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® codes, descriptions, and other data only are copyright 2019 American Dental Association (ADA). All Rights Reserved. CDT® is a registered trademark of the ADA. You, your employees, and agents are authorized to use CDT® only as contained in the following authorized materials internally within your organization within the United States for the sole use by yourself, employees, and agents. Use is limited to use in Medicare, Medicaid, or other programs administered by the Centers for Medicare & Medicaid Services (CMS). Applicable Federal Acquisition Regulation System/Defense Federal Acquisition Regulation Supplement (FARS/DFARS) apply.

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.

No codes, fee schedules, basic unit values, relative value guides, guidelines, conversion factors or scales are included in any part of CDT®. The ADA assumes no liability for the data contained herein.

Maximum allowable fees are the exclusive property of the Nebraska Department of Health and Human Services and are not covered by the American Dental Association CDT® copyright.

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	$22.00	No	Age 20 & Younger: Covered once every 180 days. Age 21 & Older: Covered once every 180 days. Special Needs and Disabled: 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 due to a disabling condition.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0140	LIMITED ORAL EVALUATION – PROBLEM FOCUSED	$22.00	No	Limited to twice in a one year period for each client. Covered for treatment of a specific problem and/or dental emergencies, trauma, acute infections, etc.
D0145	ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE & INCLUDES COUNSELING WITH PRIMARY CAREGIVER	$37.00	No	Covered as needed.
D0150	COMPREHENSIVE ORAL EVALUATION – NEW OR ESTABLISHED PATIENT	$22.00	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	$27.00	No	
D0170	RE-EVALUATION – LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT	$16.00	No	Benefit is limited to one per year per client.
D0180	COMPREHENSIVE PERIODONTAL EVALUATION – NEW OR ESTABLISHED PATIENT	$27.00	No	Limited to one per three year period per client.
D0210	INTRAORAL – COMPLETE SERIES OF RADIOGRAPHIC IMAGES(INCLUDING BITEWINGS)	$45.00	No	Maximum payment of $45.00 per date of service for any combination of codes D0210 – D0330.
D0220	INTRAORAL – PERIAPICAL FIRST RADIOGRAPHIC IMAGE	$6.00	No	Intraoral – complete series – covered every three years.
D0230	INTRAORAL – PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	$5.00	No	
D0240	INTRAORAL – OCCLUSAL RADIOGRAPHIC (2 ¼ X 3 ¼ SIZE)	$7.00	No	D0240 occlusal film is 2 ¼ x 3 ¼ size.
D0270	BITEWING – SINGLE RADIOGRAPHIC-IMAGE	$9.00	No	Bitewings – maximum of 4 per date of service.
D0272	BITEWINGS – TWO RADIOGRAPHIC IMAGES	$13.00	No	
D0273	BITEWINGS – THREE RADIOGRAPHIC-IMAGES	$15.00	No	
D0274	BITEWINGS – FOUR RADIOGRAPHIC IMAGES	$19.00	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$36.00	No	Panoramic film – covered every 3 years on a routine basis. Covered more frequently if necessary for treatment.
D0340 D0470	CEPHALOMETRIC RADIOGRAPHIC IMAGE DIAGNOSTIC CASTS	$62.00 $46.00	No 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)
D1110	PROPHYLAXIS – ADULT (AGE 14 AND OLDER)	$33.00	No	Age 14 through Age 20: Covered one time every 180 days. Age 21 & Older: Covered one time every 180 days. Special Needs: Covered at the frequency determined appropriate by the treating dental provider. Limited to one prophy 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 due to a disabling condition.
D1120	PROPHYLAXIS – CHILD (AGE 13 AND YOUNGER)	$26.00	No	Age 13 & Younger: Covered one time every 180 days. Special Needs: Covered at the frequency determined appropriate by the treating dental provider. Limited to one prophy 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 due to a disabling condition.
D1206 D1208	TOPICAL APPLICATION OF FLUORIDE VARNISH TOPICAL APPLICATION OF FLUORIDE-EXCLUDING VARNISH	$20.00 $18.00	No No	Covered for adults and children at the frequency determined appropriate by the treating dental provider.
D1351	SEALANT – PER TOOTH	$25.00	No	Covered on permanent and primary teeth, for clients ages 20 and younger. Covered once every 730 days.
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION - PER TOOTH	$10.00		Covered for adults and children once every 180 days. A permanent restoration

