

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.

Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.

C.R.S. means the Colorado Revised Statutes.

Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.

Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2014).

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.

Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.

Eligible Senior means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the state in accordance with 1 CCR 201-17, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance.

Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.

Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues.

Evaluation means a patient assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.

Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).

Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Patient Co-Pay.

Max Patient Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2014).

Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2014)

Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Palliative Treatment for dental pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.

Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal (gum) disease progression.

Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors

Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

1. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2014);
2. A community-based organization or foundation;
3. A Federally Qualified Health Center, safety-net clinic, or health district;

4. A local public health agency; or
5. A private dental practice.

Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the patient.

Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic requirements of the client.

Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2014).

8.960.2 Legal Basis

The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2014).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at <https://www.colorado.gov/hcpf/research-data-and-grants> at least 30 days prior to the due date.

8.960.3.B Evaluation of Grant Proposals

Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1. The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.
2. The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.
3. Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:
 - a. Outreach to and identify Eligible Seniors;

- b. Collaborate with community-based organizations; and
 - c. Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.
4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.3.C Grant Awards

The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.3.D Qualified Grantee Responsibilities

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1. Identify and outreach to Eligible Seniors and Qualified Providers;
2. Demonstrate collaboration with community-based organizations;
3. Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;
4. Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;
5. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;
6. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and
7. Submit an annual report as specified under 8.960.3.F.

8.960.3.E Invoicing

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

1. Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in Appendix A, and any other information required by the Department.

2. The Department will pay no more than the established Program Payment per procedure rendered.
3. Eligible Seniors shall not be charged more than the Max Patient Co-Pay as listed in Appendix A.
4. Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.3.F Annual Report

On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

The annual report shall be completed in a format specified by the Department and shall include:

1. The number of Eligible Seniors served;
2. The types of Covered Dental Care Services provided;
3. An itemization of administrative expenditures; and
4. Any other information deemed relevant by the Department.

**10 CCR 2505-10 § 8.960 APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM
FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES**

