

471-000-506 Nebraska Medicaid Practitioner Fee Schedule for Dental Services

Payment for services as outlined in this fee schedule shall be made as outlined in 471 NAC 6-000.

The four-digit numeric codes included in the Schedule are obtained from the American Dental Association's current CDT Dental Procedure Codes and Procedural Terminology (CDT®). CDT® is a listing of descriptive terms and numeric identifying codes and modifiers for reporting dental services and procedures performed by dental professionals. This Schedule includes CDT® numeric identifying codes for reporting dental services and procedures.

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The Schedule includes only CDT® numeric identifying codes for reporting dental services and procedures that were selected by the Nebraska Department of Health and Human Services, State of Nebraska. Any user of CDT® outside the Schedule should refer to CDT®. This publication contains the complete and most current listings of descriptive terms and numeric identifying codes and modifiers for reporting dental services and procedures.

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Definitions:

*"BR" (By Report) – Paid at "reasonable charge" based on the service and circumstances. A complete description of the service (and additional documentation, if applicable) is required for review. The provider's submitted charge must reflect their charge to the general public.

*FEE DETERMINED BY TREATMENT PLAN – Paid at Medicaid prior authorized amount based on the services authorized. A complete description of the services/treatment to be provided is required for prior authorization review. The provider's submitted charge on the prior authorization request must reflect their charge to the general public.

*PA (Prior Authorization) – Certain services require prior authorization.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0120	Periodic oral evaluation	\$22.89	No	<p><u>Age 20 & Younger:</u> Covered once every 180 days.</p> <p><u>Age 21 & Older:</u> Covered once every 180 days.</p> <p><u>Special Needs and Disabled:</u> Covered at the frequency determined appropriate by the treating dental provider. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition.</p>
D0140	Limited oral evaluation – problem focused	\$22.89	No	<p>Limited to twice in a one year period for each client.</p> <p>Covered for treatment of a specific problem and/or dental emergencies, trauma, acute infections, etc.</p>
D0145	Oral evaluation for a patient under 3 years of age & includes counseling with primary caregiver	\$38.49	No	Covered as needed.
D0150	Comprehensive oral evaluation – new or established patient	\$22.89	No	Limited to one per three year period per client, per provider, and location. It is not payable in conjunction with emergency treatment visits, denture repairs or similar appointments.
D0160	Detailed and extensive oral evaluation – problem focused, by report	\$28.09	No	
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	\$16.65	No	Benefit is limited to one per year per client.
D0180	Comprehensive periodontal evaluation – new or established patient	\$28.09	No	Limited to one per three year period per client.
D0210	Intraoral – complete series of radiographic images(including bitewings)	\$46.82	No	Maximum payment of \$46.82 per date of service for any combination of codes D0210 – D0330.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0220	Intraoral – periapical first radiographic image	\$6.24	No	D0240 occlusal film is 2 ¼ x 3 ¼ size. Bitewings – maximum of 4 per date of service. Intraoral – complete series – covered every three years Panoramic film – covered every 3 years on a routine basis. Covered more frequently if necessary for treatment.
D0230	Intraoral – periapical each additional radiographic image	\$5.20	No	
D0240	Intraoral – occlusal radiographic (2 ¼ x 3 ¼ size)	\$7.28	No	
D0270	Bitewing – single radiographic-image	\$9.36	No	
D0272	Bitewings – two radiographic images	\$13.53	No	
D0273	Bitewings – three radiographic images	\$15.61	No	
D0274	Bitewings – four radiographic images	\$19.77	No	
D0330	Panoramic radiographic image	\$37.45	No	
D0340	Cephalometric radiographic image	\$64.50	No	Covered for clients age 20 and younger as follows: For Orthodontic treatment IF the client will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria. (see 471 NAC 6-003.02G)
D0470	Diagnostic casts	\$47.86	No	
D1110	Prophylaxis – adult (age 14 and older)	\$34.33	No	<u>Age 14 through Age 20:</u> Covered one time every 180 days. <u>Age 21 & Older:</u> Covered one time every 180 days. <u>Special Needs:</u> Covered at the frequency determined appropriate by the treating dental provider. Limited to one prophylaxis per date of service, per client. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D1120	Prophylaxis – child (age 13 and younger)	\$27.05	No	<u>Age 13 & Younger</u> : Covered one time every 180 days. <u>Special Needs</u> : Covered at the frequency determined appropriate by the treating dental provider. Limited to one prophylaxis per date of service, per client. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition.
D1206	Topical application of fluoride varnish	\$20.81	No	Covered for adults and children at the frequency determined appropriate by the treating dental provider.
D1208	Topical application of fluoride-excluding varnish	\$18.73	No	
D1351	Sealant – per tooth	\$26.01	No	Covered on permanent and primary teeth, for clients age 20 and younger. Covered once every 730 days.
D1354	Interim caries arresting medicament application per tooth	\$10.40	No	Covered for up to 3 times per year per tooth. Frequency limitation may be exceeded for up to four times per tooth per 12-month period for members with high caries risk. Providers are required to retain documentation demonstrating medical necessity. A prior authorization would be required for the fourth application. A permanent restoration is not payable on the same tooth for three (3) months from date of service of completed D1354 per patient by the <u>same provider, facility, or group</u>
D1510	Space maintainer – fixed unilateral-per quadrant	\$114.44	No	Covered for clients age 20 and younger. Covered once every 365 days on codes D1510, D1516, D1517 and D1556.
D1516	Space maintainer – fixed – bilateral, maxillary	\$156.06	No	
D1517	Space maintainer fixed bilateral mandibular	\$156.06	No	
				Maximum of one.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D1551	Re-cement or re- bond of space maintainer-maxillary	\$21.85	No	
D1552	Re-cement or re- bond of space maintainer-mandibular	\$21.85	No	Maximum of one.
D1553	Re-cement or re- bond unilateral space maintainer-per quadrant	\$21.85	No	Maximum of one.
D1556	Removal of fixed unilateral space maintainer-per quadrant	\$21.85	No	Maximum of one.
D1557	Removal of fixed bilateral space maintainer-maxillary	\$21.85	No	Maximum of one.
D1558	Removal of fixed bilateral space maintainer-mandibular	\$21.85	No	Maximum of one.

