

Adult Medicaid members pay neither co-pays nor co-insurance but do have a \$1,000 annual allowance for dental benefits. If they surpass their annual max and wish to have further dental services they may do so with the following caveats: **1)** Member signs a provider authorization stating that they, the member, are wholly responsible for payment for these additional services beyond the \$1,000 maximum. **2)** If the additional services are a Medicaid covered benefit, the provider may charge the member no more than the Medicaid fee schedule amount for such services. **3)** If the additional services are not a Medicaid covered benefit (e.g., veneers), the provider may choose how much to charge the member.

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
<b>DIAGNOSTIC</b>								
Periodic oral evaluation - established patient	D0120	\$20.84	Two of (D0120, D0150, D0160, D0170, D0180) per 12 months per provider OR location	121%	\$46.00	\$46.00	\$0.00	Eval on patient of record to determine changes in medical or dental status since last evaluation. Includes oral cancer evaluation, periodontal evaluation, diagnosis, treatment planning. Frequency: One 1 time per 6 month period per patient; 2 week window accepted.
Limited Oral Evaluation - problem Focused	D0140	\$31.24	Not reimbursable on the same day as D0120, D0150, D0160, D0170. Dental Hygienists may only provide for an established client or record.	98%	\$62.00	\$52.00	\$10.00	Eval 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 w/in previous 12 months. Should not be used as an encounter fee.
Comprehensive Oral Evaluation - new or established patient	D0150	\$35.93	One of (D0150) per 36 months per provider OR location. Two of (D0120, D0150, D0160, D0170, D0180) per 12 months per provider OR location.	125%	\$81.00	\$81.00	\$0.00	Eval used by general dentist or specialist. Applicable to new patients or established patients w/significant health changes, or absence from active treatment for more than 5 years. This includes a thorough eval and recording of the extraoral and intraoral hard and soft tissues, and an eval and recording of the patient's dental and medical history and general health assessment. A periodontal eval, oral cancer eval, diagnosis and treatment planning should be included. Frequency: 1 per 5 years per patient. Should not be charged on the same date as D0180.
Detailed and extensive oral eval-problem focused, by report	D0160	\$65.09	Two of (D0120, D0150, D0160, D0170, D0180) per 12 months per provider OR location	N/A	N/A	N/A	N/A	N/A

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

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Re-evaluation, limited problem focused	D0170	\$28.63	Two of (D0120, D0150, D0160, D0170, D0180) per 12 months per provider OR location	N/A	N/A	N/A	N/A	N/A
Comprehensive Periodontal Evaluation - new or established patient	D0180	\$39.06	One of (D0180) per 36 months per provider OR location. Two of (D0120, D0150, D0160, D0170, D0180) per 12 months per provider OR location	125%	\$88.00	\$88.00	\$0.00	Eval for patients presenting signs & symptoms of periodontal disease & patients w/risk factors such as smoking or diabetes. This eval encompasses a comprehensive oral exam, and full, complete & detailed periodontal charting. Frequency: 1 per 3 yrs per patient. Should not be charged on the same date as D0150.
Intraoral - complete series of radiographic images	D0210	\$53.11	One of (D0210, D0277, D0330) per 60 months per location. Cannot be billed on the same date of tx as Pano, a minimum of 10 films is required, clients over the age of 12 require 12-20 films	135%	\$125.00	\$125.00	\$0.00	Radiographic survey of whole mouth, 6-22 periapical & posterior bitewing images displaying 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 not be billed as a D0210. Payment for add'l 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 yrs 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	\$11.45	Six of (D0220) per 60 months per patient. Working and final endodontic treatment films are not covered	118%	\$25.00	\$25.00	\$0.00	D0220 one (1) per day per patient. Report add'l 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	\$11.45	Not allowed on the same day as D0210	101%	\$23.00	\$23.00	\$0.00	D0230 should be utilized for add'l 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.

