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### CDT DENTAL CODES

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# INTRODUCTION

Eff. 7/1/14

 Approximately once a year, the American Dental Association issues new Current Dental Terminology (CDT) dental procedure codes which includes additions to and deletions from this schedule of codes. Providers will be notified of all such additions and deletions through the list serve, 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 dentists 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.

 **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-IID residents (with the exception of orthodontics which is not covered for residents of an ICF-IID) and the second column, indicating coverage for adults 21 and over when allowed under Section 25, Dental Services, of the MaineCare Benefits Manual (MBM), Chapter II, 25.04, Special Requirements for Adult Services.

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4. Prior Authorization Some procedures require authorization prior to the performance of a service in order for MaineCare to

 Required: 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 medically necessary criteria, prior authorization criteria, 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 MBM, Chapter II. Codes also reimbursable to 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.

Eff. 7/1/14

 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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |
| Proc.CodeEff. 7/1/14 | Description | under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 | Additional Limits | MaxAllow |
|  |  |  |  |
|  |  **I. DIAGNOSTIC** |  |  |
|  |  |  |  |  |  |  |  |
|  |  **CLINICAL ORAL EXAMINATIONS**  |  |  |
| Eff. 7/1/14 |  |  |  |  |  |  |  |
| D0120 | Periodic Oral Evaluation | YES | NO | NO |  |  Twice per calendar year, but no more than once every 150 days. | $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 |
| D0145Eff. 7/1/14 | Oral Evaluation for a Patient Under Three Years of Ageand Counseling with Primary Caregiver | YES | NO | NO |  |  For members under age 3, twice per calendar year. Code may not be used for members age 3 and over. | $20.00 |
| D0150 | Comprehensive Oral Evaluation | YES | NO | NO |  |  | $55.00 |
| D0160Eff. 7/1/14 | Detailed and Extensive Oral Evaluation - Problem Focused | 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 |  |
| Eff. 7/1/14 |  |  |  |  |  |  |  |
|  | **PRE-DIAGNOSTIC SERVICES** |  |
|  |  |  |  |  |  |  |  |
| D0190 | Screening of Patient | NO | NO |  |  | Not Covered |  |
| D0191 | Assessment of a Patient | NO | NO |  |  | Not Covered |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |
| Proc.CodeEff. 7/1/14 | Description | under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 | Additional Limits | MaxAllow |
|  | **IMAGE CAPTURE WITH INTERPRETATION** |  |
| D0210 | Intraoral - Complete Series of Radiographic Images | YES | YES | NO | NO | Must include 12 periapical plus 2 posterior bitewings, allowed only once every 3 years, except as part of approved orthodontics. IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $43.50 |
| D0220 | Intraoral - Periapical, First Radiographic Image | YES | YES | NO | NO | IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $8.00 |
| D0230 | Intraoral - Periapical, Each Additional Radiographic Image | YES | YES | NO | NO | IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $6.50 |
| D0240 | Intraoral - Occlusal Radiographic Image | YES | YES | NO | NO | IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $10.00 |
| D0250 | Extraoral - First Radiographic Image | YES | YES | NO | NO | IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $9.00 |
| D0260 | Extraoral - Each Additional Radiographic Image | YES | YES | NO | NO | IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $9.00 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Eff. 7/1/14 |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |
| Proc.Code | Description | under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 | Additional Limits | MaxAllow |
| D0270 | Bitewing-Single Radiographic Image | YES | YES | NO | NO | Posterior bitewings alone are once per calendar year. IDDHs | $8.00 |
| D0272 | Bitewings - Two Radiographic Images | YES | YES | NO | NO | Posterior bitewings alone are once per calendar year. IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $15.00 |
| D0273 | Bitewings - Three Radiographic Images | YES | YES | NO | NO | Posterior bitewings alone are once per calendar year. IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $17.50 |
| D0274 | Bitewings - Four Radiographic Images | YES | YES | NO | NO | Posterior bitewings alone are once per calendar year. IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $20.00 |
| D0277 | Vertical Bitewings – 7-8 Radiographic Images | YES | YES | NO | NO | . IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $30.00 |
| D0290 | Posterior-Anterior or Lateral Skull and Facial Bones, Survey Radiographic Image | YES | YES | NO | NO |  | $25.00 |
| D0310 | Sialography | YES | YES | NO | NO | For gland or duct, not allowed for salivary stone | $30.00 |

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| --- | --- | --- | --- | --- | --- |
|  |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |
| Proc.CodeEff. 7/1/14 | Description | under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 | Additional Limits | MaxAllow |
| D0320 | Temporomandibular Joint Arthrogram, Including Injection | YES | YES | NO | NO | Right and left trans-cranial films in open, closed, and rest required | $35.00 |
| D0321Eff. 7/1/14 | Other Temporomandibular Joint Radiographic Images  | YES | YES | YES | YES |  | $43.00 |
| D0322 | Tomographic Survey | NO | NO |  |  | Not Covered |  |
| D0330Eff. 7/1/14 | Panoramic Radiographic Image | YES | YES | NO | NO | Reimbursable: (1) for interceptive orthodontics; (2) for oral surgery. (3) once per five (5) years for either Preventive Services or Diagnostic Services . IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $43.00 |
| D0340 | Cephalometric Radiographic Image | NO | NO |  |  | Included as part of “records” in comprehensive orthodontics, not covered separately |  |
| D0350 | Oral/Facial Photographic Images Obtained Intraorally or Extraorally | NO | NO |  |  | Not Covered |  |
| D0364 | Cone Beam - CT capture and interpretation with limited field of view – less than one whole jaw | NO | NO |  |  | Not Covered |  |
| D0365 | Cone Beam - CT capture and interpretation with field of view of one full dental arch – Mandible | NO | NO |  |  | Not Covered |  |

