KY Medicaid Dental Fee Schedule 2024 Revised 2.28.2024

Notes:

- **Red indicates new codes or changes for the most current revision date.**
- **The appearance of a code and rate on this fee schedule is not a guarantee of payment.**
- **It is the responsibility of the provider to check member eligibility.**
- **Please refer to the Oral Pathology section of this fee schedule for procedures and pricing**
- **Please refer to the Orthodontic section of this fee schedule for procedures and pricing**
- **Please refer to the Oral Surgeon section of this fee schedule for procedures and pricing**

Any limit or prior authorization requirement established in 907 KAR 1:026 or 907 KAR 1:626 shall apply to this fee schedule

Procedure Description/Practitioner
(1) A comprehensive orthodontic procedure shall be paid for ages 0 - 21 as follows:
(a) Except as established in (b) the rate for an orthodontic consultation including examination and treatment plan development shall be $112
*(b) The orthodontic consultation rate shall not exceed $56 if
1. provider determines comprehensive ortho procedures are not needed;
2. provider is unable or unwilling to provide needed ortho procedure(s); or
3. Prior authorization is not approved by the department or is not requested by provider
Reimbursement for a service for an early phase of moderately severe or severe disabling malocclusion shall be:
$1367 if provided by an orthodontist
$1234 if provided by a general dentist
Reimbursement for a service for moderately severe disabling malocclusion shall be:
$1825 if provided by an orthodontist
$1659 if provided by a general dentist
A service for a severe disabling malocclusion:
$3000 if provided by an orthodontist
$2674 if provided by a general dentist
DMS Payment Process orthodontics
Reimbursement for comprehensive orthodontic treatment shall consist of two (2) payments
1. The first payment shall be two-thirds of the prior authorized payment amount
2. The second payment shall:
a. Be one-third of the prior authorized payment amount; and
b. Not be billed or paid until six (6) monthly visits are completed following the banding date
3. The two (2) payments shall include all services associated with the comprehensive orthodontic treatment

Certified Commnity Health Workers (CHW)

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D9994		DENTAL CASE MANAGEMENT - PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY	$22.53	$22.53	Effective July 1, 2023 - Units equals per patient per time frame