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Bitewing - single radiographic image	D0270	\$11.97	One of (D0270, D0272, D0273, D0274) per 12 months per patient	117%	\$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.
Bitewings - two radiographic images	D0272	\$19.26	One of (D0270, D0272, D0273, D0274) per 12 months per patient	118%	\$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	\$22.69	One of (D0270, D0272, D0273, D0274) per 12 months per patient	129%	\$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	\$27.07	One of (D0270, D0272, D0273, D0274) per 12 months per patient	122%	\$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.
Vertical bitewings - 7-8 films	D0277	\$40.10	One of (D0210, D0277, D0330) per 60 months per location.	N/A	N/A	N/A	N/A	N/A
Panoramic radiographic image	D0330	\$47.89	One of (D0210, D0277, D0330) per 60 months per location.	32%	\$63.00	\$63.00	\$0.00	Frequency: 1 per 5 yrs per patient. Should not be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 yrs.
Pulp Vitality Tests	D0460	\$24.46	One of (D0460) per 1 day per patient	N/A	N/A	N/A	N/A	N/A
<b>PREVENTATIVE</b>								

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Prophylaxis - Adult	D1110	\$38.25	Two of (D1110, D4910) per 12 months per patient. Unless patient falls into a high risk category for periodontal disease. Members with diabetes & pregnant women with histories of periodontal disease are entitled to four per 12 months. Only allowed for cases with a history of surgical or non-surgical periodontal treatment, excluding D4355.	130%	\$88.00	\$88.00	\$0.00	Removal of plaque, calculus and stains from the tooth structures w/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 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	\$15.63	Two of (D1206, D1208) per 12 months per patient. For patients with dry mouth and/or history of head or neck radiation or with high caries risk. Only a benefit for patients who fall into the high risk category.	233%	\$52.00	\$52.00	\$0.00	Topical fluoride application is to be used in conjunction w/prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Should not be used w/D1208.
Topical application of fluoride	D1208	\$10.63	Two of (D1206, D1208) per 12 months per patient. For patients with dry mouth and/or history of head or neck radiation or with high caries risk.	389%	\$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 w/D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
<b>RESTORATIVE</b>								
Amalgam - one surface, primary or permanent	D2140	\$56.23	Teeth covered: 1 - 32. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	90%	\$107.00	\$97.00	\$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included.

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Amalgam - two surfaces, primary or permanent	D2150	\$71.84	Teeth covered: 1-32. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	92%	\$138.00	\$128.00	\$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Amalgam - three surfaces, primary or permanent	D2160	\$84.87	Teeth covered: 1-32. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	97%	\$167.00	\$157.00	\$10.00	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	\$101.02	Teeth covered: 1-32, A-T. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	101%	\$203.00	\$193.00	\$10.00	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	\$67.16	Teeth covered: 6-11, 22-27. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	71%	\$115.00	\$105.00	\$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included.
Resin-based composite - two surfaces, anterior	D2331	\$83.31	Teeth covered: 6-11, 22-27. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	75%	\$146.00	\$136.00	\$10.00	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	\$98.93	Teeth covered: 6-11, 22-27. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	81%	\$179.00	\$169.00	\$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.

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Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	\$123.91	Teeth covered: 6-11, 22-27. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	71%	\$212.00	\$202.00	\$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite crown, anterior	D2390	**Not Listed	Teeth covered: 6-11, 22-27, C-H, M-R. One of (D2390) per 36 months per patient per tooth.	N/A	Not Listed	Not Listed	Not Listed	N/A
Resin-based composite - one surface, anterior	D2391	\$56.23	Teeth covered: 1-5, 12-21, 28-32. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	138%	\$134.00	\$124.00	\$10.00	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	\$71.84	Teeth covered: 1-5, 12-21, 28-32. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	145%	\$176.00	\$166.00	\$10.00	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	\$84.87	Teeth covered: 1-5, 12-21, 28-32. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	157%	\$218.00	\$208.00	\$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.

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Resin-based composite - four or more surfaces, posterior	D2394	\$101.02	Teeth covered: 1-5, 12-21, 28-32. One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 months per patient per tooth, per surface.	165%	\$268.00	\$258.00	\$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Crown - Resin-based composite (indirect)	D2710	\$223.46	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - 3/4 resin-based composite (indirect)	D2712	\$223.46	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - resin with predominantly base metal	D2721	\$223.46	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - resin with noble metal	D2722	\$223.46	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A

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Crown - porcelain/ceramic substrate	D2740	\$426.23	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - porcelain fused to high noble metal	D2750	**Not Listed	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	Not Listed	Not Listed	Not Listed	N/A
Crown - porcelain fused to predominantly base metal	D2751	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - porcelain fused to noble metal	D2752	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - 3/4 cast predominantly base metal	D2781	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A

