



ALASKA MEDICAID DENTAL CLAIMS COMMON ERRORS and EFFECTIVE SOLUTIONS

As part of its ongoing provider support efforts, the Alaska Division of Health Care Services (HCS) recently conducted an analysis of dental claims, identified common errors and error trends, and recommended steps providers can take to ensure claims are submitted accurately.

During March 2010, 38,674 dental claims were submitted to Alaska Medicaid. The majority (35075, or 90.6%) of those claims were accurate, which resulted in successful and prompt adjudication/payment. Of the 3599 claims that were denied, most were a result of 10 common coding or claims submission errors:

ERROR CODE	DESCRIPTION	TOTAL DENIED CLAIMS
551	CLAIM PROVIDER DOES NOT MATCH PA PROVIDER	842
258	RECIPIENT NOT ELIGIBLE ON DATES OF SERVICE- NO STICKER/ATTACHMENT	510
257	RECIPIENT NOT ON FILE - NO STICKER/ATTACHMENT	378
840	DUPLICATE OF PREVIOUSLY PAID CLAIM	362
376	RECIPIENT OVER 21 REQUIRES PA FOR THESE DENTAL CODES	237
288	PROCEDURE/ITEM NOT COVERED FOR MEDICAID	142
552	CLAIM RECIPIENT DOES NOT MATCH PA RECIPIENT	136
023	PATIENT NAME IS MISSING	122
233	PROCEDURE NOT COVERED ON DOS	110
234	PROCEDURE/FORMULARY AGE RESTRICTION	108

WHAT DOES THIS MEAN?

More than 41% of denials were caused by errors related to Prior Authorizations (PA) (i.e., the provider failed to obtain a required PA, the provider or recipient number on the claim does not match that of the Prior Authorization request).

An additional 34% of denials were the result of claims submitted with incorrect recipient information (i.e., recipient name and ID number mismatch, recipient name missing) or for recipients who were not eligible on the date of service.

More than 12% of denials were the result of a claim submitted for a procedure that is not covered or is age-restricted.



HOW CAN THESE COMMON ERRORS BE PREVENTED?

- Obtain a PA when required. Dental services that require a PA are annotated in the Dental Fee Schedule. NOTE: ALL Adult Enhanced Dental services require a PA.
- For GROUP practices, request the PA under the GROUP practice DDG### number, and submit the related claim with the GROUP NPI number in field 49.
- Submit claim with the same procedure code(s) and surface code(s) requested on the PA. If procedure or surface code changes are required, request an update of the PA prior to submission of the claim.
- Accurately record the PA number on the claim; be sure that the PA matches the recipient for whom it was obtained.
- Verify recipient eligibility; ensure that the recipient is eligible on the date of service.
- Accurately record the recipient's ID number and name on the claim form.
- Verify that the procedure is a Medicaid covered service and that the procedure is covered based on the recipient's age. The current dental fee schedule of covered services is available at: <http://medicaidalaska.com/providers/FeeSchedule.asp>.

Questions? Contact Affiliated Computer Services' Provider Inquiry Unit at (907) 644-6800, option 1, or toll free in Alaska at (800) 770-5650, option 1, 1.

DENTAL SERVICES TRAINING

Alaska Medical Assistance is pleased to announce a new class specifically for dental providers. Training is presented by Affiliated Computer Services (ACS), and the first scheduled class is on June 17, 2010 in Anchorage. A second training via WebEx will follow on July 7, 2010.

In-depth information and instruction will be included on the following topics:

- Remittance Advice/Resubmission Turnaround Document: What is it? What do I need to do with it? Why is it important to me?
- Prior Authorization: Why are PAs necessary? How do PAs affect claims?
- Fee Schedule, Covered Services, and Service Limitations.
- Dental Regulations.
- ADA Dental Claim Form completion: Helpful hints and problematic areas.
- Common error codes: How to avoid them.
- YOUR TURN! Discussion, questions, and concerns.

To register for this course, or any other course, or to view the training schedule, please visit www.medicaidalaska.com and select one of the drop-down options under the *Training* tab.

Additional Dental classes will be offered later in the year. Please watch your RA messages and monthly newsletter for more details on times, locations, and registration information.



Dental Claim Form Instructions

Claim Field Identification	Explanations and Instructions
HEADER INFORMATION	
1. Type of Transaction <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> EPSDT/Title XIX <input type="checkbox"/> Request for Predetermination	<i>Optional.</i> If used, check box.
2. Predetermination/ Prior Authorization Code	Required, if applicable. If services have been prior Authorized, enter the Prior Authorization Number you received from Affiliated Computer Services' PA Unit (see Field 20 of the Prior Authorization Request and Invoice, shown in Section II).
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company Plan/Name, Address, City, State, ZIP Code	Required. Enter Affiliated Computer Services (ACS) as primary payer here. If patient has other coverage, complete Items # 4-11. Affiliated Computer Services, Inc. P.O. Box 240769 Anchorage, AK 99524-0649
OTHER COVERAGE	
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip Items #5-11) <input type="checkbox"/> Yes (Complete Items #5-11)	Required. A "No" or "Yes" response is required based on information available to the dentist.
5. Name of Policyholder/Subscriber in Item #4 (Last, First, Middle Initial, Suffix)	Required, if applicable. If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.
6. Date of Birth MM/DD/CCYY	Required, if applicable. Enter the date of birth, in eight-digit format, of the person listed in Item #5.
7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Required, if applicable. Mark the gender of the person who is listed in Item #5.
8. Policyholder/Subscriber ID (SSN or ID#)	Required, if applicable. Enter the Social Security Number or the identifier number of the person who is listed in Item #5. The identifier number is a number assigned by the payer/insurance company to this individual.
9. Plan/Group Number	Required, if applicable. Enter the group plan or policy number of the person identified in Item #5.



