VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

2016 DENTAL PROCEDURE FEE SCHEDULE

Effective for services provided on or after 01/01/2016

(Updated 4/26/2016 to include Global Period information.)

Information

CDT Categories of Service

Procedure codes not covered by DVHA's Dental Program are not listed in this Fee Schedule

Non covered codes can be found at http://dvha.vermont.gov/for-providers/2016-fee-schedule-1

Legend

Fee

** = Individual Consideration.

Authorization (A)

0 = No prior authorization required.
1 = Prior authorization required by the Department of Vermont Health Access (DVHA). If appropriate, please forward radiographs for review.

Procedures Requiring Prior Authorization

Submit requests to:

Department of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495
Fax: (802) 879-5963

All Dental and Orthodontic Prior Authorization forms can be found at http://dvha.vermont.gov/for-providers .

Adult Program (AP)

- The Adult Program is limited to $510 per individual per calendar year.
- If an individual reaches their 21st birthday and has received dental care during the course of the year, the dental benefit already paid will be applied to the annual $510 adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to $510 and will not begin again until the start of the new calendar year.
- Exception to Adult Program limit: pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

Y = Procedure is a covered service for the Adult Program.
N = Procedure is not a covered service for the Adult Program.
♦ = This procedure is not subject to the Adult Program $510 annual maximum benefit.

Global Period (G)

0 = Global period does not apply.
10 = Global period is 10 days. Treatment for pain is not separately reimbursed for 10 days following these procedures.

The Global Period policy is effective for dates of service on and after 6/1/2016.

By Report

When a procedure is followed by this statement, please provide a brief description of the service and forward the claim to the Department of Vermont Health Access for review.

Co-Payment

Adults are responsible for a co-payment for all dental services. The co-payment amount is $3/adult/provider/date of service. HP Enterprise Services (HPES) will automatically deduct the co-payment from the amount paid to the provider.

Exceptions to Co-Payments

1. An individual residing in a participating long-term care facility (nursing home). HP has this information on file and will not deduct the co-payment from the amount paid to the provider.
2. Pregnant women and through the end of the calendar month during which the 60th day following the end of pregnancy occurs. HP does not have this information on file. When submitting claim forms to HP for payment, you must indicate pregnancy and 60-day post pregnancy by adding the "HD" modifier to the end of each procedure code. The "HD" modifier must be used for all procedures. For example, when submitting for a periodic oral evaluation, use procedure code D0120HD.
3. An individual who is under 21 years of age and considered a child by the Department of Vermont Health Access.

I. DIAGNOSTIC

A. Clinical Oral Evaluations:

The codes in this section recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately.

D0120	Periodic Oral Evaluation	25	0	Y	0

An evaluation performed on a patient to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures.

► Periodic oral evaluations are limited to 1 per patient per 180 days. If more frequent periodic oral evaluations are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional periodic oral evaluation.

D0140	Limited Oral Evaluation – Problem Focused	40	0	Y♦	0

An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Definitive procedures may be required on the same day as this evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

► Limited oral evaluations are limited to 1 per patient per provider per date of service.

D0145	Oral Evaluation for a patient under three years of age and counseling with primary caregiver.	39	0	N	0

Diagnostic and preventive services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

► Procedure code D0145 is limited to children under three years of age.

► The reimbursement for procedure code D0145 includes all anticipatory guidance provided to the family, including oral hygiene instructions. Note that you cannot bill for oral hygiene instructions (procedure code D1330) on the same date of service as procedure code D0145.

► Procedure code D0145 is limited to 1 per patient per 180 days. If more frequent oral evaluations are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional oral evaluation.

CODE / DESCRIPTION		FEE	A	AP	G
A.	Clinical Oral Evaluations - continued:				
D0150	Comprehensive Oral Evaluation	40	0	Y	0

An evaluation used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

► Comprehensive oral evaluations are limited to 1 per patient per provider per 3 years. If a comprehensive oral evaluation is required earlier than the 3-year limit, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional comprehensive oral evaluation.

D0170	Re-evaluation – Limited, Problem Focused Assessing the status of a previously existing condition.	32	0	Y♦	0

For example:

- a traumatic injury where no treatment was rendered but patient needs follow-up monitoring;
- evaluation for undiagnosed continuing pain;
- soft tissue lesion requiring follow-up evaluation.

This code is NOT to be used for a post-operative visit.

► Re-evaluations are limited to 1 per patient per provider per date of service.

B.	Radiographs:				
D0210	Intraoral – Complete Series (including bitewings)	65	0	Y	0

► A complete series of radiographs is limited to 1 per patient per 180 days. If a complete series of radiographs is required earlier than the 180-day limit, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional complete series of radiographs. This still includes bitewings.

D0220	Intraoral – Periapical – First radiographic image	18	0	Y	0
D0230	Intraoral – Periapical – Each Additional radiographic image	7	0	Y	0

► Intraoral periapicals are limited to 6 per date of service. If more than 6 radiographs are required, submit as a complete series.