RESTORATIVE:

- A. Tooth preparation, temporary restorations, cement bases, pulp capping, impressions and local anesthesia are included in the restorative fee for each covered service.
- B. Resin - refers to a broad category of materials including but not limited to composites, and glass ionomers.
- C. Full Labial veneers- not covered for cosmetic purposes.
- D. Documentation of carious lesions must be present.
- E. A maximum fee is covered per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a four or more surface restoration.

The D2999 code is used for procedures that are not adequately described by a code, miscellaneous codes may not be used to claim an item that Medicaid doesn't cover.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
<u>AMALGAM RESTORATIONS:</u>				
D2140	Amalgam – one surface, primary	\$52.02	No	Primary teeth A – T
D2150	Amalgam – two surfaces, primary	\$61.38	No	
D2160	Amalgam – three surfaces, primary	\$73.87	No	
D2161	Amalgam – four or more surfaces, primary	\$86.35	No	
D2140	Amalgam – one surface, permanent	\$52.02	No	Permanent Teeth – 1 – 32
D2150		\$61.38	No	

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D2160	Amalgam – two surfaces, permanent			
	Amalgam – three surfaces, permanent	\$73.87	No	
D2161	Amalgam – four or more surfaces, permanent	\$86.35	No	
<u>RESIN-BASED COMPOSITE RESTORATIONS:</u>				
D2330	Resin-based composite – one surface, anterior	\$60.34	No	<u>Primary</u> tooth numbers for anterior restorations – C – H, M – R <u>Permanent</u> tooth numbers for anterior restorations – 6 – 11, 22 - 27
D2331	Resin-based composite – two surfaces, anterior	\$74.91	No	
D2332	Resin based composite – three surfaces, anterior	\$86.35	No	
D2335	Resin based composite – four or more surfaces or involving incisal-angle (anterior)	\$100.92	No	
D2390	Resin-based composite Crown, anterior	\$201.84	No	Primary tooth numbers for posterior composite restorations – A, B, I, J, K, L, S, T
D2391	Resin-based composite – one surface posterior, permanent	\$61.38	No	
D2392	Resin-based composite – two surfaces, posterior	\$78.03	No	
D2393	Permanent resin-based composite – three surfaces, posterior,	\$90.51	No	
D2394	Permanent resin-based composite – four or more surfaces, posterior, permanent	\$95.72	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2391	Resin-based composite – one surface posterior, permanent	\$61.38	No	Permanent tooth numbers for posterior composite restorations 1 – 5, 12 – 16, 17 – 21, 28 - 32
D2392	Resin-based composite – two surfaces, posterior, permanent	\$78.03	No	
D2393	Resin-based composite – three surfaces, posterior permanent	\$90.51	No	
D2394	Resin-based composite – four or more surfaces, posterior, permanent	\$95.72	No	
D2710	Crown - resin – based composite (indirect)	\$201.84	Yes	Submit a diagnostic x-ray, either a periapical or bitewing, for molar review must be of a completed endo. Include a narrative of how a conventional restoration or stainless steel crown would not be adequate to restore. Covered for anterior and bicuspid teeth when other restoration is not possible. ONLY covered for molar teeth that have had endodontic treatment that cannot be adequately restored with a stainless steel crown, amalgam or resin restoration. A request should not be submitted for unusual or exceptional situations not covered herein. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who originally placed the crown.