Claim Field Identification		Explanations and Instructions
10.	Patient's Relationship to Person Named in Item #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Required, if applicable. Mark the patient's relationship to the other insured named in Item #5.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	Required, if applicable. Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

POLICY HOLDER/SUBSCRIBER INFORMATION
(For Insurance Company Named in #3)

12.	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	Required. Enter the recipient's name, address, and ZIP Code.
13.	Date of Birth (MM/DD/CCYY)	Optional. Enter date of birth in MM/DD/CCYY format.
14.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Optional. Enter the patient's gender in appropriate box.
15.	Policyholder/Subscriber ID	Required. Enter the recipient's Alaska Medical Assistance ID number.
16.	Plan/Group Number	Leave Blank.
17.	Employer Name	Optional. If applicable, enter the name of the recipient's employer.

PATIENT INFORMATION

18.	Relationship to Policyholder/Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Optional. If used, mark the box titled "Self" and skip to Item #23.
19.	Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS	Optional. Mark "FTS" if patient is a dependent and a part-time student. If neither applies, skip to Item #23.
20.	Name, Address, City, State, ZIP Code	Leave Blank.
21.	Date of Birth (MM/DD/YY)	Leave Blank.
22.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Leave Blank.

Claim Field Identification	Explanations and Instructions
23. Patient ID/Account # (Assigned By Dentist)	Optional. Enter the patient’s medical record or account number. This field can accommodate up to 11 characters. Both alpha and numeric characters are acceptable. This information will print following the claim control number (CCN) on your Remittance Advice (RA).

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	Required. Enter the date(s) that services were rendered, in MM/DD/CCYY format (e.g., 03/15/2007). Each service or procedure must be entered on a separate line with no more than 10 lines per claim form.
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25. Area of Oral Cavity	Optional. Always report the area of the oral cavity <i>unless</i> one of the following conditions in Item #29 (Procedure Code) exists:
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Code	Area	Code	Area
00	Entire Oral Cavity	20	Upper Left Quadrant
01	Maxillary Arch	30	Lower Left Quadrant
02	Mandibular Arch	40	Lower Right Quadrant
10	Upper Right Quadrant		

26. Tooth System	Optional.
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27. Tooth Number(s) or Letter(s)	Required, if applicable. Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth, otherwise leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form.
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If applicable, use the following codes. When a procedure involves a range of teeth, the range is reported in this field with a hyphen to separate the first and last tooth in the range (e.g., 1-4, 7-10) or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10).

Supernumerary teeth in the **permanent** dentition are identified by the numbers 51-82, beginning with the arch of the upper right third molar, and following around the upper arch to the area of the lower right third molar.

UPPER ARCH: Commencing in the upper right quadrant and rotating counterclockwise

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
“Super” #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

LOWER ARCH:

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
“Super” #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Supernumerary teeth in the **primary** dentition are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (for example, supernumerary “AS” is adjacent to “A;” supernumerary “TS” is adjacent to “T”).

UPPER ARCH: Commencing in the upper right quadrant and rotating counterclockwise

Tooth #	A	B	C	D	E	F	G	H	I	J
“Super” #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

LOWER ARCH

Tooth #	T	S	R	Q	P	O	N	M	L	K
“Super” #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

28. Tooth Surface **Required, if applicable.** When the procedure performed involves one or more tooth surfaces, use the following codes. Do not leave any spaces between surface designations in multiple surface restorations.

Code	Description	Code	Description
B	Buccal	L	Lingual
D	Distal	M	Mesial
F	Facial (or labial)	O	Occlusal
I	Incisal		

29. Procedure Code **Required.** Enter the dental procedure code that describes the service provided (refer to the table in your billing manual).

30. Description of Service **Required.** Enter a brief description of services provided. When billing for general anesthesia or any form of sedation, state justification for service in Item #35.

31. Fee **Required.** Report the dentist’s full fee for the procedure.

32. Other Fee(s) **Optional.**

33. Total Fee **Required.** Enter the total charge for all services and fees.

MISSING TEETH INFORMATION

- | | | |
|-----|------------------------------------|---|
| 34. | Place an “X” on Each Missing Tooth | Required. Missing teeth should be reported when pertinent to Periodontal, Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim. |
| 35. | Remarks | Required, if applicable. Use this field to report Third Party Liability amounts, emergency services and medical justification. If more than one situation applies to a claim, first enter the TPL amount paid followed by two spaces (\$###.##) and then any additional information. Use this field when services require justification of medical necessity or other unusual services, such as the name of the recipient’s Primary Care Dentist when care is rendered by a dentist other than the Primary Care Dentist (refer to Appendix E for additional Care Management Program information), a procedure code that requires a report or multiple supernumerary teeth. The remarks must state the reasons for treatment, including the need for anesthesia. Additional documentation may be attached to the claim, if desired. |

AUTHORIZATIONS

- | | | |
|-----|------------------------------------|--|
| 36. | Patient/Guardian Consent Signature | Optional. Alaska Medical Assistance recipients do not need to sign. |
| 37. | Insured’s Signature | Optional. Alaska Medical Assistance recipients do not need to sign. Claims prepared by the dentist’s Practice Management Software may insert “Signature on File.” |

