***DMS DENTAL FEE SCHEDULE (Dental Procedures)***
***December 2015 (effective date 2-5-2016)***
**** Please refer to the Oral Pathology Fee Schedule for pricing***
***** Please refer to Orthodontic Procedures for Pricing***

| Proc Code | | Procedure Description | UNDER AGE 21 Rate | 21 and OVER Rate |
|---|---|---|---|---|
| | | Current Dental Terminology (CDT) coding definitions shall apply to all procedures/services | | |
| | | Any limit or prior authorization requirement established in 907 KAR 1:026 or 907 KAR 1:626 shall apply to this fee schedule | | |
| D0120 | | PERIODIC ORAL EVALUATION ON AN ESTABLISHED PATIENT (1 per recipient per 12 months) | $27.50 | n/c |
| D0140 | | LIMITED ORAL EVALUATION (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** | $41.25 | $41.25 |
| 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 **( REQUIRES PRIOR AUTHORIZATION AGES 5 AND UNDER)** | $48.75 | $48.75 |
| 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** |
| D1351 | | SEALANT - PER TOOTH (AGES 5-20) | $24.38 | **n/c** |
| D1510 | | SPACE MAINTAINER-FIXED UNILATERAL | $169.00 | **n/c** |
| D1515 | | SPACE MAINTAINER-REMOVABLE-BILATERAL | $328.25 | **n/c** |
| D1520 | | SPACE MAINTAINER-REMOVABLE-UNILATERAL | $167.50 | **n/c** |
| D1525 | | SPACE MAINTAINER-REMOVABLE-BILATERAL | $252.50 | **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 |
| 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 | $101.40 | $78.00 |
| 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** |
| D2394 | | RESIN FOUR OR MORE SURFACES, POSTERIOR | $119.60 | **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 |

*DMS DENTAL FEE SCHEDULE (Dental Procedures)*
*December 2015 (effective date 2-5-2016)*
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*** Please refer to Orthodontic Procedures for Pricing*

| Proc Code | | Procedure Description | UNDER AGE 21 Rate | 21 and OVER Rate |
|---|---|---|---|---|
| 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 **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)** | $336.70 | $259.00 |
| D4211 | | GINGIVECTOMY/GINGIVOPLASTY-ONE TO THREE TEETH PER QUADRANT **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)** | $135.20 | $104.00 |
| D4341 | | PERIODONTAL SCALING AND ROOT PLANING-PER QUADRANT **(requires prior authorization)** | $101.40 | $78.00 |
| D4355 | | FULL MOUTH DEBRIDEMENT- procedure effective 9/30/2006 - LIMITED TO PREGNANT WOMEN ONLY | $68.50 | $68.50 |
| D5520 | | REPLACE MISSING/BROKEN TEETH-DENTURE | $40.30 | **n/c** |
| D5610 | | REPAIR RESIN DENTURE BASE | $61.10 | **n/c** |
| D5620 | | REPAIR CAST FRAMEWORK | $210.00 | **n/c** |
| D5640 | | REPLACE BROKEN TEETH-PER TOOTH/DENTURE | $36.40 | **n/c** |
| D5750 | | RELINE COMPLETE MAXILLARY DENTURE | $128.70 | **n/c** |
| 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 **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)** | **manually priced** | **manually priced** |
| 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 |
| D7280 | | SURGICAL EXPOSURE OF IMPACTED/UNERUPTED **(requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment)** | **manually priced** | **manually priced** |
| 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 | $101.40 | $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 |
| D7880 | | OCCLUSAL ORTHOTIC DEVICE **(requires prior authorization)** | $424.00 | **n/c** |
| D7910 | | SUTURE OF RECENT SMALL WOUND | $67.60 | $52.00 |
| D7960 | | SURGICAL FRENECTOMY (one) | $167.60 | $129.00 |
| D7960 | | SURGICAL FRENECTOMY (2nd one performed on same day) | $83.80 | $64.50 |

***DMS DENTAL FEE SCHEDULE (Dental Procedures)***
***December 2015 (effective date 2-5-2016)***
**** Please refer to the Oral Pathology Fee Schedule for pricing***
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| Proc Code | | Procedure Description | UNDER AGE 21 Rate | 21 and OVER Rate |
|---|---|---|---|---|
| D8210 | | REMOVABLE APPLIANCE THERAPY **(requires prior authorization)** | $362.00 | **n/c** |
| D8220 | | FIXED APPLIANCE THERAPY **(requires prior authorization)** | $259.00 | **n/c** |
| D8660 | | PRE-ORTHODONTIC TREATMENT VISIT **(requires prior authorization ) - and only if individual ultimately not approved for orthodontic treatment)** | $76.50 ** | **n/c** |
| D8670 | | PERIODIC ORTHODONTIC TREATMENT VISIT | **n/c **** | **n/c** |
| D8999 | | UNSPECIFIED ORTHODONTIC PROCEDURE | **n/c **** | **n/c** |
| D9110 | | PALLIATIVE TREATMENT OF DENTAL PAIN | $27.30 | $21.00 |
| D9223 | | DEEP SEDATION/GENERAL ANESTHESIA - EACH 15 MINUTE INCREMENT | $75.00 | $75.00 |
| D9243 | | INTRAVENOUS MODERATE (Conscious) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT | $79.30 | $79.30 |
| D9410 | | EXTENDED CARE FACILITIES/HOUSE CALLS | $67.60 | $52.00 |
| D9420 | | HOSPITAL CALL | $67.60 | $52.00 |
| D9986 | | MISSED APPOINTMENT | **n/c** | **n/c** |
| D9987 | | CANCELLED APPOINTMENT | **n/c** | **n/c** |
| | | **n/c = not covered** | | |
| | | | | |
| | | *** Please refer to the Oral Pathology Fee Schedule for pricing** | | |
| | | **** Please refer to Orthodontic Procedures for Pricing** | | |
| | | Effective February 5, 2016 | | |

*DMS Dental Fee Schedule (Oral Pathology)*
*December 2015 (effective date 2-5-2016)*

| Proc Code | Procedure Description | Rate |
|---|---|---|
| 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 trasmission 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 transmssion 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 | Consultaton 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 |
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| | **n/c = not covered** | |

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| ***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 a 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*** |
| 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 |