Capitalized terms within this appendix shall have the meaning specified in the Definitions section.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Periodic oral evaluation - established patient	D0120	\$46.00	\$46.00	\$0.00	Evaluation <u>performed</u> on <u>a</u> patient of record to determine <u>any</u> changes in <u>the patient's medical or dental and medical health</u> status since <u>a previous comprehensive or periodic last</u> evaluation. <u>This includes an</u> oral cancer evaluation <u>and</u> , periodontal evaluation, diagnosis, treatment planning. Frequency: One time per 6 month period per patient; 2 week window accepted.
Limited Oral Evaluation - problem Focused	D0140	\$62.00	\$52.00	\$10.00	Evaluation limited to a specific oral health problem or complaint. This code must be used in association w/a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Should not be used for adjustments made to prosthesis provided within previous 12 months. Should not be used as an encounter fee.
Comprehensive Oral Evaluation - new or established patient	D0150	\$81.00	\$81.00	\$0.00	Evaluation used by general dentist <u>and/or</u> specialist <u>when evaluating a patient comprehensively</u> . Applicable to new patients; <u>or</u> established patients <u>with/</u> of significant health changes; <u>or other unusual circumstances, by report; or established patients who have been</u> absence from active treatment for <u>three (3) or more than 5</u> years. <u>This includes a</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the patient's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 5 years per patient. Should not be charged on the same date as D0180.
Comprehensive Periodontal Evaluation - new or established patient	D0180	\$88.00	\$88.00	\$0.00	Evaluation for patients presenting signs & symptoms of periodontal disease & patients with risk factors such as smoking or diabetes. <u>It includes evaluation of This evaluation encompasses a comprehensive oral exam, and full, complete & detailed periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.</u> Frequency: 1 per 3 years per patient. Should not be charged on the same date as D0150.
Intraoral - complete series of radiographic images	D0210	\$125.00	\$125.00	\$0.00	Radiographic survey of whole mouth, <u>usually consisting of 14-22</u> periapical & posterior bitewing images <u>intended to display</u> the crowns & roots of all teeth, periapical areas of alveolar bone. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					not be billed as a D0210. Payment for additional periapical radiographs w/in 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per patient. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 should be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	\$25.00	\$25.00	\$0.00	D0220 one (1) per day per patient. Report additional radiographs as D0230. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Intraoral - periapical each additional radiographic image	D0230	\$23.00	\$23.00	\$0.00	D0230 should be utilized for additional films taken beyond D0220. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewing - single radiographic image	D0270	\$26.00	\$26.00	\$0.00	Frequency: 1 in a 12 month period. Report more than 1 radiographic image as: D0272 two (2); D0273 three (3); D0274 four (4). Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Bitewings - two radiographic images	D0272	\$42.00	\$42.00	\$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	\$52.00	\$52.00	\$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - four radiographic images	D0274	\$60.00	\$60.00	\$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	\$63.00	\$63.00	\$0.00	Frequency: 1 per 5 years per patient. Should not be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 yrs.
Prophylaxis - Adult	D1110	\$88.00	\$88.00	\$0.00	Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Prophylaxis is not a benefit when billed on the same date of service as any periodontal procedure code. Frequency: 1 time per 6 calendar months; 2 week window accepted. May be billed for routine prophylaxis for areas of mouth not periodontally involved. Should not be billed in addition to code D4910 for periodontal maintenance. D1110 may be billed w/ D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 should only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. Should not be alternated w/D4910 for maintenance of periodontally-involved individuals. Should not be used as 1 month re-evaluation following nonsurgical periodontal therapy.
Topical application of fluoride varnish	D1206	\$52.00	\$52.00	\$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Should not be used with D1208.
Topical application of fluoride - excluding varnish	D1208	\$52.00	\$52.00	\$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction w/prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Should not be used wD1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Amalgam - one surface, primary or permanent	D2140	\$107.00	\$97.00	\$10.00	<u>Placed on one of the following five surface classifications – Mesial, Distal, Incisal, Lingual, or Labial and †</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included.
Amalgam - two surfaces, primary or permanent	D2150	\$138.00	\$128.00	\$10.00	<u>Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Lingual and †</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					Frequency: 36 months for the same restoration.
Amalgam - three surfaces, primary or permanent	D2160	\$167.00	\$157.00	\$10.00	<u>Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Mesial-Labial and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Amalgam - four or more surfaces, primary or permanent	D2161	\$203.00	\$193.00	\$10.00	<u>Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Incisor-Lingual-Labial and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - one surface, anterior	D2330	\$115.00	\$105.00	\$10.00	<u>Placed on one of the following five surface classifications – Mesial, Distal, Incisor, Lingual, or Labial and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included.
Resin-based composite - two surfaces, anterior	D2331	\$146.00	\$136.00	\$10.00	<u>Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Lingual and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - three surfaces, anterior	D2332	\$179.00	\$169.00	\$10.00	<u>Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Mesial-Labial and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	\$212.00	\$202.00	\$10.00	<u>Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Incisal-Lingual-Labial and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - one surface, posterior	D2391	\$134.00	\$124.00	\$10.00	<u>Placed on one of the following five surface classifications – Mesial, Distal, Occlusal, Lingual, or Buccal and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite -two surfaces, posterior	D2392	\$176.00	\$166.00	\$10.00	<u>Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Occlusal and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - three surfaces, posterior	D2393	\$218.00	\$208.00	\$10.00	<u>Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Occlusal-Distal and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - four or more surfaces, posterior	D2394	\$268.00	\$258.00	\$10.00	<u>Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Occlusal-Lingual-Distal and</u> includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Crown - porcelain/ceramic substrate	D2740	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to high noble metal	D2750	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast predominantly base metal	D2781	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast noble metal	D2782	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 porcelain/ceramic	D2783	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast predominantly base metal	D2791	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Crown - full cast noble metal	D2792	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	\$780.00	\$730.00	\$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	\$87.00	\$77.00	\$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	\$89.00	\$79.00	\$10.00	
Core buildup, including any pins when required	D2950	\$225.00	\$200.00	\$25.00	One of (D2950, D2952, D2954) per 84 month(s) per patient per tooth. Refers to building up of <u>coronal structure when there is insufficient retention for a separate extracoronal restorative procedure.</u> <u>A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. anatomical crown when restorative crown will be placed.</u> Not payable on the same tooth and same day as D2951.
Pin Retention per tooth	D2951	\$50.00	\$40.00	\$10.00	Pins placed to aid in retention of restoration. Should only be used in combination with a multi-surface amalgam.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Cast post and core in addition to crown	D2952	\$332.00	\$307.00	\$25.00	One of (D2950, D2952, D2954) per 84 month(s) per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	\$269.00	\$244.00	\$25.00	One of (D2950, D2952, D2954) per 84 month(s) per patient per tooth. <u>Core is built around a prefabricated post. This procedure includes the core material and</u> Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	\$566.40	\$516.40	\$50.00	<u>Complete root canal therapy; pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.</u> Teeth covered - 6-11, 22-27.
Endodontic therapy, bicuspid tooth (excluding final restoration)	D3320	\$661.65	\$611.65	\$50.00	<u>Complete root canal therapy; pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.</u> Teeth covered - 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar (excluding final restoration)	D3330	\$786.31	\$736.31	\$50.00	<u>Complete root canal therapy; pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.</u> Teeth covered - 2, 3, 14,

