KENTUCKY MEDICAID DENTAL SERVICES

CDT-CODE		EFFECTIVE OCTOBER 16, 2003 - ONGOING	RATES
D0140		LIMITED ORAL EVALUATION (TRAUMA RELATED INJURIES ONLY)	$ 33.00
D0150		COMPREHENSIVE ORAL EVALUATION	$ 26.00
D0210		INTRAORAL COMPLETE SERIES	$ 49.00
D0220		INTRAORAL-PERIPICAL-FIRST FILM	$ 8.00
D0230		INTRAORAL-PERIAPICAL-EACH ADDIT	$ 6.00
D0270		BITEWING-SINGLE FILM	$ 7.00
D0272		BITEWING-TWO FILMS	$ 14.00
D0274		BITEWING-FOUR FILMS	$ 23.00
D0330	P.A.	PANORAMIC FILM (REQUIRES PRIOR AUTHORIZATION AGES 5 AND UNDER)	$ 39.00
D0340		CEPHALOMETRIC FILM	$ 47.00
D1110		PROPHYLAXIS-14 AND OVER	$ 37.00
D1201		PROPHYLAXIS-13 AND UNDER	$ 37.00
D1351	*	SEALANT - PER TOOTH { AGES 5-20}	$ 15.00
D1510	*	SPACE MAINTAINER-FIXED UNILATERAL	$ 104.00
D1515	*	SPACE MAINTAINER-FIXED BILATERAL	$ 202.00
D1520	*	SPACE MAINTAINER-REMOVABLE-UNILATERAL	$ 134.00
D1525	*	SPACE MAINTAINER-REMOVABLE-BILATERAL	$ 202.00
D2140		AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	$ 38.00
D2150		AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	$ 50.00
D2160		AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	$ 59.00
D2161		AMALGAM-FOUR/MORE SURFACES, PRIMARY OR PERMANENT	$ 72.00
D2330		RESIN-ONE SURFACE, ANTERIOR	$ 44.00
D2331		RESIN-TWO SURFACES, ANTERIOR	$ 55.00
D2332		RESIN-THREE SURFACES, ANTERIOR	$ 66.00
D2335		RESIN-FOUR/MORE SURFACES, ANTERIOR	$ 78.00
D2391		RESIN-ONE SURFACE, POSTERIOR	$ 44.00
D2392		RESIN-TWO SURFACES, POSTERIOR-	$ 55.00
D2393		RESIN-THREE SURFACES, POSTERIOR	$ 66.00
D2394		RESIN FOUR OR MORE SURFACES, POSTERIOR	$ 78.00
D2930	*	PREFAB STAINLESS STEEL CROWN-PRIMARY	$ 92.00
D2931	*	PREFAB STAINLESS STEEL CROWN-PERMANENT	$ 103.00
D2932	*	PREFAB RESIN CROWN	$ 87.00
D2951		PIN RETENTION-PER TOOTH, IN ADD. TO RESTOR	$ 13.00
D3110	*	PULP CAP-DIRECT	$ 17.00
D3220	*	THERAPEUTIC PULPOTOMY	$ 52.00
D3310	*	ROOT CANAL THERAPY-ANTERIOR	$ 211.00
D3320	*	ROOT CANAL THERAPY-BICUSPID	$ 265.00
D3330	*	ROOT CANAL THERAPY-MOLAR	$ 370.00
D3410		APICOECTOMY-ANTERIOR	$ 155.00
D3421		APICOECTOMY-BISCUSPID FIRST ROOT	$ 155.00
D3425		APICOECTOMY-MOLAR FIRST ROOT	$ 155.00
D3426		APICOECTOMY-PER TOOTH EACH ADDIT ROOT	$ 197.00
D4210		GINGIVECTOMY/GINGIVOPLASTY-PER QUAD	$ 259.00
D4211		GINGIVECTOMY/GINGIVOPLASTY-PER TOOTH	$ 104.00
D4341	P.A.	PERIODONTAL SCALING AND ROOT PLANING-PER QUAD	$ 78.00
D5520	*	REPLACE MISSING/BROKEN TEETH-DENTURE	$ 31.00
D5610	*	REPAIR RESIN DENTURE BASE	$ 47.00
D5620	*	REPAIR CAST FRAMEWORK	$ 75.00
D5640	*	REPLACE BROKEN TEETH-PER TOOTH/DENTURE	$ 28.00
D5750	*	RELINE COMPLETE MAXILLARY DENTURE	$ 99.00
D5751	*	RELINE COMPLETE MANDIBULAR DENTURE	$ 99.00
D5820	*	INTERIM PARTIAL DENTURE (MAXILLARY)	$ 246.00

