

City of Hamilton  
Special Supports Program  
1550 Upper James St, Unit 14a  
Hamilton, ON L9B 2L6



Hamilton

# **Discretionary Adult Emergency Dental Treatment Plan**

For eligible:  
Ontario Works Adults  
Low Income Adults (Age 18-64)  
ODSP Adult Dependent

**Schedule of Benefits and Fees**

**Effective: November 1, 2024**

**November 1, 2024 Schedule of Dental Services and Fees for  
Discretionary Adult Emergency Dental Treatment Plan**

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**Who is Eligible?**

<b>Program</b>	<b>Patient to provide:</b>
<b>Ontario Works Adults</b> -age 18 years and over -resident of the City of Hamilton	Ontario Works Dental Benefit Eligibility Card or Proof of Assistance for the month of treatment. Proof of Assistance can be provided by: <ul style="list-style-type: none"> <li>• Producing a hard copy of the Proof of Assistance Screen in MyBenefits,</li> <li>• Displaying the Proof of Assistance Screen in MyBenefits,</li> <li>• Showing a screenshot of the Proof of Assistance Screen from MyBenefits.</li> </ul>
<b>Ontario Disability Support Program Dependent Adults</b> -age 18 years and over who are not covered on the ODSP Dental Card (i.e. not the ODSP applicant or spouse) -resident of the City of Hamilton	Dental Approval Letter that has been provided to the patient or directly to you by our office.
<b>Low Income Dental Program -</b> non- socially assisted patients -age 18 years to 64 years -resident of the City of Hamilton	Dental Approval Letter that has been provided to the patient or directly to you by our office.

**CONTACT INFORMATION**

<b>Dental Office</b> <b>Re: claims Inquiry</b>	<b>Special Supports Program</b> <b>Phone:</b> 905-546-2424 x 2219 <b>Fax:</b> 905-546-2256 <b>Email:</b> SSPC@hamilton.ca  <b>Mailing address:</b> <b>City of Hamilton, Special Supports Program Payment Clerk</b> <b>1550 Upper James St, Unit 14a</b> <b>Hamilton, ON L9B 2L6</b>
<b>Patient Inquiries</b>	<b>Ontario Works Dental Benefit Eligibility Card:</b> <ul style="list-style-type: none"> <li>• 905-546-4800 to request a card or to have one emailed to the dentist.</li> </ul> <b>Financial Eligibility for ODSP dependent adult and Low Income:</b> <ul style="list-style-type: none"> <li>• Special Supports Case Aide 905-546-2590</li> </ul>
<b>Dental and Denture website including fee guide</b>	<a href="http://www.hamilton.ca/support">www.hamilton.ca/support</a>

## ***November 1, 2024 Schedule of Dental Services and Fees for Discretionary Adult Emergency Dental Treatment Plan***

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### **Ineligible under this fee schedule?**

**The following patients are covered under the MCSS Schedule of Dental Services and Fees and “NOT” the Adult Discretionary Dental Plan**

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| <ul style="list-style-type: none"><li>• Ontario Works children (0-17 years) including children whose guardian receives Temporary Care Assistance under Ontario Works. These claims go to ACCERTA.</li></ul>  |
| <ul style="list-style-type: none"><li>• Ontario Disability Support Program recipients, their spouses and dependent children (0-17 years) and Children whose parent(s) receive Assistance for Children with Severe Disability (ACSD). These claims go to ACCERTA.</li></ul> |

### **What is NOT covered under this fee schedule**

Ontario Works Adults who require cleaning (not a covered service in this fee guide) can contact the City of Hamilton Public Health Dental Clinic at 905-546-2424 ext. 3789 to schedule an appointment.

### **Extra or Balance Billing**

Extra billing or balance billing is **NOT** permitted for services covered under this schedule. It is the responsibility of the treating dentist to discuss what is or is not covered under this schedule with their clients.

