

2014 DENTAL PROCEDURE SCHEDULE



FEE

Effective for services provided

on or after 01/01/2014

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Legend**Fee**

** = Individual Consideration.

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.
- Due to the maximum benefit allowed for adult dental services, providers may, after written acknowledgement by the member of financial liability, bill patients for amounts that exceed the payment limit but not more than the appropriate procedure rate in the Medicaid dental fee schedule.
- 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.

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.

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.

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> .

GNOSTIC

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

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♦

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 39 0 N of age and counseling with primary caregiver.

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.

Clinical Oral Evaluations - continued:

D0150 Comprehensive Oral Evaluation 40 0 Y

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 32 0 Y♦ Assessing the status of a previously existing condition.

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

► 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.

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

B. Radiographs – continued: D0240 Intraoral – Occlusal Film 21 0 Y D0250 Extraoral – First Film 33 0 Y D0260 Extraoral – Each Additional Film 17 0 Y D0270 Bitewing – Single Film 11 0 Y D0272 Bitewings – 2 Films 24 0 Y D0273 Bitewings – 3 Films 27 0 Y D0274 Bitewings – 4 Films 30 0 Y

► 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 Film 60 0 Y

► 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 Film 70 0 N

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

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

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

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.

D0364 Cone Beam CT Capture and Interpretation with 204 1 Y Limited Field of View - Less Than One Whole Jaw

D0365 Cone Beam CT Capture and Interpretation with 306 1 Y Limited Field of View of One Full Dental Arch –
Mandible

D0366 Cone Beam CT Capture and Interpretation with 306 1 Y
Limited Field of View of One Full Dental Arch - Maxilla,
with or without Cranium

D0367 Cone Beam CT Capture and Interpretation with 409 1 Y Limited Field of View of Both Jaws, With or Without
Cranium

D0368 Cone Beam CT Capture and Interpretation for TMJ Series 409 1 Y Including Two or More Exposures

D0391 Interpretation of Diagnostic Image by a Practitioner Not 35 1 N Associated with Capture of the Image, Including the Report

C. Other Diagnostic Procedures: D0470 Diagnostic Models 50 0 Y

► Diagnostic models are limited to 1 set per patient per 2 years. . D0999 Missed Appointment or Late Cancellation Reporting Code 00 0 Y

► This code is used to report missed appointments and late cancellations to DVHA. This code is used for reporting purposes only and there is NOT a reimbursement associated with the billing of this code.

EVENTIVE TREATMENT**A. Prophylaxis:****D1110 Prophylaxis – Adult 48 0 Y**

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

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.

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 18 0 Y moderate to high caries risk patients.

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

► 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.

C. Other Preventive Services:**D1330 Oral Hygiene Instructions 21 0 N**

► 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* 35 0 N Limited to permanent first and second molars.

D1351 U9 Sealant – Per Tooth-Deciduous second molars and bicuspid* 19 0 N

When submitting claims for the placement of sealants on deciduous second molars and bicuspid 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 70 0 N risk patient - permanent tooth

* 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 D1515 Space Maintainer – Fixed – Bilateral 250 0 N D1525 Space Maintainer – Removable – Bilateral 225 0 N D1550 Recementation of Space Maintainer 50 0 N
- ▶ 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 D2150 Amalgam – Two Surfaces, Primary or Permanent 80 0 Y D2160 Amalgam – Three Surfaces, Primary or Permanent 95 0 Y D2161 Amalgam – Four or more Surfaces, Primary or Permanent 120 0 Y

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

C. Custom Crowns:

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

► 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 D2931 Stainless Steel Crown – Permanent 160 0 Y D2932 Prefabricated Resin Crown 160 0 Y D2933 Prefabricated Stainless Steel Crown with Resin Window 160 0 Y

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

E. Other Restorative Procedures:

D2940 Protective Restoration 60 0 Y

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

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

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

D2952 Post and Core in addition to crown, indirectly fabricated 307 0 N Post and core are custom fabricated as a single unit.

D2954 Prefabricated Post and Core 160 0 Y

Core is built around a prefabricated post.