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|  |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |
| Proc.CodeEff. 7/1/14 | Description | under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 | Additional Limits | MaxAllow |
| D0366 | Cone Beam - CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium | NO | NO |  |  | Not Covered |  |
| D0367 | Cone Beam - CT capture and interpretation with field of view of both jaws; with or without cranium | NO | NO |  |  | Not Covered |  |
| D0368 | Cone Beam - CT capture and interpretation for TMJ series including two or more exposures | NO | NO |  |  | Not Covered |  |
| D0369 | Maxillofacial MRI capture and interpretation | NO | NO |  |  | Not Covered |  |
| D0370 | Maxillofacial ultrasound capture and interpretation | NO | NO |  |  | Not Covered |  |
| D0371 | Sialoendoscopy capture and interpretation | NO | NO |  |  | Not Covered |  |
|  |
|  **IMAGE CAPTURE ONLY** |
|  |
|  **INTERPRETATION AND REPORT PERFORMED BY A PRACTIONER NOT ASSOCIATED WITH THE CAPTURE** |
|  |
| D0380 | Cone Beam - CT image capture with limited field of view – less than one whole jaw | NO | NO |  |  | Not Covered |  |
| D0381 | Cone Beam - CT image capture with field of view of one full dental arch – mandible | NO | NO |  |  | Not Covered |  |
| D0382 | Cone Beam - CT image capture with field of view of one full dental arch – maxilla, with or without cranium | NO | NO |  |  | Not Covered |  |
| D0383 | Cone Beam - CT image capture with field of view of both jaws, with or without cranium | NO | NO |  |  | Not Covered |  |