### **Specialist Fees**

Where a general dental practitioner has referred a patient to a specialist, the specialist will be reimbursed at the specialist rate provided that the proper procedure has been followed. Specialists must submit the name of the referring dentist on their claim form(s). A referral from the patient’s medical practitioner will be accepted. In this situation, the physician’s name and practice address should be submitted on the specialist’s claim form(s). Specialty fees are only paid to service providers that perform services within their specialty.

### **Coordination of Benefits**

Ontario Works is the second payer if client has private insurance.

Please complete a duplicate dental claim form and attach the Explanation of Benefits from the first payer. The maximum amount payable will not exceed the amounts shown in this schedule when combined with other plans.

Where a client has First Nations Inuit Health Branch (FNIHB) non-insured health benefits (NIHB), Ontario Works will be first payer.

**November 1, 2024 Schedule of Dental Services and Fees for  
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**Where and How Claims Should Be Submitted?**

City of Hamilton  
Special Supports Program  
Attention: Claims Payment  
**1550 Upper James St, Unit 14a,  
Hamilton, ON L9B 2L6**

- **ORIGINAL claim forms must be submitted by: email (preferred), fax or mail.**
- **Claims are to be sent in as treatment occurs. The only exception is for multiple appointment procedures, such as root canals, which should be submitted on completion of treatment.**
- **Ensure that your ODA/CDA approved claim form is completed fully and accurately, including signature of patient or guardian and the following sections:**
  - **Patient's name**
  - **Patient's address**
  - **Treating dentist's name**
  - **Unique identification number (UIN)**
  - **Office verification**
  - **Dental office address**
- **Dentists to visually verify eligibility by noting on the invoice that eligibility has been 'visually verified'.**
- **It is the patient's responsibility to provide his/her dental card, proof of assistance or approval letter to the dental practitioner, at the time of the appointment and it is the dental practitioner's responsibility to note that eligibility for Ontario Works was 'visually verified' on the claim.**
- **Dental Benefit Eligibility Card - Replacement:** If a patient is missing his/her dental card or approval letter, the patient must contact Ontario Works **prior to** receiving treatment at **905-546-4800** to request that a replacement dental card or approval letter be faxed or emailed to the dental practitioner **prior** to treatment.
- Alternatively, dentist can also email [OWClerkcentral@hamilton.ca](mailto:OWClerkcentral@hamilton.ca) directly to request a dental card. Please obtain consent for this information.

## **November 1, 2024 Schedule of Dental Services and Fees for Discretionary Adult Emergency Dental Treatment Plan**

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- Dentists who chose to see a patient without the dental card/proof of assistance/ approval letter are doing so at their own expense. For example: a patient may not be eligible for OW and/or not qualify for the services.
- Failure to properly submit a claim with all attachments, including a pre-approval form for a full mouth clearance, if applicable, will result in a denial of the claim by the City. The City of Hamilton assumes no responsibility for correcting a deficiency in the submission of a claim.

If you do not receive payment on submitted claims within 45 business days **please do not submit duplicate claim forms for payment. We ask that you please call ( 905) 546-2424, ext. 2219**, to verify whether your original claim was paid or received. If it was not received, instructions will be provided to you on what is necessary to have the claim paid as quickly as possible.

### **Year End**

- Each year the service providers will receive notice as to the last date claims will be accepted and honoured for payment.
- Once this date has passed, no claims from the previous year will be accepted and/or honoured for payment.

### **General Descriptions and Limitations of the Adult Dental Program**

- Pre-approvals will be honoured for 6 months from date of approval. Any claims submitted with expired pre-approvals will be paid in accordance with the fee guide..
- Treatment will be **per patient, per dental group, per address for all codes.**
- Treatment for **symptomatic emergency** dental situations only, involving pain, infection, trauma and/or pathology.
- Dentist can treat the **maximum of 4 symptomatic teeth per emergency or treatment visit** (any combination of fillings, root canals on the anterior front teeth only (1.3-2.3: 3.3-4.3) and/or extractions). Please see the remainder of the fee guide for additional limitations for each procedure.
- Eligible care is limited to appropriate treatment of the specific emergency situation of the symptomatic patient.