ANCILLARY CLAIM/TREATMENT INFORMATION

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|-----|---|--|
| 38. | Place of Treatment | Required. There are four possible choices to mark: provider or dentist office, a hospital, an extended care facility or other if none applies. |
| 39. | Number of Enclosures (Radiographs or Oral Images) | Required. This item is completed whether or not radiographs, oral images or study models are submitted with claim: No enclosures, enter “00,” or enter number of images in appropriate box using two digits. If less than 10, use “0” in the first position. <i>Please do not submit radiographs with claim or prior authorization requests unless specifically requested to do so.</i> |
| 40. | Is Treatment for Orthodontics? | Required. If “No,” skip to Item #43. If “Yes,” complete Items #41 and 42. |
| 41. | Date Appliance Placed (MM/DD/CCYY) | Required, if applicable. Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits. |

42.	Months of Treatment Remaining	Required, if applicable. Enter the estimated number of months required to complete orthodontic treatment.
43.	Replacement or Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete Item #44)	Required, if applicable. This item applies to crowns and all fixed or removable prosthesis. Follow these criteria: a. If claim does not involve a prosthetic restoration, mark “No.” b. If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark “No.” c. If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is replacement of a crown, mark “Yes.”
44.	Date of Prior Placement (MM/DD/CCYY)	Optional. Complete if answer to Item #43 was “Yes.”
45.	Treatment Resulting From: <input type="checkbox"/> Occupational Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident	Required. If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box.
46.	Date of Accident (MM/DD/CCYY)	Required, if applicable. Enter the date on which the accident noted in Item #45 occurred.
47.	Auto Accident State	Required, if applicable. Enter the state in which the auto accident noted in Item #45 occurred, otherwise leave blank.

BILLING DENTIST OR DENTAL ENTITY

48.	Dentist’s Name, Address, City, State, ZIP Code	Required. Enter the dental professional’s name (individual or group name). Enter your mailing address (street, city, state, and ZIP Code+4).
49.	Dentist’s National Provider Identifier	Required. Enter the NPI number for the billing entity.
50.	Dentist’s License Number	Optional. Note: If the billing dentist is an individual, enter the dentist’s license number. This is not the dentist’s Medicaid Contract ID. Leave blank if a billing entity (e.g. corporation).
51.	Dentist’s Social Security Number or TIN (Federal Tax ID)	Optional. Enter the SSN or TIN of the biller/pay to provider.
52.	Dentist’s Phone Number	Optional. Enter the telephone number of your office.
52a.	Additional Provider ID	Required. Enter the billing provider’s Medicaid Contract ID.

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53.	Dentist Signature	Required. The claim must be signed and dated by the dentist or authorized representative of the dentist. A facsimile signature is acceptable. Claim forms prepared by the dentist's Practice Management Software may insert the treating dentist's printed name in this Item #.
54.	Dentist's National Provider Identifier	Required. Enter the NPI for the rendering /servicing dental provider.
55.	Dentist's License Number	Required. Enter the license number of the Treating Dentist. This may vary from the Billing Dentist. Note: This is not the dentist's Medicaid Contract ID.
56.	Treating Dentist's Address, City, State, ZIP Code	Required. Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box. Enter street, city, state, and ZIP Code+4.
56a.	Dentist's Provider Specialty Code	Required, if applicable. Enter the taxonomy code that indicates the type of dental professional who delivered the treatment. The provider specialty codes (also known as provider taxonomy codes) can be viewed at http://www.wpc-edi.com/codes/taxonomy .
57.	Dentist's Phone Number	Optional. If used, enter the telephone number of your office.
58.	Additional Provider ID	Required. Enter the rendering provider's Medicaid Contract ID.

Note: This ADA claim form is a two-part form. Keep the yellow carbon copy and mail the white original to:

Affiliated Computer Services, Inc.
P.O. Box 240769
Anchorage, AK 99524-0769

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Services for Children

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT					\$48.00
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED					\$64.00
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER					\$56.70
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT					\$65.80
D0170	RE-EVALUATION-LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)					\$60.20
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT					\$79.10
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)					\$87.50
D0220	INTRAORAL-PERIAPICAL-FIRST FILM					\$24.00
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM					\$20.80
D0240	INTRAORAL-OCCLUSAL FILM					\$30.40
D0270	BITEWING-SINGLE FILM					\$24.00
D0272	BITEWINGS-TWO FILMS					\$40.00
D0273	BITEWINGS - THREE FILMS					\$44.10

^ = May use for ages 13 through 20

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D0274	BITEWINGS-FOUR FILMS					\$59.20
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS					\$63.00
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY FILM					\$61.02
D0330	PANORAMIC FILM					\$97.60
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES					\$55.00
D0417	COLLECTION AND PREPARATION OF SALIVA SAMPLE FOR LABORATORY DIAGNOSTIC TESTING		X			By Report
D0460	PULP VITALITY TESTS					\$44.45
D0472	ACCESSION OF TISSUE, GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D0473	ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D0474	ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D0480	ACCESSION OF EXFOLIATIVE CYTOLOGIC SMEARS, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D1110	PROPHYLAXIS-ADULT					\$87.60

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Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D1120	PROPHYLAXIS-CHILD					\$63.80
D1203	TOPICAL APPLICATION OF FLUORIDE - CHILD					\$28.80
D1204	TOPICAL APPLICATION OF FLUORIDE - ADULT					\$29.60
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS					\$28.00
D1351	SEALANT-PER TOOTH			X		\$48.80
D1510	SPACE MAINTAINER-FIXED UNILATERAL			X		\$163.50
D1515	SPACE MAINTAINER-FIXED BILATERAL			X		\$395.35
D1555	REMOVAL OF FIXED SPACE MAINTAINER					\$52.50
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT			X	X	\$105.00
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT			X	X	\$133.00
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT			X	X	\$163.80
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT			X	X	\$187.60
D2330	RESIN-ONE SURFACE, ANTERIOR			X	X	\$125.30
D2331	RESIN-TWO SURFACES, ANTERIOR			X	X	\$152.60

