Alaska Medical Assistance: State Fiscal Year 2024 Fee Schedule

Dental Services

Effective 7/1/2023 - 6/30/2024

Reimbursement may vary slightly from published rates as a result of rounding. RBRVS-based rates are rounded to the nearest cent following adjustments for multiple units and cutbacks.

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Coverage and rates are subject to change.

Revised 09/11/2023

Services For Children

Service Category: Dental Services for Children

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT					$48.86	
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED					$65.15	
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER					$57.72	
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT					$66.98	
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)					$89.08	
D0220	INTRAORAL-PERIAPICAL-FIRST FILM					$24.43	
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM					$21.17	
D0270	BITEWING-SINGLE FILM					$24.43	
D0272	BITEWINGS-TWO FILMS					$40.72	
D0273	BITEWINGS - THREE FILMS					$44.89	
D0274	BITEWINGS-FOUR FILMS					$60.27	
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS					$64.13	
D0330	PANORAMIC FILM					$99.36	
D0417	COLLECTION AND PREPARATION OF SALIVA SAMPLE FOR LABORATORY DIAGNOSTIC TESTING		X			By Report	Attach written medical justification to claim.
D0460	PULP VITALITY TESTS					$45.25	
D0470	DIAGNOSTIC CASTS					$50.00	
D0475	DECALCIFICATION PROCEDURE		X			By Report	Attach written medical justification to claim.
D0482	DIRECT IMMUNOFLUORESCENCE		X			By Report	Attach written medical justification to claim.
D0483	INDIRECT IMMUNOFLUORESCENCE		X			By Report	Attach written medical justification to claim.
D1110	PROPHYLAXIS-ADULT					$89.18	
D1120	PROPHYLAXIS-CHILD					$64.95	
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS					$28.50	
D1208	TOPICAL APPLICATION OF FLUORIDE					$29.32	
D1351	SEALANT-PER TOOTH			X		$49.68	
D1510	SPACE MAINTAINER-FIXED UNILATERAL			X		$166.44	
D1516	SPACE MAINTAINER-FIXED BILATERAL, MAXILLARY					$402.47	
D1517	SPACE MAINTAINER-FIXED BILATERAL, MANDIBULAR					$402.47	
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT		X			$53.44	Attach written medical justification to claim.
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MAXILLARY		X			$53.44	Attach written medical justification to claim.
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MANDIBULAR		X			$53.44	Attach written medical justification to claim.
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT			X	X	$106.89	
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT			X	X	$135.39	
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT			X	X	$166.75	
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT			X	X	$190.98	
D2330	RESIN-ONE SURFACE, ANTERIOR			X	X	$127.56	
D2331	RESIN-TWO SURFACES, ANTERIOR			X	X	$155.35	
D2332	RESIN-THREE SURFACES, ANTERIOR			X	X	$188.84	
D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)			X	X	$231.60	All surfaces must be reported on claim
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	See Billing Note		X		$247.98	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR			X	X	$141.81	
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR			X	X	$181.71	
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR			X	X	$230.88	
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES POSTERIOR			X	X	$260.81	
D2542	ONLAY-METALLIC-TWO SURFACES		X	X	X	By Report	Attach written medical justification to claim.
D2712	CROWN - 3/4 RESIN-BASED COMPOSITE (INDIRECT)	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2720	CROWN-RESIN WITH HIGH NOBLE MET	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.

Service Category: Dental Services for Children

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D2722	CROWN-RESIN WITH NOBLE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	See Billing Note		X		$826.62	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	See Billing Note		X		$826.62	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2794	CROWN-TITANIUM	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2799	PROVISIONAL CROWN	See Billing Note		X		By Report	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE					$47.59	
D2920	RECEMENT CROWN			X		$70.55	
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN - PERMANENT TOOTH	See Billing Note		X		$260.81	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH	See Billing Note		X		$199.53	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	See Billing Note		X		$199.53	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT	See Billing Note		X		$260.81	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2932	PREFABRICATED RESIN CROWN	See Billing Note		X		$200.55	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	See Billing Note		X		$274.35	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2940	PROTECTIVE RESTORATION			X	X	$82.66	
D2950	CORE BUILD-UP, INCLUDING ANY PINS			X		$209.50	
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION			X		$43.26	
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED			X		$231.60	
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN					$315.81	
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH		X			By Report	
D2962	LABIAL VENEER (PORCELAIN LAMINATE)-LABORATORY		X			By Report	
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK		X			By Report	
D2975	COPING	X				$305.40	
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT			X		$131.83	
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH			X		$195.25	
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT		X	X		$439.60	
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)			X		$295.73	
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)			X		$521.62	
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)			X		$627.09	
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)			X		$711.89	
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS			X		$448.94	
D3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH			X		$238.72	
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS			X		$125.21	
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY	X		X		$570.44	
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	X		X		$570.44	
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	X		X		$766.04	