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					15, 18, 19, 30, and 31.
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	\$177.00	\$167.00	\$10.00	<p>Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For patients w/periodontal disease and is therapeutic, not prophylactic. D4341 and D1110 can be reported on same service date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 may only be charged once, not per quadrant. A diagnosis of periodontitis w/clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance w/documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in patient chart documenting active periodontal disease. Frequency: 1 time per quadrant per 36 month interval. When 4 quadrants are completed in a single visit, consideration should be taken for individual's ability to withstand extended treatment time. Documentation of other treatment provided at same time will be requested. Should include any follow-up and re-evaluation.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	\$128.00	\$128.00	\$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For patients w/periodontal disease and is therapeutic, not prophylactic. D4341 and D1110 can be reported on same service date when date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 may only be charged once, not per quadrant. A diagnosis of periodontitis w/clinical attachment loss (CAL) included. Current periodontal charting must be present in patient chart documenting active periodontal disease. Frequency: 1 time per quadrant per 36 month interval. When 4 quadrants are completed in a single visit, consideration should be taken for individual's ability to withstand extended treatment time. Documentation of other treatment provided at same time will be requested. Should include any follow-up and re-evaluation
Periodontal maintenance procedures	D4910	\$136.00	\$136.00	\$0.00	Procedure following periodontal therapy (D4341,D4342). This procedure includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. If D1110 is once again reported then scaling and root planing will be required to use D4910. Frequency: up to four (4) times per fiscal year per patient. Should not be charged alternating with D1110. Cannot be charged w/in the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	\$793.00	\$713.00	\$80.00	<p>Reimbursement made upon DELIVERY (completed) maxillary denture. D5110 or D5120 should not be used to report an immediate denture. Immediate denture (D5130, D5140) OR interim complete denture (D5810, D5811) is inserted immediately after extraction of teeth and is not currently covered on the OAP Dental Program Provider Reimbursement Schedule. Routine follow-up adjustments/relines w/in 12 months should be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon patient, oral health, overall health, and other confounding factors. Frequency: There should be an expected life span of 5-10 years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</p>
Complete denture - mandibular	D5120	\$793.00	\$713.00	\$80.00	<p>Reimbursement made upon DELIVERY (completed) mandibular denture. D5110 or D5120 should not be used to report an immediate denture. Immediate denture (D5130, D5140) OR interim complete denture (D5810, D5811) is inserted immediately after extraction of teeth and is not currently covered on the OAP Dental Program Provider Reimbursement Schedule. Routine</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					<p>follow-up adjustments/relines w/in 12 months should be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon patient, oral health, overall health, and other confounding factors. Frequency: There should be an expected life span of 5-10 years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</p>
<p><u>Immediate denture – Maxillary</u></p>	<p><u>D5130</u></p>	<p><u>\$793.00</u></p>	<p><u>\$713.00</u></p>	<p><u>\$80.00</u></p>	<p><u>Reimbursement made upon DELIVERY (completion) of immediate maxillary denture. D5130 can be reimbursed only once per lifetime per patient. D5130 should not be used to report an interim complete denture (D5810, D5811) as they are not currently covered under the Senior Dental Program. Routine follow-up adjustments/relines within 6 months should be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: There should be an expected life span of 5 or more years before complete dentures (D5110) may be considered – documentation that existing prosthesis cannot be made serviceable should be maintained.</u></p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
<p><u>Immediate denture – Mandibular</u></p>	<p><u>D5140</u></p>	<p><u>\$793.00</u></p>	<p><u>\$713.00</u></p>	<p><u>\$80.00</u></p>	<p><u>Reimbursement made upon DELIVERY (completion) of immediate maxillary denture. D5140 can be reimbursed only once per lifetime per patient. D5140 should not be used to report an interim complete denture (D5810, D5811) as they are not currently covered under the Senior Dental Program. Routine follow-up adjustments/relines within 12 months should be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: There should be an expected life span of 5 or more years before complete dentures (D5120) may be considered – documentation that existing prosthesis cannot be made serviceable should be maintained.</u></p>
<p>Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</p>	<p>D5211</p>	<p>\$700.00</p>	<p>\$640.00</p>	<p>\$60.00</p>	<p>Reimbursement made upon DELIVERY (completion) of partial maxillary denture. D5211 or D5212 should not be used to report an interim partial denture (D5820, D5821). D5211 and D5212 should be considered definitive treatment. Routine follow-up adjustments or relines within 12 months should be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right <u>after</u> having teeth extracted (healing from only a few teeth is as extensive as healing from multiple). A partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appts may be</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					<p>necessary and are included in the cost. Frequency: There should be an expected life span of 5 - 10 years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</p>
<p>Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</p>	<p>D5212</p>	<p>\$778.00</p>	<p>\$718.00</p>	<p>\$60.00</p>	<p>Reimbursement made upon DELIVERY (completion) of partial mandibular denture. D5211 or D5212 should not be used to report an interim partial denture (D5820, D5821). D5211 and D5212 should be considered definitive treatment. Routine follow-up adjustments/relines within 12 months should be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right <u>after</u> having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appts may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 - 10 years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</p>
	<p><u>D5213</u></p>	<p><u>\$700.00</u></p>	<p><u>\$640.00</u></p>	<p><u>\$60.00</u></p>	