Dentist Procedures and Fee Schedule

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D0120		PERIODIC ORAL EVALUATION ON AN ESTABLISHED PATIENT	$27.50	$27.50	1 per 6 months - additional allowed based on medical necessity by prior authorization
D0140		LIMITED ORAL EVALUATION	$46.65	$46.65	Coverage for a limited oral evaluation shall: 1. Be limited to a trauma related injury or acute infection; and 2. Be limited to one (1) per date of service, per recipient, per provider. (b) A limited oral evaluation shall not be covered in conjunction with another service except for: 1. A periapical X-ray; 2. A bitewing X-ray; 3. A panoramic X-ray; 4. Resin, anterior; 5. A simple or surgical extraction; 6. Surgical removal of a residual tooth root; 7. Removal of a foreign body; 8. Suture of a recent small wound; 9. Intravenous sedation; or 10. Incision and drainage of infection.
D0145		ORAL EVALUATION FOR A PATIENT UNDER THREE (3) YEARS OF AGE AND COUNSELING WITH THE PRIMARY CAREGIVER.	$32.50	n/c	Under 3 years of age - 1 per 6 months
D0150		COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	$32.50	$32.50	1 per 12 months per member, per provider
D0160		DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	$98.35	$98.35	
D0170		RE-EVALUATION-LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)	$48.32	$48.32	
D0171		RE-EVALUATION - POST-OPERATIVE OFFICE VISIT	$58.64	$58.64	
D0180		COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	$71.91	$71.91	
D0190		SCREENING OF A PATIENT	n/c	n/c	
D0191		ASSESSMENT OF A PATIENT	$25.00	n/c	
D0210		INTRAORAL COMPLETE SERIES OF RADIOGRAPHIC IMAGES	$79.63	$61.25	Limited to one (1) per twenty-four (24) month period, per recipient, per provider. Periapical and bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider
D0220		INTRAORAL-PERIPICAL-FIRST RADIOGRAPHIC IMAGE	$13.00	$10.00	Limited to fourteen (14) per twelve (12) month period, per recipient, per provider. Periapical Xrays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider
D0230		INTRAORAL-PERIAPICAL-EACH ADDITIONAL RADIOGRAPHIC IMAGE	$9.75	$7.50	Limited to fourteen (14) per twelve (12) month period, per recipient, per provider. Periapical Xrays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D0270		DENTAL BITEWING-SINGLE RADIOGRAPHIC IMAGE	$11.38	$8.75	Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider
D0272		DENTAL BITEWING-TWO RADIOGRAPHIC IMAGES	$22.75	$17.50	Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider
D0273		DENTAL BITEWINGS - THREE RADIOGRAPHIC IMAGES	$39.00	$30.00	Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider
D0274		DENTAL BITEWING-FOUR RADIOGRAPHIC IMAGES	$37.38	$28.75	Limited to four (4) per twelve (12) month period, per recipient, per provider. Bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider
D0277		VERTICAL BITEWINGS 7 TO 8 RADIOGRAPHIC IMAGES	$38.00	$29.23	I set per 12 months per member, per provider
D0330		PANORAMIC RADIOGRAPHIC IMAGE	$73.70	$56.69	A panoramic film shall: a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and b. Require prior authorization in accordance with Section 15(1), (2), and (3) of this administrative regulation for a recipient under the age of six (6) years;
D0340		2D CEPHALOMETRIC RADIOGRAPHIC IMAGE-ACQUISTION, MEASUREMENT AND ANALYSIS	$76.38	$58.75	1 per 24 months per member, per provider
D1110		DENTAL PROPHYLAXIS - ADULT	n/c	$60.13	1 per 6 months per member. Additional allowed based on medical necessity by prior authorization. New rate of $60.13 effective 11/1/2023
D1120		DENTAL PROPHYLAXIS - CHILD	$60.13	n/c	1 per 6 months per member. Additional allowed based on medical necessity by prior authorization
D1206		TOPICAL APPLICATION FLUORIDE VARNISH	$18.75	n/c	Limited to 2 per 12 months per member. Additional allowed based on medical necessity by prior authorization
D1208		TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	$18.75	n/c	Limited to 2 per 12 months per member. Additional allowed based on medical necessity by prior authorization
D1321		COUNSELING FOR THE CONTROL AND PREVENTION OF ADVERSE ORAL, BEHAVIORAL, AND SYSTEMIC HEALTH EFFECTS ASSOCIATED WITH HIGH-RISK SUBSTANCE USE	$15.00	$15.00	1 per 6 months per member, per provider
D1351	Tooth numbers: 3, 14, 19, 30 2, 15, 18, 31	DENTAL SEALANT - PER TOOTH	$24.38	n/c	Limited to six (6) and twelve (12) year molars: 6 year molars are #3, #14, #19 and #30 12 year molars are #2, #15, #18, #31 once every four (4) years with a lifetime limit of three (3) sealants per tooth Limited to under 21 only

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D1352	Tooth numbers 1-32	PREVENTATIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT-PERMANENT TOOTH	$48.13	$48.13	
D1353	Tooth numbers 1-32	SEALANT REPAIR-PER TOOTH	$16.00	n/c	
D1354	Tooth numbers 1-32, A-T	APPLICATION OF CARIES ARRESTING MEDICAMENT - PER TOOTH	$12.00	$12.00	Up to two times per tooth within six months
D1510	quadrant 10, 20, 30, 40	SPACE MAINTAINER-FIXED UNILATERAL-PER QUADRANT	$169.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1516	quadrant 10, 20, 30, 40	SPACE MAINTAINER-FIXED BILATERAL, MAXILLARY	$250.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1517	quadrant 10, 20, 30, 40	SPACE MAINTAINER-FIXED BILATERAL, MANDIBULAR	$250.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1520	quadrant 10, 20, 30, 40	SPACE MAINTAINER-REMOVABLE-UNILATERAL-PER QUADRANT	$167.50	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1526	quadrant 10, 20, 30, 40	SPACE MAINTAINER-REMOVABLE-BILATERAL, MAXILLARY	$190.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1527	quadrant 10, 20, 30, 40	SPACE MAINTAINER-REMOVABLE-BILATERAL, MANDIBULAR	$190.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1551	quadrant 10, 20, 30, 40	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MAXILLARY	$19.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1552	quadrant 10, 20, 30, 40	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MANDIBULAR	$19.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1553	quadrant 10, 20, 30, 40	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER-PER QUADRANT	$19.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1556	quadrant 10, 20, 30, 40	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER-PER QUADRANT	$25.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1557	quadrant 10, 20, 30, 40	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXILLARY	$25.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.
D1558	quadrant 10, 20, 30, 40	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIBULAR	$25.00	n/c	Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination of the two (2) shall not exceed two (2) per twelve (12) month period, per member.

