

PROVIDERS MAY NOTICE A MINOR DIFFERENCE BETWEEN THE PUBLISHED PAYMENT AMOUNT ON THE FEE SCHEDULE AND THE ACTUAL PAYMENT AMOUNT. THE PAYMENT SYSTEM USES SEVEN DECIMAL PLACES IN THE REIMBURSEMENT CALCULATION, BUT THE FEE SCHEDULE PUBLISHES ONLY THE FIRST TWO DECIMAL PLACES.

SHCN = Special Health Care Needs: a client who is unable to care for their mouth properly on their own because of a disabling condition or who has a high-risk dental diagnosis

PHDH = Public Health Dental Hygienist

**PLEASE NOTE: RATES DO NOT REFLECT AN INCREASE FROM THE PREVIOUS FEE SCHEDULE AS THERE WERE NO RATE INCREASE APPROPRIATIONS FOR THIS STATE FISCAL YEAR**

NEBRASKA MEDICAID FEE SCHEDULE, DENTAL SERVICES JULY 1, 2025

471-000-506

MEDICAID

| CODE     | DESCRIPTION  | PA | COMMENTS   | PHDH CAN BILL | ALLOWABLE |
|----------|--|----|--|---------------|-----------|
| 000D0120 | PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT   |    | Covered one time every 180 days. For SHCN clients: covered at the frequency determined by the treating dental provider. The SHCN diagnosis and medical necessity for the frequency of oral evaluations must be documented in the client's dental record  |               | \$29.77   |
| 000D0140 | LIMITED ORAL EVALUATION - PROBLEM FOCUSED  |    | Covered two times every 365 days for treatment of a specific oral health problem or complaint.   |               | \$29.77   |
| 000D0145 | ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER |    | Covered two times every 365 days for clients under age 3 and includes counseling of the primary caregiver  |               | \$50.05   |
| 000D0150 | COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT                                   |    | Covered one time every 1095 days per provider per location   |               | \$29.77   |
| 000D0160 | DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT                          |    | Covered one time every 1095 days   |               | \$36.53   |
| 000D0170 | RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)     |    | Covered one time every 365 days  |               | \$21.65   |
| 000D0171 | RE-EVALUATION - POST-OPERATIVE OFFICE VISIT  |    | Covered one time every 365 days  |               | \$20.80   |
| 000D0180 | COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT                            |    | Covered one time every 1095 days   |               | \$36.53   |
| 000D0190 | SCREENING OF A PATIENT   |    | Covered two times every 365 days when provided by a licensed provider practicing within their scope of practice to determine a client's need to be evaluated by a dentist. PHDH can submit a claim for this code when performed in a public health setting   | x             | \$16.99   |
| 000D0191 | ASSESSMENT OF A PATIENT  |    | Covered two times every 365 days when provided by a licensed provider practicing within their scope of practice to determine a client's need to be evaluated by a dentist. PHDH can submit a claim for this code when performed in a public health setting   | x             | \$17.49   |
| 000D0210 | INTRAORAL - COMPLETE SERIES (INCLUDING BITEWINGS)  |    | Covered one time every 1095 days. Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330. A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record |               | \$60.89   |
| 000D0220 | INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE  |    | Covered one time per day. Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330   |               | \$8.11    |
| 000D0230 | INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE                                    |    | Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330   |               | \$6.75    |
| 000D0240 | INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE  |    | Covered two times every 180 days. Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330   |               | \$9.47    |
| 000D0270 | BITEWING - SINGLE RADIOGRAPHIC IMAGE   |    | Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330. A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record                                   |               | \$12.18   |
| 000D0272 | BITEWINGS - TWO RADIOGRAPHIC IMAGES  |    | Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330. A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record                                   |               | \$17.60   |
| 000D0273 | BITEWINGS - THREE RADIOGRAPHIC IMAGES  |    | Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330. A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record                                   |               | \$20.30   |