Service Category: Dental Services for Children

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D3351	APEXIFICATION/RECALCIFICATION/PULPAL REGENERATION- INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)			X		$193.83	
D3352	APEXIFICATION/RECALCIFICATION/PULPAL REGENERATION- INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)			X		$209.50	
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)			X		$314.97	
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR			X		$407.20	
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT)		X	X		By Report	
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT).		X	X		By Report	
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)		X	X		By Report	
D3430	RETROGRADE FILLING-PER ROOT			X		$64.13	
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY		X	X		By Report	
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					$305.40	
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					$119.97	
D4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH					$43.20	
D4230	ANATOMICAL CROWN EXPOSURE - FOUR OR MORE CONTIGUOUS TEETH PER QUADRANT		X			By Report	
D4231	ANATOMICAL CROWN EXPOSURE - ONE TO THREE TEETH PER QUADRANT		X			By Report	
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOU					By Report	
D4245	APICALLY POSITIONED FLAP					$391.93	
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP ENTRY AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					By Report	
D4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	X				By Report	
D4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT	X				By Report	
D4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER SITE	X				By Report	
D4267	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)	X				By Report	
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES, PER TOOTH	X				$458.10	
D4275	SOFT TISSUE ALLOGRAFT					By Report	
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH		X			By Report	
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT		X			By Report	
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE		X			$283.60	
D4322	SPLINT INTRA-CORONAL					$446.09	
D4323	SPLINT EXTRA-CORONAL					$351.67	
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	X				$161.05	
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	X				$142.52	
D4346	SCALING GINGIVAL INFLAMMATION - FULL MOUTH AFTER ORAL EVAL	X				$125.09	
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS					$168.99	
D4910	PERIODONTAL MAINTENANCE					$106.89	
D5110	COMPLETE DENTURE - MAXILLARY					$1,119.80	
D5120	COMPLETE DENTURE - MANDIBULAR					$1,145.25	
D5211	UPPER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)					$561.17	
D5212	LOWER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)					$587.90	
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)					$1,031.84	
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS,RESTS AND TEETH)					$926.38	
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)					$402.11	
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)					$402.11	

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Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH), MAXILLARY					$600.62	
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH), MANDIBULAR					$600.62	
D5410	ADJUST COMPLETE DENTURE - MAXILLARY					$76.35	
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR					$76.35	
D5421	ADJUST PARTIAL DENTURE - MAXILLARY					$68.05	
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR					$68.05	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR					$71.26	
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY					$71.26	
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR					$62.78	
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY					$62.78	
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR					$79.92	
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY					$79.92	
D5630	REPAIR OR REPLACE BROKEN CLASP					$178.15	
D5640	REPLACE BROKEN TEETH-PER TOOTH			X		$106.89	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE			X		$122.16	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE			X		$164.61	
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)					$374.62	
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)					$374.62	
D5710	REBASE COMPLETE MAXILLARY DENTURE					$428.27	
D5711	REBASE COMPLETE MANDIBULAR DENTURE					$428.27	
D5720	REBASE MAXILLARY PARTIAL DENTURE					$356.30	
D5721	REBASE MANDIBULAR PARTIAL DENTURE					$353.25	
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)					$229.05	
D5731	RELINE LOWER COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)					$229.05	
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)					$229.05	
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)					$229.05	
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)					$330.85	
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)					$330.85	
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)					$325.76	
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)					$325.76	
D5850	TISSUE CONDITIONING, MAXILLARY					$141.81	
D5851	TISSUE CONDITIONING, MANDIBULAR					$142.52	
D5875	MODIFICATION OF REMOVABLE PROSTHESIS FOLLOWING IMPLANT SURGERY					By Report	May use for ages 13 through 20.
D5911	FACIAL MOULAGE (SECTIONAL)		X			By Report	
D5912	FACIAL MOULAGE (COMPLETE)		X			By Report	
D5913	NASAL PROSTHESIS		X			By Report	
D5914	AURICULAR PROSTHESIS		X			By Report	
D5915	ORBITAL PROSTHESIS		X			By Report	
D5916	OCULAR PROSTHESIS		X			By Report	
D5919	FACIAL PROSTHESIS		X			By Report	
D5922	NASAL SEPTAL PROSTHESIS		X			By Report	
D5923	OCULAR PROSTHESIS, INTERIM		X			By Report	
D5931	OBTURATOR PROSTHESIS, SURGICAL					$977.28	
D5932	OBTURATOR PROSTHESIS, DEFINITIVE		X			By Report	
D5933	OBTURATOR PROSTHESIS, MODIFICATION		X			By Report	
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE		X			By Report	
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE		X			By Report	
D5937	TRISMUS APPLIANCE (NOT FOR TM TREATMENT)		X			By Report	
D5951	FEEDING AID		X			By Report	
D5952	SPEECH AID PROSTHESIS, PEDIATRIC		X			By Report	
D5954	PALATAL AUGMENTATION PROSTHESIS		X			By Report	
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE		X			By Report	
D5982	SURGICAL STENT					$40.72	
D5983	RADIATION CARRIER		X			By Report	
D5985	RADIATION CONE LOCATOR		X			By Report	