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Crown - 3/4 cast noble metal	D2782	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - 3/4 porcelain/ceramic	D2783	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - full cast high noble metal	D2790	**Not Listed	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	Not Listed	Not Listed	Not Listed	N/A
Crown - full cast predominantly base metal	D2791	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Crown - full cast noble metal	D2792	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A

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Crown - titanium	D2794	\$426.93	Teeth covered: 2-15, 18-31. One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 months per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Provisional crown	D2799	\$111.73	Teeth covered: 1-32. Preoperative x-rays required. PAR	N/A	N/A	N/A	N/A	N/A
Recement inlay onlay or part	D2910	\$45.29	Teeth covered: 1-32. Not allowed within 6 months of placement.	N/A	N/A	N/A	N/A	N/A
Recement Crown	D2920	\$46.34	Teeth covered: 1-32, A-T.	N/A	N/A	N/A	N/A	N/A
Core Buildup Including any pins when required	D2950	\$117.15	Teeth covered: 6-11, 22-27. One of (D2950, D2954) per 84 months 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. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Pin Retention per tooth	D2951	N/A	N/A	N/A	\$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.
prefabricated post and core in addition to crown	D2954	\$142.66	Teeth covered: 1-32. One of (D2950, D2954) per 84 months 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. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Unspecified Restorative Procedure, by report	D2999	*BR	Teeth covered: 1-32, A-T. Narrative of medical necessity required. PAR	N/A	N/A	N/A	N/A	N/A
<b>ENDODONTICS</b>								
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	\$301.99	Teeth covered: 6-11, 22-27. One of (D3310) per 1 lifetime per patient per tooth. Pre-operative x-ray(s) required. PAR	71%	\$516.40	\$566.40	\$50.00	Did an average of all procedures that are covered by both DentaQuest and OAP. One of (D3320) per 1 lifetime per patient per tooth. Prior authorization and pre-operative x-rays required.
Endodontic therapy, bicuspid tooth (excluding final restoration)	D3320	\$357.69	Teeth covered: 4, 5, 12, 13, 20, 21, 28, 29. One of (D3320) per 1 lifetime per patient per tooth. Pre-operative x-ray(s) required. PAR	71%	\$611.65	\$661.65	\$50.00	Did an average of all procedures that are covered by both DentaQuest and OAP. Teeth covered - 4,5,12,13,20,21,28, and 29. One of (D3320) per 1 lifetime per patient per tooth. Prior authorization and pre-operative x-rays required.
Endodontic therapy, molar (excluding final restoration)	D3330	\$430.59	Teeth covered: 2, 3, 14, 15, 18, 19, 30, 31. One of (D3330) per 1 lifetime per patient per tooth. Pre-operative x-ray(s) required. PAR	71%	\$736.31	\$816.31	\$80.00	Did an average of all procedures that are covered by both DentaQuest and OAP. Teeth covered - 2,3,14,15,18,19,30, and 31. One of (D3330) per 1 lifetime per patient per tooth. Prior authorization and pre-operative x-rays required.
Retreatment of previous root canal therapy-anterior	D3346	\$347.28	Teeth covered: 6-11, 22-27. One of (D3346) per 1 lifetime per patient per tooth. Only if original treatment not paid by CO Medicaid. Pre and post-operative x-ray(s). PAR	N/A	N/A	N/A	N/A	N/A

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Retreatment of previous root canal therapy-bicuspid	D3347	\$400.91	Teeth covered: 4, 5, 12, 13, 20, 21, 28, 29. One of (D3347) per 1 lifetime per patient per tooth. Only if original treatment not paid by CO Medicaid. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Retreatment of previous root canal therapy-molar	D3348	\$474.32	Teeth covered: 2, 3, 14, 15, 18, 19, 30, 31. One of (D3348) per 1 lifetime per patient per tooth. Only if original treatment not paid by CO Medicaid. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Unspecified endodontic procedure, by report	D3999	*BR	Teeth covered: 1-32. Narrative of medical necessity. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
<b>PERIODONTICS</b>								
Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	D4210	\$260.33	Teeth covered: Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D4210, D4211) per 36 months per patient per quadrant. Includes 6 months of routine postoperative care. Perio charting, pre-op radiographs and narrative of medical necessity required. PAR	N/A	N/A	N/A	N/A	N/A

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	D4211	\$113.29	Teeth covered: Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D4210, D4211) per 36 months per patient per quadrant. Includes 6 months of routine postoperative care. Perio charting, pre-op radiographs and narrative of medical necessity required. PAR	N/A	N/A	N/A	N/A	N/A
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	\$105.70	Teeth covered: Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D4341, D4342) per 36 months per patient per quadrant. A minimum of 4 affected teeth in the quadrant. No more than 2 quadrants per day. Not paid on the same date as D1110. pre-op x-ray(s) & perio charting required. PAR	67%	\$177.00	\$167.00	\$10.00	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 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.