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| --- | --- | --- | --- | --- | --- |
|  |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |
| Proc.CodeEff. 7/1/14 | Description | under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 | Additional Limits | MaxAllow |
| D0384 | Cone Beam - CT image capture for TMJ series including two or more exposures | NO | NO |  |  | Not Covered |  |
| D0385 | Maxillofacial MRI image capture | NO | NO |  |  | Not Covered |  |
| D0386 | Maxillofacial ultrasound image capture | NO | NO |  |  | Not Covered |  |
|  |
|  **IMAGE CAPTURE PERFORMED BY A PRACTITIONER NOT ASSOCIATED WITH INTERPRETATION AND REPORT** |
|  |
| D0391 | Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **TEST AND EXAMINATIONS** |  |  |  |  |  |  |
|  |
| 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 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |
| Proc.CodeEff. 7/1/14 | Description | under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 | Additional Limits | MaxAllow |  | Covered ServiceAge/ICF-IID | Prior Authorizationrequired |  |  |  |  |
| D0470 | Diagnostic Casts | YES | NO | NO |  |  | $32.00 |
|  | **ORAL PATHOLOGY LABORATORY CODES**  |
|  |  |
| 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 |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional LimitsMaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D0485Eff. 7/1/14 | Consultation, Including Preparation of Slides from Biopsy Material Supplied by Referring Source | NO | NO |  |  | Not Covered |  |
| D0486 | Accession of Transepithelial Cytologic Sample, Microscopic Examination | NO | NO |  |  | Not Covered |  |
| D0502 | Other Oral Pathology Procedures, by Report | NO | NO |  |  | Not Covered |  |
| D0999 | Unspecified Diagnostic Procedure, by Report | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **II. PREVENTIVE**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **DENTAL PROPHYLAXIS**  |
| Eff. 7/1/14 |  |
| D1110 | Prophylaxis – Adult | YES | YES | NO | YES |  Limited to age 13 and over. Twice per calendar year, but no more than once every 150 days. Prior Authorization necessary for greater frequency. Includes oral hygiene instruction. Dental Hygienists practicing under PHS, IPDHs practicing under PHS may use this code for all ages. IPDHs may use this code only for members up to age 21. | $40.00 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D1120 | Prophylaxis – Child | YES | NO | NO |  |  Twice per calendar year, but no more than once every 150 days. Prior Authorization necessary for greater frequency. Includes oral hygiene instruction. Dental Hygienists practicing under PHS, IPDHs practicing under PHS, and IPDHs may use this code. | $30.00 |
|  |  |
|  | **TOPICAL FLUORIDE TREATMENTS (Office Procedure)** |
|  |  |  |  |  |  |  |  |
| D1206 | Topical Application of Fluoride Varnish  | YES | NO | NO |  | Members under age 3: twice per calendar year, and a third treatment per calendar year is permitted for Members who either have a high caries rate or the Member has had new restorations placed in the previous eighteen (18) months. Members age 3 through age 20, twice per calendar year, but no more than once every 150 days, and a third treatment per calendar year is permitted for  |  $12.00 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IIDPrior Authorizationrequired | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |  |  |  |  |  | Members who either have a high caries rate or the Member has had new restorations placed in the previous eighteen (18) months. Dental Hygienists practicing under PHS, IPDHs practicing under PHS, and IPDHs may use this code. |  |
| D1208 | Topical Application of Fluoride | YES | NO | NO |  | Members under age 3: twice per calendar year, and a third treatment per calendar year is permitted for Members who either have a high caries rate or the Member has had new restorations placed in the previous eighteen (18) months. Members age 3 through age 20, twice per calendar year, but no more than once every 150 days, and a third treatment per calendar year is permitted for Members who either have a high caries rate or the Member has had new restorations placed in the previous eighteen (18)  | $12.00 |
| Eff. 7/1/14 |  |  |  |  |  | months. Dental Hygienists practicing under PHS, IPDHs practicing under PHS, and IPDHs may use this code. |  |
|  |  |  |  |  |  |  |  |
| Proc.Code | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  | **Other Preventive Services**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D1310 | Nutritional Counseling for Control of Dental Disease | NO | NO |  |  | Not Covered |  |
| D1320 | Tobacco Counseling for the Control and Prevention of Oral Disease | YES | YES | NO | NO |  | $20.00 |
| D1330 | Oral Hygiene Instructions  | YES | NO | NO |  | Three times per calendar year. Not billable the same day as prophylaxis. Dental Hygienists practicing under PHS, IPDHs practicing under PHS, and IPDHs 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. Dental Hygienists practicing under PHS, IPDHs practicing under PHS, and IPDHs may use this code. | $16.00 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D1352 | Preventive Resin Restoration in a Moderate to High Caries Risk Patient-permanent tooth | NO | NO |  |  | Not Covered |  |
|  |  |
|  | **SPACE MAINTENANCE (PASSIVE APPLIANCES)**  |
|  |
| 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 |
| D1550 | Re-cementation of Space Maintainer | YES | NO | NO |  |  | $22.50 |
| D1555 | Removal of Fixed Space Maintainer | YES | NO | NO |  |  | $50.00 |
|  |  |  |  |  |  |  |  |
|  | **III. RESTORATIVE**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | **AMALGAM RESTORATIONS (INCLUDING POLISHING)** |  |  |  |  |  |
|  |  |  |  |  |  |  |
| 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 |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |  |  |
|  | **RESIN-BASED COMPOSITE RESTORATIONS – DIRECT** |  |
|  |  |  |
| 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 |
|  |
|  **GOLD FOIL RESTORATIONS**  |
|  |
| 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 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |
|  | **INLAY/ONLAY RESTORATIONS** |
|  |  |  |  |  |  |  |  |
| 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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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |  |  |  |  |  |  |
|  | **CROWNS - SINGLE RESTORATIONS ONLY** |  |  |  |  |  |
|  |  |  |  |  |  |  |
| 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 |  |
| D2794Eff. 7/1/14 | Crown - Titanium | NO | NO |  |  | Not Covered |  |
| D2799 | Provisional Crown - further treatment or completion of diagnosis necessary prior to final impression | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
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|  | **OTHER RESTORATIVE SERVICES** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |
| D2920Eff. 7/1/14 | Recement Crown | YES | YES | NO | NO |  | $30.00  |
| D2929 | Prefabricated Porcelain/Ceramic Crown – Primary Tooth  | NO | NO |  |  | Not Covered |  |
| D2930 | Prefabricated Stainless Steel Crown - Primary Tooth | YES | NO | NO |  |  | $120.00 |
| 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 |  |
| D2934Eff. 7/1/14 | Prefabricated Esthetic Coated Stainless Steel Crown –Primary Tooth | NO | NO |  |  | Not Covered |  |
| D2940 | Protective Restoration | YES | YES | NO | NO | Not covered with Pulpotomy. IPDHs may use this code subject to the guidelines and limitations in MBM Chap II. | $30.00 |
| D2950 | Core Buildup, Including Any Pins when required | **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 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D2955 | Post Removal  | 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 |  |
| D2980Eff. 7/1/14 | Crown Repair Necessitated By Restorative Material Failure | YES | Yes | NO | NO |  | $34.00 |
| D2981 | Inlay Repair Necessitated By Restorative Material Failure | NO | NO |  |  | Not Covered |  |
| D2982 | Onlay Repair Necessitated By Restorative Material Failure | NO | NO |  |  | Not Covered |  |
| D2983 | Veneer Repair Necessitated By Restorative Material Failure | NO | NO |  |  | Not Covered |  |
| D2990 | Resin Infiltration of Incipient Smooth Surface Lesions | NO | NO |  |  | Not Covered |  |
| D2999 | Unspecified Restorative Procedure, by Report | YES | YES | YES | YES | Ex: Temp. crown – fractured tooth | By Report |