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D2140	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	$49.40	$38.00	
D2150	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	$65.00	$50.00	
D2160	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	$76.70	$59.00	
D2161	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	$93.60	$72.00	
D2330	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-ONE SURFACE, ANTERIOR	$57.20	$44.00	
D2331	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-TWO SURFACES, ANTERIOR	$71.50	$55.00	
D2332	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-THREE SURFACES, ANTERIOR	$85.80	$66.00	
D2335	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-FOUR/MORE SURFACES OR INVOLVING INCISAL ANGLE, ANTERIOR	$101.40	$78.00	
D2390	Tooth numbers 1-32, A-T	RESIN-BASED COMPOSITE CROWN, ANTERIOR	$101.40	n/c	1 per 5 years
D2391	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	$57.20	$44.00	
D2392	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR	$71.50	$55.00	

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D2393	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	$85.80	$66.00	
D2394	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR	$101.40	$78.00	
D2710	Tooth numbers 1-32, A-T	CROWN RESIN-BASED COMPOSITE INDIRECT	$150.00	$150.00	1 per 5 years per tooth
D2721	Tooth numbers 1-32, A-T	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	$200.00	$200.00	1 per 5 years per tooth
D2740	Tooth numbers 1-32, A-T	CROWN-PORCELAIN/CERAMIC	$529.95	$529.95	1 per 5 years per tooth
D2750	Tooth numbers 1-32, A-T	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	$599.25	$599.25	1 per 5 years per tooth
D2751	Tooth numbers 1-32, A-T	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$457.33	$457.33	1 per 5 years per tooth
D2752	Tooth numbers 1-32, A-T	CROWN-PORCELAIN FUSED TO NOBLE METAL	$528.29	$528.29	1 per 5 years per tooth
D2790	Tooth numbers 1-32, A-T	CROWN-FULL CAST HIGH NOBLE METAL	$492.81	$492.81	1 per 5 years per tooth
D2791	Tooth numbers 1-32, A-T	CROWN-FULL CAST PREDOMINANTLY BASE METAL	$315.41	$315.41	1 per 5 years per tooth
D2792	Tooth numbers 1-32, A-T	CROWN-FULL CAST NOBLE METAL	$386.37	$386.37	1 per 5 years per tooth
D2799	Tooth numbers 1-32, A-T	INTERIM CROWN-FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	$150.00	$150.00	1 per 5 years per tooth
D2920	Tooth numbers 1-32, A-T	RE-CEMENT OR RE-BOND CROWN	$27.50	$27.50	1 per 5 years per tooth
D2928	Tooth numbers 1-32, A-T	PREFABRICATED PORCELAIN/CERAMIC CROWN-PERMANENT TOOTH	$153.00	$153.00	1 per 5 years per tooth
D2930	Tooth numbers 1-32, A-T	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	$119.60	$119.60	1 per 5 years per tooth
D2931	Tooth numbers 1-32, A-T	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	$133.90	$133.90	1 per 5 years per tooth
D2932	Tooth numbers 1-32, A-T	PREFABRICATED RESIN CROWN	$113.10	$113.10	1 per 5 years per tooth
D2934	Tooth numbers 1-32, A-T Surface code M, O, D, B, L, F, I	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	$119.60	n/c	Once per tooth per 12 month per member. Ages 0 - 11