Service Category: Dental Services for Children

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	X				$692.24	
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL					$692.24	
D6212	PONTIC-CAST NOBLE METAL					$692.24	
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	X		X		$692.24	
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	X		X		$692.24	
D6245	PONTIC - PORCELAIN/CERAMIC	X		X		$692.24	
D6253	PROVISIONAL PONTIC	X				$692.24	
D6548	RETAINER - PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS					By Report	May use for ages 13 through 20.
D6624	INLAY - TITANIUM		X			By Report	
D6634	ONLAY - TITANIUM		X			By Report	
D6710	CROWN - INDIRECT RESIN BASED COMPOSITE	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6740	CROWN - PORCELAIN/CERAMIC	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6792	CROWN-FULL CAST NOBLE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6793	PROVISIONAL RETAINER CROWN	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6930	RECEMENT BRIDGE			X		$144.56	
D6980	BRIDGE REPAIR, BY REPORT					$229.05	
D6985	PEDIATRIC PARTIAL DENTURE, FIXED					By Report	
D7111	EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH	See Billing Note		X		$117.78	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	See Billing Note		X		$141.71	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	See Billing Note		X		$250.02	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	See Billing Note		X		$309.47	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	See Billing Note		X		$363.22	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	See Billing Note		X		$427.56	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	See Billing Note		X		$550.53	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	X		X		$301.33	
D7260	ORAL ANTRAL FISTULA CLOSURE		X			$906.03	
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION					$684.52	
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH			X		$203.60	
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION			X		$183.24	
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH					$183.24	
D7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)					$229.34	
D7286	BIOPSY OF ORAL TISSUE - SOFT					$152.70	
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION					$76.35	
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION		X			$108.93	
D7290	SURGICAL REPOSITIONING OF TEETH			X		$223.96	
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	X				$531.48	

