KY Medicaid Dental Fee Schedule 2022

Notes:

- **Red indicates new codes or changes for the most current revision date.**
- **The appearance on this website of a code and rate is not an indication of coverage, nor a guarantee of payment.**
- **It is the responsibility of the provider to check member eligibility.**
- **Current Dental Terminology (CDT) coding definitions shall apply to all procedures/services**
- **The appearance on this website of a code and rate is not an indication of coverage, nor a guarantee of payment.**

***Please refer to the Oral Pathology section of this fee schedule for procedures and pricing**

****Please refer to Orthodontic section of this fee schedule for procedures and pricing**

Any limit or prior authorization requirement established in 907 KAR 1:026 or 907 KAR 1:626 shall apply to this fee schedule

****Procedure Description/Practitioner***

(1) A comprehensive orthodontic procedure shall be paid as follows:

(a) Except as established in (b) the rate for an orthodontic consultation including examination and treatment plan development shall be $112

*(b) The orthodontic consultation rate shall not exceed $56 if

1. provider determines comprehensive ortho procedures are not needed;
2. provider is unable or unwilling to provide needed ortho procedure(s); or
3. Prior authorization is not approved by the department or is not requested by provider

Reimbursement for a service for an early phase of moderately severe or severe disabling malocclusion shall be:

$1367 if provided by an orthodontist

$1234 if provided by a general dentist

Reimbursement for a service for moderately severe disabling malocclusion shall be:

$1825 if provided by an orthodontist

$1659 if provided by a general dentist

A service for a severe disabling malocclusion:

$3000 if provided by an orthodontist

$2674 if provided by a general dentist

****DMS Payment Process orthodontics***

Reimbursement for comprehensive orthodontic treatment shall consist of two (2) payments

1. The first payment shall be two-thirds of the prior authorized payment amount
2. The second payment shall:
   a. Be one-third of the prior authorized payment amount; and
   b. Not be billed or paid until six (6) monthly visits are completed following the banding date
3. The two (2) payments shall include all services associated with the comprehensive orthodontic treatment

Proc Code	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D0120	PERIODIC ORAL EVALUATION ON AN ESTABLISHED PATIENT	$27.50	n/c	Requires Prior Authorization - (1 per recipient per 12 months) - age restriction 0-20
D0140	LIMITED ORAL EVALUATION	$41.25	$41.25	LIMITED TO A SPECIFIC ORAL HEALTH PROBLEM OR COMPLAINT AND/OR DENTAL EMERGENCY) - requires prepayment review - review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment. Claim requires documentation. Submit on paper.

Proc Code	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE (3) YEARS OF AGE AND COUNSELING WITH THE PRIMARY CAREGIVER.	$32.50	n/c	
D0150	COMPREHENSIVE ORAL EVALUATION	$32.50	$32.50	
D0190	SCREENING OF A PATIENT	n/c	n/c	
D0191	ASSESSMENT OF A PATIENT	$25.00	n/c	
D0210	INTRAORAL COMPLETE SERIES	$79.63	$61.25	
D0220	INTRAORAL-PERIPICAL-FIRST FILM	$13.00	$10.00	
D0230	INTRAORAL-PERIAPICAL-EACH ADDIT	$9.75	$7.50	
D0270	BITEWING-SINGLE FILM	$11.38	$8.75	
D0272	BITEWING-TWO FILMS	$22.75	$17.50	
D0274	BITEWING-FOUR FILMS	$37.38	$28.75	
D0330	PANORAMIC FILM	$48.75	$48.75	REQUIRES PRIOR AUTHORIZATION AGES 5 AND UNDER
D0340	CEPHALOMETRIC FILM	$76.38	$58.75	
D1110	PROPHYLAXIS-14 AND OVER	$60.13	$46.25	
D1120	PROPHYLAXIS-13 AND UNDER	$60.13	n/c	
D1206	FLUORIDE VARNISH	$18.75	n/c	
D1208	TOPICAL APPLICATION OF FLUORIDE (limited to two per year)	$18.75	n/c	
D1321	COUNS FOR HIGH RISK SUB USE	$15.00	$15.00	
D1351	SEALANT - PER TOOTH (AGES 5-20)	$24.38	n/c	
D1354	SILVER DIAMINE FLUROIDE per tooth 12.00 per tooth. Up to two times per tooth within six months if clinically indicated	$12.00	$12.00	Effective date 01/01/2018
D1510	SPACE MAINTAINER-FIXED UNILATERAL	$169.00	n/c	
D1516	FIXED BILAT SPACE MAINT, MAX	$250.00	n/c	
D1517	FIXED BILAT SPACE MAINT, MAN	$250.00	n/c	
D1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	$167.50	n/c	
D1526	REMOVE BILAT SPACE MAIN, MAX	$190.00	n/c	
D1527	REMOVE BILAT SPACE MAIN, MAN	$190.00	n/c	
D1551	RECEMENT SPACE MAINT - MAX	$19.00	n/c	
D1552	RECEMENT SPACE MAINT - MAN	$19.00	n/c	
D1553	RECEMENT UNILAT SPACE MAINT	$19.00	n/c	
D1556	REM FIXED UNILAT SPACE MAINT	$25.00	n/c	
D1557	REMOVE FIXED BILAT MAINT MAX	$25.00	n/c	
D1558	REMOVE FIXED BILAT MAN	$25.00	n/c	
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	$49.40	$38.00	
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	$65.00	$50.00	
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	$76.70	$59.00	