D2720	Crown - resin with high noble metal	\$353.74	Yes	
D2721	Crown – resin with predominantly base metal	\$342.29	Yes	
D2722	Crown – resin with noble metal	\$342.29	Yes	
D2740	Crown – porcelain/ceramic	\$353.74	Yes	
D2750	Crown – porcelain fused to high noble metal	\$353.74	Yes	
D2751	Crown porcelain fused to predominantly base metal	\$353.74	Yes	
D2752	Crown – porcelain fused to noble metal	\$353.74	Yes	
D2790	Crown – full cast high noble metal	\$353.74	Yes	
D2791	Crown – full cast predominantly base metal	\$353.74	Yes	
D2792	Crown – full cast noble metal	\$353.74	Yes	

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
<u>OTHER RESTORITIVE SERVICES:</u>				
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$20.81	No	
D2915	Re-cement or bond indirectly fabricated or prefabricated post and core	\$39.54	No	
D2920	Prefabricated post and core re-cement or bond crown	\$20.81	No	
D2929	Prefabricated porcelain/ceramic crown primary tooth	\$139.41	No	
D2930	Prefabricated stainless steel crown – primary tooth	\$120.69	<u>No</u>	
D2931	Prefabricated stainless steel crown – permanent tooth	\$120.69	No	
D2932	Prefabricated resin crown	\$107.16	No	Covered for primary anterior teeth
D2933	Prefabricated stainless steel crown with resin window	\$139.41	No	
D2934	Prefabricated esthetic coated stainless steel crown	\$139.41	No	
D2940	Protective restoration	\$33.29	No	
D2950	Core buildup, including any pins	\$75.95	No	
D2951	Pin retention – per tooth, in addition to restoration	\$11.44	No	
D2954	Prefabricated post and core in addition to crown	\$97.80	No	
D2980	Crown repair, by report	BR	No	A description of treatment provided must be submitted with the dental claim.
D2999	Unspecified restorative	BR	No	D2999 is used for procedures that are not

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
	Procedure by report			adequately described by another code.

<u>ENDODONTICS</u>				
<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D3220	Therapeutic pulpotomy (excluding final restoration)	\$72.83	No	Covered for primary teeth ONLY. Not covered for permanent teeth.
D3230	Pulpal therapy (resorbable filling) – anterior primary tooth (excluding final restoration)	\$88.43	No	
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	\$93.64	No	
D3310	Root canal therapy – anterior (excluding final restoration)	\$252.82	No	Covered for permanent teeth. Root canal treatment includes a treatment plan, necessary appointments, clinical procedures, radiographic images and follow up care.
D3320	Root canal therapy – premolar (excluding final restoration)	\$261.14	No	
D3330	Root canal therapy – molar (excluding final restoration)	\$347.49	No	
D3346	Retreatment of previous root canal therapy – anterior	\$229.33	No	Retreatment of previous root canals may be covered if at least 365 days have passed since the original treatment, and failure has been demonstrated with xray documentation and narrative summary.
D3347	Retreatment of previous root canal therapy – premolar	\$261.14	No	
D3348	Retreatment of previous root canal therapy - molar	\$347.49	No	Not covered for third molars.
D3351	Apexification/recalcification	\$91.56	No	
D3410	Apicoetomy	\$177.91	No	Covered on permanent anterior teeth
D3999	Emergency Treatment to Relieve Endodontic Pain	\$41.62	No	Tooth number must be identified on the claim submission. Not to be submitted with any other definitive treatment codes on the same tooth on the same day of service.