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	\$85.05	Teeth covered: Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D4341, D4342) per 36 months per patient per quadrant. No more than 2 quadrants per day. A minimum of 4 affected teeth in the quadrant. Pre-op x-ray(s) & perio charting required. PAR	50%	\$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	\$59.53	Two of (D1110, D4910) per 12 months per patient. Unless patient falls into a high risk category for periodontal disease. Members with diabetes & pregnant women with histories of periodontal disease are entitled to four per 12 months. Only allowed for cases with a history of surgical or non-surgical periodontal treatment, excluding D4355. Perio charting, pre-op radiographs and narrative of medical necessity required. PAR	128%	\$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.
Unspecified periodontal procedure, by report	D4999	*BR	Narrative of medical necessity required. PAR	N/A	N/A	N/A	N/A	N/A
<b>PROSTHODONTICS, REMOVABLE</b>								

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Complete denture - maxillary	D5110	\$738.42	One of (D5110, D5130) per 84 months per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only. Narrative of med necessity and pre-op x-ray(s) required. PAR	7%	\$793.00	\$713.00	\$80.00	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.
Complete denture - mandibular	D5120	\$739.73	One of (D5120, D5140) per 84 months per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only. Narrative of med necessity and pre-op x-ray(s) required. PAR	7%	\$793.00	\$713.00	\$80.00	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 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.

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	D5211	\$508.96	One of (D5211, D5213, D5225, D5281) per 84 months per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's needs.	38%	\$700.00	\$640.00	\$60.00	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 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.
Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	D5212	\$508.96	One of (D5212, D5214, D5226, D5281) per 84 months per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's needs. Narrative of med necessity and pre-op x-ray(s) required. PAR	53%	\$778.00	\$718.00	\$60.00	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.

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	\$728.93	One of (D5211, D5213, D5225, D5281) per 84 months per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's needs.	N/A	N/A	N/A	N/A	N/A
Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	\$728.93	One of (D5212, D5214, D5226, D5281) per 84 months per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's needs. Narrative of med necessity and pre-op x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Maxillary partial denture-flexible base	D5225	\$640.77	One of (D5211, D5213, D5225, D5281) per 84 months per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's needs.	N/A	N/A	N/A	N/A	N/A

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Mandibular partial denture-flexible base	D5226	\$640.77	One of (D5212, D5214, D5226, D5281) per 84 months per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's needs. Narrative of med necessity and pre-op x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Adjust complete denture - maxillary	D5410	\$38.52	One of (D5410) per 12 months per patient. Not allowed within 6 months of delivery.	N/A	N/A	N/A	N/A	N/A
Adjust complete denture - mandibular	D5411	\$38.52	One of (D5411) per 12 months per patient. Not allowed within 6 months of delivery.	N/A	N/A	N/A	N/A	N/A
Adjust partial denture - maxillary	D5421	\$38.52	One of (D5421) per 12 months per patient. Not allowed within 6 months of delivery.	N/A	N/A	N/A	N/A	N/A
Adjust partial denture - mandibular	D5422	\$38.52	One of (D5422) per 12 months per patient. Not allowed within 6 months of delivery.	N/A	N/A	N/A	N/A	N/A
Repair *Broken complete denture base	D5510	\$73.41	Teeth covered: Per Arch (01, 02, LA, UA)	19%	\$87.00	\$77.00	\$20.00	Repair *Broken complete denture base.
Replace missing or *Broken teeth - complete denture	D5520	\$77.06	Teeth covered: 1-32	-5%	\$73.00	\$63.00	\$10.00	Replacement/repair of missing or *Broken teeth.