This procedure includes the core material. D2960 Labial Veneer – Laminate 220 0 N D2980 Crown Repair, by report 110 1 N D2981 Inlay Repair Necessitated by Restorative Material Failure 133 0 Y D2982 Onlay Repair Necessitated by Restorative Material Failure 133 0 Y D2983 Veneer Repair Necessitated by Restorative Material Failure 133 0 Y D2999 Unspecified Restorative Procedure, by report ** 1 N

ENDODONTICS

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

A. Pulpotomy:

D3220 Therapeutic Pulpotomy (Excluding final restoration) 90 0 Y

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

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.

Endodontic Therapy for Primary Teeth:

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

C. Endodontic Therapy:

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

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.

Apexification/Recalcification Procedures:

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

D3355 Pulpal Regeneration – Initial Visit 75 1 Y (if <16)

► 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)

► X-ray needs to show apex of the roots.

D3357 Pulpal Regeneration – Completion of Treatment 75 1 Y (if <16)

► 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 D3421

Apicoectomy/Periradicular Surgery; Bicuspid (First Root) 297 0 Y D3425 Apicoectomy/Periradicular Surgery; Molar (First Root)

338 0 Y D3426 Apicoectomy/Periradicular Surgery; Each Additional Root 170 0 Y D3427 Periradicular Surgery without

Apicoectomy 260 0 Y D3430 Retrograde Filling – Per Root 99 0 Y

► Apicoectomy procedures are limited to 1 per tooth per lifetime.

D3450 Root Amputation – Per Root 181 0 N

F. Other Endodontic Procedures:

D3910 Surgical Procedure for Isolation of Tooth With Rubber Dam 71 0 N D3920 Hemisection (Including any Root Removal.

181 0 N Not Including Root Canal Therapy) D3999 Unspecified Endodontic Procedure, by report ** 1 N

PERIODONTICS

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

A. Surgical Services:

D4210 Gingivectomy or Gingivoplasty, Four or more contiguous 273 0 N teeth or bounded teeth spaces per quadrant

D4211 Gingivectomy or Gingivoplasty, One to three contiguous 130 0 N teeth or bounded teeth spaces, per quadrant

D4212 Gingivectomy or Gingivoplasty to Allow Access for 48 0 Y Restorative Procedure per Tooth

D4240 Gingival Flap Procedure, Including Root Planing – Four or 308 0 N more contiguous teeth or bounded teeth spaces per quadrant

D4241 Gingival Flap Procedure, Including Root Planing – One to 150 0 N three contiguous teeth or bounded teeth spaces, per quadrant

D4249 Clinical Crown Lengthening-Hard Tissue 400 0 N

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 600 0 N more contiguous teeth or bounded teeth spaces, per quadrant

D4261 Osseous Surgery (including flap entry and closure) – One to 300 0 N three contiguous teeth or bounded teeth spaces, per quadrant

D4270 Pedicle Soft Tissue Graft Procedure 338 0 N

D4277 Free Soft Tissue Graft Procedure (including Donor Site Surgery), 373 0 N First tooth or Edentulous Tooth Position in Graft

D4278 Free Soft Tissue Graft Procedure (including Donor Site Surgery), 373 0 N Each Additional Contiguous Tooth or Edentulous Tooth position in Same Graft Site

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

Adjunctive Periodontal Services:

D4320 Provisional Splinting – Intracoronal 200 0 Y

D4321 Provisional Splinting – Extracoronal 185 0 Y

D4341 Periodontal Scaling and Root Planing 120 0 Y Four or more contiguous teeth per Quadrant

D4342 Periodontal Scaling and Root Planing 80 0 Y One to three teeth, per Quadrant

► 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 85 0 Y Periodontal Evaluation and Diagnosis.

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 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

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

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.

D5860 Overdenture – Complete 875 1 N♣

B. Partial Dentures:

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

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

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

D. Denture Repairs:

D5510	Repair Broken Complete Denture Base	100	0	N	
D5520	Repair Missing or Broken Teeth – Complete Denture	82	0	N	D5710
D5610	Repair Resin Denture Base – Partial	91	0	N	Rebase
D5620	Repair Cast Framework – Partial	117	0	N	
D5630	Repair or Replace Broken Clasp – Partial Denture	150	0	N	
D5640	Replace Broken Teeth on Existing Partial – Per Tooth	83	0	N	
D5650	Add Tooth to Existing Partial Denture	100	0	N	
D5660	Add Clasp to Existing Partial Denture	116	0	N	