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<u>PERIODONTICS:</u>				
<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D4210	Gingivectomy or Gingivoplasty – four or more contiguous teeth or bonded teeth spaces per quadrant	\$97.80	No	Per tooth or per quadrant
D4211	Gingivectomy or Gingivoplasty – one to three contiguous teeth or bonded teeth spaces per quadrant	\$73.87	No	Per tooth or per quadrant
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$104.04	Yes	Benefit covers 4 quadrants once every 365 days. Each quadrant is covered one time per client. The request for approval must be accompanied by the following: A periodontal treatment plan. A completed copy of a periodontic probe chart that exhibits pocket depths of 4mm or greater. A history, including home oral care that demonstrates that curettage, scaling, or root planing is required in addition to a routine prophylaxis. Periapical x-rays demonstrating subgingival calculus and/or loss of crestal bone. For scaling and root planing that requires the use of local anesthesia, NE Medicaid does not cover more than one half of the mouth in one day, except on hospital cases.
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	\$54.10	Yes	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis <i>on a subsequent visit.</i>	\$47.86	No	Covered once every 365 days per client. Not covered on the same date of service as a prophylaxis.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D4910	Periodontal maintenance	\$30.17	Yes	Covered for clients that have had Medicaid approved periodontal scaling and root planing. Prior authorization must be renewed annually. Submit with prior authorization request: Date the Medicaid approved scaling and root planing was completed. Periodontal history. Frequency the dental provider is requesting that the client must be seen for the maintenance procedure.

PROSTHODONTICS (REMOVABLE):

- A. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.
- B. Prosthetic appliances are covered once every five years when:
 The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client.
 The client does not have a history of lost prosthetic appliances.
 A repair, reline or rebase will not make the existing prosthetic functional.
- C. Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five years.
- D. Medicaid covers a one-time replacement within the 5 year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each client's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D5110	Complete denture – maxillary	\$689.79	Yes	Covered 180 days after placement of interim dentures. Relines, rebases and adjustments are included in the 180 days after placement and not billable until after that time.
D5120	Complete denture - mandibular	\$689.79	Yes	
				Submit with ADA claim form prior authorization request: 1. Date of previous denture placement

				2. Information on condition of existing denture; and 3. For initial placements, submit Panorex or full mouth x-rays.
D5130	Immediate denture – maxillary	\$559.74	Yes	Considered a permanent denture. Not an interim or temporary. Relines, rebases and adjustments are included in the 180 days after placement and not billable until after that time. Submit with ADA claim form prior authorization request: <ol style="list-style-type: none"> 1. Date and list of teeth to be extracted; 2. Narrative documenting medical necessity; and 3. Panorex or full mouth x-rays.
D5140	Immediate denture - mandibular	\$559.74	Yes	

PARTIAL DENTURES:

- A. Only covered if client does not have adequate occlusion.
- B. Adequate occlusion is defined as 1st molar to 1st molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion. One to three missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement.

*** Note: First tooth \$78.03, each additional tooth \$29.13

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) Includes acrylic resin base denture with resin or wrought wire clasps	\$482.75	Yes	Submit with ADA claim form prior authorization request: <ol style="list-style-type: none"> 1. Chart or list missing teeth or teeth to be extracted. 2. Provide age of any existing partial and condition of that partial or a narrative identifying the partial as an initial placement and documenting how there is not adequate occlusion; 3. X-rays of remaining teeth.

D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) Includes acrylic resin base denture or wrought wire clasps	\$482.75	Yes	Same as for D5211
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$491.07	No	Coverage limited to clients age 20 and younger. More than one posterior tooth must be missing for partial placement. One to three missing anterior teeth should be replaced with a flipper partial.
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$491.07	No	
D5410	Adjust complete denture – maxillary	\$20.81	No	Not covered for 180 days following placement of a new prosthesis. After 180 days covered as needed to make prosthetic appliance wearable.
D5411	Adjust complete denture – mandibular	\$20.81	No	
D5421	Adjust partial denture – maxillary	\$20.81	No	
D5422	Adjust partial denture – mandibular	\$20.81	No	
D5511	Repair broken complete denture base- mandibular	\$106.12	No	Covered 2 repairs per prosthesis every 365 days.
D5512	Repair broken complete denture base- maxillary	\$106.12	No	
D5520	Replace missing or broken teeth – complete denture (each tooth)	***Note	No	***\$78.03 for 1 st tooth, \$29.13 for each additional.
D5611	Repair resin denture base- mandibular	\$97.80	No	Covered 2 repairs per prosthesis every 365 days.
D5612	Repair resin denture base- maxillary	\$97.80	No	
D5621	Repair cast metal partial – mandibular	\$112.36	No	Covered 2 repairs per prosthesis every 365 days.
D5622	Repair cast metal partial – maxillary	\$112.36	No	
D5630	Repair or replace broken clasp – per tooth	\$122.77	No	***\$78.03 for 1 st tooth, \$29.13 for each additional. ***\$78.03 for 1 st tooth, \$29.13 for each additional.
D5640	Replace broken teeth – per tooth	***Note	No	
D5650	Add tooth to existing partial denture	***Note	No	
D5660	Add clasp to existing partial denture – per tooth	\$107.16	No	
D5710	Rebase complete maxillary denture	\$201.84	No	Not covered for 180 days following the placement of a new prosthesis. Covered once per prosthesis every 365 days.

