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**INTRODUCTION**

Approximately once a year, the Centers for Medicare and Medicaid Services (CMS) issues to states a Healthcare Common Procedure Coding System Transaction List that includes additions to and deletions from this schedule of codes. Providers will be notified of all such additions and deletions through the regular mail, by a revised Allowances for Dental Services or by revised billing instructions.

Providers are requested to bill their usual and customary charge for all dental services.

In accordance with policy, the MaineCare Program will continue to pay the lowest of the following:

1. The fee established by MaineCare and noted in the “Maximum Allowance” column of the fee schedule;
2. The lowest amount allowed by Medicare; or
3. The provider's usual and customary charge.

**DEFINITIONS**

The following are definitions for several terms that are frequently used throughout this publication.

**By Report:** This notation in the Maximum Allowances column indicates that the fee for the procedure is to be determined based upon an operative report. Such a procedure would be one that is rarely provided, unusual, variable, or newly developed. Pertinent information contained in the report, which must accompany the claim, should include an adequate definition or description of the nature, extent, need for the procedure, time, effort, and equipment necessary to provide the service. Additional information, such as complexity of the symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care may also be included. If there is a maximum amount listed, then reimbursement is not to exceed the maximum amount listed.

**Consultation:** **Consultation** is an opinion rendered by a dentist whose advice is requested by another dentist or physician for the further

**DEFINITIONS (cont.)**

evaluation and/or management of the patient. When the consulting dentist assumes responsibility for the continuing care of the patient, any subsequent service rendered by him/her will cease to be a consultation. The Department requires a written report to be sent to the requesting practitioner.

Referral: A referral is the transfer of the total or specific care of a patient from one dentist to another and does not constitute a consultation.

**MODIFIERS**

For modifier usage, please see the most current dental billing instructions supplied by the Office of MaineCare Services.

**ELEMENTS OF HCPCS/CDT CODING**

Codes for services are arranged in tabular form. Specific information regarding each code is given under the following headings:

1. Procedure code: The actual CDT procedure code will be listed in this column.
2. CDT Description: The narrative description of the procedure code will be listed in this column.
3. Covered Service: This column identifies whether a particular service is covered under the MaineCare program, indicated by a "YES," or not covered, indicated by a "NO." It is further divided into two (2) sub columns indicating services for those under 21 and all ICF-MR residents (with the exception of orthodontics which is not covered for residents of an ICF-MR) and the second column, indicating coverage for adults 21 and over when allowed under Section 25, Dental Services, of the MaineCare Benefits Manual, Chapter II, 25.04, Special Requirements for Adult Services.
4. Prior Authorization Required: Some procedures require authorization prior to the performance of a service in order for MaineCare to allow reimbursement. If prior authorization is required, it will be indicated by the message "YES" in these columns. MaineCare will not reimburse a provider for a service that requires prior authorization if the service is provided

**ELEMENTS OF HCPCS/CDT CODING (cont.)**

before authorization is granted. Again this column is subdivided into requirements for the same two populations as column 3.

5. Additional Limits: This column lists any additional limitations affecting reimbursement for services. Examples include reimbursement frequency or the passage of time required before further reimbursement. This column is intended to parallel restrictions also described in Section 25, Dental Services, of the MaineCare Benefits Manual, Chapter II. Codes also allowed for denturists and hygienists will be indicated in this column. If reimbursement is not available for a particular procedure "Not covered" will be listed in this column. MaineCare will not reimburse for non-covered services. Providers may bill members for non-covered services only if, prior to the provision of the service, the provider has clearly explained to the member that MaineCare does not cover the service and that the member will be responsible for the payment. Providers must document in the member's record that the member was told, prior to provision, that the service was not a MaineCare covered service and that the member is responsible for the payment.
6. Maximum Allowance: This column will show the maximum reimbursement that MaineCare will allow for a particular procedure. MaineCare will pay the lowest of this allowance, or the dentist's/denturist's usual and customary fee, or the lowest amount allowed by Medicare.

Some procedures are manually priced, or priced using a specific report for the service rendered. If a service is priced this way, the message "BY REPORT" will appear in the Maximum Allowance column. All BY REPORT codes suspend for a review, which interrupts the automatic claims processing and slows payment to the provider. A complete report must accompany any claim using a BY REPORT code. Please note that occasionally a description will include the term "by report." Such a designation is part of the code description and does not indicate how MaineCare will reimburse the procedure.

Every effort should be made to utilize the correct code. Billing should be done in accordance with the CDT guidelines and Chapter II and Chapter III, Section 25.

**RATES ARE EFFECTIVE 08/09/2010**

Section 25

ALLOWANCES FOR DENTAL SERVICES

Established: 6-29-79

Proc. Code	Description	Covered Service Age/ICF-MR		Prior Authorization required		Additional Limits	Max Allow
		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
<b>I. DIAGNOSTIC</b>							
<b>CLINICAL ORAL EXAMINATIONS</b>							
D0120	Periodic Oral Evaluation	YES	NO	NO		One every six months	\$30.00
D0140	Limited Oral Evaluation (Problem Focused)	YES	YES	NO	NO	Once per episode per provider. Denturists may also use this code.	\$20.00
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver	YES	NO			One every six months	\$20.00
D0150	Comprehensive Oral Evaluation	YES	NO	NO			\$55.00
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, by Report	YES	NO	NO			\$25.00
D0170	Re-evaluation – Limited, Problem Focused, (established patient, not post-operative visit)	YES	NO	NO			\$20.00
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	NO	NO			Not Covered	
<b>RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)</b>							
D0210	Intraoral - Complete Series, (including bitewings)	YES	YES	NO	NO	Must include 12 periapical plus 2 posterior bitewings, allowed only once every 3 years, except as part of approved orthodontics	\$43.50

		Covered Service Age/ICF-MR	Prior Authorization required		
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Orthodontics are not covered services for residents of Intermediate Care Facilities for the Mentally Retarded. \* MaineCare will cover all medically necessary dental services for members under age twenty-one (21) pursuant to Section 94 of the MaineCare Benefits Manual, Prevention, Health Promotion and Optional Treatment Services (formerly EPSDT).

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D0220	Intraoral - Periapical, First Film	YES	YES	NO	NO		\$8.00
D0230	Intraoral - Periapical, Each Additional Film	YES	YES	NO	NO		\$6.50
D0240	Intraoral - Occlusal Film	YES	YES	NO	NO		\$10.00
D0250	Extraoral - First Film	YES	YES	NO	NO		\$9.00
D0260	Extraoral - Each Additional Film	YES	YES	NO	NO		\$9.00
D0270	Bitewing - Single Film	YES	YES	NO	NO	Posterior bitewings alone are once per calendar year	\$8.00
D0272	Bitewings - Two Films	YES	YES	NO	NO	Posterior bitewings alone are once per calendar year	\$15.00
D0273	Bitewings - Three Films	YES	YES	NO	NO	Posterior bitewings alone are once per calendar year	\$17.50
D0274	Bitewings - Four Films	YES	YES	NO	NO	Posterior bitewings alone are once per calendar year	\$20.00
D0277	Vertical Bitewings – 7-8 Films	YES	YES	NO	NO		\$30.00
D0290	Posterior-Anterior or Lateral Skull and Facial Bones, Survey Film	YES	YES	NO	NO		\$25.00
D0310	Sialography	YES	YES	NO	NO	For gland or duct, not allowed for salivary stone	\$30.00
D0320	Temporomandibular Joint Arthrogram, Including Injection	YES	YES	NO	NO	Right and left trans-cranial films in open, closed, and rest required	\$35.00
D0321	Other Temporomandibular Joint Films by Report	YES	YES	YES	YES		\$60.00
D0322	Tomographic Survey	NO	NO			Not Covered	
D0330	Panoramic Film	YES	YES	NO	NO	Billable with the Pre-Orthodontic visit.	\$43.00