CODE / DESCRIPTION		FEE	A	AP	G
B.	Radiographs – continued:				
D0240	Intraoral - Occlussal - radiographic image	21	0	Y	0
D0250	Extra-oral -2D projection radiographic image	33	0	Y	0
D0251	Extra-oral posterior dental radiographic image	33	0	Y	0
D0270	Bitewing –single radiographic image	11	0	Y	0
D0272	Bitewings – 2 radiographic images	24	0	Y	0
D0273	Bitewings – 3 radiographic images	27	0	Y	0
D0274	Bitewings – 4 radiographic images	30	0	Y	0

► Bitewing radiographs are limited to 1 set per 180 days. If more frequent bitewing radiographs are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional bitewing radiographs.

D0330	Panoramic radiographic image	60	0	Y	0

► A panoramic radiograph is limited to 1 per patient per 180 days. If a panoramic radiograph is required earlier than the 180-day limit, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional panoramic radiograph.

D0340	Cephalometric radiographic image	70	0	N	0

► Cephalometric radiographs are limited to 1 per patient per 2 years.

D0350	Oral/Facial Photographic Image obtained intraorally or extraorally	32	0	N	0

D0350 was intended to be used strictly for Orthodontic documentation. Therefore, The use of code D0350 is limited to Orthodontic purposes only.

This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be part of the patient's clinic record.

► Oral/Facial Photographic Images are limited to once per patient per 2 years.

Vermont Medicaid will not pay for any usually covered procedures if that procedure was done to support a non-covered procedure. As example: A CT Scan would not be covered if the reason for doing the scan was to plan the placement of an implant. As implants are not covered, the scan done to plan the implant is also not covered.

D0364	Cone Beam CT Capture and Interpretation with Limited Field of View - Less Than One Whole Jaw	204	1	Y	0
D0365	Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch – Mandible	306	1	Y	0
D0366	Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch - Maxilla,	306	1	Y	0

CODE / DESCRIPTION		FEE	A	AP	G
	with or without Cranium				
D0367	Cone Beam CT Capture and Interpretation with Limited Field of View of Both Jaws, With or Without Cranium	409	1	Y	0
D0368	Cone Beam CT Capture and Interpretation for TMJ Series Including Two or More Exposures	409	1	Y	0
D0391	Interpretation of Diagnostic Image by a Practitioner Not Associated with Capture of the Image, Including the Report	35	1	N	0
D0393	TREATMENT SIMULATION USING 3D IMAGE VOLUME	00	1	Y	0
C.	Other Diagnostic Procedures:				
D0470	Diagnostic Models	50	0	Y	0
► Diagnostic models are limited to 1 set per patient per 2 years.					
D0999	Unspecified diagnostic procedures	**	1	Y	0

CODE / DESCRIPTION		FEE	A	AP	G

II. PREVENTIVE TREATMENT

A. Prophylaxis:

D1110	Prophylaxis – Adult	48	0	Y	0

Removal of plaque, calculus and stains from the tooth structures in the permanent (adult) and transitional dentition. It is intended to control local irritational factors.

D1120	Prophylaxis – Child	34	0	N	0

Removal of plaque, calculus and stains from the tooth structures in the primary (deciduous) and transitional dentition. It is intended to control local irritational factors.

Definitions:
Primary (Deciduous) Dentition: Teeth developed and erupted first in order of time.
Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
Permanent (Adult) Dentition: The dentition that is present after the cessation of growth.

► Prophylaxis is limited to 1 per patient per 180 days. If more frequent prophylaxis is required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional prophylaxis.

B. Topical Fluoride Treatment:
Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the general supervision of a dentist or physician. Fluoride must be applied separately from prophylaxis paste.

D1206	Topical Fluoride Varnish; Therapeutic application for moderate to high caries risk patients.	18	0	Y	0

Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.

► Fluoride varnish applications are limited to 1 application per patient per 180 days. If more frequent fluoride varnish applications are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional fluoride treatment.

D1208	Topical Application of Fluoride	18	0	Y	0

► Fluoride applications are limited to 1 application per patient per 180 days. If more frequent fluoride applications are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional fluoride treatment.

CODE / DESCRIPTION		FEE	A	AP	G
C.	Other Preventive Services:				
D1330	Oral Hygiene Instructions	21	0	N	0

►Smoking and Tobacco use Cessation Counseling visit, greater than 3 minutes up to 10 minutes CPT Code 99406 (1/1/2015)

► Smoking and Tobacco use Cessation Counseling visit, greater than 10 minutes CPT Code 99407 (1/1/2015)

Please note the fee schedule for Cessation counseling CPT codes can be found at http://dvha.vermont.gov/for-providers/2015-fee-schedule-1

Information for CMS1500 forms can be found at http://www.vtmedicaid.com/Information/whatsnew.html

► Oral hygiene instructions are limited to children 4 years old and younger.

► Oral hygiene instructions are limited to 1 time per patient per year. If more frequent oral hygiene instructions are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional instructions.

D1351	Sealant – Per Tooth* Limited to permanent first and second molars.	35	0	N	0
D1351 U9	Sealant – Per Tooth-Deciduous second molars and bicuspids*	19	0	N	0

When submitting claims for the placement of sealants on deciduous second molars and bicuspids you must add the "U9" modifier to the end of procedure code D1351. For example, when submitting for a sealant placed on tooth #28, use procedure code D1351U9.

D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	70	0	N	0

* Once a sealant is placed, the provider is responsible for the maintenance of that sealant for a period of 5 years.

► Sealants are limited to 1 per tooth per 5 years.

► The surfaces eligible for sealants are limited to Occlusal (O), Buccal (B), Occlusal-Buccal (OB) and Occlusal-Lingual (OL).