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
				is not payable on the same tooth & surface for 3 months from date of service of completed D1354.
D1510	SPACE MAINTAINER – FIXED UNILATERAL	$110.00	No	Covered for clients age 20 and younger. Covered once every 365 days on codes D1510, D1516, D1517, D1550 and D1555.
D1516 D1517 D1550	SPACE MAINTAINER – FIXED – BILATERAL, MAXILLARY SPACE MAINTAINER – FIXED – BILATERAL, MANDIBULAR RECEMENT OR RE- BOND OF SPACE MAINTAINER	$150.00 $150.00 $21.00	No No No	
D1555	REMOVAL OF FIXED SPACE MAINTAINER	$21.00	No	

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 ionomer.
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
AMALGAM RESTORATIONS:				
D2140 D2150 D2160 D2161	AMALGAM – ONE SURFACE, PRIMARY AMALGAM – TWO SURFACES, PRIMARY AMALGAM – THREE SURFACES, PRIMARY AMALGAM – FOUR OR MORE SURFACES, PRIMARY	$50.00 $59.00 $71.00 $83.00	No No No No	Primary teeth A – T.
D2140 D2150 D2160	AMALGAM – ONE SURFACE, PERMANENT AMALGAM – TWO SURFACES, PERMANENT AMALGAM – THREE SURFACES, PERMANENT	$50.00 $59.00 $71.00	No No No	Permanent Teeth – 1 – 32.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2161	AMALGAM – FOUR OR MORE SURFACES, PERMANENT	$83.00	No	
RESIN-BASED COMPOSITE RESTORATIONS:				
D2330	RESIN-BASED COMPOSITE – ONE SURFACE, ANTERIOR	$58.00	No	Primary tooth numbers for anterior restorations – C – H, M – R. Permanent tooth numbers for anterior restorations – 6 – 11, 22 – 27.
D2331	RESIN-BASED COMPOSITE – TWO SURFACES, ANTERIOR	$72.00	No	
D2332	RESIN BASED COMPOSITE – THREE SURFACES, ANTERIOR	$83.00	No	
D2335	RESIN BASED COMPOSITE – FOUR OR MORE SURFACES OR INVOLVING INCISAL-ANGLE (ANTERIOR)	$97.00	No	
D2391	RESIN-BASED COMPOSITE – ONE SURFACE POSTERIOR, PERMANENT	$59.00	No	Primary tooth numbers for posterior composite restorations – A, B, I, J, K, L, S, T.
D2392	RESIN-BASED COMPOSITE – TWO SURFACES, POSTERIOR	$75.00	No	
D2393	PERMANENT RESIN-BASED COMPOSITE – THREE SURFACES, POSTERIOR,	$87.00	No	
D2394	PERMANENT RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES, POSTERIOR, PERMANENT	$92.00	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	$75.00	No	
D2393	RESIN-BASED COMPOSITE – THREE SURFACES, POSTERIOR PERMANENT	$87.00	No	
D2394	RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES, POSTERIOR, PERMANENT	$97.00	No	
D2710	CROWN - RESIN – BASED COMPOSITE (INDIRECT)	$194.00	Yes	Submit a diagnostic x-ray, either a periapical or bitewing, for molar review. It must be of a completed endodontic treatment. Include a narrative of how a conventional restoration
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	$340.00	Yes	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2721	CROWN – RESIN WITH PREDOMINANTLY BASE METAL	$329.00	Yes	or stainless steel crown would not be adequate to restore.
D2722	CROWN – RESIN WITH NOBLE METAL	$329.00	Yes	Covered for anterior and bicuspid teeth when other restoration is not possible.
D2740	CROWN – PORCELAIN/CERAMIC	$340.00	Yes	Only covered for molar teeth that have received endodontic treatment that cannot be adequately restored with a stainless steel crown, amalgam or resin restoration.
D2750	CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL	$340.00	Yes	
D2751	CROWN PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$340.00	Yes	Crowns are not covered for third molars.
D2752	CROWN – PORCELAIN FUSED TO NOBLE METAL	$340.00	Yes	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.
D2790	CROWN – FULL CAST HIGH NOBLE METAL	$340.00	Yes	
D2791	CROWN – FULL CAST PREDOMINANTLY BASE METAL	$340.00	Yes	
D2792	CROWN – FULL CAST NOBLE METAL	$340.00	Yes	
OTHER RESTORITIVE SERVICES:				
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	$20.00	No	
D2915	RE-CEMENT OR BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	$38.00	No	
D2920	PREFABRICATED POST AND CORE RE-CEMENT OR BOND CROWN	$20.00	No	
D2930	PREFABRICATED STAINLESS STEEL CROWN – PRIMARY TOOTH	$116.00	No	D2930 and D2931: Covered for primary and Permanent teeth.
D2931	PREFABRICATED STAINLESS STEEL CROWN – PERMANENT TOOTH	$116.00	No	
D2932	PREFABRICATED RESIN CROWN	$103.00	No	Covered for primary anterior teeth.
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	$134.00	No	