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3/2/2010

Table I-3. 2010 CDT¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D2332	RESIN-THREE SURFACES, ANTERIOR			X	X	\$185.50
D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)			X	X	\$227.50
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR			X		\$243.60
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR			X	X	\$139.30
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR			X	X	\$178.50
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR			X	X	\$226.80
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR			X	X	\$256.20
D2542	ONLAY-METALLIC-TWO SURFACES		X	X	X	By Report
D2712	CROWN - 3/4 RESIN-BASED COMPOSITE (INDIRECT)	X		X		\$680.00
D2720	CROWN-RESIN WITH HIGH NOBLE METAL			X		\$680.00
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL			X		\$680.00
D2722	CROWN-RESIN WITH NOBLE METAL			X		\$680.00
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE			X		\$812.00
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL			X		\$812.00

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Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY BASE METAL			X		\$680.00
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL			X		\$812.00
D2780	CROWN - 3/4 CAST HIGH NOBLE METAL			X		\$812.00
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL			X		\$680.00
D2782	CROWN - 3/4 CAST NOBLE METAL			X		\$680.00
D2783	CROWN - 3/4 PORCELAIN/CERAMIC			X		\$812.00
D2790	CROWN-FULL CAST HIGH NOBLE METAL			X		\$812.00
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL			X		\$680.00
D2792	CROWN-FULL CAST NOBLE METAL			X		\$680.00
D2794	CROWN-TITANIUM			X		\$680.00
D2799	PROVISIONAL CROWN		X	X		By Report
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE					\$46.75
D2920	RECEMENT CROWN			X		\$69.30
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH			X		\$196.00

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Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH			X		\$256.20
D2932	PREFABRICATED RESIN CROWN			X		\$197.00
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW			X		\$220.50
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH			X		\$269.50
D2940	SEDATIVE FILLING			X	X	\$81.20
D2950	CORE BUILD-UP, INCLUDING ANY PINS			X		\$205.80
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION			X		\$42.50
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED			X		\$227.50
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN					\$310.23
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK		X			By Report
D2975	COPING	X				\$300.00
D3110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)			X		\$56.70
D3120	PULP CAP-INDIRECT (EXCLUDING FINAL RESTORATION)			X		\$49.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT			X		\$129.50
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH			X		\$191.80
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT		X	X		By Report
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)			X		\$290.50
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)			X		\$512.40
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)			X		\$616.00
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)			X		\$699.30
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS			X		\$441.00
D3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH			X		\$234.50
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS			X		\$123.00
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY- ANTERIOR	X		X		\$560.35
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY- BICUSPID	X		X		\$560.35

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	X		X		\$752.50
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)			X		\$190.40
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)			X		\$205.80
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)			X		\$309.40
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR			X		\$400.00
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT)		X	X		By Report
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT).		X	X		By Report
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)		X	X		By Report
D3430	RETROGRADE FILLING-PER ROOT			X		\$63.00
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY		X	X		By Report
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					\$300.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					\$117.85
D4245	APICALLY POSITIONED FLAP					\$385.00
D4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	X	X			By Report
D4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT	X	X			By Report
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE	X	X			By Report
D4267	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE, (INCLUDES MEMBRANE REMOVAL)	X	X			By Report
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES, PER TOOTH	X				\$450.00
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	X				\$280.98
D4320	PROVISIONAL SPLINTING-INTRACORONAL			X		\$438.20
D4321	PROVISIONAL SPLINTING-EXTRACORONAL					\$345.45
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	X				\$158.20
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	X				\$140.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS					\$166.00
D4910	PERIODONTAL MAINTENANCE					\$105.00
D5110	COMPLETE DENTURE - MAXILLARY					\$1,085.00
D5120	COMPLETE DENTURE - MANDIBULAR					\$1,125.00
D5130	IMMEDIATE DENTURE - MAXILLARY					\$1,100.00
D5140	IMMEDIATE DENTURE - MANDIBULAR					\$1,100.00
D5211	UPPER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)					\$551.25
D5212	LOWER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)					\$577.50
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)					\$1,013.60
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)					\$910.00
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)					\$395.00
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)					\$395.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)					\$590.00
D5410	ADJUST COMPLETE DENTURE - MAXILLARY					\$75.00
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR					\$75.00
D5421	ADJUST PARTIAL DENTURE - MAXILLARY					\$66.85
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR					\$66.85
D5510	REPAIR BROKEN COMPLETE DENTURE BASE					\$140.00
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)			X		\$122.50
D5610	REPAIR RESIN DENTURE BASE					\$123.33
D5620	REPAIR CAST FRAMEWORK					\$157.00
D5630	REPAIR OR REPLACE BROKEN CLASP					\$175.00
D5640	REPLACE BROKEN TEETH-PER TOOTH			X		\$105.00
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE			X		\$120.00
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE					\$161.70
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)					\$368.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)					\$368.00
D5710	REBASE COMPLETE MAXILLARY DENTURE					\$420.70
D5711	REBASE COMPLETE MANDIBULAR DENTURE					\$420.70
D5720	REBASE MAXILLARY PARTIAL DENTURE					\$350.00
D5721	REBASE MANDIBULAR PARTIAL DENTURE					\$347.00
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)					\$225.00
D5731	RELINE LOWER COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)					\$225.00
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)					\$225.00
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)					\$225.00
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)					\$325.00
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)					\$325.00
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)					\$320.00
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)					\$320.00
D5850	TISSUE CONDITIONING, MAXILLARY					\$139.30