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|  | **IV. ENDODONTICS**  |  |  |  |  |  |  |
|  | **PULP CAPPING** |  |  |  |  |  |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
|  |
|  | PULPOTOMY |
|  |  |
| 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 |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  | **ENDODONTIC THERAPY ON PRIMARY TEETH** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D3230 | Pulpal Therapy (resorbable filling) - Anterior, Primary Tooth (excluding final restoration) | YES | NO |  |  |  Not separately reimbursable to same provider as part of root canal in same period of treatment | $50.00 |
| D3240 | Pulpal Therapy (resorbable filling) - Posterior, Primary Tooth (excluding final restoration) |  YES | NO |  |  |  Not separately reimbursable to same provider as part of root canal in same period of treatment | $50.00 |
|  |  |  |  |  |  |  |  |
|  | **ENDODONTIC THERAPY (including TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)** |
|  |
| 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 |  |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID |  | Prior Authorizationrequired |  | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
|  |  |  |  |  |  |  |  |
|  | **APEXIFICATION/RECALCIFICATION PROCEDURES** |  |
| Eff. 7/1/14 |  |  |  |  |  |  |  |
| D3351 | Apexification/Recalcification-Initial Visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) | YES | YES | NO | NO |  | $56.00 |
| D3352 | Apexification/Recalcification-Interim Medication Replacement  | 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 |
|  |  |  |  |  |  |  |  |
|  | **APICOECTOMY/PERIRADICULAR SERVICES** |  |  |  |  |  |  |
| Eff. 7/1/14 |  |  |  |  |  |  |  |
| D3410 | Apicoectomy - Anterior | YES | YES | NO | NO |  | $170.00 |
| D3421 | Apicoectomy - Bicuspid (first root) | NO | NO |  |  | Not Covered |  |
| D3425 | Apicoectomy– Molar (first root) | NO | NO |  |  | Not Covered |  |
| D3426 | Apicoectomy (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 |  |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D3460 | Endodontic Endosseous Implant | NO | NO |  |  | Not Covered |  |
| D3470 | Intentional Reimplantation (including necessary splinting) | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **OTHER ENDODONTIC PROCEDURES**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |
|  |  |  |  |  |  |  |  |
|  | **V. PERIODONTICS**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)**  |
|  |  |
| D4210Eff. 7/1/14 | Gingivectomy or Gingivoplasty – Four or More Con- tiguous Teeth or Tooth Bounded Spaces Per Quadrant | Yes | NO | NO |  | Member must have medication enduced gingival hyperplasia with clinical pockets greater than 4mm. | $162.00 |
| D4211 | Gingivectomy or Gingivoplasty – One to Three Teeth contiguous or Tooth bounded spaces, Per Quadrant | Yes | No | Yes |  |  | $56.00 |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | YES | NO | YES |  |  | $25.00 |
| 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 |  |
| D4260Eff. 7/1/14 | Osseous Surgery (including flap entry and closure) – Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant | Yes | No | Yes |  |  | $280.00 |
| D4261 | Osseous Surgery (including flap entry and closure) – One to Three Contiguous Teeth or Tooth Bounded 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 |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D4266 | Guided Tissue Regeneration – Resorbable Barrier, Per Site | No | No |  |  | Not Covered |  |
| D4267 | Guided Tissue Regeneration – Nonresorbable Barrier, Per Site (includes membrane removal) | No | No |  |  | Not Covered |  |
| D4268 | Surgical Revision Procedure, Per Tooth | Yes | Yes | Yes | Yes |  | $200.00 |
| D4270 | Pedicle Soft Tissue Graft Procedure | 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 |  |
| D4277Eff. 7/1/14 | Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in grafts | YES | NO | YES |  |  | $250.00 |
| D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in the same graft site | YES | NO | YES |  | Must be reported in conjunction with D4277 | $125.00 |
|  |  |  |  |  |  |  |  |
|  | NON-SURGICAL PERIODONTAL SERVICES  |  |
|  |  |  |  |  |  |  |  |
| D4320 | Provisional Splinting - Intracoronal | NO | NO |  |  | Not Covered |  |
| D4321 | Provisional Splinting – Extracoronal | No | No |  |  | Not Covered |  |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |  |
| D4355Eff. 7/1/14 | Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis | Yes | Yes | YES | YES | Once per year per provider. Dental Hygienists practicing under PHS and IPDHs practicing under PHS may use this code. | $100.00 |
| D4381 | Localized Delivery of Antimicrobial Agents Via a Controlled Release Vehicle into Diseased Crevicular Tissue, Per Tooth | No | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **OTHER PERIODONTAL SERVICES**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D4910Eff. 7/1/14 | Periodontal Maintenance  | Yes | NO | YES |  |  | $39.00 |
| D4920 | Unscheduled Dressing Change (by someone other than treating dentist or their staff) | Yes | No | No |  |  | $27.00 |
| D4999 | Unspecified Periodontal Procedure, by Report | Yes | Yes | Yes | Yes |  | By Report |

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|  | **VI. PROSTHODONTICS, REMOVABLE**  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | **COMPLETE DENTURES (INCLUDING ROUTINE POST DELIVERY CARE)**  |  |  |  |
|  |  |  |  |  |  |  |  |
| Eff. 7/1/14Proc.Code | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
|  |  |  |  |  |  |  |  |
|  | **PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)**  |
|  |  |
| D5211Eff. 7/1/14 | Maxillary Partial Denture-Resin Base (including any conventional clasps, rests and teeth) | Yes | YES | Yes | YES | Every 5 years. Denturists may also use this code. | $280.00 |
| D5212 | Mandibular Partial Denture-Resin Base (including any conventional clasps, rests and teeth) | Yes | YES | Yes | YES | Every 5 years. Denturists may also use this code. | $280.00 |
| D5213 | Maxillary Partial Denture-Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth) | Yes | YES | Yes | YES | Every 5 years. Denturists may also use this code. | $423.00 |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D5214Eff. 7/1/14 | Mandibular Partial Denture-Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth) | Yes | YES | Yes | YES | Every 5 years. Denturists may also use this code. | $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 |  |
|  |  |  |  |  |  |  |  |
|  | **ADJUSTMENTS TO DENTURES**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |
| D5421Eff. 7/1/14 | Adjust Partial Denture - Maxillary | Yes | Yes | No | No | Denturists may also use this code. | $25.00 |
| D5422 | Adjust Partial Denture - Mandibular | Yes | Yes | No | No | Denturists may also use this code. | $25.00 |
|  |  |  |  |  |  |  |  |
|  | **REPAIRS TO COMPLETE DENTURES**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D5510 | Repair Broken Complete Denture Base | Yes | Yes | No | No | Denturists may also use this code | $57.00 |
| Proc.Eff. 7/1/14Code | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D5520 | Replace Missing or Broken Teeth-Complete Denture (each tooth) | Yes | Yes | No | No | Denturists may also use this code | $50.00 |
|  |  |  |  |  |  |  |  |
|  | **REPAIRS TO PARTIAL DENTURES**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D5610Eff. 7/1/14 | Repair Resin Denture Base | Yes | Yes | No | No | Denturists may also use this code. | $56.00 |
| D5620 | Repair Cast Framework | Yes | Yes | No | No | Denturists may also use this code. | $85.00 |
| D5630 | Repair or Replace Broken Clasp | Yes | Yes | No | No | Denturists may also use this code. | $85.00 |
| D5640 | Replace Broken Teeth - Per Tooth | Yes | Yes | No | No | Denturists may also use this code. | $50.00 |
| D5650 | Add Tooth to Existing Partial Denture | Yes | Yes | No | No | Denturists may also use this code. | $55.00 |
| D5660 | Add Clasp to Existing Partial Denture | Yes | Yes | No | No | Denturists may also use this code. | $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 |  |