Service Category: Dental Services for Children

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECOND EPITHELIALIZATION)					$1,913.04	
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE RE-ATTACHMENTS, REVISION OF SOFT TISSUE ATTACHMENT, AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)					$2,099.28	
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM					$124.20	
D7412	EXCISION OF BENIGN LESION, COMPLICATED		X			$312.95	
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM					$306.30	
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM					$353.87	
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED		X			$409.26	
D7440	EXCISION OF MALIGNANT TUMOR-LESION DIAMETER UP TO 1.25 CM					$1,271.61	
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP T0 1.25 CM					$223.96	
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM					$259.59	
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR- LESION DIAMETER UP TO 1.25 CM					$223.96	
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR- LESION DIAMETER UP TO 1.25 CM					$259.59	
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHODS, BY REPORT					$354.44	
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)					$407.20	
D7472	REMOVAL OF TORUS PALATINUS					$521.11	
D7473	REMOVAL OF TORUS MANDIBULARIS					$510.96	
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY					$463.19	
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE					$1,790.72	
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE					$378.00	
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					$378.00	
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE					$378.00	
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					$378.00	
D7530	REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE					$376.32	
D7540	REMOVAL OF REACTION-PRODUCING FOREIGN BODIES- MUSCULOSKELETAL SYSTEM					$532.86	
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE					$152.70	
D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY					$644.78	
D7610	MAXILLA-OPEN REDUCTION(TEETH IMMOBILIZED IF PRESENT)					$966.90	
D7620	MAXILLA-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					$1,014.33	
D7630	MANDIBLE-OPEN REDUCTION (TEETH IMMOBILIZED IF PRESENT)					$1,757.90	
D7640	MANDIBLE-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					$1,243.75	
D7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					$776.67	
D7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					$1,027.44	
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					$780.18	
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					$917.12	
D7680	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					$2,556.32	
D7710	MAXILLA-OPEN REDUCTION					$1,140.41	
D7720	MAXILLA-CLOSED REDUCTION					$1,014.33	
D7730	MANDIBLE-OPEN REDUCTION					$1,757.90	
D7740	MANDIBLE-CLOSED REDUCTION					$1,243.75	
D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					$1,630.43	
D7760	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					$591.50	
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH					$1,064.24	
D7771	ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH					$591.56	
D7780	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					$2,556.32	
D7810	OPEN REDUCTION OF DISLOCATION					$1,334.65	
D7820	CLOSED REDUCTION OF DISLOCATION					$133.04	
D7830	MANIPULATION UNDER ANESTHESIA					$532.85	
D7840	CONDYLECTOMY					$1,298.63	
D7850	SURGICAL DISCECTOMY; WITH/WITHOUT IMPLANT					$1,185.46	
D7860	ARTHROTOMY					$1,112.62	

Service Category: Dental Services for Children

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D7865	ARTHROPLASTY					$2,603.84	
D7870	ARTHROCENTESIS					$72.99	
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE		X			By Report	
D7899	UNSPECIFIED TMD THERAPY, BY REPORT		X			By Report	
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM					$154.32	
D7911	COMPLICATED SUTURE-UP TO 5 CM		X			$535.22	
D7912	COMPLICATED SUTURE-GREATER THAN 5 CM		X			$663.32	
D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION, AND TYPE OF GRAFT)					By Report	
D7940	OSTEOPLASTY-FOR ORTHOGNATHIC DEFORMITIES					$1,224.52	
D7941	OSTEOTOMY - MANDIBULAR RAMI					$2,155.04	
D7943	OSTEOTOMY - MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT					$2,144.80	
D7944	OSTEOTOMY-SEGMENTED OR SUBAPICAL					$1,727.51	
D7945	OSTEOTOMY-BODY OF MANDIBLE					$1,870.76	
D7946	LEFORT I (MAXILLA-TOTAL)					$2,576.33	
D7947	LEFORT I (MAXILLA-SEGMENTED)					$2,576.33	
D7948	LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION)-WITHOUT BONE GRAFT					$2,446.83	
D7949	LEFORT II OR LEFORT III-WITH BONE GRAFT					$3,238.13	
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA - AUTOGENOUS OR NONAUTOGENOUS BY REPORT					$5,091.57	
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES					By Report	
D7955	REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT					$1,608.11	
D7961	BUCCAL/LABIAL FRENECTOMY					$342.56	Special billing requirements apply (See Alaska Medicaid Frenectomy Policy)
D7962	LINGUAL FRENECTOMY					$303.98	Special billing requirements apply (See Alaska Medicaid Frenectomy Policy)
D7963	FRENULOPLASTY					$422.67	
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH					$442.08	
D7971	EXCISION OF PERICORONAL GINGIVA					$162.88	
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY					$351.55	
D7980	SIALOLITHOTOMY					$517.11	
D7981	EXCISION OF SALIVARY GLAND, BY REPORT					$635.23	
D7982	SIALODOCHOPLASTY		X			By Report	
D7983	CLOSURE OF SALIVARY FISTULA					$667.53	
D7990	EMERGENCY TRACHEOTOMY					$373.91	
D7991	CORONOIDECTOMY					$929.47	
D7995	SYNTHETIC GRAFT-MANDIBLE OR FACIAL BONES, BY REPORT	X				$800.00	
D7997	APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCHBAR		X			By Report	
D7998	INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE					By Report	
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT		X			By Report	
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	X				$1,500.00	This service may only be performed by an orthodontist.
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	X				$1,677.00	This service may only be performed by an orthodontist.
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	X				$2,000.00	This service may only be performed by an orthodontist.
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	X				$1,500.00	This service may only be performed by an orthodontist.
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	X				$1,500.00	This service may only be performed by an orthodontist.
D8210	REMOVABLE APPLIANCE THERAPY	X				$356.30	
D8220	FIXED APPLIANCE THERAPY	X				$356.30	
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	X				$1,348.00	This service may only be performed by an orthodontist.
D8696	REPAIR OF ORTHODONTIC APPLIANCE - MAXILLARY	X				$175.00	
D8697	REPAIR OF ORTHODONTIC APPLIANCE - MANDIBULAR	X				$175.00	
D8698	RE-CEMENT OR RE-BOND FIXED RETAINER - MAXILLARY	X				By Report	
D8699	RE-CEMENT OR RE-BOND FIXED RETAINER - MANDIBULAR	X				By Report	
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN- MINOR PROCEDURES		X			$110.45	
D9120	FIXED PARTIAL DENTURE SECTIONING					By Report	
D9211	REGIONAL BLOCK ANESTHESIA					$68.82	
D9222	GENERAL ANESTHESIA - FIRST 15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9223	GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9230	INHALATION OF NITROUS OXIDE/ANXIOLYSIS, ANALGESIA		X			$57.01	Attach written medical justification to claim.