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN	$134.00	No	
D2940	PROTECTIVE RESTORATION	$32.00	No	
D2950	CORE BUILDUP, INCLUDING ANY PINS	$73.00	No	
D2951	PIN RETENTION – PER TOOTH, IN ADDITION TO RESTORATION	$11.00	No	
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	$94.00	No	
D2980	CROWN REPAIR, BY REPORT	BR	No	A description of treatment provided must be submitted with the dental claim.
D2999	UNSPECIFIED RESTORATIVE PROCEDURE BY REPORT	BR	No	D2999 is used for procedures that are not adequately described by another code.

ENDODONTICS				
CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	$70.00	No	Covered for primary teeth ONLY. Not covered for permanent teeth.
D3230	PULPAL THERAPY (RESORBABLE FILLING) – ANTERIOR PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	$85.00	No	
D3240	PULPAL THERAPY (RESORBABLE FILLING) – POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	$90.00	No	
D3310	ROOT CANAL THERAPY – ANTERIOR (EXCLUDING FINAL RESTORATION)	$243.00	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)	$251.00	No	
D3330	ROOT CANAL THERAPY – MOLAR (EXCLUDING FINAL RESTORATION)	$334.00	No	Retreatment of previous root canals may be covered if at least
D3346		$221.00	No	365 days have passed since the

D3347 D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – ANTERIOR RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – PREMOLAR RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	$251.00 $334.00	No No	original treatment, and failure has been demonstrated with x-ray documentation and narrative summary. Not covered for third molars.
D3351	APEXIFICATION/RECALCIFICATION	$88.00	No	
D3410	APICOETOMY	$171.00	No	Covered on permanent anterior teeth.
D3999	EMERGENCY TREATMENT TO RELIEVE ENDODONTIC PAIN	$40.00	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.

PERIODONTICS:

CODE	**DESCRIPTION**	**FEE**	**PA***	**COVERAGE CRITERIA/LIMITATIONS**
D4210	GINGIVECTOMY OR GINGIVOPLASTY – FOUR OR MORE CONTIGUOUS TEETH OR BONDED TEETH SPACES PER QUADRANT	$94.00	No	Per tooth or per quadrant
D4211	GINGIVECTOMY OR GINGIVOPLASTY – ONE TO THREE CONTIGUOUS TEETH OR BONDED TEETH SPACES PER QUADRANT	$71.00	No	Per tooth or per quadrant
D4341 D4342	PERIODONTAL SCALING AND ROOT PLANING – FOUR OR MORE TEETH PER QUADRANT PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH PER QUADRANT	$100.00 $52.00	Yes 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 sub-gingival 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.
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS ***ON A SUBSEQUENT VISIT.***	$46.00	No	Covered once every 365 days per client. Not covered on the same date of service as a prophylaxis.

CODE	**DESCRIPTION**	**FEE**	**PA***	**COVERAGE CRITERIA/LIMITATIONS**
D4910	PERIODONTAL MAINTENANCE	$29.00	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.