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| --- | --- | --- |
|  | **DENTURE REBASE PROCEDURES**  |  |
|  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
| D5720Eff. 7/1/14 | Rebase Maxillary Partial Denture | Yes | Yes | No | No | Refer to Chapter II, 25.03. Denturists may also use this code. | $150.00  |
| D5721 | Rebase Mandibular Partial Denture | Yes | Yes | No | No | Refer to Chapter II, 25.03. Denturists may also use this code. | $150.00 |
|  |  |  |  |  |  |  |  |
|  | **DENTURE RELINE PROCEDURES** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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. Denturists may also use this code. | $78.00 |
| D5740 | Reline Maxillary Partial Denture (chairside) | No | No |  |  | Not Covered |  |
| D5741 | Reline Mandibular Partial Denture (chairside) | No | No |  |  | Not Covered |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |  |
|  |
|  | **INTERIM PROSTHESIS**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |  |
|  |  |
|  | **OTHER REMOVABLE PROSTHETIC SERVICES** |
|  |
| D5850 | Tissue Conditioning, Maxillary | NO | NO |  |  | Not Covered |  |
| D5851 | Tissue Conditioning, Mandibular | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D5862Eff. 7/1/14 | Precision Attachment, by Report | No | No |  |  | Not Covered |  |
| D5863 | Overdenture – complete maxillary | YES | NO | YES |  |  | $473.00 |
| D5864 | Overdenture – partial maxillary | YES | NO | YES |  |  | $473.00 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D5865 | Overdenture – complete mandibular | YES | NO | YES |  |  | $473.00 |
| D5866 | Overdenture – partial mandibular | YES | NO | YES |  |  | $473.00 |
| 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 Implant Surgery | No | No |  |  | Not Covered |  |
| D5899 | Unspecified Removable Prosthodontic Procedure, by Report | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **VII. MAXILLOFACIAL PROSTHETICS**  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
| 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 | Commissure Splint | NO | NO |  |  | Not Covered |  |
| D5988 | Surgical Splint | No | No |  |  | Not Covered |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D5991 | Vesiculobullous disease medicament carrier | NO | NO |  |  | Not Covered |  |
| D5992 | Adjustment of Maxillofacial Prostehtic Appliance | YES | YES | YES | YES |  | By Report |
| D5993 | Maintenance and cleaning of Maxillofacial Prosthesis (extra or intraoral) other than required adjustments | YES | YES | YES | YES |  | By Report |
| D5999 | Unspecified Maxillofacial Prosthesis, by Report | Yes | Yes | Yes | Yes |  | By Report |
|  |  |  |  |  |  |  |  |
|  | **VIII. IMPLANT SERVICES** |  |  |  |  |  |  |
|  |
| 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 |  |
| D6050Eff. 7/1/14 | Surgical Placement: Transosteal Implant | No | No |  |  | Not Covered |  |
| D6051 | Interim Abutment | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | IMPLANT SUPPORTED PROSTHETICS |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D6053 | Implant/Abutment Supported Removable Denture for Completely Edentulous Arch | NO | NO |  |  | Not Covered |  |
| D6054 | Implant/Abutment Supported Removable Denture for Partially Edentulous Arch | NO | NO |  |  | Not Covered |  |
| D6055Eff. 7/1/14 | Connecting Bar Implant Supported Abutment Supported | NO | NO |  |  | Not Covered |  |
| D6056 | Prefabricated Abutment - Includes Modification and Placement | No | No |  |  | Not Covered |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D6057 | Custom Fabricated 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 mental) | 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 mental) | No | No |  |  | Not Covered |  |
| D6070 | Abutment Supported Retainer for Porcelain Fused to Metal FPD (predominantly base metal) | No | No |  |  | Not Covered |  |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D6071 | Abutment Supported Retainer for Porcelain Fused to Metal FPD (noble metal) | No | No |  |  | Not Covered |  |
| 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 |  |
|  |
|  | OTHER IMPLANT SERVICES |  |  |  |  |  |  |
|  |
| D6080Eff. 7/1/14 | Implant Maintenance Procedures, when Prostheses are Removed and Reinserted, Including Cleansing of Prostheses and Abutments  | No | No |  |  | Not Covered |  |
| D6090 | Repair Implant Supported Prosthesis, by Report | No | No |  |  | Not Covered |  |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |  |
| D6094 | Abutment Supported Crown - (titanium) | NO | NO |  |  | Not Covered |  |
| D6095 | Repair Implant Abutment, by Report | No | No |  |  | Not Covered |  |
| D6100Eff. 7/1/14 | Implant Removal, by Report | No | No |  |  | Not Covered |  |
| D6101 | Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure | NO | NO |  |  | Not Covered |  |
| D6102 | Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure | NO | NO |  |  | Not Covered |  |
| D6103 | Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration | NO | NO |  |  | Not Covered |  |
| D6104 | Bone graft at time of implant placement. Placement of a barrier membrane or biologic materials | 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**  |  |
| Eff. 7/1/14Proc.Code | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
| D6252Eff. 7/1/14 | Pontic - Resin with Noble Metal | Yes | No | Yes |  |  | $314.00 |
| D6253 | Provisional Pontic - Further Treatment Or Completion Of Diagnosis Necessary Prior To Final Impression | NO | NO |  |  | Not Covered |  |
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|  | FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS |
|  |
| D6545 | Retainer-Cast Metal for Resin Bonded Fixed Prosthesis | Yes | No | Yes |  |  | $150.00 |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |  |