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D0340	Cephalometric Film	NO	NO			Included as part of "records" in comprehensive orthodontics, not covered separately; hospitals use revenue codes to bill.	
D0350	Oral/Facial Photographic Images	NO	NO			Not Covered	
D0360	Cone Beam Ct - Craniofacial Data Capture	NO	NO			Not Covered	
D0362	Cone Beam - Two-dimensional Image Reconstruction Using Existing Data, Includes Multiple Images	NO	NO			Not Covered	
D0363	Cone Beam - Three-dimensional Image Reconstruction Using Existing Data, Includes Multiple Images	NO	NO			Not Covered	
<b>TEST AND EXAMINATIONS</b>							
D0415	Collection of Microorganisms for Culture and Sensitivity	NO	NO			Not Covered	
D0416	Viral Culture	NO	NO			Not Covered	
D0417	Collection and preparation of saliva sample	NO	NO			Not Covered	
D0418	Analysis of saliva sample	NO	NO			Not Covered	
D0421	Genetic Test for Susceptibility to Oral Diseases	NO	NO			Not Covered	
D0425	Caries Susceptibility Test	NO	NO			Not Covered	
D0431	Adjunctive Pre-diagnostic Test that Aids in Detection of Mucosal Abnormalities including Premalignant and Malignant Lesions, not to include Cytology or Biopsy Procedures	NO	NO			Not Covered	
D0460	Pulp Vitality Test	YES	YES	NO	NO	Requires documentation in member's chart of the vitality of the tooth	\$10.00
D0470	Diagnostic Casts	YES	NO	NO			\$32.00
<b>ORAL PATHOLOGY LABORATORY CODES</b>							

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D0472	Accession of Tissue, Gross Examination, Preparation and Transmission of Written Report	NO	NO			Not Covered	
D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	NO	NO			Not Covered	
D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report	NO	NO			Not Covered	
D0475	Decalcification Procedure	NO	NO			Not Covered	
D0476	Special Stains for Microorganisms	NO	NO			Not Covered	
D0477	Special Stains, not for Microorganisms	NO	NO			Not Covered	
D0478	Immunohistochemical Stains	NO	NO			Not Covered	
D0479	Tissue in-situ Hybridization, including Interpretation	NO	NO			Not Covered	
D0480	Accession of Exfoliative Cytologic Smears, Microscopic Examination, Preparation and Transmission of Written Report	NO	NO			Not Covered	
D0481	Electron Microscopy-Diagnostic	NO	NO			Not Covered	
D0482	Direct Immunofluorescence	NO	NO			Not Covered	
D0483	Indirect Immunofluorescence	NO	NO			Not Covered	
D0484	Consultation on Slides Prepared Elsewhere	NO	NO			Not Covered	
D0485	Consultation, Including Preparation of Slides from Biopsy Material Supplied by Referring Source	NO	NO			Not Covered	
D0486	Accession of Brush Biopsy Sample, Microscopic Examination, Preparation and Transmission of Written Report	NO	NO			Not Covered	
D0502	Other Oral Pathology Procedures, by Report	NO	NO			Not Covered	

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D0999	Unspecified Diagnostic Procedure, by Report	NO	NO			Not Covered	
<b>II. PREVENTIVE</b>							
<b>DENTAL PROPHYLAXIS</b>							
D1110	Prophylaxis – Adult	YES	YES	NO	YES	Limited to age 13 and over, more than once every six months requires Prior Authorization, includes oral hygiene instruction. Hygienists may use this code.	\$40.00
D1120	Prophylaxis – Child	YES	NO	NO		More than once every six months requires Prior Authorization, includes oral hygiene instruction. Hygienists may use this code.	\$30.00

**TOPICAL FLUORIDE TREATMENTS (Office Procedure)**

D1203	Topical Application of Fluoride - Child (prophylaxis not included)	YES	NO	NO		Twice per calendar year/three per calendar year if high caries rate or new restorations within 18 months as documented in record. Includes through age 20. Hygienists may use this code.	\$12.00
D1204	Topical Application of Fluoride - Adult (prophylaxis not included)	NO	NO			Not Covered	

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients	YES	NO	NO		Twice per calendar year/three per calendar year if high caries rate or new restorations within 18 months as documented in record. Includes through age 20 Hygienists may use this code.	\$12.00
<b>OTHER PREVENTIVE SERVICES</b>							
D1310	Nutritional Counseling for Control of Dental Disease	NO	NO			Not Covered	
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease	YES	NO	NO		Limited to age 8 – 20, once per year, per member, per general dentist	\$20.00
D1330	Oral Hygiene Instructions	YES	NO	NO		Three times per calendar year. Not billable the same day as prophylaxis. Hygienists may use this code.	\$13.00
D1351	Sealant – Per Tooth	YES	NO	NO		Permanent teeth: once every three calendar years per provider per tooth. Primary teeth: once per lifetime of tooth unless documented good cause. Hygienists may use this code.	\$16.00
<b>SPACE MAINTENANCE (PASSIVE APPLIANCES)</b>							
D1510	Space Maintainer, Fixed Unilateral	YES	NO	NO			\$95.00
D1515	Space Maintainer, Fixed Bilateral	YES	NO	NO			\$220.00
D1520	Space Maintainer, Removable Unilateral	NO	NO			Not Covered	
D1525	Space Maintainer, Removable Bilateral	YES	NO	NO			\$110.00

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D1550	Re-cementation of Space Maintainer	YES	NO	NO			\$22.50
D1555	Removal of Fixed Space Maintainer	YES	NO	NO			\$50.00
<b>III. RESTORATIVE</b>							
<b>AMALGAM RESTORATIONS (INCLUDING POLISHING)</b>							
D2140	Amalgam - One Surfaces, Primary or Permanent	YES	YES	NO	NO		\$38.00
D2150	Amalgam - Two Surfaces, Primary or Permanent	YES	YES	NO	NO		\$48.00
D2160	Amalgam - Three Surfaces, Primary or Permanent	YES	YES	NO	NO		\$81.00
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	YES	YES	NO	NO		\$97.00

<b>RESIN-BASED COMPOSITE RESTORATIONS – DIRECT</b>							
D2330	Resin-Based Composite - One Surface, Anterior	YES	YES	NO	NO		\$68.00
D2331	Resin-Based Composite - Two Surfaces, Anterior	YES	YES	NO	NO		\$91.00
D2332	Resin-Based Composite - Three Surfaces, Anterior	YES	YES	NO	NO		\$109.00
D2335	Resin-Based Composite, - Four or More Surfaces or Involving Incisal Angle (Anterior)	YES	YES	NO	NO		\$111.00
D2390	Resin-Based Composite Crown, Anterior	YES	YES	NO	NO		\$300.00
D2391	Resin-Based Composite – One Surface, Posterior	YES	YES	NO	NO		\$68.00
D2392	Resin-Based Composite – Two Surfaces, Posterior	YES	YES	NO	NO		\$90.00
D2393	Resin-Based Composite – Three Surfaces, Posterior	YES	YES	NO	NO		\$103.00
D2394	Resin-Based Composite – Four or More Surfaces, Posterior	YES	YES	NO	NO		\$111.00

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
<b>GOLD FOIL RESTORATIONS</b>							
D2410	Gold Foil - One Surface	NO	NO			Not Covered	
D2420	Gold Foil - Two Surfaces	NO	NO			Not Covered	
D2430	Gold Foil - Three Surfaces	NO	NO			Not Covered	
<b>INLAY/ONLAY RESTORATIONS</b>							
D2510	Inlay - Metallic-One Surface	NO	NO			Not Covered	
D2520	Inlay - Metallic-Two Surfaces	NO	NO			Not Covered	
D2530	Inlay - Metallic-Three or More Surfaces	NO	NO			Not Covered	
D2542	Onlay - Metallic-Two Surfaces	NO	NO			Not Covered	
D2543	Onlay - Metallic - Three Surfaces	NO	NO			Not Covered	
D2544	Onlay - Metallic - Four or More Surfaces	NO	NO			Not Covered	
D2610	Inlay - Porcelain/Ceramic - One Surface	NO	NO			Not Covered	
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	NO	NO			Not Covered	
D2630	Inlay - Porcelain/Ceramic - Three or More Surfaces	NO	NO			Not Covered	
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	NO	NO			Not Covered	
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	NO	NO			Not Covered	
D2644	Onlay - Porcelain/Ceramic - Four or More Surfaces	NO	NO			Not Covered	
D2650	Inlay - Resin-Based Composite - One Surface	NO	NO			Not Covered	
D2651	Inlay - Resin-Based Composite - Two Surfaces	NO	NO			Not Covered	
D2652	Inlay - Resin-Based Composite - Three or More Surfaces	NO	NO			Not Covered	
D2662	Onlay - Resin-Based Composite - Two Surfaces	NO	NO			Not Covered	
D2663	Onlay - Resin-Based Composite - Three Surfaces	NO	NO			Not Covered	
D2664	Onlay - Resin-Based Composite - Four or More Surfaces	NO	NO			Not Covered	