CODE	**DESCRIPTION**	**FEE**	**PA***	**COVERAGE CRITERIA/LIMITATIONS**
D5110 D5120	COMPLETE DENTURE – MAXILLARY COMPLETE DENTURE - MANDIBULAR	$663.00 $663.00	Yes 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.
				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	$538.00	Yes	Considered a permanent denture. Not an interim or temporary.

D5140	IMMEDIATE DENTURE - MANDIBULAR	$538.00	Yes	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: 1. Date and list of teeth to be extracted; 2. Narrative documenting medical necessity; and 3. Panorex or full mouth x-rays.

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 $75.00, each additional tooth $28.00

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D5211	MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY RETENTIVE-CLASPING MATERIALS, RESTS AND TEETH)	$464.00	Yes	Submit with ADA claim form prior authorization request: 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 Retentive- Clasping Materials, Rests And Teeth)	$464.00	Yes	Same as for D5211
D5213 D5214	MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) MANDIBULAR PARTIAL DENTURE – CAST MENTAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY	$472.00 $472.00	No 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.

	CONVENTIONAL CLASPS, RESTS AND TEETH)			
D5410	ADJUST COMPLETE DENTURE – MAXILLARY	$20.00	No	Not covered for 180 days following placement of a new prosthesis.
D5411	ADJUST COMPLETE DENTURE – MANDIBULAR	$20.00	No	After 180 days covered as needed to make prosthetic appliance wearable.
D5421	ADJUST PARTIAL DENTURE – MAXILLARY	$20.00	No	
D5422	ADJUST PARTIAL DENTURE – MANDIBULAR	$20.00	No	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE- ***MANDIBULAR***	$102.00	No	Covered 2 repairs per prosthesis every 365 days.
D5512	REPAIR BROKEN COMPLETE DENTURE BASE- ***MAXILLARY***	$102.00	No	
D5520	REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH)	***Note	No	***$75 for 1st tooth, $28 for each additional.
D5611	REPAIR RESIN DENTURE BASE- ***MANDIBULAR***	$94.00	No	Covered 2 repairs per prosthesis every 365 days.
D5612	REPAIR RESIN DENTURE BASE- ***MAXILLARY***	$94.00	No	
D5621	REPAIR CAST METAL PARTIAL – ***MANDIBULAR***	$108.00	No	Covered 2 repairs per prosthesis every 365 days.
D5622	REPAIR CAST METAL PARTIAL – ***MAXILLARY***	$108.00	No	
D5630	REPAIR OR REPLACE BROKEN RETENTIVE/ CLASPING MATERIALS – PER TOOTH	$118.00	No	
D5640	REPLACE BROKEN TEETH – PER TOOTH	***Note	No	***$75 for 1st tooth, $28 for each additional.
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	***Note	No	***$75 for 1st tooth, $28 for each additional.
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE – PER TOOTH	$103.00	No	
D5710	REBASE COMPLETE MAXILLARY DENTURE	$194.00	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	$194.00	No	Not covered for 180 days following the placement of a new prosthesis.
D5720	REBASE MAXILLARY PARTIAL DENTURE	$194.00	No	Covered once per prosthesis every 365 days.
D5721	REBASE MANDIBULAR PARTIAL DENTURE	$194.00	No	
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIR SIDE)	$102.00	No	Not covered for 180 days following the placement of a new prosthesis.
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIR SIDE)	$102.00	No	
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIR SIDE)	$102.00	No	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.
D5741		$102.00	No	

	RELINE MANDIBULAR PARTIAL DENTURE (CHAIR SIDE)			
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	$169.00	No	
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	$169.00	No	
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	$169.00	No	
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	$169.00	No	
D5810 D5811	INTERIM COMPLETE DENTURE (MAXILLARY) INTERIM COMPLETE DENTURE (MANDIBULAR)	$349.00 $349.00	Yes 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 D5821	INTERIM PARTIAL DENTURE (MAXILLARY) (FLIPPER PARTIAL) INTERIM PARTIAL DENTURE (MANDIBULAR) (FLIPPER PARTIAL)	$236.00 $236.00	Yes 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.
D5850 D5851	TISSUE CONDITIONING, MAXILLARY TISSUE CONDITIONING, MANDIBULAR	$43.00 $43.00	No 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.
D6930	RE-CEMENT OR BOND FIXED PARTIAL DENTURE/FIXED BRIDGE	$42.00	No	