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|  | FIXED PARTIAL DENTURE RETAINERS - CROWNS |  |
|  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D6710 | Crown - Indirect Resin Based Composite | NO | NO |  |  | Not Covered |  |
| D6720 | Crown - Resin with High Noble Metal | No | No |  |  | Not Covered |  |
| 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 |  |
| D6793Eff. 7/1/14 | Provisional Retainer Crown - Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression | No | NO |  |  | Not Covered |  |
| D6794 | Crown - Titanium | NO | NO |  |  | Not Covered |  |

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| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |  |  |  |  |  |  |  |
|  | OTHER FIXED PARTIAL DENTURE SERVICES |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |  |
| D6975Eff. 7/1/14 | Coping  | No | No |  |  | Not Covered |  |
| D6980 | Fixed Partial Denture Repair Necessitated By Restorative Material Failure | No | No |  |  | Not Covered |  |
| D6985 | Pediatric Partial Denture, Fixed | NO | no |  |  | Not Covered |  |
| D6999 | Unspecified Fixed Prosthodontic Procedure, by Report | No | No |  |  | Not Covered |  |
|  |  |  |  |  |  |  |
|  | **X. ORAL and Maxillofacial SURGERY**  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | **EXTRACTIONS - INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED & ROUTINE POSTOPERATIVE CARE** |  |
|  |  |  |
| 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 |

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| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |  |  |  |  |  |  |  |
|  | **SURGICAL EXTRACTIONS – (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, & ROUTINE POSTOPERATIVE CARE)**  |
|  |
| D7210 | Surgical Removal of Erupted Tooth Requiring Removal of Bone and/or Sectioning  | 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 |
| D7250Eff. 7/1/14 | Surgical Removal of Residual Tooth Roots (cutting procedure) | Yes | Yes | No | No | Documented need demonstrated by X - rays | $130.00 |
| D7251 | Coronectomy – Intentional Partial Tooth Removal | YES | YES | NO | NO |  | $110.00 |
|  |
|  | **OTHER SURGICAL PROCEDURES** |  |
|  |  |  |  |  |  |  |  |
| 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 |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
| D7290Eff. 7/1/14 | Surgical Repositioning of Teeth | Yes | Yes | No | No |  | $175.00 |
| D7291 | Transseptal Fiberotomy/Supra Crestal Fiberotomy | 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 |  |
| D7295Eff. 7/1/14 | Harvest of Bone for use in Autogenous Grafing Procedure | YES | YES | NO | YES | Only reimbursable when necessary for bone graft for reconstruction of alveolar defect. | $225.00 |

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| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |  |  |  |  |  |  |  |
|  | **ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES**  |  |
|  |
| D7310 | Alveoloplasty in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant | Yes | Yes | NO | NO |  | $64.00 |
| D7311 | Alveoloplasty in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant | NO | NO |  |  | Not Covered |  |
| D7320Eff. 7/1/14 | Alveoloplasty not in Conjunction with Extractions - Four or More Teeth or Tooth Spaces, Per Quadrant | Yes | Yes | NO | NO |  Only reimbursable for members who have alveolar segment irregularity preventing denture placement. | $94.00 |
| D7321 | Alveoloplasty not in Conjunction with Extractions - One to Three Teeth or Tooth Spaces, Per Quadrant | YES | YES | NO | NO |  Only reimbursable for members who have alveolar segment irregularity preventing denture placement. | $47.00 |
|  |
|  | **VESTIBULOPLASTY** |
|  |
| 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 |  |

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|  | **SURGICAL EXCISION OF SOFT TISSUE LESIONS**  |
|  |  |  |  |  |  |  |  |
| Proc.Eff. 7/1/14Code | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
| D7415Eff. 7/1/14 | Excision of Malignant Lesion, Complicated | yes | yes | NO | NO |  | $750.00 |
| D7465 | Destruction of Lesion(s) by Physical or Chemical Method | Yes | Yes | No | No |  | $75.00 |
|  |  |  |  |  |  |  |  |
|  | **SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS** |
|  |  |  |  |  |  |  |  |
| 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 |