D.	Space Maintenance:				
D1510	Space Maintainer - Fixed – Unilateral	160	0	N	0
D1515	Space Maintainer – Fixed – Bilateral	250	0	N	0

CODE / DESCRIPTION		FEE	A	AP	G
D1525	Space Maintainer – Removable – Bilateral	225	0	N	0
D1550	Recementation of Space Maintainer	50	0	N	0

► When submitting for payment for space maintainers, indicate a corresponding tooth number on the completed claim form.

► Space maintainers are limited to 1 identical space maintainer per patient per 2 years.

III. RESTORATIVE

Local anesthesia is considered to be a component of all restorative procedures.

Amalgam and resin based restorations are limited to once per surface per year per tooth.

It is understood that interproximal lesions are usually approached through the occlusal surface, so a mesial lesion seen only on x-ray could legitimately be billed as an MO (D2150, 2 surface). It is permissible to have a DO placed one day and an MO on the same tooth on another day within a twelve month period. That is, the claim will not be rejected because the O surface was restored twice in the same year. We will know that an O in combination with an M or D is different from a free standing O. Two isolated O's within 12 months is still rejected. Note also that an MODO is only a three surface restoration.

Another example: If tooth #8 has a small mesial restoration placed and billed one day(D2330, one surface) but shortly thereafter the patient suffers a traumatic incident that fractures away the MI corner of #8, if DVHA is billed for #8 MI (D2335, 4 surface including incisal edge), the claim will be denied. If however, a note were included in the claim describing the circumstances, payment can be facilitated.

If an MO on #30 is followed by an MB billed within 12 months, the MB will be denied as the M surface had already been treated. A large cervical or buccal lesion, it is still one lesion even if it extends toward the mesial or distal of the tooth.

If there is some extraordinary circumstance that you can describe or document with x-rays, photo's, models or words, please submit these along with any claim that you believe might set off our "red flag" system. It will facilitate timely processing.

A. Amalgam Restorations: Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

D2140	Amalgam – One Surface, Primary or Permanent	66	0	Y	10
D2150	Amalgam – Two Surfaces, Primary or Permanent	80	0	Y	10
D2160	Amalgam – Three Surfaces, Primary or Permanent	95	0	Y	10
D2161	Amalgam – Four or more Surfaces, Primary or Permanent	120	0	Y	10

B. Resin-Based Restorations: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations should be reported with these codes. If pins are used, they should be reported separately (see D2951).

D2330	Resin-Based Composite – One Surface, Anterior	80	0	Y	10
D2331	Resin-Based Composite – Two Surfaces, Anterior	99	0	Y	10
D2332	Resin-Based Composite – Three Surfaces, Anterior	116	0	Y	10
D2335	Resin – Four or more Surfaces or involving incisal angle, Anterior	145	0	Y	10
D2390	Resin-Based Composite crown, Anterior	225	0	Y	10
D2391	Resin-Based Composite – One Surface, Posterior	90	0	Y	10
D2392	Resin-Based Composite – Two Surfaces, Posterior	133	0	Y	10
D2393	Resin-Based Composite – Three Surfaces, Posterior	179	0	Y	10
D2394	Resin-Based Composite – Four or more Surfaces, Posterior	199	0	Y	10

C. Custom Crowns:

D2720	Crown – Resin to High Noble Metal	600	0	N	10
D2740	Crown – Porcelain/Ceramic	600	0	N	10
D2750	Crown – Porcelain to High Noble	600	0	N	10
D2751	Crown – Porcelain to Base Metal	420	0	N	10
D2752	Crown – Porcelain to Noble Metal	600	0	N	10
D2790	Crown – Full Cast High Noble Metal	600	0	N	10
D2791	Crown – Full Cast Base Metal	407	0	N	10
D2792	Crown – Full Cast Noble Metal	600	0	N	10
D2920	Recement Crown	60	0	Y	10

► Custom Crowns are limited to 1 per tooth per 5 years.

► When submitting for payment for custom crowns, use the start date (final impression date) as the date of service on the completed claim. Do not submit the claim until the custom crown is delivered.

D. Prefabricated Crowns:

D2930	Stainless Steel Crown – Primary	160	0	Y	10
D2931	Stainless Steel Crown – Permanent	160	0	Y	10
D2932	Prefabricated Resin Crown	160	0	Y	10
D2933	Prefabricated Stainless Steel Crown with Resin Window	160	0	Y	10

► Prefabricated crowns are limited to 1 per tooth per 2 years.

E. Other Restorative Procedures:

D2940	Protective Restoration	60	0	Y	10

Direct placement of a temporary restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.

► When submitting for a protective restoration, indicate the corresponding tooth number and tooth surfaces on the completed claim form.

D2950	Core Build-up – Including Pins	130	0	Y	10

Core build-up refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.

D2951	Pin Retention, Per Tooth	39	0	Y	10

► Pin retention is limited to once per tooth per year.