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D2940	Tooth numbers 1-32, A-T	PROTECTIVE RESTORATION	$60.78	60.78	
D2950	1-32, A-T	CORE BUILD-UP, INCLUDING ANY PINS WHEN REQUIRED	$100.00	$100.00	change to adult and child 1/1/2023 no prior auth required.
D2951	Tooth numbers 1 2 3 14 15 16 17 18 19 30 31 32	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION	$13.00	$13.00	Permanent molars only (1 2 3 14 15 16 17 18 19 30 31 32). 1 per tooth per date of service and 2 per lifetime per member
D2954	Tooth numbers 1-32, A-T	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	$130.00	$130.00	change to adult and child 1/1/2023 no prior auth required.
D2990	Tooth numbers 1-32, A-T	RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS	$97.48	$97.48	2 per tooth per lifetime
D3110	Tooth numbers 1-32, A-T	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)	$17.00	n/c	
D3120		PULP CAP-INDIRECT (EXCLUDING FINAL RESTORATION)	$190.83	190.83	Prior Authorization required
D3220	Tooth numbers 1-32, A-T	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	$67.60	n/c	1 per tooth per lifetime
D3310	Tooth numbers 6-11; 22-27	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	$274.30	$274.30	1 per tooth per lifetime
D3320	Tooth numbers 4-5; 12-13; 28-29; 20-21	ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)	$344.50	$344.50	1 per tooth per lifetime
D3330	Tooth numbers 1 2 3 14 15 16 17 18 19 30 31 32	ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)	$481.00	$481.00	1 per tooth per lifetime
D3346	Tooth numbers 6-11; 22-27	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	$606.58	$606.58	1 per tooth per lifetime
D3347	Tooth numbers 4-5; 12-13; 28-29; 20-21	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-PREMOLAR	$696.20	$696.20	1 per tooth per lifetime
D3348	Tooth numbers 1 2 3 14 15 16 17 18 19 30 31 32	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	$724.31	$724.31	1 per tooth per lifetime
D3351	Tooth numbers 1-32, A-T	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)	$149.60	$149.60	1 per tooth per lifetime
D3352	Tooth numbers 1-32, A-T	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.)	$104.50	$104.50	1 per tooth per lifetime

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D3353	Tooth numbers 1-32, A-T	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	$246.40	$246.40	1 per tooth per lifetime
D3410	Tooth numbers 6-11; 22-27	APICOECTOMY-ANTERIOR	$201.50	$155.00	1 per tooth per lifetime
D3421	Tooth numbers 4-5; 12-13; 28-29; 20-21	APICOECTOMY-PREMOLAR FIRST ROOT	$201.50	$155.00	1 per tooth per lifetime
D3425	Tooth numbers 1 2 3 14 15 16 17 18 19 30 31 32	APICOECTOMY-MOLAR FIRST ROOT	$201.50	$155.00	1 per tooth per lifetime
D3426	Tooth numbers 1-32, A-T	APICOECTOMY-PER TOOTH EACH ADDITIONAL ROOT	$197.00	$197.00	1 per tooth per lifetime
D3430	Tooth numbers 1-32, A-T	RETROGRADE FILLING-PER ROOT	$134.10	$134.10	1 per tooth per lifetime
D4210	Quadrant 10, 20, 30, 40	GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	$336.70	$259.00	Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period
D4211	Quadrant 10, 20, 30, 40	GINGIVECTOMY OR GINGIVOPLASTY-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	$104.00	$104.00	Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period
D4212	Quadrant 10, 20, 30, 40	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH	$220.16	$220.16	Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period
D4240	Quadrant 10, 20, 30, 40	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	$526.26	$526.26	Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period
D4241	Quadrant 10, 20, 30, 40	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	$341.20	$341.20	Requires prior authorization - must have chronic conditions or take medications that cause hypertrophic gingival growth. One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period
D4346		SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION	$204.00	$204.00	Prior Authorization required
D4249	Tooth numbers 1-32, A-T Quadrant 10, 20, 30, 40	CLINICAL CROWN LENGTHEN-HARD TISSUE	$483.71	$483.71	1 per tooth/quadrant per lifetime
D4263	Quadrant 10, 20, 30, 40	BONE REPLCE GRAFT-RETAINED NATURAL TOOTH-FIRST SITE IN QUADRANT	$414.97	$414.97	1 per site (quadrant) per lifetime
D4266	Quadrant 10, 20, 30, 40	GUIDED TISSUE REGENERATION, NATURAL TEETH-RESORBABLE BARRIER, PER SITE	$645.39	$645.39	1 per 36 months per quadrant