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| 000D0274 | BITEWINGS - FOUR RADIOGRAPHIC IMAGES                            |  | Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330. A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record  |   | \$25.72  |
| 000D0330 | PANORAMIC RADIOGRAPHIC IMAGE                                    |  | Covered one time every 1095 days. Maximum payment of \$60.89 per date of service for any combination of codes D0210 -D0330  |   | \$48.69  |
| 000D0340 | CEPHALOMETRIC RADIOGRAPHIC IMAGE                                |  | Covered for clients age 20 and younger for the Medicaid-approved orthodontic treatment plan   |   | \$83.86  |
| 000D0470 | DIAGNOSTIC CASTS  |  | Covered for clients age 20 and younger for the Medicaid-approved orthodontic treatment plan. Diagnostic casts for minor malocclusions are not covered by Medicaid   |   | \$62.22  |
| 000D1110 | PROPHYLAXIS - ADULT (AGE 14 AND OLDER)                          |  | Covered two times every 365 days for clients age 14 through 20 and one time every 180 days for clients age 21 and older. For SHCN clients: covered at the frequency determined by the treating dental provider and is limited to one prophylaxis per date of service. The SHCN diagnosis and medical necessity for the frequency of prophylaxis must be documented in the client's dental record. PHDH can submit a claim for this code when performed in a public health setting | x | \$44.64  |
| 000D1120 | PROPHYLAXIS - CHILD (AGE 13 AND YOUNGER)                        |  | Covered two times every 365 days. For SHCN clients: covered at the frequency determined by the treating dental provider and is limited to one prophylaxis per date of service. The SHCN diagnosis and medical necessity for the frequency of prophylaxis must be documented in the client's dental record. PHDH can submit a claim for this code when performed in a public health setting  | x | \$35.17  |
| 000D1206 | TOPICAL APPLICATION OF FLUORIDE VARNISH                         |  | Covered two times every 365 days. Covered more frequently if it is medically necessary and clinical justification must be documented in the client's dental record. PHDH can submit a claim for this code when performed in a public health setting   | x | \$27.06  |
| 000D1208 | TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH             |  | Covered two times every 365 days. Covered more frequently if it is medically necessary and clinical justification must be documented in the client's dental record. PHDH can submit a claim for this code when performed in a public health setting   | x | \$24.35  |
| 000D1351 | SEALANT- PER TOOTH  |  | Covered for permanent and primary teeth for clients ages 20 and younger. Sealants are covered one time per tooth every 730 days.  | x | \$33.82  |
| 000D1354 | APPLICATION OF CARIES ARRESTING MEDICAMENT - PER TOOTH          |  | Covered up to three times per tooth. A permanent restoration is not payable on the same tooth for 90 days following D1354 by the same provider, practice or group   |   | \$13.52  |
| 000D1355 | CARIES PREVENTITIVE MEDICAMENT APPLICATION - PER TOOTH          |  | Covered up to three times per tooth. A permanent restoration is not payable on the same tooth for 90 days following D1355 by the same provider, practice or group   |   | \$13.52  |
| 000D1510 | SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT             |  | Covered one time per arch every 365 days for clients age 20 and younger   |   | \$148.78 |
| 000D1516 | SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY                 |  | Covered one time every 365 days for clients age 20 and younger  |   | \$202.89 |
| 000D1517 | SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR                |  | Covered one time every 365 days for clients age 20 and younger  |   | \$202.89 |
| 000D1551 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY     |  | Covered one time every 365 days for clients age 20 and younger. Not payable within 180 days of initial placement by the same provider   |   | \$28.42  |
| 000D1552 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR    |  | Covered one time every 365 days for clients age 20 and younger. Not payable within 180 days of initial placement by the same provider   |   | \$28.42  |
| 000D1553 | RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT |  | Covered one time every 365 days for clients age 20 and younger. Not payable within 180 days of initial placement by the same provider   |   | \$28.42  |
| 000D1556 | REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT     |  | Covered one time every 365 days for clients age 20 and younger  |   | \$28.42  |
| 000D1557 | REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MAXILLARY         |  | Covered one time every 365 days for clients age 20 and younger  |   | \$28.42  |
| 000D1558 | REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MANDIBULAR        |  | Covered one time every 365 days for clients age 20 and younger  |   | \$28.42  |
| 000D1575 | DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT |  | Covered one time every 365 days for clients age 20 and younger  |   | \$161.36 |
| 000D2140 | AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT                     |  | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and 1-32   |   | \$67.64  |