CODE / DESCRIPTION		FEE	/ A	/ AP	/ G
D2952	Post and Core in addition to crown, indirectly fabricated Post and core are custom fabricated as a single unit.	307	0	N	10
D2954	Prefabricated Post and Core Core is built around a prefabricated post. This procedure includes the core material.	160	0	Y	10
D2960	Labial Veneer – Laminate	220	0	N	10
D2980	Crown Repair, by report	110	1	N	10
D2981	Inlay Repair Necessitated by Restorative Material Failure	133	0	Y	10
D2982	Onlay Repair Necessitated by Restorative Material Failure	133	0	Y	10
D2983	Veneer Repair Necessitated by Restorative Material Failure	133	0	Y	10
D2999	Unspecified Restorative Procedure, by report	**	1	N	10

CODE / DESCRIPTION		FEE	A	AP	G

IV. ENDODONTICS

Local anesthesia is considered to be a component of all endodontic procedures.

A. Pulpotomy:

D3220	Therapeutic Pulpotomy (Excluding final restoration)	90	0	Y	10

Removal of pulp coronal to the dentinocemental junction and application of medicament. Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

- To be performed on primary or permanent teeth.
- This is not to be construed as the first stage of root canal therapy.

D3221	Pulpal Debridement, primary and permanent teeth	90	0	Y	10

Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.

► Pulpotomy and Pulpal Therapy limited to 1 per tooth per lifetime.

B. Endodontic Therapy for Primary Teeth:

D3230	Pulpal Therapy (resorbable filling) Anterior Primary Tooth	100	0	Y	10
D3240	Pulpal Therapy (resorbable filling) Posterior Primary Tooth	125	0	Y	10

C. Endodontic Therapy:

D3310	Anterior (Excluding Final Restoration)	400	0	Y	10
D3320	Bicuspid (Excluding Final Restoration)	500	0	Y	10
D3330	Molar (Excluding Final Restoration)	650	0	Y	10

► When submitting for payment for completed endodontic therapy, use the start date as the date of service on the completed claim. Do not submit the claim until endodontic treatment is completed.

► Regardless of the funding source for the initial endodontic procedure, endodontic retreatment is not a covered service.

D. Apexification/Recalcification Procedures:

D3351	Apexification/Recalcification – Initial Visit	284	0	N	10
D3352	Apexification/Recalcification – Interim Medication Placement	300	0	N	10
D3353	Apexification/Recalcification – Final Visit	169	0	N	10

CODE / DESCRIPTION		FEE	A	AP	G
D3355	Pulpal Regeneration – Initial Visit	75	1	Y (if <16)	10
► Includes opening tooth, preparation of canal spaces, placement of medication. X-ray needs to show apex of the roots.					
D3356	Pulpal Regeneration – Interim Medication Replacement	75	1	Y (if <16)	10
► X-ray needs to show apex of the roots.					
D3357	Pulpal Regeneration – Completion of Treatment	75	1	Y (if <16)	10
► Does not include final restoration. X-ray needs to show apex of the roots.					
E.	Apicoectomy/Periradicular Surgery:				
D3410	Apicoectomy/Periradicular Surgery; Anterior	260	0	Y	10
D3421	Apicoectomy/Periradicular Surgery; Bicuspid (First Root)	297	0	Y	10
D3425	Apicoectomy/Periradicular Surgery; Molar (First Root)	338	0	Y	10
D3426	Apicoectomy/Periradicular Surgery; Each Additional Root	170	0	Y	10
D3427	Periradicular Surgery without Apicoectomy	260	0	Y	10
D3430	Retrograde Filling – Per Root	99	0	Y	10
► Apicoectomy procedures are limited to 1 per tooth per lifetime.					
D3450	Root Amputation – Per Root	181	0	N	10
F.	Other Endodontic Procedures:				
D3910	Surgical Procedure for Isolation of Tooth With Rubber Dam	71	0	N	10
D3920	Hemisection (Including any Root Removal. Not Including Root Canal Therapy)	181	0	N	10
D3999	Unspecified Endodontic Procedure, by report	**	1	N	10

CODE / DESCRIPTION		FEE	A	AP	G

V. PERIODONTICS

Local anesthesia is considered to be a component of all periodontal procedures.

A. Surgical Services:

D4210	Gingivectomy or Gingivoplasty, Four or more contiguous teeth or bounded teeth spaces per quadrant	273	0	N	10
D4211	Gingivectomy or Gingivoplasty, One to three contiguous teeth or bounded teeth spaces, per quadrant	130	0	N	10
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure per Tooth	48	0	Y	10
D4240	Gingival Flap Procedure, Including Root Planing – Four or more contiguous teeth or bounded teeth spaces per quadrant	308	0	N	10
D4241	Gingival Flap Procedure, Including Root Planing – One to three contiguous teeth or bounded teeth spaces, per quadrant	150	0	N	10
D4249	Clinical Crown Lengthening-Hard Tissue	400	0	N	10

This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity. Requires reflection of a flap and is performed in a healthy periodontal environment.

D4260	Osseous Surgery (including flap entry and closure) – Four or more contiguous teeth or bounded teeth spaces, per quadrant	600	0	N	10
D4261	Osseous Surgery (including flap entry and closure) – One to three contiguous teeth or bounded teeth spaces, per quadrant	300	0	N	10
D4263	Bone One replacement graft –First Site in Quadrant	373	0	N	10
D4270	Pedicle Soft Tissue Graft Procedure	338	0	N	10
D4277	Free Soft Tissue Graft Procedure (including Donor Site Surgery), First tooth or Edentulous Tooth Position in Graft	373	0	N	10
D4278	Free Soft Tissue Graft Procedure (including Donor Site Surgery), Each Additional Contiguous Tooth or Edentulous Tooth position in Same Graft Site	373	0	N	10

► Periodontal surgery is limited to 4 procedures per patient per lifetime.