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<b>CROWNS - SINGLE RESTORATIONS ONLY</b>							
D2710	Crown - Resin Based Composite (indirect)	YES	YES	NO	NO		\$300.00
D2712	Crown-3/4 Resin-Based Composite (indirect)	NO	NO			Not Covered	
D2720	Crown - Resin with High Noble Metal	NO	NO			Not Covered	
D2721	Crown - Resin with Predominantly Base Metal	NO	NO			Not Covered	
D2722	Crown - Resin with Noble Metal	NO	NO			Not Covered	
D2740	Crown – Porcelain/Ceramic Substrate	NO	NO			Not Covered	
D2750	Crown – Porcelain Fused to High Noble Metal	NO	NO			Not Covered	
D2751	Crown - Porcelain Fused to Predominantly Base Metal	NO	NO			Not Covered	
D2752	Crown – Porcelain Fused to Noble Metal	NO	NO			Not Covered	
D2780	Crown - 3/4 Cast High Noble Metal	NO	NO			Not Covered	
D2781	Crown-3/4 Cast Predominantly Base Metal	NO	NO			Not Covered	
D2782	Crown - 3/4 Cast Noble Metal	NO	NO			Not Covered	
D2783	Crown - 3/4 Porcelain/Ceramic	NO	NO			Not Covered	
D2790	Crown - Full Cast High Noble Metal	NO	NO			Not Covered	
D2791	Crown - Full Cast Predominantly Base Metal	NO	NO			Not Covered	
D2792	Crown - Full Cast Noble Metal	NO	NO			Not Covered	
D2794	Crown - Titanium	NO	NO			Not Covered	
D2799	Provisional Crown	NO	NO			Not Covered	
<b>OTHER RESTORATIVE SERVICES</b>							
D2910	Recement Inlay, Onlay, or Partial Coverage Restoration	NO	NO			Not Covered	
D2915	Recement Cast or Prefabricated Post and Core	YES	YES	NO	NO		\$30.00
D2920	Recement Crown	YES	YES	NO	NO		\$30.00
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	YES	NO	NO			\$120.00

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D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	YES	YES	NO	NO		\$120.00
D2932	Prefabricated Resin Crown	YES	YES	NO	NO	Limited to Primary and Permanent Anteriors	\$120.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	NO	NO			Not Covered	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	NO	NO			Not Covered	
D2940	Sedative Filling	YES	YES	NO	NO	Not covered with Pulpotomy. Limited to general dentists.	\$30.00
D2950	Core Buildup, Including Any Pins	YES	YES	NO	NO		\$150.00
D2951	Pin Retention - Per Tooth, in Addition to Restoration	YES	YES	NO	NO		\$19.00
D2952	Post & Core in Addition to Crown, Indirectly Fabricated	NO	NO			Not Covered	
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	NO	NO			Not Covered	
D2954	Prefabricated Post & Core in Addition to Crown	YES	YES	NO	NO	Permanent tooth only	\$95.00
D2955	Post Removal (Not in conjunction with endodontic therapy)	NO	NO			Not Covered	
D2957	Each Additional Prefabricated Post-Same Tooth, Use with D2954	YES	YES	NO	NO	Permanent tooth only	\$47.50
D2960	Labial Veneer (resin laminate)-Chairside	NO	NO			Not Covered	
D2961	Labial Veneer (resin laminate)-Laboratory	NO	NO			Not Covered	
D2962	Labial Veneer (porcelain laminate)-Laboratory	NO	NO			Not Covered	
D2970	Temporary Crown (Fractured Tooth)	YES	YES	NO	NO		\$40.00
D2971	Additional Procedures to Construct New Crown under Existing Partial Denture Framework	NO	NO			Not Covered	
D2975	Coping	NO	NO			Not Covered	
D2980	Crown Repair, by Report	YES	YES	NO	NO		\$34.00
D2999	Unspecified Restorative Procedure, by Report	YES	YES	YES	YES	Ex: Temp. crown – fractured tooth	By Report

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ALLOWANCES FOR DENTAL SERVICES

Established: 6-29-79

Proc. Code	Description	Covered Service Age/ICF-MR		Prior Authorization required		Additional Limits	Max Allow
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<b>IV. ENDODONTICS</b>							
<b>PULP CAPPING</b>							
D3110	Pulp Cap - Direct (excluding final restoration)	YES	YES	NO	NO	Not covered on primary teeth with more than 2/3 of root structure reabsorbed	\$7.00
D3120	Pulp Cap – Indirect (excluding final restoration)	YES	YES	NO	NO		\$19.00
<b>PULPOTOMY</b>							
D3220	Therapeutic Pulpotomy (excluding final restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament	YES	YES	NO	NO	Not separately reimbursable to same provider as part of root canal in same period of treatment	\$50.00
D3221	Pulpal Debridement, Primary and Permanent Teeth	NO	NO			Not Covered	
D3222	Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development	YES	YES			Not separately reimbursable to same provider as part of root canal in same period of treatment	\$50.00
<b>ENDODONTIC THERAPY ON PRIMARY TEETH</b>							
D3230	Pulpal Therapy (resorbable filling) - Anterior, Primary Tooth (excluding final restoration)	NO	NO			Not Covered	
D3240	Pulpal Therapy (resorbable filling) - Posterior, Primary Tooth (excluding final restoration)	NO	NO			Not Covered	
<b>ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)</b>							

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D3310	Anterior (excluding final restoration)	YES	YES	NO	NO	Only on permanent teeth with favorable prognosis for dentition	\$220.00
D3320	Bicuspid (excluding final restoration)	YES	YES	NO	NO		\$251.00
D3330	Molar (excluding final restoration)	YES	YES	NO	NO		\$338.00
D3331	Treatment of Root Canal Obstruction; Non-Surgical Access	NO	NO			Not Covered	
D3332	Incomplete Endodontic Therapy; Inoperable, unrestorable or Fractured Tooth	NO	NO			Not Covered	
D3333	Internal Root Repair of Perforation Defects	NO	NO			Not Covered	
<b>ENDODONTIC RETREATMENT</b>							
D3346	Retreatment of Previous Root Canal Therapy – Anterior	YES	YES	NO	NO		\$220.00
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	YES	YES	NO	NO		\$240.00
D3348	Retreatment of Previous Root Canal Therapy – Molar	YES	YES	NO	NO		\$320.00
<b>APEXIFICATION/RECALCIFICATION PROCEDURES</b>							
D3351	Apexification/Recalcification-Initial Visit (apical closure/calcific repair of perforations, root resorption, etc.)	YES	YES	NO	NO		\$56.00
D3352	Apexification/Recalcification-Interim Medication Replacement (apical closure/calcific repair of perforations, root resorption, etc.)	YES	YES	NO	NO		\$56.00
D3353	Apexification/Recalcification-Final Visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)	YES	YES	NO	NO		\$56.00

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<b>APICOECTOMY/PERIRADICULAR SERVICES</b>							
D3410	Apicoectomy/Periradicular Surgery - Anterior	YES	YES	NO	NO		\$170.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	NO	NO			Not Covered	
D3425	Apicoectomy/Periradicular Surgery – Molar (first root)	NO	NO			Not Covered	
D3426	Apicoectomy/Periradicular Surgery (each additional root)	NO	NO	NO	NO	Not Covered	
D3430	Retrograde Filling – Per Root	YES	YES	NO	NO		\$43.00
D3450	Root Amputation - Per Root	NO	NO			Not Covered	
D3460	Endodontic Endosseous Implant	NO	NO			Not Covered	
D3470	Intentional Reimplantation (including necessary splinting)	NO	NO			Not Covered	
<b>OTHER ENDODONTIC PROCEDURES</b>							
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	NO	NO			Not Covered	
D3920	Hemisection (including any root removal), Not Including Root Canal Therapy	NO	NO			Not Covered	
D3950	Canal Preparation and Fitting or Preformed Dowel or Post	NO	NO			Not Covered	
D3999	Unspecified Endodontic Procedure, by Report	YES	YES	YES	YES		By Report
<b>V. PERIODONTICS</b>							
<b>SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)</b>							

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D4210	Gingivectomy or Gingivoplasty – Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	YES	NO	YES			\$162.00
D4211	Gingivectomy or Gingivoplasty – One to Three Teeth contiguous or bounded teeth spaces, Per Quadrant	YES	NO	YES			\$56.00
D4230	Anatomical Crown Exposure - Four or More Contiguous Teeth per Quadrant	NO	NO			Not Covered	
D4231	Anatomical Crown Exposure - One to Three Teeth per Quadrant	NO	NO			Not Covered	
D4240	Gingival Flap Procedure, Including Root Planing Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	YES	NO	YES	NO		\$250.00
D4241	Gingival Flap Procedure, Including Root Planing – One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	YES	NO	YES	NO		\$150.00
D4245	Apically Positioned Flap	YES	NO	YES			\$162.00
D4249	Clinical Crown Lengthening-Hard Tissue	NO	NO			Not Covered	
D4260	Osseous Surgery (including flap entry and closure) – Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	YES	NO	YES			\$280.00
D4261	Osseous Surgery (including flap entry and closure) – One to Three Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	YES	NO	YES			\$140.00
D4263	Bone Replacement Graft - First Site in Quadrant	YES	NO	YES			\$330.00
D4264	Bone Replacement Graft - Each Additional Site in Quadrant	YES	NO	YES			\$66.00
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration	NO	NO			Not Covered	
D4266	Guided Tissue Regeneration – Resorbable Barrier, Per Site	NO	NO			Not Covered	
D4267	Guided Tissue Regeneration – Nonresorbable Barrier,	NO	NO			Not Covered	