## **November 1, 2024 Schedule of Dental Services and Fees for Discretionary Adult Emergency Dental Treatment Plan**

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- The dental plan is intended to be an access to urgent dental care for eligible adults and is NOT for the ongoing treatment of basic dental care.
- **Preauthorization:**  
Preauthorization is only accepted/required for **full mouth clearance:**
  - Requests can be submitted by mail, fax or email at [specialsupportsinvoices@hamilton.ca](mailto:specialsupportsinvoices@hamilton.ca)
  - Please include the following with your request:
    1. An estimate showing all procedure codes and fees.
    2. Written explanation regarding treatment plan for dentures.
    3. Note that the dental card, proof of assistance or eligibility letter has been 'visually verified'.
  - Any pre-authorization approvals issued will be valid for 6 months from the date of approval.
  - **A copy of the pre-authorization approval form is required with each claim submitted for payment.**
- **No provision for treatment of primary teeth.**

### **How will notification of approval be sent?**

Paid Payment Approved Invoice Information

Dentist will receive by password protected email -with detailed information on the approved amounts and codes..

Dentist can chose to opt out of email and receive the paid payment information approved invoice through regular mail.

Contact [SSPC@hamilton.ca](mailto:SSPC@hamilton.ca) for more information.

**November 1, 2024 Schedule of Dental Services and Fees for  
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**Examinations**

Procedure	Description	G.P.	S.P.	Limit
01205	Examination and diagnosis for the investigation of discomfort and/or infection in a localized area	19.00	22.81	<b>New: No limits to emergency exams</b>

**Radiographs, Intraoral**

Procedure	Description	G.P.	S.P.	Limit
<b>Radiographs, Intraoral, Periapical</b>				Periapical films are paid <b>cumulatively</b> up to the maximum payable of five (5) per twelve (12) month <b>calendar year</b> to a maximum of \$27.02 for general practitioners and \$32.42 for Specialists.
02111	single film	13.35	16.02	
02112	two films	16.33	19.60	
02113	three films	20.12	24.14	
02114	four films	22.52	27.03	
02115	five films	27.02	32.42	
<b>Radiographs, Intraoral, Bitewing</b>				Each bitewing counts as two (2) periapicals
02141	single film	13.35	16.02	
02142	two films	16.33	19.60	

**Panoramic**

Procedure	Description	G.P.	S.P.	Limit
<b>Radiographs, Panoramic</b>				One allowed every thirty-six (36) months per patient.
02601	single film	31.54	37.85	



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**Test/Analysis and Laboratory Examination and Diagnosis**

Procedure	Description	G.P.	S.P.	Limit
<b>Test/Analysis, Histological, Soft Tissue (Technical Procedure Only)</b>				
04311	Biopsy, Soft Tissue - by puncture + L	38.01	45.61	
04312	Biopsy, Soft Tissue - by incision + L	38.01	45.61	
<b>Test/Analysis, Histological, Hard Tissue (Technical Procedure Only)</b>				
04321	Biopsy, Hard Tissue - by puncture + L	88.69	106.42	
04322	Biopsy, Hard Tissue - by incision + L	88.69	106.42	

**Restorative Services**

*Treatment on retained primary teeth is not a covered service*

**Note: A maximum of four teeth in total may be treated per emergency (any combination of restorations, root canals (1.3-2.3: 3.3-4.3) and/or extractions)**