D5711	Rebase complete mandibular denture	\$201.84	No	Not covered for 180 days following the placement of a new prosthesis. Covered once per prosthesis every 365 days.
D5720	Rebase maxillary partial denture	\$201.84	No	
D5721	Rebase mandibular partial denture	\$201.84	No	
D5730	Reline complete maxillary denture (chair side)	\$106.12	No	Not covered for 180 days following the placement of a new prosthesis. Covered once per prosthesis every 365 days. Chair side and lab rebases are covered, but only one can be provided within the 365 day period.
D5731	Reline complete mandibular denture (chair side)	\$106.12	No	
D5740	Reline maxillary partial denture (chair side)	\$106.12	No	
D5741	Reline mandibular partial denture (chair side)	\$106.12	No	
D5750	Reline complete maxillary denture (laboratory)	\$175.83	No	
D5751	Reline complete mandibular denture (laboratory)	\$175.83	No	
D5760	Reline maxillary partial denture (laboratory)	\$175.83	No	
D5761	Reline mandibular partial denture (laboratory)	\$175.83	No	
D5810	Interim complete denture (maxillary)	\$363.10	Yes	
D5811	Interim complete denture (mandibular)	\$363.10	Yes	Not a permanent denture. Can be replaced with a complete denture 180 days after placement of the interim denture. Complete dentures require prior authorization. Relines, rebases and adjustments are not covered for 180 days after placement of the prosthesis. Submit with prior authorization request: Date and list of teeth to be extracted; and Narrative documenting the medical necessity; and Panorex or full mouth x-rays.

D5820	Interim partial denture (maxillary) (flipper partial)	\$245.53	Yes	Considered a permanent replacement for 1 to 3 missing anterior teeth. Not covered for temporary replacement of missing teeth. Relines, rebases and adjustment are not covered for 180 days after placement of the prosthesis. Submit with PA request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of existing partials, or statement identifying the prosthesis as an initial placement; and, 3. x-rays showing missing teeth or teeth to be extracted.
D5821	Interim partial denture (mandibular) (flipper partial)	\$245.53	Yes	
D5850	Tissue conditioning, maxillary	\$44.74	No	Covered one time during the first 180 days following placement of a prosthetic appliance. After the 180 days, necessary tissue conditioning is limited to two times per prosthesis every 365 days.
D5851	Tissue conditioning, mandibular	\$44.74	No	
D6930	Re-cement or bond fixed partial denture/fixed bridge	\$43.70	No	
ORAL AND MAXILLOFACIAL SURGERY:				
D7111	Extraction, coronal remnants – primary tooth (A – T)(Primary Teeth only)	\$45.78	No	Extractions are covered when there is documented medical need.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (A – T) (1 – 32)(Primary and Permanent Teeth)	\$68.67	No	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	\$96.76	No	The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care.
D7220	Removal of impacted tooth – soft tissue	\$126.93	No	
D7230	Removal of impacted tooth – partially bony	\$173.75	No	