Proc Code	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D2161	AMALGAM-FOUR/MORE SURFACES, PRIMARY OR PERMANENT	$93.60	$72.00	
D2330	RESIN-ONE SURFACE, ANTERIOR	$57.20	$44.00	
D2331	RESIN-TWO SURFACES, ANTERIOR	$71.50	$55.00	
D2332	RESIN-THREE SURFACES, ANTERIOR	$85.80	$66.00	
D2335	RESIN-FOUR/MORE SURFACES, ANTERIOR	$101.40	$78.00	
D2390	RESIN-BASED COMPOSITE CROWN	$101.40	n/c	
D2391	RESIN-ONE SURFACE, POSTERIOR	$57.20	$44.00	
D2392	RESIN-TWO SURFACES, POSTERIOR	$71.50	$55.00	
D2393	RESIN-THREE SURFACES, POSTERIOR	$85.80	$66.00	
D2394	RESIN FOUR OR MORE SURFACES, POSTERIOR	$78.00	n/c	
D2928	PREFAB PORC/CER CROWN PERM	$153.00	n/c	1 per 5 years
D2930	PREFAB STAINLESS STEEL CROWN-PRIMARY	$119.60	n/c	
D2931	PREFAB STAINLESS STEEL CROWN-PERMANENT	$133.90	n/c	
D2932	PREFAB RESIN CROWN	$113.10	n/c	
D2951	PIN RETENTION-PER TOOTH, IN ADD. TO RESTOR	$13.00	$13.00	
D3110	PULP CAP-DIRECT	$17.00	n/c	
D3220	THERAPEUTIC PULPOTOMY	$67.60	n/c	
D3310	ROOT CANAL THERAPY-ANTERIOR	$274.30	n/c	
D3320	ROOT CANAL THERAPY-BICUSPID	$344.50	n/c	
D3330	ROOT CANAL THERAPY-MOLAR	$481.00	n/c	
D3410	APICOECTOMY-ANTERIOR	$201.50	$155.00	
D3421	APICOECTOMY-BISCUSPID FIRST ROOT	$201.50	$155.00	
D3425	APICOECTOMY-MOLAR FIRST ROOT	$201.50	$155.00	
D3426	APICOECTOMY-PER TOOTH EACH ADDIT ROOT	$197.00	$197.00	
D4210	GINGIVECTOMY/GINGIVOPLASTY-FOUR OR MORE TEETH PER QUADRANT	$336.70	$259.00	Requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment
D4211	GINGIVECTOMY/GINGIVOPLASTY-ONE TO THREE TEETH PER QUADRANT	$104.00	$104.00	Requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment
D4341	PERIODONTAL SCALING AND ROOT PLANING-PER QUADRANT	$101.40	$78.00	Requires prior authorization
D4342	PERIODONTAL SCALING 1-3 TEETH	$36.42	$26.00	
D4355	FULL MOUTH DEBRIDEMENT- procedure effective 9/30/2006 - LIMITED TO PREGNANT WOMEN ONLY	$68.50	$68.50	
D5282	REMOVE UNIL PART DENTURE,MAX	$360.00	n/c	1 per 5 years
D5283	REMOVE UNIL PART DENTURE,MAN	$360.00	n/c	1 per 5 years
D5284	REM UNILAT DENT FLEX BASE	$400.00	n/c	1 PER 5 YEARS
D5286	REM UNILAT DENT 1 PC RESIN	$400.00	n/c	1 PER 5 YEARS
D5520	REPLACE MISSING/BROKEN TEETH-DENTURE	$31.00	n/c	
D5640	REPLACE BROKEN TEETH-PER TOOTH/DENTURE	$36.40	n/c	
D5750	RELINE COMPLETE MAXILLARY DENTURE	$128.70	n/c	