B. Adjunctive Periodontal Services:

D4320	Provisional Splinting – Intracoronal	200	0	Y	10
D4321	Provisional Splinting – Extracoronal	185	0	Y	10
D4341	Periodontal Scaling and Root Planing Four or more contiguous teeth per Quadrant	120	0	Y	10
D4342	Periodontal Scaling and Root Planing One to three teeth, per Quadrant	80	0	Y	10

► Periodontal scaling and root planing is limited to 4 quadrants per patient per year. If more frequent scaling and root planing is required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional scaling and root planing.

D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis.	85	0	Y	10

The gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation.

► Full mouth debridement is limited to 1 per patient per 2 years. If more frequent full mouth debridements are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional full mouth debridement.

► A prophylaxis cannot be completed on the same date of service as a full mouth debridement.

C. Other Periodontal Services:

D4910	Periodontal Maintenance	69	0	Y	10

This procedure is instituted following periodontal therapy and continues at varying levels, determined by the clinical evaluation by the dentist. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth.

This procedure is performed rather than a prophylaxis for patients following periodontal therapy.

► Periodontal maintenance procedures are limited to 1 per patient per 180 days. If more frequent periodontal maintenance procedures are required, use the Dental Services Prior Authorization Request Form to submit a prior authorization request to the Department of Vermont Health Access documenting the need for the additional procedure.

D4999	Unspecified Periodontal Procedure, by report	**	1	N	10

VI. REMOVABLE PROSTHODONTICS

Local anesthesia is considered to be a component of all removable prosthodontic procedures.

A. Complete Dentures, Immediate Dentures and Overdentures:

D5110	Complete Denture – Maxillary	850	1	N♣	0
D5120	Complete Denture – Mandibular	850	1	N♣	0
D5130	Immediate Denture – Maxillary	875	1	N♣	0
D5140	Immediate Denture – Mandibular	875	1	N♣	0

► Immediate dentures are limited to 1 per arch per lifetime.
► Following the delivery of an immediate denture, a complete denture cannot be prior authorized for a minimum of 5 years.
► An immediate denture will be prior authorized if 6 or fewer anterior teeth only are remaining in the arch.

B. Partial Dentures:

D5211	Maxillary Partial Denture – Resin Base*	575	1	N♣	0
D5212	Mandibular Partial Denture – Resin Base*	575	1	N♣	0
D5213	Maxillary Partial Denture – Cast Framework*	900	1	N♣	0
D5214	Mandibular Partial Denture – Cast Framework*	900	1	N♣	0
D5225	Maxillary Partial Denture – Flexible Base*	775	1	N♣	0
D5226	Mandibular Partial Denture – Flexible Base*	775	1	N♣	0

* Including Any Conventional Clasps, Rests and Teeth.

♣ To prior authorize denture(s) submit a completed "Denture Prior Authorization Request Form" to the Department of Vermont Health Access.

♣ When submitting for payment of prior authorized denture(s), use the start date (final impression date) as the date of service on the completed claim form. Do not submit the claim until the denture(s) are delivered.

♣ Reimbursement includes all necessary post delivery denture adjustments for 3 months.

♣ Regardless of the funding source, dentures are limited to 1 per arch per 5 years. However, replacement denture(s) will be considered in less than 5 years in the following circumstances:
a. The previous denture(s) have been stolen or destroyed in an accident and a police report has been filed.
b. The previous denture(s) have been destroyed in a fire and a fire report has been filed.
c. There are other equally compelling circumstances beyond the recipient's control.
♣ Dentures will not be prior authorized if existing dentures are serviceable.

C. Denture Adjustments:

D5410	Adjust Complete Denture – Maxillary	50	0	Y	0
D5411	Adjust Complete Denture – Mandibular	50	0	Y	0
D5421	Adjust Partial Denture – Maxillary	50	0	Y	0
D5422	Adjust Partial Denture – Mandibular	50	0	Y	0

CODE / DESCRIPTION		FEE	A	AP	G

► Denture adjustments are limited to 1 per denture per 180 days.

D. Denture Repairs:

D5510	Repair Broken Complete Denture Base	100	0	N	0
D5520	Repair Missing or Broken Teeth – Complete Denture	82	0	N	0
D5610	Repair Resin Denture Base – Partial	91	0	N	0
D5620	Repair Cast Framework – Partial	117	0	N	0
D5630	Repair or Replace Broken Clasp – Partial Denture	150	0	N	0
D5640	Replace Broken Teeth on Existing Partial – Per Tooth	83	0	N	0
D5650	Add Tooth to Existing Partial Denture	100	0	N	0
D5660	Add Clasp to Existing Partial Denture	116	0	N	0

► Denture repairs are limited to one per denture per 180 days.

E. Denture Rebases:

D5710	Rebase Complete Maxillary Denture (Laboratory)	250	1	N	0
D5711	Rebase Complete Mandibular Denture (Laboratory)	250	1	N	0
D5720	Rebase Maxillary Partial Denture (Laboratory)	250	1	N	0
D5721	Rebase Mandibular Partial Denture (Laboratory)	250	1	N	0

► Denture rebases and/or relines are limited to 1 per denture per 2 years.
► To prior authorize denture rebase(s) submit a completed "Denture Prior Authorization Request Form" to the Department of Vermont Health Access.