D7240	Removal of impacted tooth – completely bony	\$210.16	No	
D7241	Removal of impacted tooth – completely bony, unusual surgical complications	\$220.56	No	
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$91.56	No	The Medicaid fee includes splinting and/or stabilization.
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	\$156.06	No	
D7280	Surgical access of an un-erupted tooth (permanent teeth only)	\$145.66	No	
D7282	Mobilization of erupted or mal-positioned tooth to aid eruption	\$118.61	No	
D7283	Placement of device to facilitate eruption of impacted tooth (permanent teeth only)	\$140.45	No	
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	\$97.80	No	The Medicaid fee is for the professional component only.
D7286	Incisional biopsy of oral tissue – soft	\$88.43	No	The lab must bill the specimen charge.
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant	\$91.56	No	The Medicaid fee for extractions includes routine re-contouring of the ridge and/or suturing as necessary. D7310 and D7311 are covered when it is necessary beyond routine re-contouring to prepare the ridge for a prosthetic appliance.
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$73.87	No	
D7320	Alveoloplasty not in conjunction with extractions four or more teeth or tooth spaces per quadrant	\$97.80	No	
D7321	Alveoloplasty not in conjunction with extractions one to three teeth or tooth spaces, per quadrant	\$79.07	No	
D7410	Radical excision – lesion diameter up to 1.25 cm	BR	No	
D7411	Excision of benign lesion greater than 1.25 cm	BR	No	

D7412	Excision of benign lesion, complicated	BR	No	
D7413	Excision of malignant lesion up to 1.25 cm	BR	No	
D7414	Excision of malignant lesion, greater than 1.25 cm	BR	No	
D7415	Excision of malignant lesion, complicated	BR	No	
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	BR	No	
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	BR	No	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	BR	No	
D7451	Removal of benign odontogenic cyst or tumor – lesion diam. greater than 1.25 cm	BR	No	
D7460	Removal of cyst or tumor – lesion diameter up to 1.25 cm	BR	No	
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diam. greater than 1.25 cm	BR	No	
D7465	Destruction of lesion(s) by physical or chemical method, by report	BR	No	
D7471	Removal of lateral exostosis (maxilla or mandible)	\$114.44	No	
D7510	Incision and drainage of abscess – intraoral soft tissue	\$43.70	No	
D7880	Occlusal orthotic device, by report	BR	No	<p>Occlusal orthotic devices are defined as splints that are provided for the treatment of TMJ.</p> <p>The fee includes any necessary adjustments.</p> <p>Document the type of appliance made and medical condition on or in the claim. For treatment of bruxism see D9940</p>

D7960	Frenulectomy (frenectomy or frenotomy)	\$95.72	No	
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ORTHODONTICS:

Orthodontic treatment is covered for clients age 20 and younger when determined to have a handicapping malocclusion. Orthodontic codes D8060 – D8999 are restricted to age 20 and younger.

Refer to Dental Regulations:

471 NAC 6-003.02H for coverage criteria for orthodontic treatment.

Refer to Orthodontic Forms in: Appendix 471-000-406

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D8060	Interceptive orthodontic treatment of the transitional dentition: Covered if cost effective to lessen the severity of a malformation such that extensive treatment is not required.	Fee determined by approved treatment plan.	Yes	Required Documentation to Submit: 1. ADA claim form prior authorization request. 2. Interceptive Treatment Ortho Request form. 3. Narrative of necessity. 4. X-rays and photos that show qualifying conditions.
	<u>Procedures covered under code D8060</u>			
	Chrome steel wire clasps-each .036 or minimum .030	\$21.85	Yes	
	Inclined plane (hawley) appliance, bite plane, with clasps	\$162.30	Yes	
	Cross-bite appliance, anterior, acrylic	\$134.21	Yes	
	Cross-bite appliance, posterior, two bands plus attachments	\$134.21	Yes	
	Attachment springs for any orthodontic or pedodontic appliance – each	\$21.85	Yes	
	Adjustment of pedodontic and interceptive orthodontic appliances (allowed one per month)	\$17.69	Yes	
	Space maintainer – fixed – unilateral, part of interceptive orthodontic treatment plan	\$114.44	Yes	
	• Space maintainer – fixed – bilateral, part of interceptive orthodontic treatment plan	\$197.68	Yes	