Proc Code	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D5751	RELINE COMPLETE MANDIBULAR DENTURE	$128.70	n/c	
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	$319.80	n/c	
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	$336.70	n/c	
D5913	NASAL PROSTHESIS	$2,036.00	$2,036.00	
D5914	AURICULAR PROSTHESIS	$1,881.00	$1,881.00	
D5919	FACIAL PROSTHESIS	$3,408.00	$3,408.00	
D5931	OBTURATOR (TEMPORARY)	$1,121.90	$863.00	
D5932	OBTURATOR (PERMANENT)	$1,992.00	$1,992.00	
D5934	MANDIBULAR RESECTION PROSTHESIS	$1,660.00	$1,660.00	
D5952	SPEECH AID-PEDIATRIC (13 AND UNDER)	$2,036.00	n/c	
D5953	SPEECH AID-ADULT (14 AND OVER)	$2,036.00	$2,036.00	
D5954	PALATAL AUGMENTATION PROSTHESIS	$1,550.00	$1,550.00	
D5955	PALATAL LIFT PROSTHESIS	$1,836.00	$1,836.00	
D5988	ORAL SURGICAL SPLINT	$896.00	$896.00	
D5999	UNLISTED MAXILLOFACIAL PROSTHETIC PROC	manually priced	manually priced	Requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment
D7111	CORONAL REMNANTS DECIDUOUS TOOTH	$49.40	$38.00	
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	$49.40	$38.00	
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	$93.60	$72.00	
D7220	REMOVAL OF IMPACTED TOOTH (SOFT TISSUE)	$127.40	$98.00	
D7230	REMOVAL OF IMPACTED TOOTH (PARTIALLY BONY)	$179.40	$138.00	
D7240	REMOVAL OF IMPACTED TOOTH (COMPLETELY BONY)	$215.80	$166.00	
D7241	REMOVAL OF IMPACTED TOOTH (COMP BONY-UNUSUAL]	$222.30	$171.00	
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	$107.90	$83.00	
D7260	OROANTRAL FISTULA CLOSURE	$135.20	$104.00	
D7270	TOOTH REIMPLANTATION	$200.00	$200.00	
D7280	SURGICAL EXPOSURE OF IMPACTED/UNERUPTED	manually priced	manually priced	Requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment
D7310	ALVEOPLASTY IN CONJUN WITH EXTRACT/PER QUAD	$101.40	$78.00	
D7320	ALVEOPLASTY NOT IN CONJ WITH EXTRACT/PER QUAD	$101.40	$78.00	
D7410	EXCISION OF BENIGN SOFT TISSUE LESION LESS THAN 1.25 CM	$87.10	$67.00	
D7411	EXCISION OF BENIGN SOFT TISSUE LESION GREATER THAN 1.25 CM	$87.10	$67.00	
D7471	LATERAL EXTOSIS REMOVAL	$78.00	$78.00	
D7472	REMOVAL OF TORUS PALATINUS UPPER ARCH (1 PER LIFETIME)	$302.47	$302.47	
D7473	SURGICAL REMOVAL OF TORUS MANDIBULARIS	$209.28	$209.28	
D7510	INCISION & DRAINAGE OF ABSCESS (INTRAORAL)	$67.60	$52.00	
D7520	INCISION & DRAINAGE OF ABSCESS (EXTRAORAL)	$80.60	$62.00	
D7530	REMOVAL OF FOREIGN BODY	$201.50	$155.00	