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| 000D2150 | AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT  |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and 1-32  |  | \$79.81  |
| 000D2160 | AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT                                      |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and 1-32  |  | \$96.05  |
| 000D2161 | AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT                               |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and 1-32  |  | \$112.28 |
| 000D2330 | RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR  |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27   |  | \$78.46  |
| 000D2331 | RESIN-BASED COMPOSITE - TWO SURFACES ANTERIOR                                       |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27   |  | \$97.39  |
| 000D2332 | RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR                                     |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27   |  | \$112.28 |
| 000D2335 | RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR) |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27   |  | \$131.21 |
| 000D2390 | RESIN-BASED COMPOSITE CROWN, ANTERIOR   |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27   |  | \$262.42 |
| 000D2391 | RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR                                      |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32   |  | \$79.81  |
| 000D2392 | RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR                                     |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32   |  | \$101.45 |
| 000D2393 | RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR                                   |   | Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32   |  | \$117.68 |
| 000D2394 | RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR                            |   | Only one D2140-D2394 every 365 days per surface per tooth is covered teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32   |  | \$124.44 |
| 000D2710 | CROWN - RESIN BASED COMPOSITE (INDIRECT)  | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$262.42 |
| 000D2720 | CROWN - RESIN WITH HIGH NOBLE METAL   | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |
| 000D2721 | CROWN - RESIN WITH PREDOMINANTLY BASE METAL   | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$445.02 |
| 000D2722 | CROWN - RESIN WITH NOBLE METAL  | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$445.02 |
| 000D2740 | CROWN - PORCELAIN / CERAMIC   | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |
| 000D2750 | CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL   | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |

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| 000D2751 | CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL                       | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |
| 000D2752 | CROWN - PORCELAIN FUSED TO NOBLE METAL                                    | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |
| 000D2790 | CROWN - FULL CAST HIGH NOBLE METAL  | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |
| 000D2791 | CROWN - FULL CAST PREDOMINANTLY BASE METAL                                | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |
| 000D2792 | CROWN - FULL CAST NOBLE METAL   | X | Covered for anterior and bicuspid teeth when other restoration procedures are not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who initially placed the crown |  | \$459.90 |
| 000D2915 | RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE |   | Covered one time every 365 days per tooth. Not payable within the first 180 days of initial placement  |  | \$51.40  |
| 000D2920 | RE-CEMENT OR RE-BOND CROWN  |   | Covered one time every 365 days per tooth. Not payable within the first 180 days of initial placement  |  | \$27.06  |
| 000D2929 | PREFABRICATED PORCELAIN / CERAMIC CROWN - PRIMARY TOOTH                   |   | Covered one time every 730 days per tooth for teeth C-H and M-R  |  | \$181.25 |
| 000D2930 | PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH                       |   | Covered one time every 730 days per tooth  |  | \$156.90 |
| 000D2931 | PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH                     |   | Covered one time every 730 days per tooth  |  | \$156.90 |
| 000D2932 | PREFABRICATED RESIN CROWN   |   | Covered one time every 730 days per tooth for teeth C-H and M-R  |  | \$139.32 |
| 000D2933 | PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW                     |   | Covered one time every 730 days per tooth for teeth C-H and M-R  |  | \$181.25 |
| 000D2934 | PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH       |   | Covered one time every 730 days per tooth for teeth C-H and M-R  |  | \$181.25 |
| 000D2940 | PLACEMENT OF INTERIM DIRECT RESTORATION                                   |   | Covered one time per lifetime per tooth  |  | \$43.29  |
| 000D2950 | CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED                            |   | One D2950 or D2954 every 1825 days per tooth is covered for teeth 2-15, 18-31  |  | \$98.75  |
| 000D2951 | PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION                     |   | Covered one time every 365 days per tooth  |  | \$14.88  |
| 000D2954 | PREFABRICATED POST AND CORE IN ADDITION TO CROWN                          |   | One D2950 or D2954 every 1825 days per tooth is covered for teeth 2-15, 18-31  |  | \$127.16 |
| 000D2980 | CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE                 |   | Covered one time per lifetime per tooth  |  | BR       |