Service Category: Dental Services for Children

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D9239	INTRAVENOUS SEDATION - FIRST 15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9243	INTRAVENOUS SEDATION - EACH SUBSEQUENT15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION		X			$188.33	Attach written medical justification to claim.
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN		X			$85.51	
D9410	HOUSE/EXTENDED CARE FACILITY CALL		X			By Report	
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL		X			$98.85	
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED HOURS					$91.21	
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION					$81.95	
D9920	BEHAVIOR MANAGEMENT, BY REPORT					$53.44	Attach written medical justification to claim.
D9930	TREATMENT OF COMPLICATIONS (POSTSURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT		X			$123.28	
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH		X			$175.00	
D9945	OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH		X			$175.00	
D9946	OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH		X			$87.50	
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT		X			By Report	

Services For Adults

Service Category: Enhanced Adult Dental Services

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT					$48.86	
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT					$66.98	
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)					$89.08	
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM					$21.17	
D0240	INTRAORAL-OCCLUSAL FILM					$30.95	
D0270	BITEWING-SINGLE FILM					$24.43	
D0272	BITEWINGS-TWO FILMS					$40.72	
D0273	BITEWINGS - THREE FILMS					$44.89	
D0274	BITEWINGS-FOUR FILMS					$60.27	
D0277	VERTICAL BITEWINGS - 7 TO 8 FILMS					$64.13	
D0330	PANORAMIC FILM					$99.36	
D0460	PULP VITALITY TESTS					$45.25	
D1110	PROPHYLAXIS-ADULT					$89.18	
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS					$28.50	
D1208	TOPICAL APPLICATION OF FLUORIDE					$29.32	
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT			X	X	$106.89	
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT			X	X	$135.39	
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT			X	X	$166.75	
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT			X	X	$190.98	
D2330	RESIN-ONE SURFACE, ANTERIOR			X	X	$127.56	
D2331	RESIN-TWO SURFACES, ANTERIOR			X	X	$155.35	
D2332	RESIN-THREE SURFACES, ANTERIOR			X	X	$188.84	
D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)			X	X	$231.60	All surfaces must be reported on claim
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR			X	X	$141.81	
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR			X	X	$181.71	
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR			X	X	$230.88	
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR			X	X	$260.81	
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	See Billing Note		X		$826.62	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2751	CROWN-PROCELAIN FUSED TO PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	See Billing Note		X		$826.62	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2794	CROWN-TITANIUM	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE					$47.59	
D2920	RECEMENT CROWN			X		$70.55	
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN - PERMANENT TOOTH	See Billing Note		X		$260.81	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.