ORAL AND MAXILLOFACIAL SURGERY:				
D7111	EXTRACTION, CORONAL REMNANTS – PRIMARY TOOTH (A – T)(PRIMARY TEETH ONLY)	$44.00	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)	$66.00	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.
D7220	REMOVAL OF IMPACTED TOOTH – SOFT TISSUE	$122.00	No	
D7230	REMOVAL OF IMPACTED TOOTH – PARTIALLY BONY	$167.00	No	
D7240	REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY	$202.00	No	
D7241	REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY, UNUSUAL SURGICAL COMPLICATIONS	$212.00	No	
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$88.00	No	
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH AND/OR ALVEOLUS	$150.00	No	The Medicaid fee includes splinting and/or stabilization.
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH (PERMANENT TEETH ONLY)	$140.00	No	
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	$114.00	No	
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH. PLACEMENT OF AN ATTACHMENT ON AN UN-ERUPTED TOOTH, AFTER ITS EXPOSURE, TO AID IN ITS ERUPTION. REPORT THE SURGICAL EXPOSURE SEPARATELY USING D7280.	$135.00	No	
D7285	INCISIONAL BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)	$94.00	No	The Medicaid fee is for the professional component only.
D7286	INCISIONAL BIOPSY OF ORAL TISSUE – SOFT	$85.00	No	The lab must bill the specimen charge.

D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT	$88.00	No	The Medicaid fee for extractions includes routine re-contouring of the ridge and/or suturing as necessary.
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	$71.00	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	$76.00	No	D7310 and D7311 are covered when it is necessary beyond routine re-contouring to prepare the ridge for a prosthetic appliance.
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 TO1.25 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)	$110.00	No	
D7510	INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE	$42.00	No	
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	BR	No	Occlusal orthotic devices are defined as splints that are provided for treatment of TMJ. The fee includes any necessary adjustments. Document the type of appliance and medical condition on or in the claim. For treatment of bruxism see D9940 .
D7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY)	$92.00	No	

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

CODE	**DESCRIPTION**	**FEE**	**PA***	**COVERAGE CRITERIA/LIMITATIONS**
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 deter-mined 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.
	PROCEDURES COVERED UNDER CODE D8060			
	CHROME STEEL WIRE CLASPS-EACH .036 OR MINIMUM .030	$21.00	Yes	
	INCLINED PLANE (HAWLEY) APPLIANCE, BITE PLANE, WITH CLASPS	$156.00	Yes	
	CROSS-BITE APPLIANCE, ANTERIOR, ACRYLIC	$129.00	Yes	
	CROSS-BITE APPLIANCE, POSTERIOR, TWO BANDS PLUS ATTACHMENTS	$129.00	Yes	

	ATTACHMENT SPRINGS FOR ANY ORTHODONTIC OR PEDODONTIC APPLIANCE – EACH	$21.00	Yes	
	ADJUSTMENT OF PEDODONTIC AND INTERCEPTIVE ORTHODONTIC APPLIANCES (ALLOWED ONE PER MONTH)	$17.00	Yes	
	SPACE MAINTAINER – FIXED – UNILATERAL, PART OF INTERCEPTIVE ORTHODONTIC TREATMENT PLAN	$110.00	Yes	
	• SPACE MAINTAINER – FIXED – BILATERAL, PART OF INTERCEPTIVE ORTHODONTIC TREATMENT PLAN	$190.00	Yes	

CODE	**DESCRIPTION**	**FEE**	**PA***	**COVERAGE CRITERIA/LIMITATIONS**
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.
	PROCEDURES COVERED UNDER CODE D8090:			
	• CONSTRUCTING AND PLACING FIXED MAXILLARY APPLIANCE, ACTIVE TREATMENT	$355.00	Yes	

