral	—	145.50	D - 10
T401	Incision and drainage of soft tissue – intraoral	38.55	46.25	D - 10
T402	Trephination and drainage of bone and/or cartilage tissue – intraoral	90.75	108.90	D - 10
T403	Incision and drainage of soft tissue – extraoral	—	193.50	D - 10
T404	Sequestrectomy for osteomyelitis – intraoral	—	165.85	D - 10

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T405	Sequestrectomy for osteomyelitis – extraoral	—	373.70	D - 10
T406	Sequestrectomy and saucerization	—	401.05	D - 10
T407	up to 3 cm	—	818.15	D - 12
T408	over 3 cm	—	1227.45	D - 12
T409	Total mandibulectomy	—	1840.95	D - 12
T410	Maxillomandibular fixation	—	145.15	D - 18
T412	circumzygomatic wiring – each add	—	50.75	D - 18
T413	peralveolar or transpalatal wiring – each add	—	50.75	D - 18
T414	nasal spine wiring – each add	—	50.75	D - 18
T415	piriform aperture wiring – each add	—	50.75	D - 18
T416	circummandibular wiring - (payment limited to a maximum of three) – each add	—	50.75	D - 18
T419	orbital suspension – each add	—	211.60	D - 18
T420	Extraskkeletal suspension (e.g. Head Frame)	—	285.85	D - 18
T422	Removal of arch splint(s)	—	97.30	D - 18
T423	Removal of fixation screw(s) and/or plate(s) – per operative site	—	223.40	D - 18
T424	Open reduction	—	2585.80	D - 15
T425	Closed reduction	—	1745.00	D - 15
T426	with rigid internal fixation – per sid add	—	146.35	D - 16
T426	with rigid internal fixation - per side add	—	146.35	D - 15, 16
T426	with rigid internal fixation – per side add	—	146.35	D - 14, 15, 16
T426	with rigid internal fixation –per side add	—	146.35	D - 14
T427	up to 3 cm	—	818.15	D - 12
T428	over 3 cm	—	1227.45	D - 12
T429	Total maxillectomy	—	1840.95	D - 12
T430	Closed reduction (will not be paid with T431 – T433)	502.10	627.25	D - 14
T431	single	—	833.30	D - 14
T432	double	—	1137.10	D - 14
T433	multiple	—	1745.00	D - 14

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T435	Removal of maxillomandibular fixation devices	—	156.55	D - 18
T436	Removal of extraskeletal suspension	—	154.65	D - 18
T437	metal or allogeneic crib for particulate bone graft add	—	252.50	D - 18
T438	Removal of TMJ Fossa Prosthesis or Condylar Prosthesis or major reconstruction plate - per device	—	926.85	D - 18
T439	Removal of transosseous wire(s) - per operative site	111.70	134.55	D - 18
T440	Closed reduction (will not be paid with T441 – T443)	502.10	627.25	D - 14
T441	single	—	833.30	D - 14
T442	double	—	1137.10	D - 14
T443	multiple	—	1745.00	D - 14
T445	interim stabilization with bone plate – per side add	—	309.30	D - 12
T450	Closed reduction (will not be paid with T451 or T452)	—	627.25	D - 14
T451	unilateral	—	833.30	D - 14
T452	bilateral	—	1745.00	D - 14
T454	Excision – sublingual gland	—	344.45	D - 24
T455	Excision – submandibular gland	—	549.70	D - 24
T456	*Excision, subtotal, parotid gland		800.65	D - 24
T457	*Excision, total, parotid gland		1182.25	D - 24
T458	*Parotid biopsy		222.95	D - 25
T460	transcutaneous approach	—	931.35	D - 16
T461	transoral approach	—	705.95	D - 16
T462	Orbital blowout – isolated injury	—	1039.05	D - 16
T463	Closed reduction	—	302.00	D - 16
T464	Open reduction (including nasal septum)	—	645.35	D - 16
T465	Open reduction (including canthal ligament repair)	—	1039.50	D - 16
T468	with antral packing add	—	146.35	D - 16
T470	Reduction – transoral approach	—	705.95	D - 16