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

E. Denture Rebases:

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

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

► 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 D5851 Tissue Conditioning – Mandibular 72 0 Y D5863 Overdenture – Complete Maxillary 850 1 N D5864 Overdenture – Partial Maxillary 575 1 N D5865 Overdenture – Complete Mandibular 850 1 N D5866 Overdenture – Partial Mandibular 575 1 N D5899 Unspecified Removable Prosthodontic Procedure, by report ** 1 N 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 150 1 Y
of Exposed Implant Surfaces, Including Flap Entry and Closure D6102 Debridement and Osseous Contouring of a
Peri-implant Defect, 175 1 Y
Includes Surface Cleaning of Exposed Implant Surfaces and
Flap Entry and Closure D6103 Bone Graft for Repair of Peri-implant Defect - Not Including 475 1 Y
Flap Entry and Closure or, When Indicated, Placement of a Barrier
Membrane or Biologic Materials to Aid in Osseous Regeneration

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

Fixed Partial Denture Pontics:

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

C. Fixed Partial Denture Retainers – Crowns:

D6750 Crown – Porcelain Fused to High Noble Metal 600 0 N D6751 Crown – Porcelain Fused to Base Metal 423 0 N
D6752 Crown – Porcelain Fused to Noble Metal 600 0 N D6790 Crown – Full Cast High Noble Metal 600 0 N D6791 Crown
– Full Cast Base Metal 418 0 N D6792 Crown – Full Cast Noble Metal 600 0 N
Fixed partial dentures are limited to 1 per tooth per 5 years.

Other Prosthodontic Services:

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

♣ 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.

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 64 0 Y Removal of soft tissue-retained coronal remnants.

D7140 Extraction, Erupted Tooth or Exposed Root 98 0 Y (elevation and/or forceps removal) Includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

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

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

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 Soft Tissue Impaction 155 0 Y Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

D7230 Removal of Partially Bone Impacted Tooth 172 0 Y Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

D7240 Removal of Completely Bone Impacted Tooth 209 0 Y Most of crown is covered by bone; requires mucoperiosteal flap elevation and bone removal.

D7241 Removal of Completely Bone Impacted Tooth 386 0 Y with unusual surgical complications.

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.

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

C. Other Surgical Procedures/Splints: D7260 Oroantral Fistula Closure 458 0 Y♦ D7261 Primary Closure of a Sinus Perforation 461 0 Y♦

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 250 0 Y♦ avulsed or displaced tooth. Includes splinting and/or stabilization.

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

D7280 Surgical Access of an Unerupted Tooth 300 0 N

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 To move/luxate teeth to eliminate ankylosis; not in conjunction with an extraction.

Placement of Device to Facilitate Eruption of Impacted Tooth 100 0 N

Placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption.

Biopsy of Oral Tissue – Hard (Bone, tooth) 155 0 Y◆

Biopsy of Oral Tissue – Soft 145 0 Y◆

D7295 Harvest of bone for use in autogenous grafting procedure 425 1 Y

Alveoloplasty in Conjunction with Extractions – per Quadrant 25 0 Y◆

D7311 Alveoloplasty in Conjunction with Extractions, 1-3 Teeth – 15 0 Y◆ per Quadrant

Alveoloplasty not in Conjunction with Extractions – per Quadrant 150 0 Y◆

D7340 Vestibuloplasty – Ridge Extension 324 0 Y◆ Secondary Epithelialization

Vestibuloplasty – Ridge Extension 324 0 Y◆

Including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue.

D7410 Excision of Benign Lesion 194 0 Y◆ Lesion diameter up to 1.25 cm

D7411 Excision of Benign Lesion 246 0 Y◆ Lesion diameter greater than 1.25 cm

D7412 Excision of Benign Lesion, Complicated 280 0 Y◆ Requires extensive undermining with advancement or rotational flap closure.

D7413 Excision of Malignant Lesion 231 0 Y◆ Lesion diameter up to 1.25 cm

D7414 Excision of Malignant Lesion 360 0 Y◆ Lesion diameter greater than 1.25 cm

D7415 Excision of Malignant Lesion, Complicated 400 0 Y◆ Requires extensive undermining with advancement or rotational flap closure.

