



**PROVIDER BULLETIN**

**No. 07 – 02**

January 16, 2007

TO: Dental Providers

FROM: Mary Steiner, Administrator  
Medicaid Division *Mary Steiner*

BY: Marsha Rekart, Program Specialist  
Medicaid Division *Marsha Rekart*

RE: Medicaid Dental Fee Schedule – CDT-2007/2008

**Please share this information with your staff and billing department.**

Effective with dates of service beginning January 1, 2007, the Nebraska Medicaid Program is updating the Nebraska Medicaid dental fee schedule to incorporate CDT-2007/2008.

New procedure codes covered by Nebraska Medicaid effective January 1, 2007:

- D0145 – oral evaluation for a patient under three years of age and counseling with primary caregiver
- D0273 – bitewings – three films
- D1206 – topical fluoride varnish; therapeutic application for moderate to high caries risk patients
- D1555 – removal of fixed space maintainer
- D2970 – temporary crown (fractured tooth)

Deleted dental procedure codes – invalid January 1, 2007:

- D1201 – topical application of fluoride (including prophylaxis) child
- D1205 – topical application of fluoride (including prophylaxis) adult

The format of the fee schedule has been modified to add information regarding Medicaid coverage criteria/limitations for each procedure. The coverage criteria/limitation information is from 471 NAC 6-000 Dental Services of the Nebraska Medicaid Program Provider Handbook – Dental Services (Revised September 1, 2004).

A copy of 471 NAC 6-000 Dental Services can be printed from address - [www.hhs.state.ne.us/reg/t471.htm](http://www.hhs.state.ne.us/reg/t471.htm) or a complete provider handbook can be requested from this Department.

Services are to be provided and billed to Medicaid as allowed by Medicaid policy. Payment for services does not indicate compliance with Medicaid regulations. Monitoring of services billed may be accomplished by post-payment review to verify that regulations have been followed.

Please review the coverage criteria/limitation information on the attached fee schedule and in the Nebraska Medicaid Program Provider Handbook – Dental Services.

If you would like a Dental Handbook mailed to your office or have questions regarding Medicaid coverage of services please contact Marsha Rekart at:

Phone Number - 402-471-9395

Email - [marsha.rekart@hss.ne.gov](mailto:marsha.rekart@hss.ne.gov)

**Thank you for your participation in the Medicaid Dental Program.**

Attachment

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

Steps to Determine the Fee Schedule Allowable:

1. LOCATE THE PROCEDURE CODE. Procedure codes are listed numerically.
2. LOCATE THE MAXIMUM ALLOWABLE FEE FOR THE PROCEDURE CODE. The maximum allowable fee is listed to the right of the procedure code and description. If "BR" is listed, go to Step #4 for special pricing.
3. PAYMENT IS THE LOWER OF THE FEE SCHEDULE ALLOWABLE OR THE PROVIDER'S SUBMITTED CHARGE. The provider's submitted charge must reflect their charge to the general public.
4. SPECIAL PRICING. Certain procedure codes will not have a maximum allowable fee:
  - A. "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.

471-000-506 NEBRASKA MEDICAID DENTAL FEE SCHEDULE

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D0120	periodic oral evaluation	16.00	No	<u>Age 20 &amp; Younger:</u> Routine recall exam covered every 6 months Can be seen more frequently if determined necessary by treating dentist.
D0140	limited oral evaluation – problem focused	16.00	No	<u>Age 21 &amp; Older:</u> Routine recall exam covered 1 time every 12 months.
D0145	oral evaluation for a patient under 3 years of age & counseling with primary caregiver	27.00	No	
D0150	comprehensive oral evaluation – New or established patient	16.00	No	<u>Age 21 &amp; Older with Special Needs</u> Exam covered at the frequency determined appropriate by treating dentist. 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 or a pregnant woman.
D0160	detailed and extensive oral evaluation – problem focused, by report	27.00	No	
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)	16.00	No	
D0180	comprehensive periodontal evaluation - new or established patient	27.00	No	<u>Note – All Clients:</u> Exams are covered for new patients, emergency treatment, second opinions and specialists

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PA\* - Prior Authorization Required