F. Denture Relines:

D5750	Reline Complete Maxillary Denture (Laboratory)	212	1	N	0
D5751	Reline Complete Mandibular Denture (Laboratory)	212	1	N	0
D5760	Reline Maxillary Partial Denture (Laboratory)	212	1	N	0
D5761	Reline Mandibular Partial Denture (Laboratory)	212	1	N	0

► Denture relines and/or rebases are limited to 1 per denture per 2 years.
► To prior authorize denture reline(s) submit a completed "Denture Prior Authorization Request Form" to the Department of Vermont Health Access.

G. Other Removable Prosthetic Services:

D5850	Tissue Conditioning – Maxillary	72	0	Y	0
D5851	Tissue Conditioning – Mandibular	72	0	Y	0
D5863	Overdenture – Complete Maxillary	850	1	N	0
D5864	Overdenture – Partial Maxillary	575	1	N	0
D5865	Overdenture – Complete Mandibular	850	1	N	0
D5866	Overdenture – Partial Mandibular	575	1	N	0
D5899	Unspecified Removable Prosthodontic Procedure, by report	**	1	N	0
D5992	Adjust Maxillofacial Prosthetic applicance, by report	55	0	Y	0
D6055	Connecting Bar-Implanted Supported or Abutment supported	380	1	Y	10

Tissue Conditioning is limited to 1 per denture per 2 years.

VII. FIXED PROSTHODONTICS

Local anesthesia is considered to be a component of all fixed prosthodontic procedures.

A. Implant Services

D6101	Debridement of a Peri-implant Defect and Surface Cleaning of Exposed Implant Surfaces, Including Flap Entry and Closure	150	1	Y	10
D6102	Debridement and Osseous Contouring of a Peri-implant Defect, Includes Surface Cleaning of Exposed Implant Surfaces and Flap Entry and Closure	175	1	Y	10
D6103	Bone Graft for Repair of Peri-implant Defect - Not Including Flap Entry and Closure	475	1	Y	10

► No intention is implied for payment for implants; but the maintenance of existing implants is supported.

B. Fixed Partial Denture Pontics:

D6210	Pontic – Cast High Noble Metal	600	0	N	0
D6211	Pontic – Cast Base Metal	402	0	N	0
D6212	Pontic – Cast Noble Metal	600	0	N	0
D6240	Pontic – Porcelain Fused to High Noble Metal	600	0	N	0
D6241	Pontic – Porcelain Fused to Base Metal	406	0	N	0
D6242	Pontic – Porcelain Fused to Noble Metal	600	0	N	0
D6545	Cast Metal Retainer for Acid Etched Bridge	357	0	N	0

C. Fixed Partial Denture Retainers – Crowns:

D6750	Crown – Porcelain Fused to High Noble Metal	600	0	N	0
D6751	Crown – Porcelain Fused to Base Metal	423	0	N	0
D6752	Crown – Porcelain Fused to Noble Metal	600	0	N	0
D6790	Crown – Full Cast High Noble Metal	600	0	N	0
D6791	Crown – Full Cast Base Metal	418	0	N	0
D6792	Crown – Full Cast Noble Metal	600	0	N	0

► Fixed partial dentures are limited to 1 per tooth per 5 years.

D. Other Prosthodontic Services:

D6930	Recement Bridge	83	0	Y	0
D6980	Bridge Repair, by report	220	1	N	0
D6985	Pediatric Partial Denture, fixed	600	1	N♣	0
D6999	Unspecified Fixed Prosthodontic Procedure, by report	**	1	N	0

♣ To prior authorize denture(s) submit a completed "Denture Prior Authorization Request Form" to the Department of Vermont Health Access.

♣ When submitting for payment of prior authorized denture(s), use the start date (final impression date) as the date of service on the completed claim form. Do not submit the claim until the denture(s) are delivered.
♣ Reimbursement includes all necessary post delivery denture adjustments for 3 months.
♣ Regardless of the funding source, dentures are limited to 1 per arch per 5 years.

► When submitting for payment for cast bridges, use the start date (final impression date) as the date of service on the completed claim. Do not submit the claim until the cast bridge is delivered.

CODE / DESCRIPTION		FEE	A	AP	G

VIII. ORAL AND MAXILLOFACIAL SURGERY

Local anesthesia is considered to be a component of all oral and maxillofacial procedures.

A. Extractions: Includes local anesthesia, suturing if needed, and routine post operative care.

D7111	Extraction, Coronal Remnants – Deciduous Tooth Removal of soft tissue-retained coronal remnants.	64	0	Y	10
D7140	Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal) Includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.	98	0	Y	10

B. Surgical Extractions: Includes local anesthesia, suturing if needed, and routine post operative care.

D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal flap	150	0	Y	10

(Flap and Removal of Bone and/or Section of Tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.)

D7220	Removal of impacted tooth - soft Tissue Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.	155	0	Y	10
D7230	Removal of impacted tooth - partially bony Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.	172	0	Y	10
D7240	Removal of impacted tooth - completely bony Most of crown is covered by bone; requires mucoperiosteal flap elevation and bone removal.	209	0	Y	10
D7241	Removal of impacted tooth -completely bony, with unusual surgical complications.	386	0	Y	10

Most or all of the crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.