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D8090	Comprehensive orthodontic treatment of the adult dentition	Fee determined by approved treatment plan.	Yes	Required Documentation to Submit: 1. ADA claim form prior authorization request. 2. Comprehensive Treatment Ortho Request form outlining all requested treatment to be completed and estimate of time. 3. HLD completed form that meets the criteria for a possible approval. 4. Narrative of necessity, diagnosis and prognosis. 5. Diagnostic records: Casts and/or oral facial photographic images. Panorex and Cephalometric x-rays On surgical cases include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.
	<u>Procedures covered under code D8090:</u>			
	<ul style="list-style-type: none"> Constructing and placing fixed maxillary appliance, active treatment 	\$369.34	Yes	
	<ul style="list-style-type: none"> Constructing and placing fixed mandibular appliance, active treatment 	\$369.34	Yes	
	Each one month period of active treatment – maxillary arch	\$36.41	Yes	
	Each one month period of active treatment – maxillary arch, unusual service (surgical correction case)	\$53.06	Yes	
	Each one month period of active treatment – mandibular arch	\$36.41	Yes	
	Each one month period of active treatment – mandibular arch	\$53.06	Yes	

	arch, unusual service (surgical correction case)			
	Retainer or retention appliance	\$98.84	Yes	
	Each one-month period of retention appliance	\$19.77	Yes	
	Treatment, maxillary arch	\$19.77	Yes	
	Each one-month period of retention appliance treatment, mandibular arch	\$19.77	Yes	
	Rapid palatal expander (RPE) or cross-bite correcting (fixed) appliance	\$187.27	Yes	
	Herbst appliance	\$280.91	Yes	
	Protraction facemask	\$168.54	Yes	
	Slow expansion appliance	\$184.15	Yes	
	• Headgear	\$168.54	Yes	
	Inclined plane (hawley) appliance, bite plane, with clasps	\$162.30	Yes	
	Orthodontic appliance not listed	BR	Yes	
	• Orthodontic procedure not listed	BR	Yes	
	Space maintainer – fixed – unilateral, part of comprehensive orthodontic treatment plan	\$114.44	Yes	
	• Space maintainer – fixed – bilateral, part of comprehensive orthodontic treatment plan	\$197.68	Yes	
D8210	Removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	\$156.06	No	Covered for clients age 20 and younger. Includes adjustments.
D8220	Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	\$214.32	No	Covered for clients age 20 and younger. Includes adjustments.
D8696	Repair of orthodontic appliance-maxillary	BR	No	
D8697	Repair of orthodontic appliance-mandibular	BR	No	
D8698	Re-cement or re-bond fixed retainer-maxillary	\$10.20/ per bond	No	Maximum of one set of re-cement/re-bond per lifetime benefit. (No limit on the number of bonds within the set).
D8699	re-cement or re-bond fixed retainer-mandibular	\$10.20/ per bond	No	Maximum of one set of re-cement/re-bond per lifetime benefit. (No limit on the number of bonds within the set).

D8703	replacement of lost or broken retainer-maxillary	\$98.84	No	Maximum of 01.
D8704	replacement of lost or broken retainer-mandibular	\$98.84	No	Maximum of 01.
D8999	Unspecified orthodontic procedure, by report	BR	No	Billable for repairs associated with orthodontic treatment when repairs exceed routine repairs associated with orthodontic treatment. Include a description of the repair on or in the claim.

ADJUNCTIVE GENERAL SERVICES:				
CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$23.93	No	Covered once per date of service per location. Examples: treatment of soft tissue infections, smoothing a fractured tooth. Palliative treatment on a specific tooth is not covered if definitive treatment (e.g. restorative or endodontic treatment) was provided on the same tooth for the same date of service. Include a description of the treatment with the claim.
D9222	Deep sedation/general anesthesia- <i>first</i> 15 min.	\$91.56	No	Covered when medically necessary to treat the client. A sedation record must be maintained.
D9223	Deep sedation/general anesthesia- each <i>subsequent</i> 15 min.	\$84.27	No	
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$29.13	No	
D9239	Intravenous moderate (conscious) sedation/analgesia - <i>first</i> 15 min	\$53.06	No	Covered when medically necessary to treat the client. A sedation record must be maintained.
D9243	Intravenous moderate (conscious) sedation/analgesia - each <i>subsequent</i> 15 min.	\$53.06	No	
D9248	Non-intravenous moderate (conscious) sedation	\$41.62	No	
D9410	House/extended care facility	\$36.41	No	Covered <u>one per day per facility</u>
D9420	Hospital call	\$83.23	No	
D9440	Office visit – after regularly scheduled hours	\$46.82	No	Covered in addition to exam and treatment provided when treatment is provided after dental office normal office hours.
D9944	Occlusal guard hard appliance full arch removable dental appliance	\$170.63	No	
D9945	Occlusal guard soft appliance full arch removable dental appliance	\$170.63	No	

D9946	Occlusal guard hard appliance partial arch removable dental appliance	\$170.63	No	
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