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| 000D2999 | UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT  |   | This code is used for procedures that are not adequately described by another code. The code must not be used to claim an item or service that is not covered by Medicaid. A description of the treatment provided and medical necessity must be submitted with the claim. This service is retrospectively reviewed for approval of payment |  | BR       |
| 000D3220 | THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT |   | Covered one time per lifetime per primary tooth   |  | \$94.69  |
| 000D3230 | PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)   |   | Covered one time per lifetime per primary tooth   |  | \$114.98 |
| 000D3240 | PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)  |   | Covered one time per lifetime per primary tooth   |  | \$121.74 |
| 000D3310 | ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)  |   | Covered one time per lifetime per permanent tooth   |  | \$328.70 |
| 000D3320 | ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)  |   | Covered one time per lifetime per permanent tooth   |  | \$339.51 |
| 000D3330 | ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)   |   | Covered one time per lifetime per permanent tooth. Not covered for third molars   |  | \$451.78 |
| 000D3346 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR   |   | Covered one time per lifetime per permanent tooth. Not payable within 365 days of D3310   |  | \$298.16 |
| 000D3347 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - PREMOLAR   |   | Covered one time per lifetime per permanent tooth. Not payable within 365 days of D3320   |  | \$339.51 |
| 000D3348 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - POSTERIOR  |   | Covered one time per lifetime per permanent tooth. Not payable within 365 days of D3330. Not covered for third molars   |  | \$451.78 |
| 000D3351 | APEXIFICATION / RECALCIFICATION - INITIAL VISIT (APICAL CLOSURE / CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)                   |   | Covered one time per lifetime per permanent tooth. Not covered for third molars   |  | \$119.04 |
| 000D3410 | APICOECTOMY - ANTERIOR  |   | Covered one time per lifetime per tooth for teeth 6-11 and 22-27  |  | \$231.31 |
| 000D4210 | GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT  |   | Covered one time per quadrant every 730 days  |  | \$127.16 |
| 000D4211 | GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT  |   | Covered one time per quadrant every 730 days  |  | \$96.05  |
| 000D4323 | SPLINT - EXTRA-CORONAL: NATURAL TEETH OR PROSTHETIC CROWNS  |   | Covered one time per day per arch for trauma. A description of the treatment provided and medical necessity must be submitted with the claim. This service is retrospectively reviewed for approval of payment  |  | \$214.10 |
| 000D4341 | PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT  | X | Covered one time per quadrant every 365 days. Only two quadrants of the mouth are covered on the same date of service except for hospital cases. Not allowed within 21 days of D4355  |  | \$135.26 |
| 000D4342 | PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT  | X | Covered one time per quadrant every 365 days. Only two quadrants of the mouth are covered on the same date of service except for hospital cases. Not allowed within 21 days of D4355  |  | \$70.34  |

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| 000D4355 | DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT  |   | Covered one time every 365 days. Not covered on the same date of service as other periodontal treatment or dental exam  | x | \$62.22  |
| 000D4910 | PERIODONTAL MAINTENANCE PROCEDURES  | X | Covered four times every 365 days for clients who received Medicaid-approved scaling and root planning. Prior authorization must be renewed annually  |   | \$39.23  |
| 000D5110 | COMPLETE DENTURE - MAXILLARY  | X | Covered one time every 1825 days. Only one D5110, D5130, D5211, D5213, D5820 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis |   | \$896.82 |
| 000D5120 | COMPLETE DENTURE - MANDIBULAR   | X | Covered one time every 1825 days. Only one D5120, D5140, D5212, D5214, D5821 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis |   | \$896.82 |
| 000D5130 | IMMEDIATE DENTURE - MAXILLARY   | X | Covered one time per lifetime. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis. D5110 is not payable within 1825 days of D5130                           |   | \$727.72 |
| 000D5140 | IMMEDIATE DENTURE - MANDIBULAR  | X | Covered one time per lifetime. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis. D5120 is not payable within 1825 days of D5140                           |   | \$727.72 |
| 000D5211 | MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS, AND TEETH)                                     | X | Covered one time every 1825 days. Only one D5110, D5130, D5211, D5213, D5820 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis |   | \$627.64 |
| 000D5212 | MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS, AND TEETH)                                    | X | Covered one time every 1825 days. Only one D5120, D5140, D5212, D5214, D5821 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis |   | \$627.64 |
| 000D5213 | MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS, AND TEETH)  | X | Covered one time every 1825 days. Only one D5110, D5130, D5211, D5213, D5820 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis |   | \$638.45 |
| 000D5214 | MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS, AND TEETH) | X | Covered one time every 1825 days. Only one D5120, D5140, D5212, D5214, D5821 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis |   | \$638.45 |
| 000D5410 | ADJUST COMPLETE DENTURE - MAXILLARY   |   | Covered one time per day. Adjustments are inclusive for the first 180 days following placement of the prosthesis  | x | \$27.06  |
| 000D5411 | ADJUST COMPLETE DENTURE - MANDIBULAR  |   | Covered one time per day. Adjustments are inclusive for the first 180 days following placement of the prosthesis  | x | \$27.06  |
| 000D5421 | ADJUST PARTIAL DENTURE - MAXILLARY  |   | Covered one time per day. Adjustments are inclusive for the first 180 days following placement of the prosthesis  | x | \$27.06  |
| 000D5422 | ADJUST PARTIAL DENTURE - MANDIBULAR   |   | Covered one time per day. Adjustments are inclusive for the first 180 days following placement of the prosthesis  | x | \$27.06  |
| 000D5511 | REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR   |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$137.96 |
| 000D5512 | REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY  |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$137.96 |
| 000D5520 | REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE - PER TOOTH  | X | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$79.56  |
| 000D5611 | REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR   |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$127.16 |
| 000D5612 | REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY  |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$127.16 |
| 000D5621 | REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR   |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$146.08 |
| 000D5622 | REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY  |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$146.08 |
| 000D5630 | REPAIR OR REPLACE BROKEN RETENTIVE / CLASPING MATERIALS - PER TOOTH   |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis  |   | \$159.62 |