Procedure	Description	G.P.	S.P.	Limit
<b>Caries/Trauma/Pain Control (removal of carious lesions or existing restorations and placement of sedative / protective dressings, includes pulp caps when necessary, as a separate procedure)</b>				Sedative dressing allowed only once per tooth.  Six (6) weeks must elapse between the placement of the sedative and the placement of the permanent restoration in order for both services to be covered.
20111	First tooth	31.68	38.01	
20119	Each additional tooth, same quadrant	31.68	38.01	
<b>Caries/Trauma/Pain Control (removal of carious lesions or existing restorations and placement of sedative / protective dressings, includes pulp caps when necessary and the use of a band for retention and support, as a separate procedure)</b>				
20121	First tooth	31.68	38.01	
20129	Each additional tooth, same quadrant	31.68	38.01	
<b>Trauma Control, Smoothing of Fractured Surfaces per tooth</b>				
20131	First tooth	21.98	26.38	
20139	Each additional tooth, same quadrant	21.98	26.38	

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**Amalgam restorations - permanent bicuspid and anterior teeth, non-bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Amalgam, Non-bonded, Permanent Bicuspids and Anteriors</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
21211	One surface	25.34	30.41	
21212	Two surfaces	55.49	66.59	
21213	Three surfaces	63.35	76.02	
21214	Four surfaces	76.02	91.22	
21215	Five surfaces or maximum surfaces per tooth	76.02	91.22	

**Amalgam restorations - permanent molar teeth, non-bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Amalgam, Non-bonded, Permanent Molars</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
21221	One surface	31.68	38.01	
21222	Two surfaces	63.35	76.02	
21223	Three surfaces	79.32	95.17	
21224	Four surfaces	79.32	95.17	
21225	Five surfaces or maximum surfaces per tooth	79.32	95.17	

**Amalgam restorations - permanent bicuspid and anterior teeth, bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Amalgam, Bonded, Permanent Bicuspids and Anteriors</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
21231	One surface	25.34	30.41	
21232	Two surfaces	55.49	66.59	
21233	Three surfaces	63.35	76.02	
21234	Four surfaces	76.02	91.22	
21235	Five surfaces or maximum surfaces per tooth	76.02	91.22	

**Amalgam restorations - permanent molar teeth, bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Amalgam, Bonded, Permanent Molars</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in twenty-four (24) month period per patient.
21241	One surface	31.68	38.01	
21242	Two surfaces	63.35	76.02	
21243	Three surfaces	79.32	95.17	
21244	Four surfaces	79.32	95.17	
21245	Five surfaces or maximum surfaces per tooth	79.32	95.17	

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**Retentive Pins**

Procedure	Description	G.P.	S.P.	Limit
<b>Pins, Retentive per restoration (for amalgams and tooth coloured restorations)</b>				Pins must be combined with restoration on same tooth, same day. Maximum of two (2) pins per tooth, within a twenty-four (24) month period per patient.
21401	One pin	10.91	13.08	
21402	Two pins	18.20	21.83	

**Tooth colored/plastic restorations - permanent anterior teeth, non-bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Tooth Coloured Permanent Anteriors Non Bonded Technique</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
23101	One surface	44.34	53.22	
23102	Two surfaces	57.01	68.42	
23103	Three surfaces	87.17	104.59	
23104	Four surfaces	87.17	104.59	
23105	Five surfaces or maximum surfaces per tooth	97.56	117.07	

**Tooth colored/plastic restorations - permanent bicuspid teeth, non-bonded**

Procedure Description	G.P.	S.P.	Limit	
<b>Restorations, Tooth Coloured/Plastic with/without Silver Filings, Permanent Posteriors, Non-Bonded - Permanent Bicuspids</b>			Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.	
23211	One surface	25.34		30.41
23212	Two surfaces	55.49		66.59
23213	Three surfaces	63.35		76.02
23214	Four surfaces	76.02		91.22
23215	Five surfaces or maximum surfaces per tooth	76.02		91.22

**November 1, 2024, Schedule of Dental Services and Fees for  
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**Tooth colored/plastic restorations - permanent molar teeth, non-bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Tooth Coloured/Plastic with/without Silver Filings, Permanent Posteriors, Non-Bonded - Permanent Molars</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
23221	One surface	31.68	38.01	
23222	Two surfaces	63.35	76.02	
23223	Three surfaces	79.32	95.17	
23224	Four surfaces	79.32	95.17	
23225	Five surfaces or maximum surfaces per tooth	79.32	95.17	