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5851	TISSUE CONDITIONING, MANDIBULAR					\$140.00
D5911	FACIAL MOULAGE (SECTIONAL)		X			By Report
D5912	FACIAL MOULAGE (COMPLETE)		X			By Report
D5913	NASAL PROSTHESIS		X			By Report
D5914	AURICULAR PROSTHESIS		X			By Report
D5915	ORBITAL PROSTHESIS		X			By Report
D5916	OCULAR PROSTHESIS		X			By Report
D5919	FACIAL PROSTHESIS		X			By Report
D5922	NASAL SEPTAL PROSTHESIS		X			By Report
D5923	OCULAR PROSTHESIS, INTERIM		X			By Report
D5924	CRANIAL PROSTHESIS		X			By Report
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS		X			By Report
D5926	NASAL PROSTHESIS, REPLACEMENT		X			By Report
D5927	AURICULAR PROSTHESIS, REPLACEMENT		X			By Report
D5928	ORBITAL PROSTHESIS, REPLACEMENT		X			By Report

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5929	FACIAL PROSTHESIS, REPLACEMENT		X			By Report
D5931	OBTURATOR PROSTHESIS, SURGICAL					\$960.00
D5932	OBTURATOR PROSTHESIS, DEFINITIVE		X			By Report
D5933	OBTURATOR PROSTHESIS, MODIFICATION		X			By Report
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE		X			By Report
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE		X			By Report
D5936	OBTURATOR/PROSTHESIS, INTERIM		X			By Report
D5937	TRISMUS APPLIANCE (NOT FOR TM TREATMENT)		X			By Report
D5951	FEEDING AID		X			By Report
D5952	SPEECH AID PROSTHESIS, PEDIATRIC		X			By Report
D5954	PALATAL AUGMENTATION PROSTHESIS		X			By Report
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE		X			By Report
D5958	PALATAL LIFT PROSTHESIS, INTERIM		X			By Report
D5959	PALATAL LIFT PROSTHESIS, MODIFICATION		X			By Report
D5960	SPEECH AID PROSTHESIS, MODIFICATION		X			By Report

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5982	SURGICAL STENT					\$40.00
D5983	RADIATION CARRIER		X			By Report
D5984	RADIATION SHIELD		X			By Report
D5985	RADIATION CONE LOCATOR		X			By Report
D5991	TOPICAL MEDICAMENT CARRIER		X			By Report
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	X				\$680.00
D6214	PONTIC - TITANIUM	X				\$680.00
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	X		X		\$680.00
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	X		X		\$680.00
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	X		X		\$680.00
D6245	PONTIC - PORCELAIN/CERAMIC	X		X		\$680.00
D6250	PONTIC-RESIN WITH HIGH NOBLE METAL	X		X		\$680.00
D6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL	X		X		\$680.00
D6252	PONTIC-RESIN WITH NOBLE METAL	X		X		\$680.00
D6253	PROVISIONAL PONTIC	X				\$680.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D6710	CROWN - INDIRECT RESIN BASED COMPOSITE			X		\$680.00
D6740	CROWN - PORCELAIN/CERAMIC	X		X		\$680.00
D6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	X		X		\$680.00
D6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	X		X		\$680.00
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	X		X		\$680.00
D6780	CROWN-3/4 CAST HIGH NOBLE METAL	X		X		\$680.00
D6781	^ CROWN - 3/4 CAST PREDOMINANTLY BASED METAL	X		X		\$680.00
D6782	^ CROWN - 3/4 CAST NOBLE METAL	X		X		\$680.00
D6783	^ CROWN - 3/4 PORCELAIN/CERAMIC	X		X		\$680.00
D6790	CROWN-FULL CAST HIGH NOBLE METAL	X		X		\$680.00
D6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	X		X		\$680.00
D6792	CROWN-FULL CAST NOBLE METAL	X		X		\$680.00
D6793	PROVISIONAL RETAINER CROWN	X		X		\$680.00
D6794	CROWN - TITANIUM	X		X		\$680.00
D6930	RECEMENT BRIDGE			X		\$142.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7111	EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH			X		\$115.70
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)			X		\$139.20
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH			X		\$245.60
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE			X		\$304.00
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY			X		\$356.80
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY			X		\$420.00
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS			X		\$540.80
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)			X		\$296.00
D7260	ORAL ANTRAL FISTULA CLOSURE					\$658.94
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION					\$672.42
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH			X		\$358.75
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH			X		\$200.00
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION			X		\$180.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH					\$180.00
D7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)					\$967.60
D7286	BIOPSY OF ORAL TISSUE - SOFT					\$150.00
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION					\$75.00
D7288	BRUSH BIOPSY - TRANSEPIHELIAL SAMPLE COLLECTION		X			\$107.00
D7290	SURGICAL REPOSITIONING OF TEETH			X		\$220.00
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$516.91
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$228.00
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$516.91
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$228.00
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECOND EPITHELIALIZATION)					\$1,885.39
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE RE-ATTACHMENTS, REVISION OF SOFT TISSUE ATTACHMENT, AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)					\$2,250.55

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM					\$122.00
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM					\$249.44
D7412	EXCISION OF BENIGN LESION, COMPLICATED		X			\$307.42
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM					\$300.88
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM					\$347.61
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED		X			\$402.02
D7440	EXCISION OF MALIGNANT TUMOR-LESION DIAMETER UP TO 1.25 CM					\$612.49
D7441	EXCISION OF MALIGNANT TUMOR-LESION DIAMETER GREATER THAN 1.25 CM		X			By Report
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM					\$220.00
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM					\$255.00
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM					\$220.00
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM					\$255.00
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHODS, BY REPORT					\$285.05