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
<u>Maxillary Partial Denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</u>					<u>Reimbursement made upon DELIVERY (completion) of partial maxillary denture. D5213 or D5214 should not be used to report an interim partial denture (D5820, D5821). D5213 and D5214 should be considered definitive treatment. Routine follow-up adjustments or relines within 6 months should be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appts may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 or more years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</u>
<u>Mandibular Partial Denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</u>	<u>D5214</u>	<u>\$778.00</u>	<u>\$718.00</u>	<u>\$60.00</u>	<u>Reimbursement made upon DELIVERY (completion) of partial maxillary denture. D5213 or D5214 should not be used to report an interim partial denture (D5820, D5821). D5213 and D5214 should be considered definitive treatment. Routine follow-up adjustments or relines within 6 months should be anticipated and are included in</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					<p><u>the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appts may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 or more years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</u></p>
<p><u>Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)</u></p>	<p><u>D5221</u></p>	<p><u>\$700.00</u></p>	<p><u>\$640.00</u></p>	<p><u>\$60.00</u></p>	<p><u>Reimbursement made upon DELIVERY (completion) of immediate partial maxillary denture. D5221 can be reimbursed only once per lifetime per patient and must be on the same date of service as the extraction. D5221 should not be used to report an interim partial denture (D5820, D5821). Routine follow-up adjustments or relines within 6 months should be anticipated and are included in the initial reimbursement. A partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 or more</u></p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					<p><u>years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</u></p>
<p><u>Immediate Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)</u></p>	<p><u>D5222</u></p>	<p><u>\$778.00</u></p>	<p><u>\$718.00</u></p>	<p><u>\$60.00</u></p>	<p><u>Reimbursement made upon DELIVERY (completion) of immediate partial maxillary denture. D5222 can be reimbursed only once per lifetime per patient and must be on the same date of service as the extraction. D5222 should not be used to report an interim partial denture (D5820, D5821). Routine follow-up adjustments or relines within 6 months should be anticipated and are included in the initial reimbursement. A partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 or more years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</u></p>
<p><u>Immediate Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</u></p>	<p><u>D5223</u></p>				<p><u>Reimbursement made upon DELIVERY (completion) of immediate partial maxillary denture. D5223 can be reimbursed only once per lifetime per patient and must be on the same date of service as the extraction. D5223 should not be used to report an interim partial denture (D5820, D5821). Routine follow-up adjustments or relines within 6 months should be anticipated and</u></p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
		<u>\$700.00</u>	<u>\$640.00</u>	<u>\$60.00</u>	<p>are included in the initial reimbursement. A partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 or more years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.</p>
<p><u>Immediate Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</u></p>	<u>D5224</u>	<u>\$778.00</u>	<u>\$718.00</u>	<u>\$60.00</u>	<p>Reimbursement made upon DELIVERY (completion) of immediate partial maxillary denture. D5224 can be reimbursed only once per lifetime per patient and must be on the same date of service as the extraction. D5224 should not be used to report an interim partial denture (D5820, D5821). Routine follow-up adjustments or relines within 6 months should be anticipated and are included in the initial reimbursement. A partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 or more years before replacement dentures should be considered - documentation that existing prosthesis cannot be made</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					<u>serviceable should be maintained.</u>
Repair *Broken complete denture base	D5510	\$87.00	\$77.00	\$20.00	Repair *Broken complete denture base.
Replace missing or *Broken teeth - complete denture (each tooth)	D5520	\$73.00	\$63.00	\$10.00	Replacement/repair of missing or *Broken teeth.
Repair resin denture base	D5610	\$95.00	\$85.00	\$10.00	Repair of upper/lower partial denture base.
Repair or replace *Broken clasp	D5630	\$123.00	\$113.00	\$10.00	Repair of *Broken clasp on partial denture base <u>- per tooth.</u>
Replace *Broken teeth-per tooth	D5640	\$80.00	\$70.00	\$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	\$109.00	\$99.00	\$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months.
Add clasp to existing partial denture	D5660	\$131.00	\$121.00	\$10.00	Adding clasp to partial denture base <u>- per tooth.</u> Documentation may be requested when charged on partial delivered in last 12 months.
Rebase complete maxillary denture	D5710	\$322.00	\$297.00	\$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. May not be charged on denture provided in the last 12 months. May not be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	\$308.00	\$283.00	\$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. May not be charged on denture provided in the last 12 months. May not be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Rebase maxillary partial denture	D5720	\$304.00	\$279.00	\$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. May not be charged on denture provided in the last 12 months. May not be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	\$304.00	\$279.00	\$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. May not be charged on denture provided in the last 12 months. May not be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	\$182.00	\$172.00	\$10.00	Chair side reline that resurfaces w/out processing denture base. Frequency: One (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	\$182.00	\$172.00	\$10.00	Chair side reline that resurfaces w/out processing denture base. Frequency: One (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	\$167.00	\$157.00	\$10.00	Chair side reline that resurfaces w/out processing partial denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside)	D5741	\$167.00	\$157.00	\$10.00	Chair side reline that resurfaces w/out processing partial denture base. Frequency: one (1) time per