Proc Code	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D7880	OCCLUSAL ORTHOTIC DEVICE	$424.00	n/c	Requires prior authorization
D7910	SUTURE OF RECENT SMALL WOUND	$67.60	$52.00	
D7961	BUCCAL/LABIAL FRENECTOMY	$129.00	$167.70	
D7962	LINGUAL FRENECTOMY	$129.00	$167.70	
D8210	REMOVABLE APPLIANCE THERAPY	$362.00	n/c	Requires prior authorization
D8220	FIXED APPLIANCE THERAPY	$259.00	n/c	Requires prior authorization
D8698	RECEMENT FIXED RETAINER MAX	$75.00	n/c	
D8699	RECEMENT FIXED RETAINER MAN	$75.00	n/c	
D8701	REPAIR FIXED RETAINER MAX	$25.00	n/c	1 per 4 years
D8702	REPAIR OF FIXED RETAINER MAN	$25.00	n/c	1 per 4 years
D8703	REPLACE BROKEN RETAINER MAX	$93.64	n/c	1 per 4 years
D8704	REPLACE BROKEN RETAINER MAN	$93.64	n/c	1 per 4 years
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN	$27.30	$21.00	
D9222	Deep sedation/general anesthesia D9222-deep sedation/general anesthesia-first 15 minutes	$75.00	$75.00	Effective date 01/01/2018 Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT	$75.00	$75.00	D9222-deep sedation/general anesthesia each 15 minutes Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service
D9230	ANALGESIA	$39.00	$39.00	
D9239	for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes	$75.00	n/c	
D9241	INTRAVENOUS SEDATION	$158.60	n/c	End dated 12/31/2017. 1 unit
D9243	INTRAVENOUS MODERATE (Conscious) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$75.00	$75.00	+15 min @ $75.00 per unit
D9248	SEDATION (NON-IV)	$39.00	$39.00	
D9410	EXTENDED CARE FACILITIES/HOUSE CALLS	$67.60	$52.00	
D9420	HOSPITAL CALL	$67.60	$52.00	
D9944	OCC GUARD, HARD, FULL ARCH	$150.00	n/c	
D9945	OCC GUARD, SOFT, FULL ARCH	$250.00	$250.00	1 per 2 years
D9946	OCC GUARD, HARD, PART ARCH	$100.00	$100.00	1 per 2 years
D9986	MISSED APPOINTMENT	n/c	n/c	
D9987	CANCELLED APPOINTMENT	n/c	n/c	

Proc Code	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
Oral Pathology Procedures and Fee Schedule				
D0472	Accession of tissue gross examination, preparation and transmission of written report (only covered if provided by an oral pathologist)	$43.71		
D0473	Accession of tissue gross and microscopic examination, preparation and transmission of written report *(only covered if provided by an oral pathologist)*	$61.81		
D0474	Access of tissue, gross and microscopic examination including assessment of surgical margins for presence of disease, preparation and transmission of written report *(only covered if provided by an oral pathologist)*	$152.38		
D0486	Laboratory accession of transepithelial cytologic sample microscopic examination and preparation and transmission of written report *(only covered if provided by an oral pathologist)*	$35.44		
D0475	Decalcification procedure *(only covered if provided by an oral pathologist)*	$12.57		
D0476	Special stain for microorganisms *(only covered if provided by an oral pathologist)*	$71.03		
D0477	Special stain not for microorganisms *(only covered if provided by an oral pathologist)*	$71.03		
D0478	Immunohistochemical stains *(only covered if provided by an oral pathologist)*	$71.97		
D0479	Tissue in-situ hybridization, including interpretation *(only covered if provided by an oral pathologist)*	$55.43		
D0482	Direct immunofluorescence (only covered if provided by an oral pathologist)	$52.09		
D0484	Consultation report on slides prepared elsewhere *(only covered if provided by an oral pathologist)*	$52.09		
D0485	Consultation report on referred material requiring preparation of slide *(only covered if provided by an oral pathologist)*	$88.10		
Orthodontic Procedures and Fee Schedule				
D8660	PRE-ORTHODONTIC TREATMENT VISIT	$112.00 *		Requires prior authorization - and only if individual ultimately not approved for orthodontic treatment. Age limit 0-20
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	*		Requires prior authorization. Age limit 0-20
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE	*		Requires prior authorization. Age limit 0-20