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Repair resin denture base	D5610	\$87.98	Teeth covered: Per Arch (01, 02, LA, UA)	8%	\$95.00	\$85.00	\$10.00	Repair of upper/lower partial denture base.
Repair cast framework	D5620	\$123.91	Teeth covered: Per Arch (01, 02, LA, UA)	N/A	N/A	N/A	N/A	N/A
Repair or replace *Broken clasp	D5630	\$112.46		9%	\$123.00	\$113.00	\$10.00	Repair of *Broken clasp on partial denture base.
Replace *Broken teeth-per tooth	D5640	\$78.10	Teeth covered: 1-32	2%	\$80.00	\$70.00	\$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	\$69.27	Teeth covered: 1-32	57%	\$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	\$117.15		12%	\$131.00	\$121.00	\$10.00	Adding clasp to partial denture base. Documentation may be requested when charged on aptial delivered in last 12 months.
Replace all teeth & acrylic on cast metal framework (maxillary)	D5670	\$289.27		N/A	N/A	N/A	N/A	N/A
Replace all teeth & acrylic on cast metal framework (mandibular)	D5671	\$289.27	Subject to pre-payment review. Narrative of med necessity required.	N/A	N/A	N/A	N/A	N/A
Rebase complete maxillary denture	D5710	\$244.71	One of (D5710, D5730, D5750) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	32%	\$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.

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Rebase complete mandibular denture	D5711	\$245.75	One of (D5711, D5731, D5751) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	25%	\$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.
Rebase maxillary partial denture	D5720	\$234.81	One of (D5720, D5740, D5760) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	29%	\$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	\$234.81	One of (D5721, D5741, D5761) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	29%	\$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	\$156.20	One of (D5710, D5730, D5750) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	17%	\$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	\$156.20	One of (D5711, D5731, D5751) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	17%	\$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	\$154.12	One of (D5720, D5740, D5760) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	8%	\$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.

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Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
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Reline mandibular partial denture (chairside)	D5741	\$155.67	One of (D5721, D5741, D5761) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	7%	\$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 complete maxillary denture (laboratory)	D5750	\$197.85	One of (D5710, D5730, D5750) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	23%	\$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	\$198.88	One of (D5711, D5731, D5751) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	22%	\$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	\$196.29	One of (D5720, D5740, D5760) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	22%	\$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.
Reline mandibular partial denture (laboratory)	D5761	\$196.29	One of (D5721, D5741, D5761) per 60 months per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	22%	\$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.
Tissue conditioning, maxillary	D5850	\$85.39	One of (D5850) per 1 lifetime per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	N/A	N/A	N/A	N/A	N/A

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Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Tissue conditioning, mandibular	D5851	\$85.39	One of (D5851) per 1 lifetime per patient. Not allowed for first 6 months after delivery. Subject to pre-payment review. Narrative of med necessity required.	N/A	N/A	N/A	N/A	N/A
<b>PROSTHODONTICS, FIXED</b>								
Fixed prosthodontic procedure	D6999	*BR	Teeth covered: 1-32. Narrative of medical necessity. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
<b>ORAL AND MAXILLOFACIAL SURGERY</b>								
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	\$72.24	Teeth covered: 1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS. One of (D7140) per 1 lifetime per patient per tooth.	14%	\$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.
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	\$117.15	Teeth covered: 1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS. One of (D7210) per 1 lifetime per patient per tooth. Subject to pre-payment review. Pre-operative x-ray(s) required.	15%	\$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.