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	Per Site (includes membrane removal)						
D4268	Surgical Revision Procedure, Per Tooth	YES	YES	YES	YES		\$200.00
D4270	Pedicle Soft Tissue Graft Procedure	YES	NO	YES			\$250.00
D4271	Free Soft Tissue Graft Procedure (including donor site surgery)	YES	NO	YES			\$250.00
D4273	Subepithelial Connective Tissue Graft Procedures Per Tooth	NO	NO			Not Covered	
D4274	Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	NO	NO			Not Covered	
D4275	Soft Tissue Allograft	NO	NO			Not Covered	
D4276	Combined Connective Tissue and Double Pedicle Graft, Per Tooth	NO	NO			Not Covered	
<b>NON-SURGICAL PERIODONTAL SERVICES</b>							
D4320	Provisional Splinting - Intracoronal	NO	NO			Not Covered	
D4321	Provisional Splinting – Extracoronal	NO	NO			Not Covered	
D4341	Periodontal Scaling and Root Planing – Four or More Teeth Per Quadrant	YES	YES	YES	YES	No PA required for diagnosis code 101 and the Department may authorize payment for Diagnosis Code 101 retroactively.	\$40.00
D4342	Periodontal Scaling and Root Planing – One to Three Teeth, Per Quadrant	NO	NO			Not Covered	
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	YES	YES	YES	YES	Once per year per provider.	\$100.00
D4381	Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle into Diseased Crevicular	NO	NO			Not Covered	

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
	Tissue, Per Tooth, by Report						
<b>OTHER PERIODONTAL SERVICES</b>							
D4910	Periodontal Maintenance	YES	NO	YES			\$39.00
D4920	Unscheduled Dressing Change (by someone other than treating dentist)	YES	NO	NO			\$27.00
D4999	Unspecified Periodontal Procedure, by Report	YES	YES	YES	YES		By Report
<b>VI. PROSTHODONTICS, REMOVABLE</b>							
<b>COMPLETE DENTURES (INCLUDING ROUTINE POST DELIVERY CARE)</b>							
D5110	Complete Denture - Maxillary	YES	YES	YES	YES	Every 5 years, Denturists may also use this code	\$393.00
D5120	Complete Denture - Mandibular	YES	YES	YES	YES	Every 5 years, Denturists may also use this code	\$393.00
D5130	Immediate Denture - Maxillary	YES	YES	YES	YES	Every 5 years, Denturists may also use code	\$423.00
D5140	Immediate Denture - Mandibular	YES	YES	YES	YES	Every 5 years, Denturists may also use this code	\$423.00
<b>PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)</b>							
D5211	Maxillary Partial Denture-Resin Base (including any conventional clasps, rests and teeth)	YES	YES	YES	YES	Every 5 years	\$280.00
D5212	Mandibular Partial Denture-Resin Base (including any conventional clasps, rests and teeth)	YES	YES	YES	YES	Every 5 years	\$280.00
D5213	Maxillary Partial Denture-Cast Metal Framework with	YES	YES	YES	YES	Every 5 years	\$423.00

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	Resin Denture Bases (including any conventional clasps, rests and teeth)						
D5214	Mandibular Partial Denture-Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	YES	YES	YES	YES	Every 5 years	\$423.00
D5225	Maxillary Partial Denture-Flexible Base (including any clasps, rests and teeth)	NO	NO			Not Covered	
D5226	Mandibular Partial Denture-Flexible Base (including any clasps, rests and teeth)	NO	NO			Not Covered	
D5281	Removable Unilateral Partial Denture - One Piece Case Metal (including clasps and teeth)	NO	NO			Not Covered	
<b>ADJUSTMENTS TO DENTURES</b>							
D5410	Adjust Complete Denture - Maxillary	YES	YES	NO	NO	Denturists may also use this code	\$26.00
D5411	Adjust Complete Denture - Mandibular	YES	YES	NO	NO	Denturists may also use this code	\$26.00
D5421	Adjust Partial Denture - Maxillary	YES	YES	NO	NO		\$25.00
D5422	Adjust Partial Denture - Mandibular	YES	YES	NO	NO		\$25.00
<b>REPAIRS TO COMPLETE DENTURES</b>							
D5510	Repair Broken Complete Denture Base	YES	YES	NO	NO	Denturists may also use this code	\$57.00
D5520	Replace Missing or Broken Teeth-Complete Denture (each tooth)	YES	YES	NO	NO	Denturists may also use this code	\$50.00
<b>REPAIRS TO PARTIAL DENTURES</b>							

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D5610	Repair Resin Denture Base	YES	YES	NO	NO		\$56.00
D5620	Repair Cast Framework	YES	YES	NO	NO		\$85.00
D5630	Repair or Replace Broken Clasp	YES	YES	NO	NO		\$85.00
D5640	Replace Broken Teeth - Per Tooth	YES	YES	NO	NO		\$50.00
D5650	Add Tooth to Existing Partial Denture	YES	YES	NO	NO		\$55.00
D5660	Add Clasp to Existing Partial Denture	YES	YES	NO	NO		\$65.00
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (maxillary)	NO	NO			Not Covered	
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (mandibular)	NO	NO			Not Covered	
<b>DENTURE REBASE PROCEDURES</b>							
D5710	Rebase Complete Maxillary Denture	YES	YES	NO	NO	Refer to Chapter II, 25.03. Denturists may also use this code.	\$150.00
D5711	Rebase Complete Mandibular Denture	YES	YES	NO	NO	Refer to Chapter II, 25.03. Denturists may also use this code.	\$150.00
D5720	Rebase Maxillary Partial Denture	YES	YES	NO	NO	Refer to Chapter II, 25.03.	\$150.00
D5721	Rebase Mandibular Partial Denture	YES	YES	NO	NO	Refer to Chapter II, 25.03.	\$150.00
<b>DENTURE RELINE PROCEDURES</b>							
D5730	Reline Complete Maxillary Denture (chairside)	YES	YES	NO	NO	Refer to Chapter II, 25.03. Denturists may also use this code.	\$78.00
D5731	Reline Complete Mandibular Denture (chairside)	YES	YES	NO	NO	Refer to Chapter II, 25.03.	\$78.00

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						Denturists may also use this code.	
D5740	Reline Maxillary Partial Denture (chairside)	NO	NO			Not Covered	
D5741	Reline Mandibular Partial Denture (chairside)	NO	NO			Not Covered	
D5750	Reline Complete Maxillary Denture (laboratory)	YES	YES	NO	NO	Refer to Chapter II, 25.03. Denturists may also use this code.	\$150.00
D5751	Reline Complete Mandibular Denture (laboratory)	YES	YES	NO	NO	Refer to Chapter II, 25.03. Denturists may also use this code.	\$150.00
D5760	Reline Maxillary Partial Denture (laboratory)	NO	NO			Not Covered	
D5761	Reline Mandibular Partial Denture (laboratory)	NO	NO			Not Covered	
<b>INTERIM PROSTHESIS</b>							
D5810	Interim Complete Denture (maxillary)	NO	NO			Not Covered	
D5811	Interim Complete Denture (mandibular)	NO	NO			Not Covered	
D5820	Interim Partial Denture (maxillary)	NO	NO			Not Covered	
D5821	Interim Partial Denture (mandibular)	NO	NO			Not Covered	
<b>OTHER REMOVABLE PROSTHETIC SERVICES</b>							
D5850	Tissue Conditioning, Maxillary	NO	NO			Not Covered	
D5851	Tissue Conditioning, Mandibular	NO	NO			Not Covered	
D5860	Overdenture – Complete, by Report	YES	NO	YES			\$473.00
D5861	Overdenture – Partial, by Report	YES	NO	YES			\$473.00
D5862	Precision Attachment, by Report	NO	NO			Not Covered	
D5867	Replacement of Replaceable Part of Semi-Precision or Precision Attachment (male or female component)	NO	NO			Not Covered	
D5875	Modification of Removable Prosthesis Following	NO	NO			Not Covered	