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory)	D5750	\$243.00	\$218.00	\$25.00	Laboratory reline that resurfaces w/processing denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory)	D5751	\$243.00	\$218.00	\$25.00	Laboratory reline that resurfaces w/processing denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	\$239.00	\$214.00	\$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	\$239.00	\$214.00	\$25.00	Laboratory reline that resurfaces w/processing partial denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	\$82.00	\$72.00	\$10.00	Routine removal of tooth structure, including minor smoothing of socket bone, and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	\$135.00	\$125.00	\$10.00	Includes removal of bone, and/or sectioning of erupted tooth, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Surgical removal of residual tooth roots (cutting procedure)	D7250	\$143.00	\$133.00	\$10.00	Includes removal of bone, and/or sectioning of residual tooth roots, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth. May only be charged once per tooth. May not be charged for removal of broken off roots for recently extracted tooth.
Incisional biopsy of oral tissue-soft	D7286	\$381.00	\$381.00	\$0.00	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	\$150.00	\$140.00	\$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	\$138.00	\$128.00	\$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	\$150.00	\$140.00	\$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	\$138.00	\$128.00	\$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Incision & drainage of abscess - intraoral soft tissue	D7510	\$193.00	\$183.00	\$10.00	Incision through mucosa, including periodontal origins.
Palliative (emergency) treatment of dental pain - minor procedure	D9110	\$61.00	\$36.00	\$25.00	Emergency treatment to alleviate pain/discomfort. This code should not be used for file claims for writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.