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|  | **EXCISION OF BONE TISSUE** |  |  |  |  |  |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D7471 | Removal of Lateral Exostosis (maxilla or mandible) | Yes | Yes | NO | NO | Only reimbursable when Lateral Exostosis prevents denture placement. | $300.00 |
| D7472 | Removal of Torus Palatinus | YES | YES | NO | NO | Only reimbursable when Torus Palatinus prevents denture placement. | By Report |
| D7473 | Removal of Torus Mandibularis | YES | YES | NO | NO | Only reimbursable when Torus Manibulus prevents denture placement. | By Report |
| D7485 | Surgical Reduction of Osseous Tuberosity | No | NO |  |  | Not Covered |  |
| D7490 | Radical Resection of Maxilla or Mandible | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **SURGICAL INCISION**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |
| 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 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D7540 | Removal of Reaction Producing Foreign Bodies, Musculoskeletal System | YES | YES | NO | NO |  | By Report |
| D7550 | Partial Ostectomy/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 |
|  |
|  | **TREATMENT OF FRACTURES - SIMPLE**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 Multiple Surgical Approaches | Yes | Yes | No | No |  | $1,383.00 |

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|  | **TREATMENT OF FRACTURES - COMPOUND**  |  |  |  |  |  |
|  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| 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 |
|  |  |  |  |  |  |  |  |
|  | **REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS**  |  |
|  |  |  |  |  |  |  |  |
| 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 |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
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| D7860 | Arthrotomy | Yes | Yes | Yes | Yes |  | $1,185.50 |
| D7865 | Arthroplasty | NO | No |  |  | Not Covered |  |
| D7870 | Arthrocentesis | NO | NO |  |  | Not Covered |  |
| 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 |  |
| D7877Eff. 7/1/14 | Arthroscopy – Surgical; Debridement | NO | NO |  |  | Not Covered |  |
| D7880 | Occlusal Orthotic Device | Yes | Yes | Yes | Yes |  | $250.00 |
| D7899 | Unspecified TMD Therapy, by Report | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **REPAIR OF TRAUMATIC WOUNDS**  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D7910 | Suture of Recent Small Wounds Up to 5 cm | YES | Yes | No | No |  | $84.75 |
|  |  |
|  | **COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)** |
|  |  |  |  |  |  |  |  |
| 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 |

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|  |  |  |  |  |  |  |  |
|  | OTHER REPAIR PROCEDURES |  |  |  |  |  |  |
|  |
| D7920Eff. 7/1/14 | Skin Grafts (identify defect covered, location, and type of graft) | NO | NO |  |  | Not Covered |  |
| D7921 | Collection and Application of Autologous Blood Concentrate Product | 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; Includes Obtaining The Graft | Yes | Yes | Yes | Yes |  | $2,529.00 |
| 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 |
| D7950Eff. 7/1/14 | 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 via a Lateral Open Approach | NO | NO |  |  | Not Covered |  |
| D7952 | Sinus Augmentation via a Vertical Approach | NO | NO |  |  | Not Covered |  |