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	Implant Surgery						
D5899	Unspecified Removable Prosthodontic Procedure, by Report	NO	NO			Not Covered	
<b>VII. MAXILLOFACIAL PROSTHETICS</b>							
D5911	Facial Moulage (sectional)	YES	YES	YES	YES		By Report
D5912	Facial Moulage (complete)	YES	YES	YES	YES		By Report
D5913	Nasal Prosthesis	YES	YES	YES	YES		By Report
D5914	Auricular Prosthesis	YES	YES	YES	YES		By Report
D5915	Orbital Prosthesis	YES	YES	YES	YES		By Report
D5916	Ocular Prosthesis	YES	YES	YES	YES		By Report
D5919	Facial Prosthesis	YES	YES	YES	YES		By Report
D5922	Nasal Septal Prosthesis	YES	YES	YES	YES		By Report
D5923	Ocular Prosthesis, Interim	YES	YES	YES	YES		By Report
D5924	Cranial Prosthesis	YES	YES	YES	YES		By Report
D5925	Facial Augmentation Implant Prosthesis	YES	YES	YES	YES		By Report
D5926	Nasal Prosthesis, Replacement	YES	YES	YES	YES		By Report
D5927	Auricular Prosthesis, Replacement	YES	YES	YES	YES		By Report
D5928	Orbital Prosthesis, Replacement	YES	YES	YES	YES		By Report
D5929	Facial Prosthesis, Replacement	YES	YES	YES	YES		By Report
D5931	Obturator Prosthesis, Surgical	YES	YES	NO	NO		\$1,494.43
D5932	Obturator Prosthesis, Definitive	YES	YES	NO	NO		\$1,693.82
D5933	Obturator Prosthesis, Modification	YES	YES	NO	NO		By Report
D5934	Mandibular Resection Prosthesis with Guide Flange	YES	YES	YES	YES		By Report
D5935	Mandibular Resection Prosthesis without Guide Flange	YES	YES	YES	YES		By Report
D5936	Obturator Prosthesis, Interim	YES	YES	YES	YES		By Report
D5937	Trismus Appliance (not for TMD treatment)	NO	NO			Not Covered	
D5951	Feeding Aid	YES	YES	NO	NO		\$433.00

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D5952	Speech Aid Prosthesis, Pediatric	YES	NO	NO			By Report
D5953	Speech Aid Prosthesis, Adult	YES	YES	YES	YES		By Report
D5954	Palatal Augmentation Prosthesis	YES	YES	YES	YES		By Report
D5955	Palatal Lift Prosthesis, Definitive	YES	YES	YES	YES		By Report
D5958	Palatal Lift Prosthesis, Interim	YES	YES	YES	YES		By Report
D5959	Palatal Lift Prosthesis, Modification	YES	YES	YES	YES		By Report
D5960	Speech Aid Prosthesis, Modification	YES	YES	YES	YES		By Report
D5982	Surgical Stent	YES	YES	YES	YES		\$175.00
D5983	Radiation Carrier	YES	YES	YES	YES		By Report
D5984	Radiation Shield	YES	YES	YES	YES		By Report
D5985	Radiation Cone Locator	YES	YES	YES	YES		By Report
D5986	Fluoride Gel Carrier	YES	YES	YES	YES		By Report
D5987	Commisure Splint	NO	NO			Not Covered	
D5988	Surgical Splint	NO	NO			Not Covered	
D5991	Topical medicament carrier	NO	NO			Not Covered	
D5999	Unspecified Maxillofacial Prosthesis, by Report	YES	YES	YES	YES		By Report
<b>VIII. IMPLANT SERVICES</b>							
D6010	Surgical Placement of Implant Body: Endosteal Implant	NO	NO			Not Covered	
D6012	Surgical Placement of Interim Implant Body for Transitional Prosthesis: Endosteal Implant	NO	NO			Not Covered	
D6040	Surgical Placement: Eposteal Implant	NO	NO			Not Covered	
D6050	Surgical Placement: Transosteal Implant	NO	NO			Not Covered	
<b>IMPLANT SUPPORTED PROSTHETICS</b>							
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	NO	NO			Not Covered	

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D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	NO	NO			Not Covered	
D6055	Dental Implant Supported Connecting Bar	NO	NO			Not Covered	
D6056	Prefabricated Abutment - Includes Placement	NO	NO			Not Covered	
D6057	Custom Abutment - Includes Placement	NO	NO			Not Covered	
D6058	Abutment Supported Porcelain/Ceramic Crown	NO	NO			Not Covered	
D6059	Abutment Supported Porcelain Fused to Metal Crown (high noble metal)	NO	NO			Not Covered	
D6060	Abutment Supported Porcelain Fused to Metal Crown (predominantly base metal)	NO	NO			Not Covered	
D6061	Abutment Supported Porcelain Fused to Metal Crown (noble metal)	NO	NO			Not Covered	
D6062	Abutment Supported Cast Metal Crown (high noble metal)	NO	NO			Not Covered	
D6063	Abutment Supported Cast Metal Crown (predominantly base metal)	NO	NO			Not Covered	
D6064	Abutment Supported Cast Metal Crown (noble metal)	NO	NO			Not Covered	
D6065	Implant Supported Porcelain/Ceramic Crown	NO	NO			Not Covered	
D6066	Implant Supported Porcelain Fused to Metal Crown (titanium, titanium alloy, high noble metal)	NO	NO			Not Covered	
D6067	Implant Supported Metal Crown (titanium, titanium alloy, high noble metal)	NO	NO			Not Covered	
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	NO	NO			Not Covered	
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (high noble metal)	NO	NO			Not Covered	
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (predominantly base metal)	NO	NO			Not Covered	
D6071	Abutment Supported Retainer for Porcelain Fused to	NO	NO			Not Covered	

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**RATES ARE EFFECTIVE 08/09/2010**

Section 25

ALLOWANCES FOR DENTAL SERVICES

Established: 6-29-79

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
	Metal FPD (noble metal)						
D6072	Abutment Supported Retainer for Cast Metal FPD (high noble metal)	NO	NO			Not Covered	
D6073	Abutment Supported Retainer for Cast Metal FPD (predominantly base metal)	NO	NO			Not Covered	
D6074	Abutment Supported Retainer for Cast Metal FPD (noble metal)	NO	NO			Not Covered	
D6075	Implant Supported Retainer for Ceramic FPD	NO	NO			Not Covered	
D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (titanium, titanium alloy, or high noble metal)	NO	NO			Not Covered	
D6077	Implant Supported Retainer for Cast Metal FPD (titanium, titanium alloy, or high noble metal)	NO	NO			Not Covered	
D6078	Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch	NO	NO			Not Covered	
D6079	Implant/Abutment Supported Fixture Denture for Partially Edentulous Arch	NO	NO			Not Covered	
<b>OTHER IMPLANT SERVICES</b>							
D6080	Implant Maintenance Procedures, Including Removal of Prosthesis, Cleansing of Prosthesis and Abutments and Reinsertion of Prosthesis	NO	NO			Not Covered	
D6090	Repair Implant Supported Prosthesis, by Report	NO	NO			Not Covered	
D6091	Replacement of Semi-precision or Precision Attachment (male or female component) of Implant/Abutment Supported Prosthesis, per Attachment	NO	NO			Not Covered	
D6092	Recement Implant/Abutment Supported Crown	NO	NO			Not Covered	
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	NO	NO			Not Covered	

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D6094	Abutment Supported Crown - (titanium)	NO	NO			Not Covered	
D6095	Repair Implant Abutment, by Report	NO	NO			Not Covered	
D6100	Implant Removal, by Report	NO	NO			Not Covered	
D6190	Radiographic/Surgical Implant Index, by Report	NO	NO			Not Covered	
D6194	Abutment Supported Retainer Crown for FPD - (titanium)	NO	NO			Not Covered	
D6199	Unspecified Implant Procedure, by Report	NO	NO			Not Covered	

**IX. PROSTHODONTICS, FIXED**

**FIXED BRIDGES (EACH ABUTMENT AND EACH PONTIC CONSTITUTES A UNIT)**

**FIXED PARTIAL DENTURE PONTICS**

D6205	Pontic - Indirect Resin Based Composite	NO	NO			Not Covered	
D6210	Pontic - Cast High Noble Metal	NO	NO			Not Covered	
D6211	Pontic - Cast Predominantly Base Metal	NO	NO			Not Covered	
D6212	Pontic - Cast Noble Metal	NO	NO			Not Covered	
D6214	Pontic - Titanium	NO	NO			Not Covered	
D6240	Pontic - Porcelain Fused to High Noble Metal	NO	NO			Not Covered	
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	YES	NO	YES			\$325.00
D6242	Pontic - Porcelain Fused to Noble Metal	YES	NO	YES			\$344.00
D6245	Pontic - Porcelain/Ceramic	NO	NO			Not Covered	
D6250	Pontic - Resin with High Noble Metal	NO	NO			Not Covered	
D6251	Pontic - Resin with Predominantly Base Metal	YES	NO	YES			\$276.00
D6252	Pontic - Resin with Noble Metal	YES	NO	YES			\$314.00
D6253	Provisional Pontic	NO	NO			Not Covered	

**FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS**

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D6545	Retainer-Cast Metal for Resin Bonded Fixed Prosthesis	YES	NO	YES			\$150.00
D6548	Retainer-Porcelain/Ceramic for Resin Bonded Fixed Prosthesis	NO	NO			Not Covered	
D6600	Inlay – Porcelain/Ceramic, Two Surfaces	NO	NO			Not Covered	
D6601	Inlay – Porcelain/Ceramic, Three or More Surfaces	NO	NO			Not Covered	
D6602	Inlay – Cast High Noble Metal, Two Surfaces	NO	NO			Not Covered	
D6603	Inlay – Cast High Noble Metal, Three or More Surfaces	NO	NO			Not Covered	
D6604	Inlay – Cast Predominantly Base Metal, Two Surfaces	NO	NO			Not Covered	
D6605	Inlay – Cast Predominantly Base Metal, Three or More Surfaces	NO	NO			Not Covered	
D6606	Inlay – Cast Noble Metal, Two Surfaces	NO	NO			Not Covered	
D6607	Inlay – Cast Noble Metal, Three or More Surfaces	NO	NO			Not Covered	
D6608	Onlay – Porcelain/Ceramic, Two Surfaces	NO	NO			Not Covered	
D6609	Onlay – Porcelain/Ceramic, Three or More Surfaces	NO	NO			Not Covered	
D6610	Onlay – Cast High Noble Metal, Two Surfaces	NO	NO			Not Covered	
D6611	Onlay - Cast High Noble Metal, Three or More Surfaces	NO	NO			Not Covered	
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	NO	NO			Not Covered	
D6613	Onlay - Cast Predominantly Base Metal, Three or More Surfaces	NO	NO			Not Covered	
D6614	Onlay - Cast Noble Metal, Two Surfaces	NO	NO			Not Covered	
D6615	Onlay - Cast Noble Metal, Three or More Surfaces	NO	NO			Not Covered	
D6624	Inlay - Titanium	NO	NO			Not Covered	
D6634	Onlay - Titanium	NO	NO			Not Covered	
<b>FIXED PARTIAL DENTURE RETAINERS - CROWNS</b>							
D6710	Crown - Indirect Resin Based Composite	NO	NO			Not Covered	
D6720	Crown - Resin with High Noble Metal	NO	NO			Not Covered	

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D6721	Crown - Resin with Predominantly Base Metal	NO	NO			Not Covered	
D6722	Crown - Resin with Noble Metal	NO	NO			Not Covered	
D6740	Crown - Porcelain/Ceramic	NO	NO			Not Covered	
D6750	Crown - Porcelain Fused to High Noble Metal	NO	NO			Not Covered	
D6751	Crown - Porcelain Fused to Predominantly Base Metal	NO	NO			Not Covered	
D6752	Crown - Porcelain Fused to Noble Metal	NO	NO			Not Covered	
D6780	Crown - 3/4 Cast High Noble Metal	NO	NO			Not Covered	
D6781	Crown - 3/4 Cast Predominantly Base Metal	NO	NO			Not Covered	
D6782	Crown - 3/4 Cast Noble Metal	NO	NO			Not Covered	
D6783	Crown - 3/4 Porcelain/Ceramic	NO	NO			Not Covered	
D6790	Crown - Full Cast High Noble Metal	NO	NO			Not Covered	
D6791	Crown - Full Cast Predominantly Base Metal	NO	NO			Not Covered	
D6792	Crown - Full Cast Noble Metal	NO	NO			Not Covered	
D6793	Provisional Retainer Crown	NO	NO			Not Covered	
D6794	Crown - Titanium	NO	NO			Not Covered	
<b>OTHER FIXED PARTIAL DENTURE SERVICES</b>							
D6920	Connector Bar	NO	NO			Not Covered	
D6930	Recement Fixed Partial Denture	NO	NO			Not Covered	
D6940	Stress Breaker	NO	NO			Not Covered	
D6950	Precision Attachment	NO	NO			Not Covered	
D6970	Post and Core in Addition to Fixed Partial Denture Retainer, Indirectly Fabricated	NO	NO			Not Covered	
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	NO	NO			Not Covered	
D6973	Core Buildup for Retainer, Including Any Pins	NO	NO			Not Covered	
D6975	Coping - Metal	NO	NO			Not Covered	
D6976	Each Additional Indirectly Fabricated Post - Same Tooth	NO	NO			Not Covered	

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D6977	Each Additional Prefabricated Post – Same Tooth	NO	NO			Not Covered	
D6980	Fixed Partial Denture Repair, by Report	NO	NO			Not Covered	
D6985	Pediatric Partial Denture, Fixed	NO	NO			Not Covered	
D6999	Unspecified Fixed Prosthodontic Procedure, by Report	NO	NO			Not Covered	
<b>X. ORAL AND MAXILLOFACIAL SURGERY</b>							
<b>EXTRACTIONS - INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED &amp; ROUTINE POSTOPERATIVE CARE</b>							
D7111	Extraction, Coronal Remnants – Deciduous Tooth	YES	YES	NO	NO		\$55.00
D7140	Extraction, Erupted Tooth or exposed Root (elevation and/or forceps removal)	YES	YES	NO	NO		\$91.00
<b>SURGICAL EXTRACTIONS – (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, &amp; ROUTINE POSTOPERATIVE CARE)</b>							
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	YES	YES	NO	NO	Documented need demonstrated by X-rays	\$110.00
D7220	Removal of Impacted Tooth - Soft Tissue	YES	YES	NO	NO	Documented need demonstrated by X-rays	\$95.00
D7230	Removal of Impacted Tooth - Partially Bony	YES	YES	NO	NO	Documented need demonstrated by X-rays	\$155.00
D7240	Removal of Impacted Tooth – Completely Bony	YES	YES	NO	NO	Documented need demonstrated by X-rays	\$185.00
D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications	YES	YES	NO	NO	Documented need demonstrated by X - rays	\$215.00
D7250	Surgical Removal of Residual Tooth Roots (cutting procedure)	YES	YES	NO	NO	Documented need demonstrated by X - rays	\$130.00

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<b>OTHER SURGICAL PROCEDURES</b>							
D7260	Oroantral Fistula Closure	YES	YES	NO	NO		\$250.00
D7261	Primary Closure of a Sinus Perforation	YES	YES	NO	NO		\$250.00
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	YES	YES	NO	NO		\$175.00
D7272	Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	NO	NO			Not Covered	
D7280	Surgical Access of an Unerupted Tooth	YES	NO	NO			\$220.00
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	NO	NO			Not Covered	
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	YES	NO	NO			\$225.00
D7285	Biopsy of Oral Tissue – Hard (bone, tooth)	YES	YES	NO	NO		\$110.00
D7286	Biopsy of Oral Tissue – Soft	YES	YES	NO	NO		\$85.00
D7287	Exfoliative Cytological Sample Collection	NO	NO			Not Covered	
D7288	Brush Biopsy-Transepithelial Sample Collection	YES	YES				By Report
D7290	Surgical Repositioning of Teeth	YES	YES	NO	NO		\$175.00
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, by Report	YES	NO	NO			\$45.00
D7292	Surgical Placement: Temporary Anchorage Device (screw retained plate) Requiring Surgical Flap	NO	NO			Not Covered	
D7293	Surgical Placement: Temporary Anchorage Device Requiring Surgical Flap	NO	NO			Not Covered	
D7294	Surgical Placement: Temporary Anchorage Device Without Surgical Flap	NO	NO			Not Covered	
<b>ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES</b>							
D7310	Alveoloplasty in Conjunction with Extractions - Four or	YES	YES	NO	NO		\$64.00