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T471	Reduction – transcutaneous approach	—	711.20	D - 16
T480	Open reduction – transoral approach	—	352.75	D - 16
T481	Transcutaneous approach	—	705.95	D - 16
T488	closed	595.50	714.35	D - 16
T489	open	812.60	931.45	D - 16
T491	Reimplantation of avulsed or subluxated tooth (including root canal therapy and surgery)	294.45	353.40	D - 16
T493	Anterior table and/or posterior table repair – local access	—	771.90	D - 16
T494	with coronal incision and pericranial flap to obliterate sinus and nasal frontal duct to include cranialization – per side add	—	643.25	D - 16
T495	with fat to obliterate sinus and nasal frontal duct add	—	192.95	D - 16
T496	nasal frontal duct reconstruction with stent or creating opening into ethmoid sinuses add	—	128.80	D - 16
T501	under 2 cm	59.30	71.25	D - 17
T504	under 2 cm	—	136.55	D - 17
T505	over 2 cm	—	303.40	D - 17
T507	2 cm to 5 cm	117.00	140.40	D - 17
T508	over 5 cm	—	180.65	D - 17
T510	Primary closure at time of initial surgery	—	248.00	D - 17
T511	with palatal flap	—	812.95	D - 17
T512	with pharyngeal flap	—	1247.50	D - 17
T513	with tongue flap	—	1247.50	D - 17
T514	with buccal flap	—	812.95	D - 17
T520	under 2.5 cm	—	93.55	D - 17
T521	2.6 cm to 5 cm	—	149.75	D - 17
T522	over 5 cm	—	299.30	D - 17
T523	Unilateral repair	—	533.30	D - 17
T524	Reconstruction with lip switch flap	—	652.65	D - 17
T525	unilateral	—	614.25	D - 17
T526	bilateral	—	1233.50	D - 17

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T527	Plication of disc posterior attachment (includes capsulorrhaphy)	—	1049.10	D - 23
T528	Reconstruction of glenoid fossa, zygomatic arch and temporal bone autogenous tissue, graft or prosthesis	—	1622.00	D - 23
T530	Split thickness skin graft to face	—	363.40	D - 17
T531	Repair or reconstruction of TMJ disc with tissue graft or prosthesis (includes menisectomy)	—	1170.50	D - 23
T532	in one segment	—	1371.75	D - 20
T533	Reconstruction of mandibular condyle with prosthesis or tissue graft	—	1170.50	D - 23
T534	in one segment	—	1371.75	D - 21
T535	Removal of temporary intra-articular implant	—	180.80	D - 23
T536	in one segment	—	1453.40	D - 21
T537	revision surgery – previous open TMJ arthrotomy add	—	25% to listed fee	D - 23
T538	in one segment	—	1600.75	D - 21
T540	closed	—	948.10	D - 19
T541	extraoral	—	1371.75	D - 19
T542	extraoral	—	1371.75	D - 19
T543	intraoral	—	1371.75	D - 19
T544	Body osteotomy or ostectomy	—	1371.75	D - 19
T545	Coronoidectomy - unilateral	—	586.45	D - 19
T546	Osteotomy of the condylar neck - unilateral	—	586.45	D - 19
T547	intraoral	—	1371.75	D - 19
T548	extraoral	—	1371.75	D - 19
T550	Inverted L osteotomy	—	1371.75	D - 19
T551	C osteotomy	—	1371.75	D - 19
T553	unilateral	—	823.05	D - 20
T554	LeFort II osteotomy	—	1550.25	D - 21
T555	Anterior segmental osteotomy maxilla	—	1223.90	D - 19
T556	Posterior segmental osteotomy maxilla	—	1371.75	D - 19

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T558	mandible	—	1223.90	D - 19
T559	with transfer of mental eminence	—	1371.75	D - 19
T560	without transfer of mental eminence	—	1371.75	D - 19
T561	Posterior segmental osteotomy of the mandible	—	1371.75	D - 19
T562	Full arch dentoalveolar osteotomy of the mandible	—	1371.75	D - 19
T565	Genioplasty (including alloplast)	—	573.70	D - 19
T567	Lower border osteotomy of the mandible (unilateral)	—	684.65	D - 19
T568	anterior	—	630.75	D - 17
T569	posterior	—	770.90	D - 17
T570	total	—	1247.50	D - 17
T579	unilateral	—	823.05	D - 19
T580	Lingual frenectomy or Z plasty	57.20	68.90	D - 26
T581	Lingual frenectomy or Z plasty with genioglossus myotomy	—	94.50	D - 26
T582	anterior wedge	—	169.95	D - 26
T583	anterior-posterior wedge	—	278.55	D - 26
T589	Removal of intraosseous prosthesis (not to include dental implants)	—	926.85	D - 18
T590	open reduction	—	509.95	D - 23
T591	closed reduction	46.30	55.65	D - 23
T592	Manipulation under general anaesthesia (not to be billed with any other TMJ surgery)	—	110.60	D - 23
T593	Menisectomy	—	509.95	D - 23
T594	Capsulorrhaphy (not to be billed with any other TMJ surgery)	—	509.95	D - 23
T595	Lateral pterygoid myotomy (not to be billed with any other TMJ surgery)	—	509.95	D - 23
T596	Condylectomy or condyloplasty	—	509.95	D - 23
T598	Osteotomy – ramus with interpositional alloplastic material for ankylosis	—	745.50	D - 23
T599	Arthroplasty of articular eminence	—	583.70	D - 23