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D0210	intraoral – complete series (including bitewings)	45.00	No	<u>Maximum payment of \$45.00 per date of service for any combination of codes D0210 – D0330.</u>
D0220	intraoral – periapical first film	6.00	No	
D0230	intraoral – periapical each additional film	5.00	No	
D0240	intraoral – occlusal film (2 ¼ x 3 ¼ size)	7.00	No	Intraoral-complete series – covered every 3 years.
D0270	bitewing – single film	8.00	No	Panoramic film – covered every 3 years on routine basis. Covered more frequently if necessary for treatment.
D0272	bitewings – two films	12.00	No	
D0273	bitewings – three films	15.00	No	
D0274	bitewings – four films	18.00	No	
D0330	panoramic film	34.00	No	
D0340	cephalometric film	62.00	No	Covered for clients age 20 and younger to diagnosis if treating dentist believes through visual exam that the client may qualify for Medicaid coverage of orthodontic treatment (see 471 NAC 6-005 page 11 of 14)
D0470	diagnostic casts	46.00	No	

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PREVENTIVE

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D1110	prophylaxis – adult (age 14 and older)	31.00	No	<u>Age 21 &amp; Older</u> : Covered one time per year. BILL ON CODE D1110
D1120	prophylaxis – child (age 13 and younger)	20.25	No	<p><u>Age 13 &amp; Younger</u>: Covered at the frequency determined appropriate by the treating dentist with a 6-month prophylaxis considered the standard. BILL ON CODE D1120</p> <p><u>Age 14 through Age 20</u>: Covered at the frequency determined appropriate by the treating dentist with a 6-month prophylaxis considered the standard BILL ON CODE D1110.</p> <p><u>Age 21 &amp; Older with Special Needs</u>: Covered at the frequency determined appropriate by the treating dentist. 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 or a pregnant women.</p>

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D1203	topical application of fluoride (prophylaxis not included) – child (age 13 and younger)	7.50	No	Covered at the frequency determined appropriate by the treating dentist.
D1204	topical application of fluoride (prophylaxis not included) – adult (age 14 and older)	7.50	No	<u>Age 13 and younger</u> bill on code D1203.
D1206	topical fluoride varnish; therapeutic application for moderate to high caries risk patients	7.50	No	<u>Age 14 and older</u> bill on code D1204.
D1351	sealant – per tooth	20.00	No	Covered on permanent and primary teeth. <u>A re-seal is not covered more often than every 2 years.</u> Covered for children and adults.
D1510	space maintainer – fixed unilateral	104.00	No	<u>Covered for clients age 20 and younger.</u>
D1515	space maintainer – fixed – bilateral	184.00	No	
D1550	recementation of space maintainer	21.00	No	
D1555	removal of fixed space maintainer	21.00	No	
<p><u>RESTORATIVE</u> Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.</p> <p><u>Maximum fee per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a 4 or more surface restoration.</u></p> <p>Full labial veneers for cosmetic purposes are not covered. Documentation of carious lesions must be present.</p>				
<u>Amalgam Restorations:</u>				
D2140	amalgam – one surface, primary	49.00	No	Primary teeth A – T
D2150	amalgam – two surfaces, primary	60.00	No	
D2160	amalgam – three surfaces, primary	72.00	No	
D2161	amalgam – four or more surfaces, primary	72.00	No	

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D2140	amalgam – one surface, permanent	49.00	No	Permanent Teeth – 1 – 32
D2150	amalgam – two surfaces, permanent	60.00	No	
D2160	amalgam – three surfaces, permanent	72.00	No	
D2161	amalgam – four or more surfaces, permanent	84.00	No	
<b>Resin-Based Composite Restorations:</b>				
D2330	resin-based composite – one surface, anterior	57.00	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	74.00	No	
D2332	resin-based composite – three surfaces, anterior	86.00	No	
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)	100.00	No	
D2391	resin-based composite – one surface posterior, primary	59.00	No	<u>Primary</u> tooth numbers for posterior restorations – A, B, I, J, K, L, S, T
D2392	resin-based composite – two surfaces, posterior, primary	74.00	No	
D2393	resin-based composite – three surfaces, posterior, primary	86.00	No	
D2394	resin-based composite – four or more surfaces, posterior, primary	86.00	No	
D2391	resin-based composite – one surface posterior, permanent	59.00	No	Permanent tooth numbers for posterior composite restorations - 1 – 5, 12 – 16, 17 – 21, 28 – 32.
D2392	resin-based composite – two surfaces, posterior, permanent	74.00	No	
D2393	resin-based composite – three surfaces, posterior, permanent	86.00	No	
D2394	resin-based composite – four or more surfaces, posterior, permanent	100.00	No	