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)					\$400.00
D7472	REMOVAL OF TORUS PALATINUS					\$511.90
D7473	REMOVAL OF TORUS MANDIBULARIS					\$501.93
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY					\$455.00
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE					\$4,795.66
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE					\$318.73
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					\$225.67
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE					\$280.27
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					\$225.67
D7530	REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE					\$328.96
D7540	REMOVAL OF REACTION-PRODUCING FOREIGN BODIES-MUSCULOSKELETAL SYSTEM					\$483.83
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE					\$150.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY					\$983.14
D7610	MAXILLA-OPEN REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$1,013.52
D7620	MAXILLA-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$746.09
D7630	MANDIBLE-OPEN REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$1,863.08
D7640	MANDIBLE-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$1,204.26
D7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					\$812.99
D7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					\$638.94
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					\$746.09
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					\$900.90
D7680	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					\$290.28
D7710	MAXILLA-OPEN REDUCTION					\$1,224.16
D7720	MAXILLA-CLOSED REDUCTION					\$1,055.67
D7730	MANDIBLE-OPEN REDUCTION					\$1,863.08

^ = May use for ages 13 through 20

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7740	MANDIBLE-CLOSED REDUCTION					\$1,204.26
D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					\$1,742.54
D7760	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					\$638.94
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH					\$1,063.49
D7771	ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH					\$581.10
D7780	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					\$1,417.04
D7810	OPEN REDUCTION OF DISLOCATION					\$1,423.37
D7820	CLOSED REDUCTION OF DISLOCATION					\$125.12
D7830	MANIPULATION UNDER ANESTHESIA					\$125.12
D7840	CONDYLECTOMY					\$1,334.90
D7850	SURGICAL DISCECTOMY; WITH/WITHOUT IMPLANT					\$1,239.84
D7860	ARTHROTOMY					\$1,153.28
D7870	ARTHROCENTESIS					\$87.12
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM					\$234.21
D7911	COMPLICATED SUTURE-UP TO 5 CM					\$382.93

^ = May use for ages 13 through 20

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7912	COMPLICATED SUTURE-GREATER THAN 5 CM					\$599.54
D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION, AND TYPE OF GRAFT)		X			By Report
D7940	OSTEOPLASTY-FOR ORTHOGNATHIC DEFORMITIES					\$1,214.33
D7941	OSTEOTOMY - MANDIBULAR RAMI					\$2,270.06
D7943	OSTEOTOMY - MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT		X			By Report
D7944	OSTEOTOMY-SEGMENTED OR SUBAPICAL					\$1,802.02
D7945	OSTEOTOMY-BODY OF MANDIBLE					\$1,106.63
D7946	LEFORT I (MAXILLA-TOTAL)					\$2,113.86
D7947	LEFORT I (MAXILLA-SEGMENTED)					\$2,627.58
D7948	LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION)-WITHOUT BONE GRAFT					\$2,576.56
D7949	LEFORT II OR LEFORT III-WITH BONE GRAFT					\$3,238.13
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT					\$4,795.66
D7955	REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT					\$1,661.62

^ = May use for ages 13 through 20

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY)-SEPARATE PROCEDURE					\$427.29
D7963	FRENULOPLASTY					\$415.20
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH					\$437.42
D7971	EXCISION OF PERICORONAL GINGIVA					\$160.00
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY					\$345.33
D7980	SIALOLITHOTOMY					\$535.65
D7981	EXCISION OF SALIVARY GLAND, BY REPORT					\$667.19
D7982	SIALODOCHOPLASTY		X			By Report
D7983	CLOSURE OF SALIVARY FISTULA					\$710.68
D7990	EMERGENCY TRACHEOTOMY					\$373.91
D7991	CORONOIDECTOMY					\$973.63
D7995	SYNTHETIC GRAFT-MANDIBLE OR FACIAL BONES, BY REPORT	X	X			By Report
D7996	IMPLANT-MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT	X	X			By Report
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	X				\$1,250.00

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	X				\$1,250.00
D8210	REMOVABLE APPLIANCE THERAPY	X				\$350.00
D8220	FIXED APPLIANCE THERAPY	X				\$350.00
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	X				\$168.50
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES			X		\$108.50
D9211	REGIONAL BLOCK ANESTHESIA					\$67.60
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA					\$83.20
D9220	DEEP SEDATION/GENERAL ANESTHESIA-FIRST 30 MINUTES			X		\$108.00
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES			X		\$54.00
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE					\$56.00
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - FIRST 30 MINUTES					\$280.00
D9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - EACH ADDITIONAL 15 MINUTES					\$128.00
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION					\$185.00

^ = May use for ages 13 through 20

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-3. 2010 CDT ¹ Procedure Codes: Dental Services for Children

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN		X			\$84.00
D9410	HOUSE/EXTENDED CARE FACILITY CALL		X			By Report
D9420	HOSPITAL CALL		X			\$97.10
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED HOURS					\$89.60
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION					\$80.50
D9920	BEHAVIOR MANAGEMENT, BY REPORT					\$52.50
D9930	TREATMENT OF COMPLICATIONS (POSTSURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT		X			\$121.10
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT		X			50% Billed Charges

^ = May use for ages 13 through 20

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Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Services for Adults

Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED					\$64.00
D0170	RE-EVALUATION-LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)					\$60.20
D0220	INTRAORAL-PERIAPICAL-FIRST FILM					\$24.00
D0270	BITEWING-SINGLE FILM					\$24.00
D0272	BITEWINGS-TWO FILMS					\$40.00
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS					\$63.00
D0330	PANORAMIC FILM					\$97.60
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES					\$55.00
D0472	ACCESSION OF TISSUE, GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D0473	ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D0474	ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D0480	ACCESSION OF EXFOLIATIVE CYTOLOGIC SMEARS, MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT		X			By Report
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT			X	X	\$163.80