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T601	Sialodochoplasty	—	245.85	D - 24
T602	anterior 1/3 of duct	76.50	91.90	D - 24
T603	posterior 2/3 of duct	—	149.20	D - 24
T605	when injury older than eight weeks add	—	30% to basic fee	D - 24
T606	Marsupialization of ranula	—	123.00	D - 25
T607	Decompression of infraorbital nerve intraoral facial approach - anterior	—	702.10	D - 24
T608	Decompression of infraorbital nerve transantral approach - posterior	—	1084.95	D - 24
T609	with laser coagulation add	—	69.95	D - 24
T610	Injection of nerve (lytic destruction or steroid)	—	158.25	D - 24
T611	partial	—	339.95	D - 24
T612	total	—	698.95	D - 24
T613	Transposition of mental nerve	—	461.00	D - 24
T614	Decompression of inferior alveolar nerve	—	341.80	D - 24
T618	when operating microscope required for any of the above procedures add	—	40% to basic fee	D - 24
T619	Physiologic monitoring (e.g., stimulation and recording evoked potentials)	—	275.35	D - 24
T620	Recovery of dental root or foreign body from antrum immediate	—	118.15	D - 26
T622	Delayed recovery root or foreign body via antrostomy	—	174.85	D - 26
T623	Antrum lavage - transoral approach	—	70.80	D - 26
T624	Antrum lavage - transnasal approach	—	70.80	D - 26
T625	Closure of oro-antral fistula	—	200.20	D - 26
T628	Transnasal antrostomy	—	83.15	D - 26
T629	Antral packing		115.75	D - 26
T630	Control of bleeding secondary to dental extraction	78.40	93.95	D - 8
T631	Post-surgical care, minor	17.40	20.85	D - 8
T632	Post-surgical care, major	38.55	46.25	D - 8
T633	Primary repair	—	300.55	D - 24

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T634	Secondary repair	—	707.45	D - 24
T635	neuroma excision and biopsy add	—	89.95	D - 24
T636	with nerve graft (includes harvesting) add	—	363.25	D - 24
T637	with conduit (up to 3 cm) (includes harvesting) add	—	241.65	D - 24
T638	with conduit (over 3 cm) (includes harvesting) add	—	317.95	D - 24
T639	with fibrin adhesive per anastomosis add	—	69.95	D - 24
T643	Assisting at major oral and maxillofacial surgical procedure	30% of surgical fee	30% of surgical fee	D - 8
T644	Assisting at physician's surgery	30% of surgical fee‡	30% of surgical fee‡	D - 8
T645	Trigger point injection for chronic pain per site	—	33.20	D - 24
T646	Diagnostic or therapeutic nerve block per site	—	66.45	D - 24
T647	fascicular anastomosis add	—	767.10	D - 24
T650	Consultation in hospital	70.15	84.15	D - 8
T651	Follow-up assessments within 12 months of initial consultation same diagnosis, in hospital, emergency or outpatient department	57.00	65.10	D - 8
T652	Hospital visit, admitted bed patient	38.10	47.55	D - 8
T653	Examination under general anesthesia (sole procedure)	38.10	47.55	D - 8
T654	with diagnostic imaging (may be billed in addition to T653) add	32.55	40.70	D - 8
T655	Consultation	70.15	84.15	D - 5
T656	Follow-up assessments within 12 months of initial consultation same diagnosis	57.00	65.10	D - 5
T660	Biopsy of oral tissue – soft	78.40	93.95	D - 10
T662	Cytological or bacteriological smear	26.10	28.55	D - 10
T663	Biopsy of oral tissue - bone and/or cartilage	241.50	298.55	D - 10
T664	Exploration of maxillary sinus via antrostomy	—	127.55	D - 26
T665	Aspiration of oral tissue – soft	—	33.60	D - 10
T666	with fibre-optic scope add	—	105.15	D - 26