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| 000D5640 | REPLACE MISSING OR BROKEN TEETH - PARTIAL DENTURE - PER TOOTH                                    | X | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$79.56  |
| 000D5650 | ADD TOOTH TO EXISTING PARTIAL DENTURE - PER TOOTH  | X | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$79.56  |
| 000D5660 | ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH - PER TOOTH                                      |   | Covered two times every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$139.32 |
| 000D5710 | REBASE COMPLETE MAXILLARY DENTURE  |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$262.42 |
| 000D5711 | REBASE COMPLETE MANDIBULAR DENTURE   |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$262.42 |
| 000D5720 | REBASE MAXILLARY PARTIAL DENTURE   |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$262.42 |
| 000D5721 | REBASE MANDIBULAR PARTIAL DENTURE  |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$262.42 |
| 000D5730 | RELINE COMPLETE MAXILLARY DENTURE (DIRECT)   |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$137.96 |
| 000D5731 | RELINE COMPLETE MANDIBULAR DENTURE (DIRECT)  |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$137.96 |
| 000D5740 | RELINE MAXILLARY PARTIAL DENTURE (DIRECT)  |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$137.96 |
| 000D5741 | RELINE MANDIBULAR PARTIAL DENTURE (DIRECT)   |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$137.96 |
| 000D5750 | RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)   |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$228.61 |
| 000D5751 | RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)  |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$228.61 |
| 000D5760 | RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)  |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$228.61 |
| 000D5761 | RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)   |   | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$228.61 |
| 000D5765 | SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE - INDIRECT                                  | X | Covered one time per prosthesis every 365 days. Not payable within 180 days of initial placement of the prosthesis   | \$210.04 |
| 000D5810 | INTERIM COMPLETE DENTURE (MAXILLARY)   | X | Covered one time every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis   | \$472.07 |
| 000D5811 | INTERIM COMPLETE DENTURE (MANDIBULAR)  | X | Covered one time every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis   | \$472.07 |
| 000D5820 | INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY  | X | Covered one time every 1825 days and this is considered a permanent replacement for one to three missing anterior teeth. Only one D5110, D5130, D5211, D5213, D5820 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis | \$319.21 |
| 000D5821 | INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR | X | Covered one time every 1825 days and this is considered a permanent replacement for one to three missing anterior teeth. Only one D5120, D5140, D5212, D5214, D5821 is covered every 1825 days. Adjustments and relines are inclusive for the first 180 days following placement of the prosthesis | \$319.21 |
| 000D5850 | TISSUE CONDITIONING, MAXILLARY   |   | Covered one time during the first 180 days following placement of the initial prosthesis and two times after the first 180 days every 365 days. Medical necessity must be documented in the client's dental record   | \$58.16  |
| 000D5851 | TISSUE CONDITIONING, MANDIBULAR  |   | Covered one time during the first 180 days following placement of the initial prosthesis and two times after the first 180 days every 365 days. Medical necessity must be documented in the client's dental record   | \$58.16  |
| 000D5899 | UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT   |   | This code can be used to inform Medicaid when denture treatment is interrupted   | BR       |
| 000D7111 | EXTRACTION, CORONAL REMNANTS - PRIMARY TOOTH   |   | Covered one time per lifetime per tooth  | \$59.52  |
| 000D7140 | EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND / OR FORCEPS REMOVAL)                   |   | Covered one time per lifetime per tooth  | \$89.27  |