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Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT			X	X	\$187.60
D2332	RESIN-THREE SURFACES, ANTERIOR			X	X	\$185.50
D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)			X	X	\$227.50
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR			X	X	\$226.80
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR			X	X	\$256.20
D2940	SEDATIVE FILLING			X	X	\$81.20
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN					\$310.23
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)			X		\$290.50
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY		X	X		By Report
D5922	NASAL SEPTAL PROSTHESIS		X			By Report
D5923	OCULAR PROSTHESIS, INTERIM		X			By Report
D5924	CRANIAL PROSTHESIS		X			By Report
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS		X			By Report
D5926	NASAL PROSTHESIS, REPLACEMENT		X			By Report
D5927	AURICULAR PROSTHESIS, REPLACEMENT		X			By Report
D5928	ORBITAL PROSTHESIS, REPLACEMENT		X			By Report

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Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5929	FACIAL PROSTHESIS, REPLACEMENT		X			By Report
D5936	OBTURATOR/PROSTHESIS, INTERIM		X			By Report
D5953	SPEECH AID PROSTHESIS, ADULT		X			By Report
D5958	PALATAL LIFT PROSTHESIS, INTERIM		X			By Report
D5959	PALATAL LIFT PROSTHESIS, MODIFICATION		X			By Report
D5960	SPEECH AID PROSTHESIS, MODIFICATION		X			By Report
D7111	EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH			X		\$115.70
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)			X		\$139.20
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH			X		\$245.60
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE			X		\$304.00
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY			X		\$356.80
D7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY			X		\$420.00
D7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY, WITH UNUSUAL SURGICAL COMPLICATIONS			X		\$540.80
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)			X		\$296.00
D7260	ORAL ANTRAL FISTULA CLOSURE					\$658.94
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION					\$672.42

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Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)					\$967.60
D7286	BIOPSY OF ORAL TISSUE - SOFT					\$150.00
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION					\$75.00
D7288	BRUSH BIOPSY - TRANSEPIHELIAL SAMPLE COLLECTION		X			\$107.00
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$516.91
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$228.00
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$516.91
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	X				\$228.00
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM					\$122.00
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM					\$249.44
D7412	EXCISION OF BENIGN LESION, COMPLICATED		X			\$307.42
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM					\$300.88
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM					\$347.61
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED		X			\$402.02
D7440	EXCISION OF MALIGNANT TUMOR-LESION DIAMETER UP TO 1.25 CM					\$612.49

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Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7441	EXCISION OF MALIGNANT TUMOR-LESION DIAMETER GREATER THAN 1.25 CM		X			By Report
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM					\$220.00
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM					\$255.00
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM					\$220.00
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM					\$255.00
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHODS, BY REPORT					\$285.05
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE					\$318.73
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					\$225.67
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE					\$280.27
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					\$225.67
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE					\$150.00
D7610	MAXILLA-OPEN REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$1,013.52

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Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7620	MAXILLA-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$746.09
D7630	MANDIBLE-OPEN REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$1,863.08
D7640	MANDIBLE-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					\$1,204.26
D7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					\$812.99
D7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					\$638.94
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					\$746.09
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					\$900.90
D7680	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					\$290.28
D7710	MAXILLA-OPEN REDUCTION					\$1,224.16
D7720	MAXILLA-CLOSED REDUCTION					\$1,055.67
D7730	MANDIBLE-OPEN REDUCTION					\$1,863.08
D7740	MANDIBLE-CLOSED REDUCTION					\$1,204.26
D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					\$1,742.54
D7760	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					\$638.94
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH					\$1,063.49

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Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7771	ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH					\$581.10
D7780	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					\$1,417.04
D7820	CLOSED REDUCTION OF DISLOCATION					\$125.12
D7830	MANIPULATION UNDER ANESTHESIA					\$125.12
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM					\$234.21
D7911	COMPLICATED SUTURE-UP TO 5 CM					\$382.93
D7912	COMPLICATED SUTURE-GREATER THAN 5 CM					\$599.54
D7980	SIALOLITHOTOMY					\$535.65
D7995	SYNTHETIC GRAFT-MANDIBLE OR FACIAL BONES, BY REPORT	X	X			By Report
D7996	IMPLANT-MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT	X	X			By Report
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES			X		\$108.50
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA					\$83.20
D9220	DEEP SEDATION/GENERAL ANESTHESIA-FIRST 30 MINUTES			X		\$108.00
D9221	DEEP SEDATION/GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES			X		\$54.00
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE					\$56.00

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Table I-4a 2010 CDT¹ Procedure Codes: Emergent Dental Services for Adults

Code	Description	Prior Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - FIRST 30 MINUTES					\$280.00
D9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - EACH ADDITIONAL 15 MINUTES					\$128.00
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION					\$185.00
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN		X			\$84.00
D9420	HOSPITAL CALL		X			\$97.10
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION					\$80.50
D9930	TREATMENT OF COMPLICATIONS (POSTSURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT		X			\$121.10
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT		X			50% Billed Charges

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Services For Adults

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT				\$48.00
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT				\$65.80
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT				\$79.10
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)				\$87.50
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM				\$20.80
D0240	INTRAORAL-OCCLUSAL FILM				\$30.40
D0273	BITEWINGS - THREE FILMS				\$44.10
D0274	BITEWINGS-FOUR FILMS				\$59.20
D0460	PULP VITALITY TESTS				\$44.45
D1110	PROPHYLAXIS-ADULT				\$87.60
D1204	TOPICAL APPLICATION OF FLUORIDE - ADULT				\$29.60
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS				\$28.00
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT		X	X	\$105.00
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT		X	X	\$133.00

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All enhanced dental services require prior authorization

Dental Services
Rates effective 1/1/2010
Coverage and rates are subject to change.