Service Category: Enhanced Adult Dental Services

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT	See Billing Note		X		$260.81	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2932	PREFABRICATED RESIN CROWN	See Billing Note		X		$200.55	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D2940	PROTECTIVE RESTORATION			X	X	$82.66	
D2950	CORE BUILD-UP, INCLUDING ANY PINS			X		$209.50	
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION			X		$43.26	
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN					$315.81	
D2975	COPING					$305.40	
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH			X		$195.25	
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)			X		$521.62	
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)			X		$627.09	
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)			X		$711.89	
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS			X		$448.94	
D3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH			X		$238.72	
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS			X		$125.21	
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY			X		$570.44	
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID			X		$570.44	
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR			X		$766.04	
D3351	APEXIFICATION/RECALCIFICATION/PULPAL REGENERATION- INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)			X		$193.83	
D3352	APEXIFICATION/RECALCIFICATION/PULPAL REGENERATION- INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)			X		$209.50	
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)			X		$314.97	
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					$305.40	
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					$119.97	
D4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH					$43.20	
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOU					By Report	
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP ENTRY AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT					By Report	
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE					By Report	
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT		X			By Report	
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE		X			$283.60	
D4322	SPLINT INTRA-CORONAL					$446.09	
D4323	SPLINT EXTRA-CORONAL					$351.67	
D4322	SPLINT INTRA-CORONAL					$446.09	

Service Category: Enhanced Adult Dental Services

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D4323	SPLINT EXTRA-CORONAL					$351.67	
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT					$161.05	
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT					$142.52	
D4346	SCALING GINGIVAL INFLAMMATION -FULL MOUTH AFTER ORAL EVAL					$125.09	
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS					$168.99	
D4910	PERIODONTAL MAINTENANCE					$106.89	
D5850	TISSUE CONDITIONING, MAXILLARY					$141.81	
D5851	TISSUE CONDITIONING, MANDIBULAR					$142.52	
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL					$692.24	
D6212	PONTIC-CAST NOBLE METAL					$692.24	
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL			X		$692.24	
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL			X		$692.24	
D6245	PONTIC - PORCELAIN/CERAMIC			X		$692.24	
D6740	CROWN - PORCELAIN/CERAMIC	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6792	CROWN-FULL CAST NOBLE METAL	See Billing Note		X		$692.24	Attach written medical justification to claim if 1-2 crowns on date of service; 3 crowns on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D6930	RECEMENT BRIDGE			X		$144.56	
D6980	BRIDGE REPAIR, BY REPORT					$229.05	
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	See Billing Note		X		$427.56	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	See Billing Note		X		$550.53	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	See Billing Note		X		$301.33	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECOND EPITHELIALIZATION)					$1,913.04	
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)					$407.20	
D7472	REMOVAL OF TORUS PALATINUS					$521.11	
D7473	REMOVAL OF TORUS MANDIBULARIS					$510.96	
D7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY					$463.19	
D7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION - PER SITE					$972.00	
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH					$442.08	
D7971	EXCISION OF PERICORONAL GINGIVA					$162.88	
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY					$351.55	

Services For Adults

Service Category: Prosthodontic Adult Dental Services

Code	Description	Service Authorization Required with Medical Justification	Tooth Code Required	Surface Code Required	Maximum Allowable
D5110	COMPLETE DENTURE - MAXILLARY	X			$1,119.80
D5120	COMPLETE DENTURE - MANDIBULAR	X			$1,145.25
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	X			$1,031.84
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	X			$926.38
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	X			$76.35
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	X			$76.35
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	X			$68.05
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	X			$68.05
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	X			$71.26
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	X			$71.26
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	X			$62.78
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	X			$62.78
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	X			$79.92
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	X			$79.92
D5630	REPAIR OR REPLACE BROKEN CLASP	X			$178.15
D5640	REPLACE BROKEN TEETH-PER TOOTH	X			$106.89
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	X			$122.16
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	X			$164.61
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	X			$374.62
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	X			$374.62
D5710	REBASE COMPLETE MAXILLARY DENTURE	X			$428.27
D5711	REBASE COMPLETE MANDIBULAR DENTURE	X			$428.27
D5720	REBASE MAXILLARY PARTIAL DENTURE	X			$356.30
D5721	REBASE MANDIBULAR PARTIAL DENTURE	X			$353.25

Service Category: Prosthodontic Adult Dental Services

Code	Description	Service Authorization Required with Medical Justification	Tooth Code Required	Surface Code Required	Maximum Allowable
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	X			$229.05
D5731	RELINE LOWER COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	X			$229.05
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	X			$229.05
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	X			$229.05
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	X			$330.85
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	X			$330.85
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	X			$325.76
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	X			$325.76