	• CONSTRUCTING AND PLACING FIXED MANDIBULAR APPLIANCE, ACTIVE TREATMENT	$355.00	Yes	
	EACH ONE MONTH PERIOD OF ACTIVE TREATMENT – MAXILLARY ARCH EACH ONE MONTH PERIOD OF ACTIVE TREATMENT – MAXILLARY ARCH, UNUSUAL SERVICE (SURGICAL CORRECTION CASE) EACH ONE MONTH PERIOD OF ACTIVE TREATMENT – MANDIBULAR ARCH EACH ONE MONTH PERIOD OF ACTIVE TREATMENT – MANDIBULAR ARCH, UNUSUAL SERVICE (SURGICAL CORRECTION CASE)	$35.00 $51.00 $35.00 $51.00	Yes Yes Yes Yes	
	RETAINER OR RETENTION APPLIANCE	$95.00	Yes	
	EACH ONE-MONTH PERIOD OF RETENTION APPLIANCE TREATMENT, MAXILLARY ARCH	$19.00 $19.00	Yes Yes	
	EACH ONE-MONTH PERIOD OF RETENTION APPLIANCE TREATMENT, MANDIBULAR ARCH RAPID PALATAL EXPANDER (RPE) OR CROSS-BITE CORRECTING (FIXED) APPLIANCE HERBST APPLIANCE PROTRACTION FACEMASK	$19.00 $180.00 $270.00 $162.00	Yes Yes Yes Yes	
	SLOW EXPANSION APPLIANCE • HEADGEAR INCLINED PLANE (HAWLEY) APPLIANCE, BITE PLANE, WITH CLASPS ORTHODONTIC APPLIANCE NOT LISTED • ORTHODONTIC PROCEDURE NOT LISTED	$177.00 $162.00 $156.00 BR BR	Yes Yes Yes Yes Yes	
	SPACE MAINTAINER – FIXED – UNILATERAL, PART OF COMPREHENSIVE ORTHODONTIC TREATMENT PLAN • SPACE MAINTAINER – FIXED – BILATERAL, PART OF COMPREHENSIVE ORTHODONTIC TREATMENT PLAN	$110.00 $190.00	Yes Yes	
D8210	REMOVABLE APPLIANCE THERAPY (INCLUDES APPLIANCES FOR THUMB SUCKING AND TONGUE THRUSTING)	$150.00	No	Covered for clients age 20 and younger. Includes adjustments.
D8220	FIXED APPLIANCE THERAPY (INCLUDES APPLIANCES FOR THUMB SUCKING AND TONGUE THRUSTING)	$206.00	No	Covered for clients age 20 and younger. Includes adjustments.

D8691	REPAIR OF ORTHODONTIC APPLIANCE	BR	No	Include a description of the repair with 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.

ADJUNCTIVE GENERAL SERVICES:				
CODE	**DESCRIPTION**	**FEE**	**PA***	**COVERAGE CRITERIA/LIMITATIONS**
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$23.00	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- ***first*** 15 min.	$88.00	No	Covered when medically necessary to treat the client. ***A sedation record must be maintained***.
D9223	Deep sedation/general anesthesia- each ***subsequent*** 15 min.	$81.00	No	
D9230	Analgesia, anxiolytic, inhalation of nitrous oxide	$28.00	No	Covered when medically necessary to treat the client. ***A sedation record must be maintained***.
D9239	Intravenous moderate (conscious) sedation/analgesia - ***first*** 15 min	$51.00	No	Covered when medically necessary to treat the client. ***A sedation record must be maintained***.
D9243	Intravenous moderate (conscious) sedation/analgesia - each ***subsequent*** 15 min.	$51.00	No	
D9248	Non-intravenous moderate (conscious) sedation	$40.00	No	Covered when medically necessary to treat the client. ***A sedation record must be maintained***.
D9410	House/extended care facility	$35.00	No	Covered one per day per facility
D9420	Hospital call	$80.00	No	
D9440	Office visit – after regularly scheduled hours	$45.00	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 designed to minimize the effects of Bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	$164.00	No No	Covered to minimize the effects of bruxism. Not covered as an athletic guard.

D9945	Occlusal guard-soft appliance, full arch. Removable dental appliance designed to minimize the effects of Bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	$164.00	No	
D9946	Occlusal guard-hard appliance, partial arch. Removable dental appliance designed to minimize the effects of Bruxism or other occlusal factors. Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	$164.00	No	