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D2710	crown – resin – based composite (indirect)	205.00	Yes	Submit x-rays with prior authorization request.  Covered for anterior and bicuspid teeth when conventional restoration is not possible.  Covered for molar teeth that have been endodontically treated that can not be adequately restored with a stainless steel crown, amalgam or resin restoration.
D2720	crown – resin with high noble metal	350.00	Yes	
D2721	crown – resin with predominantly base metal	350.00	Yes	
D2722	crown – resin with noble metal	350.00	Yes	
D2740	crown – porcelain/ceramic substrate	350.00	Yes	
D2750	crown – porcelain fused to high noble metal	350.00	Yes	
D2751	crown – porcelain fused to predominantly base metal	350.00	Yes	
D2752	crown – porcelain fused to noble metal	350.00	Yes	
D2790	crown – full cast high noble metal	350.00	Yes	
D2791	crown – full cast predominantly base metal	350.00	Yes	
D2792	crown – full cast noble metal	350.00	Yes	
<u>Other Restorative Services:</u>				
D2910	recement inlay, onlay, or partial coverage restoration	21.00	No	Covered for primary anterior teeth.
D2915	recement cast or prefabricated post and core	35.00	No	
D2920	recement crown	21.00	No	
D2930	prefabricated stainless steel crown – primary tooth	122.00	No	
D2931	prefabricated stainless steel crown – permanent tooth	122.00	No	
D2932	prefabricated resin crown	100.00	No	
D2933	prefabricated stainless steel crown with resin window	132.00	No	
D2940	sedative filling	34.00	No	
D2950	core buildup, including any pins	78.00	No	
D2951	pin retention – per tooth, in addition to restoration	12.00	No	

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D2954	prefabricated post and core in addition to crown	100.00	No	
D2970	temporary crown (fractured tooth)	78.00	No	
D2980	crown repair, by report	BR	No	A description of treatment provided must be submitted on or in the dental claim. This service is reviewed prior to payment
D2999	unspecified restorative procedure, by report	BR	No	
<b>ENDODONTICS</b>				
D3220	therapeutic pulpotomy (excluding final restoration)	70.00	No	Covered for primary teeth.
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	85.00	No	<u>Not covered for permanent teeth.</u>
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	90.00	No	
D3310	root canal therapy – anterior (excluding final restoration)	234.00	Yes	Submit x-rays with prior authorization request.
D3320	root canal therapy – bicuspid (excluding final restoration)	266.00	Yes	
D3330	root canal therapy – molar (excluding final restoration)	354.00	Yes	
D3346	retreatment of previous root canal therapy - anterior	234.00	Yes	Covered for permanent teeth.
D3347	retreatment of previous root canal therapy – bicuspid	266.00	Yes	
D3348	retreatment of previous root canal therapy – molar	354.00	Yes	<u>Age 21 &amp; older:</u> Not covered for maxillary 2 <sup>nd</sup> molar if 1 <sup>st</sup> molar is in occlusion.
D3351	apexification/recalcification	BR	Yes	Submit x-rays with prior authorization request.

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D3410	apicoectomy	180.00	No	Covered on permanent anterior teeth.
D3999	unspecified endodontic procedure	37.00	No	Covered for emergency treatment to relieve endodontic pain. Include the tooth number on the claim.
<b><u>PERIODONTICS</u></b>				
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bonded teeth spaces per quadrant	98.00	No	
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bonded teeth spaces per quadrant	75.00	No	
D4341	periodontal scaling and root planning – four or more teeth per quadrant	95.00	Yes	Submit with PA request: 1. PA x-rays 2. Perio charting 3. Health history & medical information about the client 4. Information on how long a patient in dental office. 5. Information on home care (see 471 NAC 6-005 page 5 of 14)
D4342	periodontal scaling and root planing – one to three teeth, per quadrant	50.00	Yes	
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	60.00	No	<u>Covered in addition to a prophylaxis procedure.</u> (See page 4) <u>Clients with special needs:</u> Cover one-D4355, (maximum of 1) and one prophylaxis procedure <u>per-quadrant</u> (maximum of 4) for clients that have special needs. Special need clients are clients with mental retardation, or clients that must be treated in a hospital outpatient or Ambulatory Surgical Center setting.