Services For Adults

Service Category: Emergent Adult Dental Services

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED					$65.15	
D0220	INTRAORAL-PERIAPICAL-FIRST FILM					$24.43	
D5922	NASAL SEPTAL PROSTHESIS		X			By Report	
D5923	OCULAR PROSTHESIS, INTERIM		X			By Report	
D5953	SPEECH AID PROSTHESIS, ADULT		X			By Report	
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	See Billing Note		X		$141.71	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	See Billing Note		X		$250.02	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	See Billing Note		X		$309.47	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	See Billing Note		X		$363.22	Attach written medical justification to claim if 1-2 extractions on date of service; 3 extractions on date of service, or 4 or more in 12 months must be prior authorized for consideration. Written medical justification not required if prior authorization on file.
D7260	ORAL ANTRAL FISTULA CLOSURE		X			$906.03	
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	X				$684.52	
D7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)					$229.34	
D7286	BIOPSY OF ORAL TISSUE - SOFT					$152.70	
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION					$76.35	
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION		X			$108.93	
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	X				$531.48	
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	X				$232.10	
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	X				$531.48	
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	X				$232.10	
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM					$124.20	
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM					$253.93	
D7412	EXCISION OF BENIGN LESION, COMPLICATED		X			$312.95	
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM					$306.30	
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM					$353.87	
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED		X			$409.26	
D7440	EXCISION OF MALIGNANT TUMOR-LESION DIAMETER UP TO 1.25 CM					$1,271.61	
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP T0 1.25 CM					$223.96	
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM					$259.59	
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR- LESION DIAMETER UP TO 1.25 CM					$223.96	
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR- LESION DIAMETER GREATER THAN 1.25 CM					$259.59	
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHODS, BY REPORT					$354.44	
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE					$378.00	

Service Category: Emergent Adult Dental Services

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					$378.00	
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE					$378.00	
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)					$378.00	
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON- VITAL BONE					$152.70	
D7610	MAXILLA-OPEN REDUCTION (TEETH IMMOBILIZED IF PRESENT)					$966.90	
D7620	MAXILLA-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					$1,014.33	
D7630	MANDIBLE-OPEN REDUCTION (TEETH IMMOBILIZED IF PRESENT)					$1,757.90	
D7640	MANDIBLE-CLOSED REDUCTION (TEETH IMMOBILIZED IF PRESENT)					$1,243.75	
D7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					$776.67	
D7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					$1,027.44	
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					$780.18	
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH					$917.12	
D7680	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					$2,556.32	
D7710	MAXILLA-OPEN REDUCTION					$1,140.41	
D7720	MAXILLA-CLOSED REDUCTION					$1,014.33	
D7730	MANDIBLE-OPEN REDUCTION					$1,757.90	
D7740	MANDIBLE-CLOSED REDUCTION					$1,243.75	
D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION					$1,630.43	
D7760	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION					$591.50	
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH					$1,064.24	
D7771	ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH					$591.56	
D7780	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES					$2,556.32	
D7820	CLOSED REDUCTION OF DISLOCATION					$133.04	
D7830	MANIPULATION UNDER ANESTHESIA					$532.85	
D7865	ARTHROPLASTY					$2,603.84	
D7899	UNSPECIFIED TMD THERAPY, BY REPORT		X			By Report	
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM					$154.32	
D7911	COMPLICATED SUTURE-UP TO 5 CM		X			$535.22	
D7912	COMPLICATED SUTURE-GREATER THAN 5 CM		X			$663.32	
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES	X				By Report	
D7980	SIALOLITHOTOMY					$517.11	
D7995	SYNTHETIC GRAFT-MANDIBLE OR FACIAL BONES, BY REPORT	X				$800.00	
D7998	INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE	X				By Report	
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT		X			By Report	
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES		X			$110.45	
D9222	GENERAL ANESTHESIA - FIRST 15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9223	GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9230	INHALATION OF NITROUS OXIDE/ANXIOLYSIS, ANALGESIA		X			$57.01	Attach written medical justification to claim.
D9239	INTRAVENOUS SEDATION - FIRST15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9243	INTRAVENOUS SEDATION - EACH SUBSEQUENT 15 MINUTES	See Billing Note				$170.76	Must be prior authorized for consideration. Submit chart notes from completed procedure with claim.
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION		X			$188.33	Attach written medical justification to claim.
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN		X			$85.51	
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL		X			$98.85	
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION					$81.95	
D9930	TREATMENT OF COMPLICATIONS (POSTSURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT		X			$123.28	

Service Category: Emergent Adult Dental Services

Code	Description	Service Authorization Required	Written Medical Justification Required	Tooth Code Required	Surface Code Required	Maximum Allowable	Billing Notes
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT		X			By Report	