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	More Teeth or Tooth Spaces, Per Quadrant						
D7311	Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	NO	NO			Not Covered	
D7320	Alveoloplasty not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant	YES	YES	YES	YES	Only after approval for prosthesis	\$94.00
D7321	Alveoloplasty not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant	YES	YES	YES	YES	Only after approval for prosthesis	\$47.00
<b>VESTIBULOPLASTY</b>							
D7340	Vestibuloplasty - Ridge Extension (secondary epithelialization)	NO	NO			Not Covered	
D7350	Vestibuloplasty - Ridge Extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)	NO	NO			Not Covered	
<b>SURGICAL EXCISION OF SOFT TISSUE LESIONS</b>							
D7410	Excision of Benign Lesion Up to 1.25 Cm	YES	YES	NO	NO		\$75.00
D7411	Excision of Benign Lesion Greater Than 1.25 Cm	YES	YES	NO	NO		\$120.00
D7412	Excision of Benign Lesion, Complicated	YES	YES	NO	NO		\$200.00
D7413	Excision of Malignant Lesion up to 1.25 Cm	YES	YES	NO	NO		\$350.00
D7414	Excision of Malignant Lesion Greater Than 1.25 Cm	YES	YES	NO	NO		\$750.00
D7415	Excision of Malignant Lesion, Complicated	YES	YES	NO	NO		\$750.00
D7465	Destruction of Lesion(s) by Physical or Chemical Method, by Report	YES	YES	NO	NO		\$75.00
<b>SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS</b>							

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D7440	Excision of Malignant Tumor - Lesion Diameter Up to 1.25 Cm	YES	YES	NO	NO		\$350.00
D7441	Excision of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm	YES	YES	NO	NO		\$750.00
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 Cm	YES	YES	NO	NO		\$220.00
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25 Cm	YES	YES	NO	NO		\$400.00
D7460	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter up to 1.25 Cm	YES	YES	NO	NO		\$200.00
D7461	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25 Cm	YES	YES	NO	NO		\$400.00
<b>EXCISION OF BONE TISSUE</b>							
D7471	Removal of Lateral Exostosis (maxilla or mandible)	YES	YES	YES	YES		\$300.00
D7472	Removal of Torus Palatinus	YES	YES	YES	YES		By Report
D7473	Removal of Torus Mandibularis	YES	YES	YES	YES		By Report
D7485	Surgical Reduction of Osseous Tuberosity	NO	NO			Not Covered	
D7490	Radical Resection of Maxilla or Mandible	NO	NO			Not Covered	
<b>SURGICAL INCISION</b>							
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	YES	YES	NO	NO		\$75.00
D7511	Incision and Drainage of Abscess - Intraoral Soft Tissue Complicated (includes drainage of multiple fascial spaces)	YES	YES	NO	NO		\$90.00
D7520	Incision and Drainage of Abscess – Extraoral Soft Tissue	YES	YES	NO	NO		\$150.00

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D7521	Incision and Drainage of Abscess - Extraoral Soft Tissue-Complicated (includes drainage of multiple fascial spaces)	YES	YES	NO	NO		\$165.00
D7530	Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue	YES	YES	NO	NO		\$100.00
D7540	Removal of Reaction Producing Foreign Bodies, Musculoskeletal System	YES	YES	NO	NO		By Report
D7550	Partial Osteotomy/Sequestrectomy for Removal of Non-Vital Bone	YES	YES	NO	NO		By Report
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body	YES	YES	NO	NO		\$350.00
<b>TREATMENT OF FRACTURES - SIMPLE</b>							
D7610	Maxilla - Open Reduction (teeth immobilized, if present)	YES	YES	NO	NO		\$900.00
D7620	Maxilla - Closed Reduction (teeth immobilized, if present)	YES	YES	NO	NO		\$450.00
D7630	Mandible - Open Reduction (teeth immobilized, if present)	YES	YES	NO	NO		\$900.00
D7640	Mandible - Closed Reduction (teeth immobilized, if present)	YES	YES	NO	NO		\$450.00
D7650	Malar and/or Zygomatic Arch - Open Reduction	YES	YES	NO	NO		\$750.00
D7660	Malar and/or Zygomatic Arch - Closed Reduction	YES	YES	NO	NO		\$300.00
D7670	Alveolus – Closed Reduction, May Include Stabilization of Teeth	YES	YES	NO	NO		\$400.00
D7671	Alveolus – Open Reduction, May Include Stabilization of Teeth	NO	NO			Not Covered	
D7680	Facial Bones - Complicated Reduction with Fixation and	YES	YES	NO	NO		\$1,383.00

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	Multiple Surgical Approaches						
<b>TREATMENT OF FRACTURES - COMPOUND</b>							
D7710	Maxilla - Open Reduction	YES	YES	NO	NO		\$900.00
D7720	Maxilla - Closed Reduction	YES	YES	NO	NO		\$450.00
D7730	Mandible - Open Reduction	YES	YES	NO	NO		\$900.00
D7740	Mandible - Closed Reduction	YES	YES	NO	NO		\$450.00
D7750	Malar and/or Zygomatic Arch - Open Reduction	YES	YES	NO	NO		\$750.00
D7760	Malar and/or Zygomatic Arch - Closed Reduction	YES	YES	NO	NO		\$300.00
D7770	Alveolus – Open Reduction Stabilization of Teeth	YES	YES	NO	NO		\$400.00
D7771	Alveolus, Closed Reduction Stabilization of Teeth	YES	YES	NO	NO		\$400.00
D7780	Facial Bones - Complicated Reduction with Fixation and Multiple Surgical Approaches	YES	YES	NO	NO		\$1,383.00
<b>REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS</b>							
D7810	Open Reduction of Dislocation	NO	NO			Not Covered	
D7820	Closed Reduction of Dislocation	NO	NO			Not Covered	
D7830	Manipulation Under Anesthesia	NO	NO			Not Covered	
D7840	Condylectomy	NO	NO			Not Covered	
D7850	Surgical Discectomy, with/without Implant	YES	YES	YES	YES		\$1,185.50
D7852	Disc Repair	NO	NO			Not Covered	
D7854	Synovectomy	NO	NO			Not Covered	
D7856	Myotomy	NO	NO			Not Covered	
D7858	Joint Reconstruction	NO	NO			Not Covered	
D7860	Arthrotomy	YES	YES	YES	YES		\$1,185.50
D7865	Arthroplasty	NO	NO			Not Covered	
D7870	Arthrocentesis	NO	NO			Not Covered	

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Proc. Code	Description	Covered Service Age/ICF-MR		Prior Authorization required		Additional Limits	Max Allow
		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D7871	Non-arthroscopic Lysis and Lavage	NO	NO			Not Covered	
D7872	Arthroscopy - Diagnosis, with or without Biopsy	NO	NO			Not Covered	
D7873	Arthroscopy - Surgical; Lavage and Lysis of Adhesions	NO	NO			Not Covered	
D7874	Arthroscopy – Surgical; Disc Repositioning and Stabilization	NO	NO			Not Covered	
D7875	Arthroscopy – Surgical; Synovectomy	NO	NO			Not Covered	
D7876	Arthroscopy – Surgical; Discectomy	NO	NO			Not Covered	
D7877	Arthroscopy – Surgical; Debridement	NO	NO			Not Covered	
D7880	Occlusal Orthotic Device, by Report	YES	YES	YES	YES		\$250.00
D7899	Unspecified TMD Therapy, by Report	NO	NO			Not Covered	
<b>REPAIR OF TRAUMATIC WOUNDS</b>							
D7910	Suture of Recent Small Wounds Up to 5 cm	YES	YES	NO	NO		\$84.75
<b>COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)</b>							
D7911	Complicated Suture - Up to 5 cm	YES	YES	NO	NO		\$193.00
D7912	Complicated Suture – Greater Than 5 cm	YES	YES	NO	NO		\$263.50
<b>OTHER REPAIR PROCEDURES</b>							
D7920	Skin Grafts (identify defect covered, location, and type of graft)	NO	NO			Not Covered	
D7940	Osteoplasty for Orthognathic Deformities	YES	YES	YES	YES		By Report
D7941	Osteotomy – Mandibular Rami	YES	YES	YES	YES		By Report
D7943	Osteotomy – Mandibular Rami with Bone Graft;	YES	YES	YES	YES		\$2,529.00