**Tooth colored/plastic restorations - permanent anterior teeth, bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Permanent Anteriors, Bonded Technique (not to be used for Veneer Applications or Diastema Closure)</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
23111	One surface	50.68	60.81	
23112	Two surfaces (continuous)	63.35	76.02	
23113	Three surfaces (continuous)	95.02	114.03	
23114	Four surfaces (continuous)	95.02	114.03	
23115	Five surfaces or maximum surfaces per tooth	106.42	127.71	

**Tooth colored/plastic restorations - permanent bicuspid teeth, bonded**

Procedure	Description	G.P.	S.P.	Limit
<b>Restorations, Tooth Coloured, Permanent Posteriors, Bonded Permanent Bicuspid</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
23311	One surface	25.34	30.41	
23312	Two surfaces (continuous)	55.49	66.59	
23313	Three surfaces (continuous)	63.35	76.02	
23314	Four surfaces (continuous)	76.02	91.22	
23315	Five surfaces or maximum surfaces per tooth	76.02	91.22	

**November 1, 2024, Schedule of Dental Services and Fees for  
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**Tooth colored/plastic restorations - permanent molar teeth, bonded**

<b>Procedure</b>	<b>Description</b>	<b>G.P.</b>	<b>S.P.</b>	<b>Limit</b>
<b>Restorations, Tooth Coloured, Permanent Posteriors, Bonded Permanent Molars</b>				Fees payable are determined by counting the total number of surfaces restored to a maximum of <b>five (5) surfaces per tooth</b> . Each surface will be paid once in a twenty-four (24) month period per patient.
23321	One surface	31.66	38.01	
23322	Two surfaces (continuous)	63.35	76.02	
23323	Three surfaces (continuous)	79.32	95.17	
23324	Four surfaces (continuous)	79.32	95.17	
23325	Five surfaces or maximum surfaces per tooth	79.32	95.17	

**November 1, 2024, Schedule of Dental Services and Fees for  
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**Endodontic Services**

**Note: A maximum of four teeth in total may be treated per emergency (any combination of restorations, root canals (1.3-2.3: 3.3-4.3) and/or extractions)**

Procedure	Description	G.P.	S.P.	Limit
<b>Pulpotomy, Permanent Teeth (as a separate emergency procedure)</b>				Two (2) root canals are allowed within a twelve (12) months.
32221	Anterior teeth	63.35	76.02	
<b>PULPECTOMY</b> (An emergency procedure and/or as a pre-emptive phase to the preparation of the root canal system for obturation)				Fees paid for previous pulpectomies/pulpotomies will be deducted from fees claimed for completed root canal treatment or extractions of the same tooth within twelve (12) months.  Pulpectomies/pulpotomies and root canal therapy are covered expenses for the permanent upper/lower anterior teeth only (1.3-2.3: 3.3-4.3).
<b>Pulpectomy, Permanent Teeth <u>ONLY</u></b>				
32311	one canal	63.35	76.02	
32312	two canals	76.02	91.22	
32313	three canals	114.03	136.83	
<b>Root Canals, Permanent Teeth <u>ONLY</u>, One Canal</b>				
33111	one canal	253.39	304.06	
<b>Root Canals, Permanent Teeth <u>ONLY</u>, Two Canals</b>				
33121	two canals	316.74	380.08	
<b>Root Canals, Permanent Teeth <u>ONLY</u>, Three Canals</b>				
33131	three canals	494.11	592.92	

**Periodontal Services**

Procedure	Description	G.P.	S.P.	Limit
<b>Periodontal Abscess or Pericoronitis, may include one or more of the following procedures: Lancing, Scaling, Curettage, Surgery or Medication</b>				Maximum one unit per twelve (12) month calendar year per patient.
42831	One unit of time	38.01	45.61	