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| D7953 | Bone Replacement Graft for Ridge Preservation - Per Site | YES | YES | NO | NO | Only reimbursable when necessary for bone graft for reconstruction of alveolar defect. | $325.00 |
| D7955 | Repair of Maxillofacial Soft and/or Hard Tissue Defect  | Yes | Yes | No | No |  | $412.00 |
| D7960Eff. 7/1/14 | Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure Not Incidental to Another | Yes | Yes | No | NO |  | $97.00 |
| D7963 | Frenuloplasty | YES | YES | NO | NO |  | $125.00 |
| D7970 | Excision of Hyperplastic Tissue - Per Arch | Yes | Yes | NO | NO | Only reimbursable when Hyperplastic Tissue prevents denture placement. | $356.00 |
| D7971 | Excision of Pericoronal Gingiva | Yes | Yes | NO | NO | Only reimbursable when necessary to prevent chronic infection. | $ 58.00 |
| D7972 | Surgical Reduction of Fibrous Tuberosity | YES | yes | yes | yes |  | $70.00 |
| D7980 | Sialolithotomy | Yes | Yes | NO | NO | Only reimbursable if removal of salivary stone is interfering with normal salivary gland function. | $263.50 |
| D7981 | Excision of Salivary Gland, by Report | Yes | Yes | Yes | Yes |  | By Report |
| D7982 | Sialodochoplasty | Yes | Yes | Yes | Yes |  | By Report |
| D7983Eff. 7/1/14 | Closure of Salivary Fistula | Yes | Yes | NO | NO | Only reimbursable for repair of draining salivary fistula. | By Report |
| D7990 | Emergency Tracheotomy | Yes | Yes | No | No |  |  $159.50 |
| D7991Eff. 7/1/14 | Coronoidectomy | Yes | Yes | Yes | Yes |  | By Report |
| D7995 | Synthetic Graft - Mandible or Facial Bones | Yes | Yes | Yes | Yes |  | $1,106.50 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
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| D7996 | Implant - Mandible for Augmentation Purposes (Excluding Alveolar Ridge), by Report | No | No |  |  | Not Covered |  |
| D7997 | Appliance Removal (not by dentist who placed appliance), Includes Removal of Archbar | YES | No | YES |  |  | By Report |
| 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 |
| Eff. 7/1/14 |
|  | **XI. ORTHODONTICS (Orthodontics are not covered services for residents of ICF-IID facilities)** |
|  |
|  | **LIMITED ORTHODONTIC TREATMENT** |
|  |
| 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 |  |
|  |  |  |  |  |  |  |  |
|  | INTERCEPTIVE ORTHODONTIC TREATMENT |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D8050 | Interceptive Orthodontic Treatment of The Primary Dentition | Yes | No | Yes |  |  | $592.00 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D8060 | Interceptive Orthodontic Treatment of The Transitional Dentition | Yes | No | Yes |  |  | $592.00 |
|  |  |  |  |  |  |  |  |
|  | COMPREHENSIVE ORTHODONTIC TREATMENT |  |  |  |  |  |  |
|  |
| D8070Eff. 7/1/14 | Comprehensive Orthodontic Treatment of The Transitional Dentition | Yes | No | Yes |  | The Department will reimburse for one comprehensive orthodontic treatment per member per lifetime. D8070, D8080 and D8090 - all inclusive fee includes  | $2,725.00 |
| D8080 | Comprehensive Orthodontic Treatment of The Adolescent Dentition | Yes | No | Yes |  | appliances, brackets, treatment visits, one appliance repair or | $2,725.00 |
| D8090 | Comprehensive Orthodontic Treatment of The Adult Dentition | Yes | No | YES |  | replacement, and one retainer repair or replacement. Covered to age 21 | $2,725.00 |
|  |  |  |  |  |  |  |  |
|  | **MINOR TREATMENT TO CONTROL HARMFUL HABITS** |
|  |  |  |  |  |  |  |  |
| D8210 | Removable Appliance Therapy | Yes | No | Yes |  |  | $375.00 |
| D8220 | Fixed Appliance Therapy | Yes | No | Yes |  |  | $375.00 |
|  |  |  |  |  |  |  |  |
|  | OTHER ORTHODONTIC SERVICES |
|  |  |  |  |  |  |  |  |
| D8660 | Pre-Orthodontic Treatment Visit | Yes | No | No |  |  | $22.50 |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
|  |  |  |  |  |  |  |  |
| 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 |
| D8692Eff. 7/1/14 | Replacement of Lost or Broken Retainer | YES | NO | NO |  |  | $125.00 |
| D8693 | Rebonding or Recementing of Fixed Retainers | YES | NO | NO |  |  | $50.00 |
| D8999 | Unspecified Orthodontic Procedure, by Report | Yes | No | Yes |  |  | By Report |
|  |
|  | **XII. ADJUNCTIVE GENERAL SERVICES** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **UNCLASSIFIED TREATMENT** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D9110 | Palliative (emergency) Treatment of Dental Pain - Minor Procedure | Yes | Yes | No | No |  | $35.00 |
| D9120 | Fixed Partial Denture Sectioning | NO | NO |  |  | Not Covered |  |
|  |  |  |  |  |  |  |  |
|  | **ANESTHESIA** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| D9210 | Local Anesthesia not in Conjunction with Operative or Surgical Procedures | No | No |  |  | Not Covered |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D9211 | Regional Block Anesthesia | No | No |  |  | Not Covered |  |
| D9212Eff. 7/1/14 | Trigeminal Division Block Anesthesia | No | No |  |  | Not Covered |  |
| D9215 | Local Anesthesia in Conjunction with Operative or Surgical Procedures | No | No |  |  | Not Covered |  |
| D9220 | Deep Sedation/General Anesthesia – First 30 Minutes | Yes | Yes | NO | NO |  | $150.00 |
|  |  |  |  |  |  |  |  |
| D9221Eff. 7/1/14 | Deep Sedation/General Anesthesia - Each Additional 15 Minutes | Yes | Yes | NO | NO |  | $50.00 |
| D9230 | Inhalation of Nitrous Oxide/ Analgesia Anxiolysis | 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 |  |
|  |  |  |  |  |  |  |  |
|  | PROFESSIONAL CONSULTATION |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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 |

|  |  |
| --- | --- |
|  | **PROFESSIONAL VISITS** |
|  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D9410Eff. 7/1/14 | 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 or Ambulatory Surgical Call Center | Yes | Yes | No | No | Use for emergency room trauma care |  $100.00 |
| 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 |
|  |  |
|  | **DRUGS** |
|  |
| 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 |
|  |
|  | **MISCELLANEOUS SERVICES** |
|  |
| D9910 | Application of Desensitizing Medicament | No | No |  |  | Not Covered |  |
| Proc.CodeEff. 7/1/14 | Description | Covered ServiceAge/ICF-IID | Prior Authorizationrequired | Additional Limits | MaxAllow |
| under age 21 & all ICF-IID residents\* | age 21 & over when allowed under 25.04 | under age 21 & all ICF-IID residents | age 21 & over when allowed under 25.04 |
| D9911 | Application of Desensitizing Resin for Cervical and/or Root Surface, Per Tooth | No | No |  |  | Not Covered |  |
| D9920Eff. 7/1/14 | Behavior Management | Yes | No | No |  | Limit 3 visits per member per provider. Limited to dentist. | $13.00  |
| D9930 | Treatment of Complications (post-surgical) - Unusual Circumstances | Yes | Yes | No | No |  | $25.00 |
| D9940 | Occlusal Guard | Yes | Yes | NO | NO | Only reimbursable when used in conjunction with bruxism and other occlusal habits to protect the dentition from parafunctional habits. | $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 |  |
| D9971Eff. 7/1/14 | Odontoplasty 1-2 Teeth; Includes Removal of Enamel Projections | No | No |  |  | Not Covered |  |
| D9972 | External Bleaching – Per Arch Performed In Office | No | NO |  |  | Not Covered |  |
| D9973 | External Bleaching – Per Tooth | No | No |  |  | Not Covered |  |
| D9974Eff. 7/1/14 | Internal Bleaching – Per Tooth | No | No |  |  | Not Covered |  |
| D9975 | External Bleaching For Home Application, Per Arch; Includes Materials And Fabrication Of Custom Trays | NO | NO |  |  | Not Covered |  |
| D9999 | Unspecified Adjunctive Procedure, by Report | YES | YES | YES | YES |  | By Report |