D7250	Surgical Removal of residual tooth Roots (cutting procedure) Includes cutting of soft tissue and bone, removal of tooth structure, and closure.	140	0	Y	10
D7251	Coronectomy - intentional partial tooth removal 1 per tooth per lifetime	200	0	Y	10

C. Other Surgical Procedures/Splints:

D7260	Oral antral fistula Closure	458	0	Y♦	10
D7261	Primary Closure of a sinus perforation	461	0	Y♦	10

CODE / DESCRIPTION		FEE	A	AP	G
	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.				
D7270	Tooth Reimplantation and/or stabilization of accidentally evulsed or displaced tooth. Includes splinting and/or stabilization.	250	0	Y♦	10
	♦ This procedure is not subject to the Adult Program $510 annual maximum benefit.				
D7280	Surgical Access of an Unerupted Tooth	300	0	N	10
	An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.				
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	155	0	N	10
	To move/luxate teeth to eliminate ankylosis; not in conjunction with an extraction.				
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	100	0	N	10
	Placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption.				
D7285	Incisional biopsy of oral tissue- hard (bone,tooth)	155	0	Y♦	10
D7286	Incisional biopsy of oral tissue – Soft	145	0	Y♦	10
D7290	SURGICAL REPOSITIONING OF TEETH (6/1/2015)	144	1	Y	10
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	62	1	Y	10
D7295	Harvest of bone for use in autogenous grafting procedure	425	1	Y	10
D7310	Alveoloplasty in Conjunction with Extractions – per Quadrant	25	0	Y♦	10
D7311	Alveoloplasty in Conjunction with Extractions, 1-3 Teeth – per Quadrant	15	0	Y♦	10
D7320	Alveoloplasty not in Conjunction with Extractions – per Quadrant	150	0	Y♦	10
D7340	Vestibuloplasty – Ridge Extension Secondary Epithelialization	324	0	Y♦	10
D7350	Vestibuloplasty – Ridge Extension	324	0	Y♦	10
	Including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue.				
D7410	Excision of Benign Lesion up to 1.25 cm	194	0	Y♦	10
D7411	Excision of Benign Lesion greater than 1.25 cm	246	0	Y♦	10
D7412	Excision of Benign Lesion, Complicated	280	0	Y♦	10
	Requires extensive undermining with advancement or rotational flap closure.				
D7413	Excision of Malignant Lesion up to 1.25 cm	231	0	Y♦	10
D7414	Excision of Malignant Lesion greater than 1.25 cm	360	0	Y♦	10

CODE / DESCRIPTION		FEE	A	AP	G
D7415	Excision of Malignant Lesion, Complicated Requires extensive undermining with advancement or rotational flap closure.	400	0	Y♦	10
D7440	Excision of Malignant Tumor –lesion Diameter up to 1.25 cm	222	0	Y♦	10
D7441	Excision of Malignant Tumor – Lesion diameter greater than 1.25 cm	347	0	Y♦	10
D7450	Removal of benign Odontogenic Cyst or Tumor Lesion diameter up to 1.25 cm	201	0	Y♦	10
D7451	Removal of benign odontogenic Cyst or Tumor Lesion diameter greater than 1.25 cm	238	0	Y♦	10

♦ This procedure is not subject to the Adult Program $510 annual maximum benefit.

D7460	Removal of benign nonodontogenic Cyst or Tumor- Lesion diameter up to 1.25 cm	197	0	Y♦	10
D7461	Removal of benign nonodontogenic Cyst or Tumor Lesion diameter greater than 1.25 cm	282	0	Y♦	10
D7465	Destruction of lesion(s) by physical or chemical methods,by report	105	0	Y♦	10
D7471	Removal of Lateral Exostosis (maxilla or mandible)	200	0	Y♦	10
D7472	Removal of Torus Palatinus	200	0	Y♦	10
D7473	Removal of Torus Mandibularis	200	0	Y♦	10
D7485	Surgical Reduction Osseous Tuberosity	200	0	Y♦	10
D7510	Incision and Drainage of Abscess-intraoral soft tissue	82	0	Y♦	10

► When submitting for the incision and drainage of an abscess, indicate a corresponding tooth number on the completed claim form.

D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	261	0	Y♦	10

D7610 to D7680
Fracture of bones of the facial structures.
Codes are not reimbursable; however, certain CPT codes may be reimbursable to dentists.

D7810 to D7877
Related to Temporomandibular joint problems.
Codes are not reimbursable; however, certain CPT codes may be reimbursable to dentists.

D7880	Occlusal Orthotic Appliance (TMJ Splint)	500	0	Y♦	10

► Occlusal orthotic appliances are limited to 1 appliance per patient per year.

D7881	Occlusal orthotic device adjustment	40	0	Y	10

► Providers may use a CMS-1500 medical claim form or an ADA dental claim form when submitting for payment of an occlusal orthotic appliance.