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D4910	periodontal maintenance	31.00	Yes	<p>Submit with PA request:</p> <ol style="list-style-type: none"> <li>1. Date scaling &amp; root planing completed.</li> <li>2. Health history &amp; medical information about the client.</li> <li>3. Frequency client must be seen for maintenance procedure</li> </ol> <p>Covered for clients that have had periodontal scaling &amp; root planing, and are compliant with home care within their abilities.</p>

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CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
<p><b>PROSTHODONTICS (REMOVABLE):</b> A complete prosthetic appliance case includes all materials and necessary adjustments for a period of six months following placement of the prosthesis. Tissue conditioning is covered one time during the first six months following the placement of the prosthesis. (See D5850 and D5851.)</p> <p>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.</p>				
D5110	complete denture – maxillary	570.00	Yes	<p>Covered 6 months after placement of treatment/interim dentures (D5810 &amp; D5811) or as replacement of existing denture that is no longer wearable and can not be made wearable.</p> <p>Denture relines and rebases are not covered for 6 months after placement of the prosthesis. Adjustments are included in the prosthetic appliance fee for 6 months following placement of the prosthesis.</p> <p>Submit with PA request:                      1. Date of previous denture placement                      2. Information on condition of existing denture.</p>
D5120	complete denture – mandibular	570.00	Yes	
D5130	immediate denture – maxillary	570.00	No	<p><u>Considered a permanent denture.</u>  <u>Covered one time.</u>  <u>Relines, rebases, adjustments are</u>  <u>Covered 6 months after placement of</u>  <u>the denture.</u></p>
D5140	immediate denture – mandibular	570.00	No	

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
<b>PARTIAL DENTURES:</b> (Codes D5211, D5212, D5213, D5214) Covered if client does not have adequate occlusion. Adequate occlusion is defined as 1 <sup>st</sup> molar to 1 <sup>st</sup> 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).				
D5211**	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	400.00	Yes	Submit with PA request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of any existing partial. 3. Information on existing partial. 4. X-rays of remaining teeth.
D5212**	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	400.00	No	
D5213	maxillary partial denture – case metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500.00	No	<b><u>Covered for clients age 20 &amp; younger. Not covered for clients age 21 &amp; older. Replaced one time if lost or broken.</u></b>
D5214	mandibular partial denture – case metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500.00	No	
D5410	adjust complete denture – maxillary	21.00	No	<u>Adjustments are included in the prosthetic appliance fee for 6 months following placement of the appliance.</u> Adjustments after 6 months are covered as needed.
D5411	adjust complete denture – mandibular	21.00	No	
D5421	adjust partial denture – maxillary	21.00	No	
D5422	adjust partial denture – mandibular	21.00	No	
D5510	repair broken complete denture base	100.00	No	Covered as needed to make existing prosthetic appliance wearable.
D5520	replace missing or broken teeth – complete denture (each tooth)	***Note	No	
D5610	repair resin denture base	100.00	No	

PA\* - Prior Authorization Required.

\*\* Maxillary resin partial requires prior authorization. Mandibular resin partial does not require prior authorization. Mandibular partial replaced one time if lost or broken.