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Removal of impacted tooth-soft tissue	D7220	\$132.77	Teeth covered: 1-32, 51-82. One of (D7220) per 1 lifetime per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Removal of impacted tooth-partially bony	D7230	\$169.74	Teeth covered: 1-32, 51-82. One of (D7230) per 1 lifetime per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Removal of impacted tooth-completely bony	D7240	\$208.26	Teeth covered: 1-32, 51-82. One of (D7240) per 1 lifetime per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Removal of impacted tooth-completely bony, with unusual surgical complications	D7241	\$247.32	Teeth covered: 1-32, 51-82. One of (D7241) per 1 lifetime per patient per tooth. Pre-operative x-ray(s) required. PAR	N/A	N/A	N/A	N/A	N/A
Surgical removal of residual tooth roots (cutting procedure)	D7250	\$128.08	Teeth covered: 1-32, 51-82. Will not be paid to the dentists or group that removed the tooth.	12%	\$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.
Biopsy of oral tissue-hard (bone, tooth)	D7285	\$161.92	Subject to pre-payment review. Pathology report required.	N/A	N/A	N/A	N/A	N/A
Biopsy of oral tissue-soft (all others)	D7286	\$129.13	Subject to pre-payment review. Pathology report required.	195%	\$381.00	\$381.00	\$0.00	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Cytology sample collection	D7287	*BR	Subject to pre-payment review. Narrative of med necessity required.	N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	\$120.28	Teeth covered: per quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D7310, D7311) per 1 lifetime per patient per quadrant. Subject to pre-payment review. Pre-operative x-ray(s) required.	25%	\$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	\$120.28	Teeth covered: per quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D7310, D7311) per 1 lifetime per patient per quadrant. Minimum of 1 to 3 teeth or tooth spaces. Subject to pre-payment review. Pre-operative x-ray(s) and narrative of med necessity required.	15%	\$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	\$177.03	Teeth covered: per quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D7320, D7321) per 1 lifetime per patient per quadrant. Subject to pre-payment review. Pre-operative x-ray(s) and narrative of med necessity required.	-15%	\$150.00	\$140.00	\$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	\$177.03	Teeth covered: per quadrant (10, 20, 30, 40, LL, LR, UL, UR). One of (D7320, D7321) per 1 lifetime per patient per quadrant. Subject to pre-payment review. Pre-operative x-ray(s) and narrative of med necessity required.	-22%	\$138.00	\$128.00	\$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.

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Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Vestibuloplasty - ridge extension (secondary epithelialization)	D7340	\$413.40	Teeth covered: Per arch (01, 02, LA, UA). Subject to pre-payment review. Narrative of medical necessity required.	N/A	N/A	N/A	N/A	N/A
Radical excision - lesion diameter up to 1.25 cm	D7410	\$165.57	Subject to pre-payment review. Pathology report required.	N/A	N/A	N/A	N/A	N/A
Excision of benign lesion greater than 1.25 cm	D7411	\$245.24	Subject to pre-payment review. Pathology report required.	N/A	N/A	N/A	N/A	N/A
Excision of benign lesion, complicated	D7412	\$614.53	Subject to pre-payment review. Pathology report required.	N/A	N/A	N/A	N/A	N/A
Excision of malignant lesion up to 1.25 cm	D7413	\$275.95	Subject to pre-payment review.	N/A	N/A	N/A	N/A	N/A
Excision of malignant lesion greater than 1.25 cm	D7414	\$413.93	Subject to pre-payment review.	N/A	N/A	N/A	N/A	N/A
Excision of malignant lesion, complicated	D7415	\$507.66	Subject to pre-payment review.	N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Excision of malignant tumor - lesion diameter up to 1.25 cm	D7440	\$229.10		N/A	N/A	N/A	N/A	N/A
Excision of malignant tumor - lesion diameter greater than 1.25 cm	D7441	\$442.40	Subject to pre-payment review. Pathology report required.	N/A	N/A	N/A	N/A	N/A
Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm	D7450	\$202.55		N/A	N/A	N/A	N/A	N/A
Removal of odontogenic cyst or tumor - lesion greater than 1.25 cm	D7451	\$265.53		N/A	N/A	N/A	N/A	N/A
Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	D7460	\$210.88		N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Removal of nonodontogenic cyst or tumor - lesion greater than 1.25 cm	D7461	\$298.86		N/A	N/A	N/A	N/A	N/A
Removal of exostosis - per site	D7471	\$260.33	Teeth covered: Per arch (01, 02, LA, UA). Limited to the removal of tori, osseous, tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal.	N/A	N/A	N/A	N/A	N/A
Removal of torus palatinus	D7472	\$307.70		N/A	N/A	N/A	N/A	N/A
Removal of torus mandibularis	D7473	\$299.90		N/A	N/A	N/A	N/A	N/A
Surgical reduction of osseous tuberosity	D7485	\$277.00		N/A	N/A	N/A	N/A	N/A
Radical resection of mandible with bone graft	D7490	\$3,488.44		N/A	N/A	N/A	N/A	N/A
Incision & drainage of abscess - intraoral soft tissue	D7510	\$94.76	Teeth covered: 1-32. One of (D7510, D7511) per 1 lifetime per patient per tooth.	104%	\$193.00	\$183.00	\$10.00	Incision through mucosa, including periodontal origins.