KENTUCKY MEDICAID DENTAL SERVICES

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D5821	*	INTERIM PARTIAL DENTURE (MANDIBULAR)	$ 259.00
D5913	@	NASAL PROSTHESIS	$ 2,036.00
D5914	@	AURICULAR PROSTHESIS	$ 1,881.00
D5919	@	FACIAL PROSTHESIS	$ 3,408.00
D5931		OBTURATOR (TEMPORARY)	$ 863.00
D5932		OBTURATOR (PERMANENT)	$ 1,992.00
D5934	@	MANDIBULAR RESECTION PROSTHESIS	$ 1,660.00
D5952	@	SPEECH AID-PEDIATRIC (13 AND UNDER)	$ 2,036.00
D5953	@	SPEECH AID-ADULT (14 AND OVER)	$ 2,036.00
D5954	@	PALATAL AUGMENTATION PROSTHESIS	$ 1,550.00
D5955	@	PALATAL LIFT PROSTHESIS	$ 1,836.00
D5988	@	ORAL SURGICAL SPLINT	$ 896.00
D5999	@	UNLISTED MAXILLOFACIAL PROSTHETIC PROC	B/R
D7111		CORONAL REMNANTS DECIDUOUS TOOTH	$ 38.00
D7140		EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	$ 38.00
D7210		SURGICAL REMOVAL OF ERUPTED TOOTH	$ 72.00
D7220		REMOVAL OF IMPACTED TOOTH (SOFT TISSUE)	$ 98.00
D7230		REMOVAL OF IMPACTED TOOTH (PARTIALLY BONY)	$ 138.00
D7240		REMOVAL OF IMPACTED TOOTH (COMPLETELY BONY)	$ 166.00
D7241		REMOVAL OF IMPACTED TOOTH (COMP BONY-UNUSUAL]	$ 171.00
D7250		SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	$ 83.00
D7260		OROANTRAL FISTULA CLOSURE	$ 104.00
D7280		SURGICAL EXPOSURE OF IMPACTED/UNERUPTED	B/R
D7310		ALVEOPLASTY IN CONJUN WITH EXTRACT/PER QUAD	$ 78.00
D7320		ALVEOPLASTY NOT IN CONJ WITH EXTRACT/PER QUAD	$ 78.00
D7410		EXCISION OF BENIGN LESION	$ 67.00
D7510		INCISION & DRAINAGE OF ABSCESS (INTRAORAL)	$ 52.00
D7520		INCISION & DRAINAGE OF ABSCESS (EXTRAORAL)	$ 62.00
D7530		REMOVAL OF FOREIGN BODY	$ 155.00
D7880	*	OCCLUSAL ORTHOTIC DEVICE	P.A.
D7910		SUTURE OF RECENT SMALL WOUND	$ 52.00
D7960		FRENULECTOMY	$ 129.00
D8210	*	REMOVABLE APPLIANCE THERAPY	P.A.
D8220	*	FIXED APPLIANCE THERAPY	P.A.
D8660	*	PRE-ORTHODONTIC TREATMENT VISIT	P.A.
D8670	*	PERIODIC ORTHODONTIC TREATMENT VISIT	P.A.
D8999	*	UNSPECIFIED ORTHODONTIC PROCEDURE [FINAL THIRD]	P.A.
D9110		PALLIATIVE TREATMENT OF DENTAL PAIN	$ 21.00
D9241	*	INTRAVENOUS SEDATION	$ 122.00
D9420		HOSPITAL CALL	$ 52.00

* LIMITED TO RECIPIENTS UNDER THE AGE OF 21
@ PROCEDURES LIMITED TO KENTUCKY BOARD CERTIFIED PROSTHODONTIST
P.A. PRIOR-AUTHORIZED
B/R BY-REPORT (MANUALLY PRICED)