3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D2330	RESIN-ONE SURFACE, ANTERIOR		X	X	\$125.30
D2331	RESIN-TWO SURFACES, ANTERIOR		X	X	\$152.60
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR		X	X	\$139.30
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR		X	X	\$178.50
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE		X		\$812.00
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL		X		\$812.00
D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY BASE METAL		X		\$680.00
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL		X		\$812.00
D2790	CROWN-FULL CAST HIGH NOBLE METAL		X		\$812.00
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL		X		\$680.00
D2792	CROWN-FULL CAST NOBLE METAL		X		\$680.00
D2794	CROWN-TITANIUM		X		\$680.00
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE				\$46.75
D2920	RECEMENT CROWN		X		\$69.30
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH		X		\$256.20
D2932	PREFABRICATED RESIN CROWN		X		\$197.00

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Dental Services
Rates effective 1/1/2010
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3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW		X		\$220.50
D2950	CORE BUILD-UP, INCLUDING ANY PINS		X		\$205.80
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION		X		\$42.50
D2975	COPING				\$300.00
D3120	PULP CAP-INDIRECT (EXCLUDING FINAL RESTORATION)		X		\$49.00
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH		X		\$191.80
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)		X		\$512.40
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)		X		\$616.00
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)		X		\$699.30
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS		X		\$441.00
D3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH		X		\$234.50
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS		X		\$123.00
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY- ANTERIOR		X		\$560.35
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY- BICUSPID		X		\$560.35

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3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR		X		\$752.50
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)		X		\$190.40
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)		X		\$205.80
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)		X		\$309.40
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT				\$300.00
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT				\$117.85
D4320	PROVISIONAL SPLINTING-INTRACORONAL		X		\$438.20
D4321	PROVISIONAL SPLINTING-EXTRACORONAL				\$345.45
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT				\$158.20
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT				\$140.00
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS				\$166.00

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3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D4910	PERIODONTAL MAINTENANCE				\$105.00
D5110	COMPLETE DENTURE - MAXILLARY				\$1,085.00
D5120	COMPLETE DENTURE - MANDIBULAR				\$1,125.00
D5130	IMMEDIATE DENTURE - MAXILLARY				\$1,100.00
D5140	IMMEDIATE DENTURE - MANDIBULAR				\$1,100.00
D5211	UPPER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)				\$551.25
D5212	LOWER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)				\$577.50
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)				\$1,013.60
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)				\$910.00
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)				\$395.00
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)				\$395.00
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)				\$590.00
D5410	ADJUST COMPLETE DENTURE - MAXILLARY				\$75.00

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3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR				\$75.00
D5421	ADJUST PARTIAL DENTURE - MAXILLARY				\$66.85
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR				\$66.85
D5510	REPAIR BROKEN COMPLETE DENTURE BASE				\$140.00
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)		X		\$122.50
D5610	REPAIR RESIN DENTURE BASE				\$123.33
D5620	REPAIR CAST FRAMEWORK				\$157.00
D5630	REPAIR OR REPLACE BROKEN CLASP				\$175.00
D5640	REPLACE BROKEN TEETH-PER TOOTH		X		\$105.00
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE		X		\$120.00
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE				\$161.70
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)				\$368.00
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)				\$368.00
D5710	REBASE COMPLETE MAXILLARY DENTURE				\$420.70
D5711	REBASE COMPLETE MANDIBULAR DENTURE				\$420.70
D5720	REBASE MAXILLARY PARTIAL DENTURE				\$350.00

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3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D5721	REBASE MANDIBULAR PARTIAL DENTURE				\$347.00
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)				\$225.00
D5731	RELINE LOWER COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)				\$225.00
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)				\$225.00
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)				\$225.00
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)				\$325.00
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)				\$325.00
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)				\$320.00
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)				\$320.00
D5850	TISSUE CONDITIONING, MAXILLARY				\$139.30
D5851	TISSUE CONDITIONING, MANDIBULAR				\$140.00
D6214	PONTIC - TITANIUM				\$680.00
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL		X		\$680.00
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL		X		\$680.00
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL		X		\$680.00
D6245	PONTIC - PORCELAIN/CERAMIC		X		\$680.00

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3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D6250	PONTIC-RESIN WITH HIGH NOBLE METAL		X		\$680.00
D6251	PONTIC-RESIN WITH PREDOMINANTLY BASE METAL		X		\$680.00
D6252	PONTIC-RESIN WITH NOBLE METAL		X		\$680.00
D6740	CROWN - PORCELAIN/CERAMIC		X		\$680.00
D6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL		X		\$680.00
D6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL		X		\$680.00
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL		X		\$680.00
D6790	CROWN-FULL CAST HIGH NOBLE METAL		X		\$680.00
D6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL		X		\$680.00
D6792	CROWN-FULL CAST NOBLE METAL		X		\$680.00
D6794	CROWN - TITANIUM		X		\$680.00
D6930	RECEMENT BRIDGE		X		\$142.00
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH		X		\$358.75
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECOND EPITHELIALIZATION)				\$1,885.39
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)				\$400.00
D7472	REMOVAL OF TORUS PALATINUS				\$511.90

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3/2/2010

Table I-4b. 2010 CDT¹ Procedure Codes: Enhanced Dental Services For Adults

Code	Description	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable
D7473	REMOVAL OF TORUS MANDIBULARIS				\$501.93
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY				\$455.00
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH				\$437.42
D7971	EXCISION OF PERICORONAL GINGIVA				\$160.00
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY				\$345.33

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3/2/2010