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Incision & drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	D7511	\$274.35	One of (D7510, D7511) per 1 lifetime per patient per tooth.	N/A	N/A	N/A	N/A	N/A
Incision & Drainage of abscess - extraoral soft tissue	D7520	\$161.92	One of (D7520, D7521) per 1 lifetime per patient per tooth.	N/A	N/A	N/A	N/A	N/A
Incision & drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	D7521	\$229.63	One of (D7520, D7521) per 1 lifetime per patient per tooth.	N/A	N/A	N/A	N/A	N/A
Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	D7530	\$146.31		N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Removal of reaction-producing foreign bodies, musculoskeletal system	D7540	\$301.96		N/A	N/A	N/A	N/A	N/A
Partial ostectomy/Squestrectomy for removal of non-vital bone	D7550	\$215.04	Teeth covered: Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	N/A	N/A	N/A	N/A	N/A
Maxillary sinusotomy for removal of tooth fragment or foreign body	D7560	\$471.72		N/A	N/A	N/A	N/A	N/A
Maxilla - open reduction	D7610	\$1,773.38		N/A	N/A	N/A	N/A	N/A
Maxilla - closed reduction	D7620	\$1,403.71		N/A	N/A	N/A	N/A	N/A
Mandible - open reduction	D7630	\$1,774.93		N/A	N/A	N/A	N/A	N/A
Mandible - closed reduction	D7640	\$1,370.38		N/A	N/A	N/A	N/A	N/A
Malar and/or zygomatic arch-open reduction	D7650	\$1,595.83		N/A	N/A	N/A	N/A	N/A

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Malar and/or zygomatic arch-closed	D7660	\$1,313.11		N/A	N/A	N/A	N/A	N/A
Alveolus stabilization of teeth, closed reduction splinting	D7670	\$561.79		N/A	N/A	N/A	N/A	N/A
Alveolus - open reduction, may include stabilization of teeth	D7671	\$744.94		N/A	N/A	N/A	N/A	N/A
Facial bones - complicated reduction with fixation and multiple surgical approaches	D7680	\$2,659.56		N/A	N/A	N/A	N/A	N/A
Maxilla - open reduction	D7710	\$1,848.87		N/A	N/A	N/A	N/A	N/A
Maxilla - closed reduction	D7720	\$1,381.85		N/A	N/A	N/A	N/A	N/A
Mandible - closed reduction	D7740	\$1,475.55		N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Malar and/or zygomatic arch-open reduction	D7750	\$1,685.91		N/A	N/A	N/A	N/A	N/A
Malar and/or zygomatic arch-closed reduction	D7760	\$1,954.06		N/A	N/A	N/A	N/A	N/A
Alveolus, stabilization of teeth, open reduction splinting	D7770	\$1,101.72		N/A	N/A	N/A	N/A	N/A
Alveolus, closed reduction stabilization of teeth	D7771	\$1,055.35		N/A	N/A	N/A	N/A	N/A
Facial bones - complicated reduction with fixation and multiple surgical approaches	D7780	\$3,294.24		N/A	N/A	N/A	N/A	N/A
Open reduction of dislocation	D7810	\$1,736.93		N/A	N/A	N/A	N/A	N/A
Closed reduction of dislocation	D7820	\$234.31		N/A	N/A	N/A	N/A	N/A