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**Oral and Maxillofacial Surgery**

**Note: A maximum of four teeth in total may be treated per emergency (any combination of restorations, root canals (1.3-2.3: 3.3-4.3) and/or extractions)**

**For full mouth clearance see pre-approval information on page 7 of this fee guide**

Procedure	Description	G.P.	S.P.	Limit
<b>Removals, Erupted Teeth, Uncomplicated</b>				Any service related to space maintenance, crowding, and/or orthodontics is <b>NOT</b> covered.  NOTE: When a tooth is extracted within twelve (12) months of being restored and/or endodontically treated, payment is limited to the greater of the fees payable for the extraction of the root canal and/or restoration.
71101	Single Tooth, Uncomplicated	38.01	45.61	
71109	Each additional tooth in same quadrant, same appointment	19.00	22.81	
<b>Removals, Erupted Complicated</b>				
71201	Odontectomy, (extraction), Erupted Tooth, Surgical Approach, Requiring Surgical Flap and/or Sectioning of Tooth	88.69	106.42	
71209	Each additional tooth, same quadrant	88.69	106.42	
<b>Removals, Impaction, Requiring Incision of Overlying Soft Tissue and Removal of Tooth</b>				
72111	Single tooth	88.69	106.42	
72119	Each additional tooth, same quadrant	88.69	106.42	
<b>Removals, Impactions, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap and EITHER Removal of Bone and Tooth OR Sectioning and Removal of Tooth</b>				
72211	Single tooth	133.03	159.64	
72219	Each additional tooth, same quadrant	133.03	159.64	
<b>Removals, Impactions, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap, Removal of Bone AND Sectioning and Removal of Tooth</b>				
72221	Single tooth	177.37	212.84	
72229	Each additional tooth, same quadrant	177.37	212.84	
<b>Removals, Impactions, Requiring Incision of Overlying Soft Tissue, Elevation of a Flap, Removal of Bone AND/OR Sectioning of the Tooth for Removal AND/OR presents Unusual Difficulties and Circumstances</b>				
72231	Single tooth	202.71	243.25	
72239	Each additional tooth, same quadrant	202.71	243.25	
<b>Removals, Residual Roots, Erupted</b>				
72311	First tooth	38.01	45.61	
72319	Each additional tooth, same quadrant	38.01	45.61	

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Removals, Residual Roots, Soft Tissue Coverage				Limit
72321		76.02	91.22	
72329	Each additional tooth, same quadrant	76.02	91.22	
Removals, Residual Roots, Bone Tissue Coverage				Limit
72331	First tooth	88.69	106.42	
72339	Each additional tooth, same quadrant	88.69	106.42	

**Surgical incision**

Procedure	Description	G.P.	S.P.	Limit
Surgical Incision and Drainage and/or Exploration, Intraoral Soft Tissue				Limit
75111	Intraoral, Surgical Exploration, Soft Tissue	68.01	81.61	
75112	Intraoral, Abscess, Soft Tissue	68.01	81.61	

**Avulsed tooth/teeth**

Procedure	Description	G.P.	S.P.	Limit
Replantation, Avulsed Tooth/Teeth (including splinting)				Limit
76941	First tooth	88.69	106.42	
76949	Each additional tooth	88.69	106.42	
Repositioning of Traumatically Displaced Teeth				Limit
76951	One unit of time	31.68	38.01	

**Adjunctive General Services**

Procedure	Description	G.P.	S.P.	Limit
<b>Nitrous Oxide Time is measured from the placement of the inhalation device and terminates with the removal of the inhalation device</b>				Nitrous Oxide is limited to four (4) units in a twelve (12) month calendar year per patient.
92411	One unit	16.98	20.38	
92412	Two units	29.66	35.58	
92413	Three units	42.34	50.81	
92414	Four units	55.01	66.00	