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| 000D7210 | EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND / OR SECTIONING OF TOOTH AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED |  | Covered one time per lifetime per tooth   |  | \$125.81 |
| 000D7220 | REMOVAL OF IMPACTED TOOTH - SOFT TISSUE  |  | Covered one time per lifetime per tooth   |  | \$165.03 |
| 000D7230 | REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY   |  | Covered one time per lifetime per tooth   |  | \$225.90 |
| 000D7240 | REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY  |  | Covered one time per lifetime per tooth   |  | \$273.23 |
| 000D7241 | REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS   |  | Covered one time per lifetime per tooth   |  | \$286.75 |
| 000D7250 | REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)  |  | Covered one time per lifetime per tooth   |  | \$119.04 |
| 000D7270 | TOOTH RE-IMPLANTATION AND / OR STABILIZATION OF ACCIDENTLY EVULSED OR DISPLACED TOOTH  |  | Fee is inclusive of splinting and/or stabilization  |  | \$202.89 |
| 000D7280 | EXPOSURE OF AN UNERUPTED TOOTH   |  | Covered one time per lifetime per tooth. Only covered for the Medicaid-approved orthodontic treatment plan. Fee is inclusive of orthodontic attachment  |  | \$189.37 |
| 000D7282 | MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION   |  | Covered one time per lifetime per tooth   |  | \$154.20 |
| 000D7285 | INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE TOOTH)   |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | \$127.16 |
| 000D7286 | INCISIONAL BIOPSY OF ORAL TISSUE - SOFT  |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | \$114.98 |
| 000D7310 | ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT   |  | One D7310, D7311, D7320, D7321 per quadrant is covered per lifetime. Removal of tori is considered inclusive to this procedure. Only allowed to prepare the quadrant for a prosthetic appliance |  | \$119.04 |
| 000D7311 | ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT   |  | One D7310, D7311, D7320, D7321 per quadrant is covered per lifetime. Removal of tori is considered inclusive to this procedure. Only allowed to prepare the quadrant for a prosthetic appliance |  | \$96.05  |
| 000D7320 | ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT   |  | One D7310, D7311, D7320, D7321 per quadrant is covered per lifetime. Removal of tori is considered inclusive to this procedure. Only allowed to prepare the quadrant for a prosthetic appliance |  | \$127.16 |
| 000D7321 | ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT   |  | One D7310, D7311, D7320, D7321 per quadrant is covered per lifetime. Removal of tori is considered inclusive to this procedure. Only allowed to prepare the quadrant for a prosthetic appliance |  | \$102.80 |
| 000D7410 | EXCISION OF BENIGN LESION UP TO 1.25 CM  |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7411 | EXCISION OF BENIGN LESION GREATER THAN 1.25 CM   |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7412 | EXCISION OF BENIGN LESION, COMPLICATED   |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7413 | EXCISION OF MALIGNANT LESION UP TO 1.25 CM   |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7414 | EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM  |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7415 | EXCISION OF MALIGNANT LESION, COMPLICATED  |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7440 | EXCISION OF MALIGNANT TUMOR - LESION DIAMETER UP TO 1.25 CM  |  | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |