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Section 25

ALLOWANCES FOR DENTAL SERVICES

Established: 6-29-79

Proc. Code	Description	Covered Service Age/ICF-MR		Prior Authorization required		Additional Limits	Max Allow
		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
	Includes Obtaining The Graft						
D7944	Osteotomy - Segmented or Subapical	YES	YES	YES	YES		\$2,213.00
D7945	Osteotomy - Body of The Mandible	YES	YES	YES	YES		\$2,213.00
D7946	LeFort I (maxilla - total)	YES	YES	YES	YES		\$2,213.00
D7947	LeFort I (maxilla - segmented)	YES	YES	YES	YES		\$2,213.00
D7948	LeFort II or LeFort III (Osteoplasty of Facial Bones for Midface Hypoplasia or Retrusion) - without Bone Graft	YES	YES	YES	YES		\$2,213.00
D7949	LeFort II or LeFort III – with Bone Graft	YES	YES	YES	YES		\$2,529.00
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of The Mandible or Maxilla - Autogenous or Nonautogenous, by Report	YES	YES	YES	YES		By Report
D7951	Sinus Augmentation with Bone or Bone Substitutes	NO	NO			Not Covered	
D7953	Bone Replacement Graft for Ridge Preservation - Per Site	YES	YES	NO	YES		\$325.00
D7955	Repair of Maxillofacial Soft and/or Hard Tissue Defect	YES	YES	NO	NO		\$412.00
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	YES	YES	NO	YES		\$97.00
D7963	Frenuloplasty	YES	YES	NO	YES		\$125.00
D7970	Excision of Hyperplastic Tissue - Per Arch	YES	YES	YES	YES		\$356.00
D7971	Excision of Pericoronal Gingiva	YES	YES	YES	YES		\$ 58.00
D7972	Surgical Reduction of Fibrous Tuberosity	YES	YES	YES	YES		\$70.00
D7980	Sialolithotomy	YES	YES	YES	YES		\$263.50
D7981	Excision of Salivary Gland, by Report	YES	YES	YES	YES		By Report
D7982	Sialodochoplasty	YES	YES	YES	YES		By Report
D7983	Closure of Salivary Fistula	YES	YES	YES	YES		By Report
D7990	Emergency Tracheotomy	YES	YES	NO	NO		\$159.50
D7991	Coronoidectomy	YES	YES	YES	YES		By Report
D7995	Synthetic Graft - Mandible or Facial Bones, by Report	YES	YES	YES	YES		\$1,106.50
D7996	Implant - Mandible for Augmentation Purposes (Excluding Alveolar Ridge), by Report	NO	NO			Not Covered	
D7997	Appliance Removal (not by dentist who placed	YES	NO	YES			By Report

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
	appliance), Includes Removal of Archbar						
D7998	Intraoral Placement of a Fixation Device Not in Conjunction with a Fracture	NO	NO			Not Covered	
D7999	Unspecified Oral Surgery Procedure, by Report	YES	YES	YES	YES		By Report
<b>XI. LIMITED ORTHODONTIC TREATMENT (Orthodontics are not covered services for residents of ICF/MR facilities)</b>							
D8010	Limited Orthodontic Treatment of The Primary Dentition	YES	NO	YES			\$332.50
D8020	Limited Orthodontic Treatment of The Transitional Dentition	YES	NO	YES			\$332.50
D8030	Limited Orthodontic Treatment of The Adolescent Dentition	YES	NO	YES			\$332.50
D8040	Limited Orthodontic Treatment of The Adult Dentition	NO	NO			Not Covered	
<b>INTERCEPTIVE ORTHODONTIC TREATMENT</b>							
D8050	Interceptive Orthodontic Treatment of The Primary Dentition	YES	NO	YES			\$592.00
D8060	Interceptive Orthodontic Treatment of The Transitional Dentition	YES	NO	YES			\$592.00
<b>COMPREHENSIVE ORTHODONTIC TREATMENT</b>							
D8070	Comprehensive Orthodontic Treatment of The Transitional Dentition	YES	NO	YES		D8070, D8080 and D8090 - all inclusive fee includes appliances, brackets, treatment visits, one appliance repair or replacement, and one retainer repair or replacement. Covered	\$2,725.00
D8080	Comprehensive Orthodontic Treatment of The Adolescent Dentition	YES	NO	YES			\$2,725.00
D8090	Comprehensive Orthodontic Treatment of The Adult Dentition	YES	NO	YES			\$2,725.00

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		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
						to age 21	
<b>MINOR TREATMENT TO CONTROL HARMFUL HABITS</b>							
D8210	Removable Appliance Therapy	YES	NO	YES			\$375.00
D8220	Fixed Appliance Therapy	YES	NO	YES			\$375.00
<b>OTHER ORTHODONTIC SERVICES</b>							
D8660	Pre-Orthodontic Treatment Visit	YES	NO	NO			\$22.50
D8670	Periodic Orthodontic Treatment Visit (as part of contract)	YES	NO	YES		Cannot be billed in conjunction with D8070, D8080, D8090	\$66.00
D8680	Orthodontic Retention (removal of appliances, construction and placement of retainer(s))	NO	NO			Not Covered	
D8690	Orthodontic Treatment (alternative billing to a contract fee)	NO	NO			Not Covered	
D8691	Repair of Orthodontic Appliance	YES	NO	YES			\$75.00
D8692	Replacement of Lost or Broken Retainer	YES	NO	NO			\$125.00
D8693	Rebonding or Recementing; and/or Repair, as Required, of Fixed Retainers	YES	NO	NO			\$50.00
D8999	Unspecified Orthodontic Procedure, by Report	YES	NO	YES			By Report
<b>XII. ADJUNCTIVE GENERAL SERVICES</b>							
<b>UNCLASSIFIED TREATMENT</b>							
D9110	Palliative (emergency) Treatment of Dental Pain - Minor Procedure	YES	YES	NO	NO		\$35.00
D9120	Fixed Partial Denture Sectioning	NO	NO			Not Covered	
<b>ANESTHESIA</b>							

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D9210	Local Anesthesia not in Conjunction with Operative or Surgical Procedures	NO	NO			Not Covered	
D9211	Regional Block Anesthesia	NO	NO			Not Covered	
D9212	Trigeminal Division Block Anesthesia	NO	NO			Not Covered	
D9215	Local Anesthesia	NO	NO			Not Covered	
D9220	Deep Sedation/General Anesthesia – First 30 Minutes	YES	YES	NO	NO		\$150.00
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes	YES	YES	NO	NO		\$50.00
D9230	Analgesia Anxiolysis, Inhalation of Nitrous Oxide	YES	YES	NO	NO		\$19.00
D9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes	YES	YES				\$150.00
D9242	Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes	YES	YES				\$50.00
D9248	Non-Intravenous Conscious Sedation	NO	NO			Not Covered	
<b>PROFESSIONAL CONSULTATION</b>							
D9310	Consultation - diagnostic service provided by dentist or physician other than Requesting Dentist or Physician	YES	YES	NO	NO	Denturists may also use this code	\$31.00
<b>PROFESSIONAL VISITS</b>							
D9410	House/Extended Care Facility Call	YES	YES	NO	NO	Limited to dentist/denturist, only if medically necessary and providing a covered service under this policy	\$60.00
D9420	Hospital Call	YES	YES	NO	NO	Use for emergency room trauma care	\$100.00

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D9430	Office Visit for Observation (during regularly scheduled hours) - No Other Services Performed	YES	YES	NO	NO		\$18.00
D9440	Office Visit - After Regularly Scheduled Hours	YES	YES	NO	NO		\$38.00
D9450	Case Presentation, Detailed and Extensive Treatment Planning	YES	NO	NO		Limited to orthodontia	\$127.50
<b>DRUGS</b>							
D9610	Therapeutic Parenteral Drug, Single Administration	YES	YES	NO	NO	Acquisition cost only	By Report
D9612	Therapeutic Parenteral Drugs, Two or More Administrations, Different Medications	YES	YES	NO	NO	Acquisition cost only. Not to be reported in addition to D9610.	By Report
D9630	Other Drugs and/or Medications, by Report	YES	YES	NO	NO	Acquisition cost only	By Report
<b>MISCELLANEOUS SERVICES</b>							
D9910	Application of Desensitizing Medicament	NO	NO			Not Covered	
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, Per Tooth	NO	NO			Not Covered	
D9920	Behavior Management, by Report	YES	NO	NO		Limit 3 visits per member per provider. Limited to general dentist only.	\$13.00
D9930	Treatment of Complications (post-surgical) - Unusual Circumstances, by Report	YES	YES	NO	NO		\$25.00
D9940	Occlusal Guard, by Report	YES	YES	YES	YES		\$110.00
D9941	Fabrication of Athletic Mouthguard	NO	NO			Not Covered	
D9942	Repair and/or Reline of Occlusal Guard	NO	NO			Not Covered	
D9950	Occlusion Analysis - Mounted Case	NO	NO			Not Covered	
D9951	Occlusal Adjustment - Limited	NO	NO			Not Covered	
D9952	Occlusal Adjustment - Complete	NO	NO			Not Covered	
D9970	Enamel Microabrasion	NO	NO			Not Covered	

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D9971	Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections	NO	NO			Not Covered	
D9972	External Bleaching – Per Arch	NO	NO			Not Covered	
D9973	External Bleaching – Per Tooth	NO	NO			Not Covered	
D9974	Internal Bleaching – Per Tooth	NO	NO			Not Covered	
D9999	Unspecified Adjunctive Procedure, by Report	YES	YES	YES	YES		By Report

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