\*\*\* Note: First tooth \$80.00, each additional tooth \$30.00

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D5620	repair cast framework	115.00	No	Covered as needed to make existing prosthetic appliance wearable.
D5630	repair or replace broken clasp	115.00	No	
D5640	replace broken teeth – per tooth	***Note	No	
D5650	add tooth to existing partial denture	***Note	No	
D5660	add clasp to existing partial denture	110.00	No	
D5710	rebase complete maxillary denture	196.00	No	Not covered for 6 months following the placement of a new prosthesis. After 6 months, covered as necessary to Make existing prosthetic appliance wearable.
D5711	rebase complete mandibular denture	196.00	No	
D5720	rebase maxillary partial denture	196.00	No	
D5721	rebase mandibular partial denture	196.00	No	
D5730	reline complete maxillary denture (chairside)	100.00	No	Not covered for 6 months following the placement of a new prosthesis. After 6 months, covered as necessary to make existing prosthetic appliance wearable.
D5731	reline complete mandibular denture (chairside)	100.00	No	
D5740	reline maxillary partial denture (chairside)	100.00	No	
D5741	reline mandibular partial denture (chairside)	100.00	No	
D5750	reline complete maxillary denture (laboratory)	165.00	No	During the first 6 month period, following placement of a prosthetic appliance, tissue conditioning (D5850 & D5851) are covered. (See page 14 of 20). Can be replaced with a complete denture 6 months after placement of the interim denture. Complete dentures require prior authorization. (See page 11).
D5751	reline complete mandibular denture (laboratory)	165.00	No	
D5760	reline maxillary partial denture (laboratory)	165.00	No	
D5761	reline mandibular partial denture (laboratory)	165.00	No	
D5810	Interim complete denture (maxillary)	370.00	No	
D5811	Interim complete denture (mandibular)	370.00	No	

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\*\*\* Note: First tooth \$80.00, each additional tooth \$30.00

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D5820	interim partial denture (maxillary) (flipper partial)	250.00	Yes	Considered a permanent replacement for 1 to 3 missing anterior teeth. Not covered for temporary replacement of missing teeth until resin or cast partial is made.
D5821	interim partial denture (mandibular) (flipper partial)	250.00	Yes	Submit with PA request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of existing partials. 3. Information on condition of existing partial.
D5850	tissue conditioning, maxillary	46.00	No	Covered one time during the first 6 months following placement of prosthesis. Covered at other times with documentation of medical necessity.
D5851	tissue conditioning, mandibular	46.00	No	
D6930	recement fixed partial denture	42.00	No	
<u>ORAL AND MAXILLOFACIAL SURGERY</u>				
D7111	extraction, coronal remnants – deciduous tooth (A – T)	42.00	No	Extractions are covered when there is documented medical need in the dental chart for the extraction.
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal) (A – T) (I - 32)	50.00	No	
D7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	93.00	No	The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care.  (See 471 NAC 6-005, page 9 of 14).
D7220	removal of impacted tooth – soft tissue	122.00	No	
D7230	removal of impacted tooth – partially bony	167.00	No	

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
D7240	removal of impacted tooth – completely bony	202.00	No	(Continued from previous page).
D7241	removal of impacted tooth – completely bony, unusual surgical complications	212.00	No	
D7250	surgical removal of residual tooth roots (cutting procedure)	85.00	No	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	114.00	No	
D7280	surgical access of an unerupted tooth (permanent teeth only)	88.00	No	
D7282	mobilization of erupted or malpositioned tooth to aid eruption	114.00	No	
D7283	placement of device to facilitate eruption of impacted tooth (permanent teeth only)	135.00	No	
D7285	biopsy of oral tissue – hard (bone, tooth)	78.00	No	
D7286	biopsy of oral tissue – soft	78.00	No	
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant	94.00	No	The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary. It is not a separate billable procedure. D7310 and D7311 covered when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	75.00	No	
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant	94.00	No	
D7321	alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	75.00	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	

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<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
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 benign nonodontogenic 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)	89.00	No	
D7510	incision and drainage of abscess – intraoral soft tissue	37.00	No	
D7880	occlusal orthotic device, by report	BR	No	<p>Occlusal orthotic devices are defined as Splints that are provided for treatment of Temporomandibular joint dysfunction. The fee includes any necessary Adjustments.</p> <p>Document the type of appliance made and medical condition on or in the claim.</p> <p>For treatment of bruxism or for minor occlusal problems, see D9940. (See page 20 of 20).</p>
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	88.00	No	

