DMS DENTAL FEE SCHEDULE (Dental Procedures)

January 2018

Codes in red are for 2018 Rates

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***** Please refer to Orthodontic Procedures for Pricing***

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
D0120	PERIODIC ORAL EVALUATION ON AN ESTABLISHED PATIENT (1 per recipient per 12 months)	$27.50	n/c	
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.
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**	

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
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**	
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**	
D1515	SPACE MAINTAINER-REMOVABLE-BILATERAL	$328.25	**n/c**	
D1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	$167.50	**n/c**	

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
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	$78.00	n/c	
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**	

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
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)

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
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	
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**	
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	

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
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	

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
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	
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	
D8210	REMOVABLE APPLIANCE THERAPY **(requires prior authorization)**	$362.00	**n/c**	

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
D8220	FIXED APPLIANCE THERAPY **(requires prior authorization)**	$259.00	**n/c**	
D8660	PRE-ORTHODONTIC TREATMENT VISIT	$112.00 **	**n/c**	(requires prior authorization) - and only if individual ultimately not approved for orthodontic treatment)
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	
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

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Proc Code	**Procedure Description**	**UNDER AGE 21 Rate**	**21 and OVER Rate**	**Notes**
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 +15 min @ $75.00 per unit
D9243	INTRAVENOUS MODERATE (Conscious) SEDATION/ANALGESIA - EACH 15 MINUTE INCREMENT	$75.00	$75.00	
D9248	SEDATION (NON-IV)	$39.00	$39.00	
D9230	ANAlGESIA	$39.00	$39.00	
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			
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	Effective January 1, 2018			

DMS Dental Fee Schedule (Oral Pathology)

effective Jan 2020

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
	n/c = not covered	

DMS Dental Fee Schedule - Orthodontic Procedures

effective Jan. 2020
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

effective Jan. 2020
3. The two (2) payments shall include all services associated with the comprehensive orthodontic treatment