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| 000D7441 | EXCISION OF MALIGNANT TUMOR - LESION DIAMETER GREATER THAN 1.25 CM                    |   | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7450 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM           |   | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7451 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM    |   | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7460 | REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM |   | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7461 | REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM |   | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7465 | DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT                    |   | Covered one time per day. The fee is for the professional component only. The lab must bill charges for the specimen separately   |  | BR       |
| 000D7471 | REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)                                    |   | Covered two times per arch per lifetime   |  | \$148.78 |
| 000D7510 | INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE                              |   | Covered one time per day. Not allowed on the same date of service as an extraction in the same area of the mouth  |  | \$56.81  |
| 000D7880 | OCCLUSAL ORTHOTIC DEVICE, BY REPORT   |   | Covered one time every 1095 days for the treatment of TMJ   |  | BR       |
| 000D7961 | BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)   |   | Covered two times per arch per lifetime   |  | \$124.44 |
| 000D7962 | LINGUAL FRENECTOMY (FRENULECTOMY)   |   | Covered one time per lifetime   |  | \$124.44 |
| 000D8020 | LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION                           | X | Fee is determined by the Medicaid-approved orthodontic treatment plan   |  | BR       |
|          | <b>Procedures covered under code D8020</b>  |   | Only one D8020 or D8080 is covered per lifetime. Fee is inclusive of all materials, appointments and repairs for completion of the Medicaid-approved orthodontic treatment plan |  |          |
|          | Constructing and placing fixed maxillary appliance, active treatment                  | x |   |  | \$489.78 |
|          | Constructing and placing fixed mandibular appliance, active treatment                 | x |   |  | \$489.78 |
|          | Each one-month period of active treatment - maxillary arch                            | x |   |  | \$48.29  |
|          | Each one-month period of active treatment - mandibular arch                           | x |   |  | \$48.29  |
|          | Retainer or retention appliance   | x |   |  | \$131.07 |
|          | Each one-month period of retention appliance treatment - maxillary arch               | x |   |  | \$26.20  |
|          | Each one-month period of retention appliance treatment - mandibular arch              | x |   |  | \$26.20  |
| 000D8080 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION                       | X | Fee is determined by the Medicaid-approved orthodontic treatment plan   |  | BR       |
|          | <b>Procedures covered under code D8080</b>  | x | Only one D8020 or D8080 is covered per lifetime. Fee is inclusive of all materials, appointments and repairs for completion of the Medicaid-approved orthodontic treatment plan |  |          |
|          | Constructing and placing fixed maxillary appliance, active treatment                  | x |   |  | \$489.78 |
|          | Constructing and placing fixed mandibular appliance, active treatment                 | x |   |  | \$489.78 |

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|          | Each one-month period of active treatment - maxillary arch   | x |  |   | \$48.29  |
|          | Each one-month period of active treatment - maxillary arch, unusual service (surgical correction case) | x |  |   | \$70.36  |
|          | Each one-month period of active treatment-mandibular arch  | x |  |   | \$48.29  |
|          | Each one-month period of active treatment-mandibular arch, unusual service (surgical correction case)  | x |  |   | \$70.36  |
|          | Retainer or retention appliance  | x |  |   | \$131.07 |
|          | Each one-month period of retention appliance treatment-maxillary arch                                  | x |  |   | \$26.20  |
|          | Each one-month period of retention appliance treatment-mandibular arch                                 | x |  |   | \$26.20  |
|          | Rapid palatal expander (RPE) or cross-bite correcting (fixed) appliance                                | x |  |   | \$248.33 |
|          | Herbst appliance   | x |  |   | \$372.51 |
|          | Protraction facemask   | x |  |   | \$223.50 |
|          | Slow expansion appliance   | x |  |   | \$244.20 |
|          | Headgear   | x |  |   | \$223.50 |
|          | Inclined plane (Hawley) appliance, bite plane, with clasps   | x |  |   | \$215.25 |
|          | Orthodontic appliance, not listed  | x |  |   | BR       |
|          | Orthodontic procedure, not listed  | x |  |   | BR       |
|          | Space maintainer-fixed-unilateral, part of comprehensive orthodontic treatment plan                    | x |  |   | \$151.75 |
|          | Space maintainer-fixed-bilateral, part of comprehensive orthodontic treatment plan                     | x |  |   | \$262.14 |
| 000D8210 | REMOVABLE APPLIANCE THERAPY (THUMB-SUCKING & TONGUE THRUST)  | X |  | Covered one time per lifetime for clients 20 and younger. Fee is inclusive of adjustments   | \$202.89 |
| 000D8220 | FIXED APPLIANCE THERAPY (THUMB-SUCKING AND TONGUE THRUST)  | X |  | Covered one time per lifetime for clients 20 and younger. Fee is inclusive of adjustments   | \$278.64 |
| 000D8696 | REPAIR OF ORTHODONTIC APPLIANCE - MAXILLARY  |   |  | Covered up to five times per lifetime   | BR       |
| 000D8697 | REPAIR OF ORTHODONTIC APPLIANCE - MANDIBULAR   |   |  | Covered up to five times per lifetime   | BR       |
| 000D8698 | RE-CEMENT OR RE-BOND FIXED RETAINER - MAXILLARY  |   |  | Covered up to five times per lifetime   | \$12.75  |
| 000D8699 | RE-CEMENT OR RE-BOND FIXED RETAINER - MANDIBULAR   |   |  | Covered up to five times per lifetime   | \$12.75  |
| 000D8703 | REPLACEMENT OF LOST OR BROKEN RETAINER - MAXILLARY   |   |  | Covered one time per lifetime for clients age 20 and younger if the client is compliant with wearing the appliance  | \$128.51 |
| 000D8704 | REPLACEMENT OF LOST OR BROKEN RETAINER - MANDIBULAR  |   |  | Covered one time per lifetime for clients age 20 and younger if the client is compliant with wearing the appliance  | \$128.51 |
| 000D8999 | UNSPECIFIED ORTHODONTIC PROCEDURE BY REPORT  | X |  | This code is to be used only for continuation of care by a provider or office other than the original provider for the completion of the Medicaid-approved orthodontic treatment plan | BR       |
| 000D9110 | PALLIATIVE TREATMENT OF DENTAL PAIN - PER VISIT  |   |  | Covered one time on one date of service per location. Not allowed on the same date of service as definitive treatment   | \$31.12  |
| 000D9219 | EVALUATION FOR MODERATE SEDATION, DEEP SEDATION OR GENERAL ANESTHESIA                                  |   |  | Covered one time per day  | \$50.32  |