\*REVISED\* CROSSWALK OF ALLOWABLE PROCEDURES AND FEES

Procedure Description	Code	Medicaid (DentaQuest)		% Diff	OAP Dental Asst Program (DPHE)			
		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Manipulation under anesthesia	D7830	\$311.87		N/A	N/A	N/A	N/A	N/A
Condylectomy	D7840	\$2,186.79		N/A	N/A	N/A	N/A	N/A
Surgical discectomy, with/without implant	D7850	\$3,404.33		N/A	N/A	N/A	N/A	N/A
Disc repair	D7852	\$2,307.58		N/A	N/A	N/A	N/A	N/A
Synovectomy	D7854	\$2,142.90		N/A	N/A	N/A	N/A	N/A
Myotomy	D7856	\$1,441.19		N/A	N/A	N/A	N/A	N/A
Joint reconstruction	D7858	*BR		N/A	N/A	N/A	N/A	N/A
Arthrotomy	D7860	*BR		N/A	N/A	N/A	N/A	N/A
Artoplasty	D7865	*BR		N/A	N/A	N/A	N/A	N/A
Arthrocentesis	D7870	\$167.66		N/A	N/A	N/A	N/A	N/A
Non-arthroscopic lysis and lavage	D7871	*BR		N/A	N/A	N/A	N/A	N/A
Arthroscopy diagnosis with or without biopsy	D7872	*BR		N/A	N/A	N/A	N/A	N/A
Arthroscopy-surgical: lavage & lysis of adhesions	D7873	*BR		N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Arthroscopy-surgical: disc Repositioning and stabilization	D7874	*BR		N/A	N/A	N/A	N/A	N/A
Arthroscopy-surgical synovectomy	D7875	*BR		N/A	N/A	N/A	N/A	N/A
Arthroscopy-surgical discectomy	D7876	*BR		N/A	N/A	N/A	N/A	N/A
Arthroscopy-surgical debridement	D7877	*BR		N/A	N/A	N/A	N/A	N/A
Unspecified TMD therapy, by report	D7899	*BR		N/A	N/A	N/A	N/A	N/A
Suture small wounds up to 5 cm	D7910	\$122.87		N/A	N/A	N/A	N/A	N/A
Complicated suture up to 5 cm	D7911	\$230.62		N/A	N/A	N/A	N/A	N/A
Complex suture - greater than 5 cm	D7912	\$369.80		N/A	N/A	N/A	N/A	N/A
Skin graft (identify defect covered, location and type of)	D7920	\$992.38		N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Osseous, osteoperioseal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	D7950	\$1,309.12		N/A	N/A	N/A	N/A	N/A
Repair of maxillofacial soft and/or hard tissue defect	D7955	\$2,216.26		N/A	N/A	N/A	N/A	N/A
Excision of hyperplastic tissue - per arch	D7970	\$208.26	Teeth covered: Per arch (01, 02, LA, UA). One of (D7970) per 1 lifetime per patient per arch.	N/A	N/A	N/A	N/A	N/A
Excision of pericoronal gingiva	D7971	\$97.36	Teeth covered: 1-32. One of (D7971) per 1 lifetime per patient per tooth.	N/A	N/A	N/A	N/A	N/A
Surgical reduction of fibrous tuberosity	D7972	\$303.03		N/A	N/A	N/A	N/A	N/A
Sialolithotomy	D7980	\$340.96		N/A	N/A	N/A	N/A	N/A
Excision of salivary gland, by report	D7981	*BR		N/A	N/A	N/A	N/A	N/A
Sialodochoplasty	D7982	\$699.77		N/A	N/A	N/A	N/A	N/A
Closure of salivary fistula	D7983	\$508.70		N/A	N/A	N/A	N/A	N/A

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		Max Allowable Fee	DENTAL PROCEDURE GUIDELINES		Max Allowable Fee	Program Payment	Max Patient Co-Pay	DENTAL PROCEDURE GUIDELINES
Emergency tracheotomy	D7990	\$526.92		N/A	N/A	N/A	N/A	N/A
Coronoidectomy	D7991	*BR		N/A	N/A	N/A	N/A	N/A
Appliance removal (not by dentist who placed appliance), includes removal of archbar	D7997	**Not Listed	Narrative of medical necessity required. PAR	N/A				N/A
Unspecified oral surgery procedure, by report	D7999	*BR	Narrative of medical necessity required. PAR	N/A	N/A	N/A	N/A	N/A
<b>ADJUNCTIVE GENERAL SERVICES</b>								
Palliative (emergency) treatment of dental pain - minor procedure	D9110	\$49.46		23%	\$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 fiscal yr. May not be charged as an encounter fee. maintain documentation that specifies problem and treatment.
Deep sedation/general anesthesia - first 30 minutes	D9220	\$186.08		N/A	N/A	N/A	N/A	
Deep sedation/general anesthesia - each additional 15 minutes	D9221	\$80.59		N/A	N/A	N/A	N/A	

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Intravenous conscious sedation/analgia - first 30 Minutes	D9241	\$186.08		N/A	N/A	N/A	N/A	
Intravenous conscious sedation/analgia - each additional 15 Minutes	D9242	\$80.59		N/A	N/A	N/A	N/A	
Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	D9310	\$38.01		N/A	N/A	N/A	N/A	
House/extended care facility call	D9410	\$91.11		N/A	N/A	N/A	N/A	
Hospital or ambulatory surgical center call	D9420	\$104.14		N/A	N/A	N/A	N/A	
Unspecified adjunctive procedure, by report	D9999	*BR		N/A	N/A	N/A	N/A	