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T667	Aspiration of oral tissue – bone and/or cartilage	—	50.30	D - 10
T668	Needle aspiration, extraoral lesion - soft	—	99.65	D - 10
T669	Needle aspiration, extraoral lesion - bone and/or cartilage	—	126.25	D - 10
T670	unilateral add	—	519.15	D - 22
T671	bilateral add	—	1038.30	D - 22
T672	unilateral add	—	778.70	D - 22
T673	bilateral add	—	1297.85	D - 22
T674	unilateral add	—	519.15	D - 22
T675	bilateral add	—	1038.30	D - 22
T676	unilateral add	—	778.70	D - 22
T677	bilateral add	—	1297.85	D - 22
T678	unilateral add	—	519.15	D - 22
T679	bilateral add	—	1038.30	D - 22
T680	unilateral add	—	519.15	D - 22
T681	bilateral add	—	1038.30	D - 22
T682	unilateral add	—	830.60	D - 22
T683	bilateral add	—	1661.25	D - 22
T684	unilateral add	—	830.60	D - 22
T685	bilateral add	—	1661.25	D - 22
T686	unilateral add	—	830.60	D - 22
T687	bilateral add	—	1661.25	D - 22
T688	unilateral add	—	830.60	D - 22
T689	bilateral add	—	1661.25	D - 22
T690	Removal of device - per device	—	259.55	D - 22
T701	uncomplicated	177.85	213.35	D - 29
T709	One root - uncomplicated	212.85	255.40	D - 29
T710	One root - complicated	284.70	341.65	D - 29
T711	Two roots – same tooth	284.70	341.65	D - 29
T712	Three roots – same tooth	338.15	405.75	D - 29
T740	unilateral - closed	—	823.05	D - 19

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T741	unilateral - extraoral	—	823.05	D - 19
T742	unilateral - extraoral	—	823.05	D - 19
T743	unilateral - intraoral	—	823.05	D - 19
T744	unilateral	—	823.05	D - 19
T747	unilateral - intraoral	—	823.05	D - 19
T748	unilateral - extraoral	—	823.05	D - 19
T750	unilateral	—	823.05	D - 19
T751	unilateral	—	823.05	D - 19
T760	Dilation of salivary duct	—	77.10	D - 24
T761	Insertion of polyethylene tube in duct	—	77.10	D - 24
T800	Independent Consideration will be given to claims for other dental surgical procedures approved by the Ontario Dental Association but not listed specifically in this Schedule	I.C.	I.C.	D - 26
T809	Premium when non-elective surgical procedures commence between 5:00 p.m. and midnight, or on a Saturday, Sunday or holiday	30% of amt payable	30% of amt payable	D - 26
T810	Premium when non-elective surgical procedures commence between midnight and 7:00 a.m. any night of the week	50% of amt payable	50% of amt payable	D - 26
T811	*Premium for a consultation or visit between 5:00 p.m. and midnight, or on a Saturday, Sunday or holiday	30% of amt payable	30% of amt payable	D - 26
T812	*Premium for any consultation or visit to a patient in an intensive care facility (e.g., ICU or CCU)	30% of amt payable	30% of amt payable	D - 26
T813	*Premium for a consultation or visit between midnight and 7:00 a.m.	50% of amt payable	50% of amt payable	D - 27
T814	Premium for a consultation or visit between 5:00 p.m. and midnight, or on a Saturday, Sunday or holiday	30% of amt payable	30% of amt payable	D - 5
T815	Premium for any consultation or visit to a patient in an intensive care facility (e.g., ICU or CCU)	30% of amt payable	30% of amt payable	D - 5

SERVICES OF DENTISTS

Code	Description	D.D.S.	Spec	Page
T816	Premium for a consultation or visit between midnight and 7:00 a.m.	50% of amt payable	50% of amt payable	D - 5
T901	Removal of single erupted tooth - per quadrant	40.65	48.80	D - 31
T902	Removal of each additional erupted tooth in the same quadrant	21.05	25.25	D - 31
T903	Removal of each erupted tooth – complicated	95.75	114.85	D - 31
T904	Removal of each tooth covered by soft tissue	95.75	114.85	D - 31
T905	Removal of each impacted tooth, partial bony impaction	144.35	173.15	D - 31
T906	Removal of each impacted tooth, complete bony impaction	191.55	229.90	D - 31
T907	Removal of each impacted tooth, unusual position, age factor (incl. super-numerary)	219.25	262.95	D - 31
T908	with soft tissue coverage	82.70	99.10	D - 31
T909	with bone tissue coverage	95.75	114.85	D - 31
T910	Uncomplicated soft tissue coverage	36.95	44.35	D - 31
T911	Complicated hard tissue coverage	131.25	157.45	D - 31
T912	With orthodontic attachment	261.25	313.45	D - 31
T925	Maxillary labial frenectomy	70.45	84.55	D - 31
T926	Mandibular labial frenectomy	70.45	84.55	D - 31
T927	Maxillary Z frenoplasty	70.45	84.55	D - 31
T928	Mandibular Z frenoplasty	70.45	84.55	D - 31
T936	Alveoloplasty independent of tooth extraction - per quadrant	44.10	53.00	D - 31