CODE / DESCRIPTION		FEE	A	AP	G
D7899					
Related to Temporomandibular joint problems.					
Codes are not reimbursable; however, certain CPT codes may be reimbursable to dentists.					
D7910	Suture of recent Small Wounds up to 5 cm	107	0	Y♦	10
► Note that suturing of recent small wounds excludes the closure of surgical incisions.					
D7911	Complicated suture – up to 5 cm	161	0	Y♦	10
Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.					
D7912	Complicated suture – greater than 5 cm	237	0	Y♦	10
Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.					
► Note that complicated suturing involves reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure and excludes the closure of surgical incisions.					
D7960	Frenulectomy (Frenectomy or Frenotomy)	150	0	N	10
D7971	Excision of Pericoronal Gingiva	75	0	N	10
Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted tooth.					
D7972	Surgical Reduction of Fibrous Tuberosity	150	0	Y♦	10
D.	Miscellaneous Surgical Procedures:				
D7999	Unspecified Surgical Procedure, by report	**	1	N	10

♦ This procedure is not subject to the Adult Program $510 annual maximum benefit.

CODE / DESCRIPTION		FEE	A	AP	G
IX.	**ORTHODONTICS**				
A.	Limited Orthodontic Treatment:				
D8010	Limited Orthodontic Treatment of the Primary Dentition	655	1*	N	10
D8020	Limited Orthodontic Treatment of the Transitional Dentition	655	1*	N	10
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	655	1*	N	10
D8040	Limited Orthodontic Treatment of the Adult Dentition	655	1*	N	10
B.	Interceptive Orthodontic Treatment:				
D8050	Interceptive Orthodontic Treatment of the Primary Dentition	940	1*	N	10
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition	940	1*	N	10
C.	Comprehensive Orthodontic Treatment:				
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	3,925	1*	N	10
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	3,925	1*	N	10
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	3,925	1*	N	10
D.	Treatment to Control Harmful Habits:				
D8210	Removable Appliance Therapy	415	1*	N	0
D8220	Fixed Appliance Therapy	415	1*	N	0
E.	Other Orthodontic Services:				
D8692	Replacement of Lost or Broken Retainer	134	0	N	0
► Replacement retainers are limited to 1 per patient per arch per lifetime.					
D8694	Repair of Fixed Retainers, includes Reattachment	134	0	N	0
D8999	Unspecified Orthodontic Procedure, by report	**	1	N	0

* All orthodontic treatment (A-D above) requires prior authorization. Prior authorization forms for orthodontic treatment can be found at http://dvha.vermont.gov/for-providers.

Definitions:
Primary (Deciduous) Dentition: Teeth developed and erupted first in order of time.
Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
Adult (Permanent) Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.
► Reimbursement for orthodontic treatment includes all necessary maintenance to and replacement of brackets and wires.

► When submitting for payment of prior authorized orthodontic appliances, please place a "U" to indicate upper and an "L" to indicate lower in the "surface" section of the claim form.

X. ADJUNCTIVE GENERAL SERVICES

A.	Unclassified Treatment:				
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedures	55	0	Y♦	0
B.	Anesthesia:				
D9223	Deep sedation/general anesthesia - each 15 minute increment	90	0	Y	0
D9230	Inhalation of Nitrous Oxide/ analgesia, anxiolysis	57	0	Y	0
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute incr.	90	0	Y	0
D9248	Non-intravenous conscious sedation	125	0	Y	0

Oral conscious sedation with central nervous system depressants which causes a moderately depressed level of consciousness. This does not include written prescriptions, mild sedatives and/or nitrous oxide sedation.

C.	Professional Visits:				
D9310	Consultation Diagnostic serive provided by Dentist other than requesting dentist	48	0	Y	0
D9420	Hospital Call	100	0	Y	0
D.	Patient Management:				
D9920	Behavior Management	52	0	Y	0

► Behavior management cannot be billed when one of the above methods of anesthesia is billed on the same date of service.

E.	Occlusal Therapy:				
D9932	Cleaning and inspection of removable complete denture, maxillary	30	0	Y	10
D9933	Cleaning and inspection of removable complete denture, mandibular	30	0	Y	10
D9934	Cleaning and inspection of removable partial denture, maxillary	30	0	Y	10
D9935	Cleaning and inspection of removable partial denture, mandibular	30	0	Y	10
D9940	Occlusal Guard	250	0	Y	10
D9942	Repair and/or Reline Occlusal Guard	90	0	Y	10
D9943	Occlusal guard adjustment	40	0	Y	10

A removable dental appliance which is designed to minimize the effects of bruxism and other occlusal factors.

► Occlusal guards are limited to 1 per patient per 2 years.

D9950	Occlusal Analysis – Mounted Case	240	0	N	10
D9951	Occlusal Adjustment – Limited	70	0	N	10
D9952	Occlusal Adjustment – Complete	260	0	N	10

CODE / DESCRIPTION		FEE	A	AP	G
F.	Miscellaneous Services:				
D9973	External Bleaching – Per Tooth	116	0	N	10
D9974	Internal Bleaching – Per Tooth	116	0	N	10
G.	Unspecified Care:				
D9986	Missed Appointment (1/1/2015)	00	0	N	0

►The patient missed an appointment without prior notification

D9987	Cancelled Appointment (1/1/2015)	00	0	N	0

►The patient cancels a previously scheduled appointment with the dentist

Please note that these codes are not reimbursable by Vermont Medicaid and are used for reporting purposes only.

D9999	Unspecified Adjunctive Procedure, by report	**	1	N	10
H.	Interpreter Services:				
T1013	Interpreter Services – 15 minutes	15	0	Y♦	0

► Interpreter services must be submitted on a CMS-1500 medical claim form.

► Indicate the number of 15 minute increments (units) in section 24G of the CMS-1500 claim form.