D7440 Excision of Malignant Tumor – Intra-Osseous 222 0 Y◆ Lesion diameter up to 1.25 cm

D7441 Excision of Malignant Tumor – Intra-Osseous 347 0 Y◆ Lesion diameter greater than 1.25 cm

D7450 Removal of Odontogenic Cyst or Tumor 201 0 Y◆ Lesion diameter up to 1.25 cm

D7451 Removal of Odontogenic Cyst or Tumor 238 0 Y◆ Lesion diameter greater than 1.25 cm

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

Removal of Nonodontogenic Cyst or Tumor 197 0 Y◆ Lesion diameter up to 1.25 cm D7461 Removal of Nonodontogenic Cyst or Tumor 282 0 Y◆

Lesion diameter greater than 1.25 cm D7465 Destruction of lesion(s) by physical or chemical method 105 0 Y◆

D7471 Removal of Lateral Exostosis (maxilla or mandible) 200 0 Y◆ D7472 Removal of Torus Palatinus 200 0 Y◆ D7473 Removal of Torus Mandibularis 200 0 Y◆ D7485 Surgical Reduction Osseous Tuberosity 200 0 Y◆ D7510 Incision and Drainage of Abscess 82 0 Y◆

► 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 261 0 Y◆ or foreign body

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 D7879 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◆

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

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

D7881 to 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◆

► Note that suturing of recent small wounds excludes the closure of surgical incisions.

D7911 Complicated Suture – up to 5 cm 161 0 Y◆ Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure. D7912 Complicated Suture – greater than 5 cm 237 0 Y◆ 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 D7971 Excision of Pericoronal Gingiva 75 0 N Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted tooth. D7972 Surgical Reduction of Fibrous Tuberosity 150 0 Y◆

D. Miscellaneous Surgical Procedures: D7999 Unspecified Surgical Procedure, by report ** 1 N

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

IX. ORTHODONTICS**A. Limited Orthodontic Treatment:**

D8010 Limited Orthodontic Treatment of the Primary Dentition 655 1* N D8020 Limited Orthodontic Treatment of the Transitional Dentition 655 1* N D8030 Limited Orthodontic Treatment of the Adolescent Dentition 655 1* N D8040 Limited Orthodontic Treatment of the Adult Dentition 655 1* N

B. Interceptive Orthodontic Treatment:

D8050 Interceptive Orthodontic Treatment of the Primary Dentition 940 1* N D8060 Interceptive Orthodontic Treatment of the Transitional Dentition 940 1* N

C. Comprehensive Orthodontic Treatment:

D8070 Comprehensive Orthodontic Treatment of the Transitional Dentition 3,925 1* N D8080 Comprehensive Orthodontic Treatment of the Adolescent Dentition 3,925 1* N D8090 Comprehensive Orthodontic Treatment of the Adult Dentition 3,925 1* N

D. Treatment to Control Harmful Habits:

D8210 Removable Appliance Therapy 415 1* N D8220 Fixed Appliance Therapy 415 1* N

E. Other Orthodontic Services:

D8692 Replacement of Lost or Broken Retainer 134 0 N

► Replacement retainers are limited to 1 per patient per arch per lifetime.

D8694 Repair of Fixed Retainers, includes Reattachment 134 0 N

D8999 Unspecified Orthodontic Procedure, by report ** 1 N

* 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.

FUNCTIONAL GENERAL SERVICES

A. Unclassified Treatment:

D9110 Palliative (Emergency) Treatment of Dental Pain – 55 0 Y ♦ Minor Procedures

B. Anesthesia:

D9220 General Anesthesia – First 30 Minutes 225 0 Y D9221 General Anesthesia – Each Additional 15 Minutes 63 0 Y
 D9230 Analgesia, Anxiolysis, Inhalation of Nitrous Oxide 57 0 Y D9241 Intravenous Sedation/Analgesia – First 30 Minutes
 161 0 Y D9242 Intravenous Sedation/Analgesia – Each Additional 15 Minutes 65 0 Y D9248 Non-Intravenous Conscious
 Sedation 125 0 Y

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: D9420 Hospital Call 100 0 Y

D. Patient Management: D9920 Behavior Management 52 0 Y

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

Occlusal Therapy: D9940 Occlusal Guard 250 0 Y 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. D9941 Fabrication of Athletic Mouthguard 100 0 N

Athletic mouthguards are limited to 1 per patient per 2 years.

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

F. Miscellaneous Services: D9974 Internal Bleaching – Per Tooth 116 0 N

G. Unspecified Care: D9999 Unspecified Adjunctive Procedure, by report ** 1 N

H. Interpreter Services: T1013 Interpreter Services – 15 minutes 15 0 Y◆

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.