PA\* - Prior Authorization Required

<u>CODE</u>	<u>DESCRIPTION</u>	<u>FEE</u>	<u>PA*</u>	<u>COVERAGE CRITERIA/LIMITATIONS</u>
<p><b>ORTHODONTICS:</b> Orthodontic treatment is covered for clients age 20 and younger when determined to have a handicapping malocclusion by a Medicaid Dental Consultant. Orthodontic codes restricted to age 20 and younger are D8060 – D8999.</p>				
D8060	<p>interceptive orthodontic treatment of the transitional dentition                      Procedures covered under code D8060</p> <ul style="list-style-type: none"> <li>• Chrome steel wire clasps-each .036 or minimum .030</li> <li>• inclined plane (hawley) appliance, bite plane, with clasps</li> <li>• cross-bite appliance, anterior, acrylic</li> <li>• cross-bite appliance, posterior, two bands plus attachments</li> <li>• attachment springs for any orthodontic or pedodontic appliance - each</li> <li>• adjustment of pedodontic and interceptive orthodontic appliances (allowed one per month)</li> <li>• space maintainer – fixed – unilateral, part of interceptive orthodontic treatment plan</li> <li>• space maintainer – fixed – bilateral, part of interceptive orthodontic treatment plan</li> </ul>	<p>BR</p> <p>21.00</p> <p>156.00</p> <p>129.00</p> <p>129.00</p> <p>21.00</p> <p>17.00</p> <p>104.00</p> <p>184.00</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>See 471 NAC 6-005 page 11 of 14 and page 12 of 14 for coverage criteria for orthodontic treatment.</p>

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D8090	comprehensive orthodontic treatment of the adult dentition	BR	Yes	
	Procedures covered under code D8090:			
	• constructing and placing fixed maxillary appliance, active treatment	350.00	Yes	
	• constructing and placing fixed mandibular appliance, active treatment	350.00	Yes	
	• each one month period of active treatment – maxillary arch	35.00	Yes	
	• each one month period of active treatment – maxillary arch, unusual service (surgical correction cases)	51.00	Yes	
	• each one month period of active treatment – mandibular arch	35.00	Yes	
	• each one month period of active treatment – mandibular arch, unusual service (surgical correction cases)	51.00	Yes	
	• retainer or retention appliance	95.00	Yes	
	• each one-month period of retention appliance treatment, maxillary arch	19.00	Yes	
	• each one-month period of retention appliance treatment, mandibular arch	19.00	Yes	

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	<ul style="list-style-type: none"> <li>• rapid palatal expander (RPE) or cross-bite correcting (fixed) appliance</li> <li>• herbst appliance</li> <li>• protraction facemask</li> <li>• slow expansion appliance</li> <li>• headgear</li> <li>• inclined plane (hawley) appliance, bite plane, with clasps</li> <li>• orthodontic appliance not listed</li> <li>• orthodontic procedure not listed</li> <li>• space maintainer – fixed – unilateral, part of comprehensive orthodontic treatment plan</li> <li>• space maintainer – fixed – bilateral, part of comprehensive orthodontic treatment plan</li> </ul>	<p>178.00</p> <p>270.00</p> <p>162.00</p> <p>177.00</p> <p>162.00</p> <p>156.00</p> <p>BR</p> <p>BR</p> <p>104.00</p> <p>184.00</p>	<p>Yes</p>	
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	127.00	No	
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	200.00	No	
D8691	repair of orthodontic appliance	BR	No	Include a description of the repair on or in the claim.
D8692	replacement of lost or broken retainer	95.00	No	Covered if the client is compliant with wearing the appliance.
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.

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<u>ADJUNCTIVE GENERAL SERVICES:</u>				
D9110	palliative (emergency) treatment of dental pain – minor Procedure	21.00	No	Examples: treatment of soft tissue infections, smoothing a fractured tooth. Include a description of the treatment on or in the claim.
D9220	general anesthesia – first 30 minutes	162.00	No	Covered when it is medically necessary to treat the client.  Document the medical need in the dental chart.
D9221	general anesthesia – each additional 15 minutes	81.00	No	
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	20.00	No	
D9241	intravenous conscious sedation/analgesia – first 30 minutes	94.00	No	
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	43.00	No	
D9248	non-intravenous conscious sedation	150.00	No	
D9410	house/extended care facility	35.00	No	Cover <u>one per day per facility</u> regardless of the number of patients seen.  Document on or in the claim the name of the facility, or home address where treatment was provided.
D9420	hospital call	80.00	No	
D9440	office visit – after regularly scheduled hours	40.00	No	Covered in addition to exam and treatment provided when treatment is provided after dental office normal office hours.
D9940	occlusal guard, by report	173.00	No	Covered to minimize the effects of bruxism and other occlusal factors. Occlusal guards are defined as removable appliances.  Document the medical need in the dental chart.

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