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| 000D9222 | DEEP SEDATION / GENERAL ANESTHESIA - FIRST 15 MINUTES   |  | Covered one time per day for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day |   | \$119.04 |
| 000D9223 | DEEP SEDATION / GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT                                      |  | Covered for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day                  |   | \$109.58 |
| 000D9230 | INHALATION OF NITROUS OXIDE / ANXIOLYSIS ANALGESIA  |  | Covered one time per day for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day |   | \$37.87  |
| 000D9239 | INTRAVENOUS MODERATE (CONSCIOUS ) SEDATION / ANALGESIA - FIRST 15 MINUTES                                     |  | Covered one time per day for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day |   | \$68.99  |
| 000D9243 | INTRAVENOUS MODERATE (CONSCIOUS ) SEDATION / ANALGESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT                  |  | Covered for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day                  |   | \$68.99  |
| 000D9248 | NON-INTRAVENOUS MODERATE CONSCIOUS SEDATION   |  | Covered one time per day for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day |   | \$54.11  |
| 000D9310 | CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN |  | Covered one time every 365 days. Not payable if another exam procedure is billed by the same dental practice on the same date of service                  |   | \$29.77  |
| 000D9410 | HOUSE / EXTENDED CARE FACILITY CALL   |  | Covered one time per day per facility   | x | \$47.34  |
| 000D9420 | HOSPITAL OR AMBULATORY SURGICAL CENTER CALL   |  | Covered one time per day per facility   |   | \$108.20 |
| 000D9440 | OFFICE VISIT- AFTER REGULARLY SCHEDULED HOURS   |  | Covered one time per day  |   | \$60.89  |
| 000D9944 | OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH  |  | Covered one time every 1095 days to minimize the effects of bruxism and other occlusal factors. Medicaid does not cover athletic guards                   |   | \$221.83 |
| 000D9945 | OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH  |  | Covered one time every 1095 days to minimize the effects of bruxism and other occlusal factors. Medicaid does not cover athletic guards                   |   | \$221.83 |
| 000D9946 | OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH   |  | Covered one time every 1095 days to minimize the effects of bruxism and other occlusal factors. Medicaid does not cover athletic guards                   |   | \$221.83 |
| 000D9997 | DENTAL CASE MANAGEMENT - PATIENTS WITH SPECIAL HEALTH CARE NEEDS  |  | This code is to be used to identify a client with SHCN. The SHCN diagnosis must be documented in the client's dental record. This code is not payable     |   | NA       |