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D4267	Quadrant 10, 20, 30, 40	GUIDED TISSUE REGENERATION, NATURAL TEETH-NONRESORBABLE BARRIER, PER SITE	$692.29	$692.29	1 per 36 months per quadrant
D4270	Tooth numbers 1-32, A-T Quadrant 10, 20, 30, 40	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$554.25	$554.25	1 per area (Quadrant/tooth) per lifetime
D4273	Tooth numbers 1-32, A-T	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	$654.75	$654.75	1 per area (tooth) per lifetime
D4277	Tooth numbers 1-32, A-T	FREE SOFT TISSUE GRAFT PROCEDURE (INCUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	$363.17	$363.17	1 per area (tooth) per lifetime
D4322	Tooth numbers 1-32, A-T	SPLINT-INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$240.79	$240.79	
D4323	Tooth numbers 1-32, A-T	SPLINT-EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS	$212.46	$212.46	
D4341	Quadrant 10, 20, 30, 40	PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH, PER QUADRANT	$101.40	$78.00	Requires prior authorization- not to exceed 1 per quadrant, per twelve months, per recipient, per provider
D4342	Tooth numbers 1-32, A-T	PERIODONTAL SCALING AND ROOT PLANING-ONE TO THREE TEETH, PER QUADRANT	$36.42	$28.02	
D4355		FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIDONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	$68.50	$68.50	Adults and children
D4381	Tooth numbers 1-32, A-T	LOCALIZED DELIVERY ANTIMICROBIAL AGENTS VIA CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	$110.28	$110.28	Prior authorization required - only allowed after treatment of periodontal disease; received perio maintenance; or an isolated pocket depth of greater than 5mm – not to be used for generalized perio thearopy.
D4910		PERIODONTAL MAINTENANCE PROCEDURES	$96.88	$96.88	
D4920		UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST OR THEIR STAFF)	$94.05	$94.05	
D5110		DENTURES COMPLETE MAXILLARY	$656.11	$656.11	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5120		DENTURES COMPLETE MANDIBULAR	$611.73	$611.73	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5130		DENTURES IMMEDIATE MAXILLARY	$567.40	$567.40	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5140		DENTURES IMMEDIATE MANDIBULAR	$543.95	$543.95	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D5211		MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$624.64	$624.64	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5212		MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$595.80	$595.80	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5213		MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$545.30	$545.30	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5214		MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$571.75	$571.75	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5221		IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$585.18	$585.18	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5222		IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$487.67	$487.67	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5225		MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$793.00	$793.00	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5226		MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	$920.55	$920.55	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5282		REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY	$360.00	$360.00	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5283		REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR	$360.00	$360.00	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5284		REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE FLEXIBLE BASE (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), PER QUADRANT	$400.00	$400.00	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5286		REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE RESIN (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), PER QUADRANT	$400.00	$400.00	Every 5 years - more frequent for children under 21 if medically necessary due to growth - Prior Authorization Required for children if more than 1 needed in 5 year period
D5410		ADJUST COMPLETE DENTURE-MAXILLARY	$15.40	$15.40	1 per 12 months
D5411		ADJUST COMPLETE DENTURE-MANDIBULAR	$15.40	$15.40	1 per 12 months
D5421		ADJUST PARTIAL DENTURE-MAXILLARY	$15.40	$15.40	1 per 12 months
D5422		ADJUST PARTIAL DENTURE-MANDIBLUAR	$15.40	$15.40	1 per 12 months
D5511		REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	$50.60	$50.60	1 per 12 months

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D5512		REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	$50.60	$50.60	1 per 12 months
D5520	Tooth numbers 1-32, A-T	REPLACE MISSING/BROKEN TEETH-DENTURE-COMPLETE DENTURE (EACH TOOTH)	$31.00	$31.00	1 per 12 months
D5621		REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	$72.60	$72.60	not exceed three (3) repairs per twelve (12) month
D5622		REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	$72.60	$72.60	1 per 12 months
D5630		REPAIR OR REPLACE BROKEN RETENTIVE CLASPING MATERIALS - PER TOOTH	$64.90	$64.90	1 per 12 months
D5640	Tooth numbers 1-32, A-T	REPLACE BROKEN TEETH-PER TOOTH/DENTURE	$36.40	$36.40	1 per 12 months
D5731		RELINE LOWER COMPLETE MANDIBULAR DENTURE (DIRECT)	$88.00	$88.00	1 per 12 months
D5740		RELINE MAXILLARY PARTIAL DENTURE (DIRECT)	$88.00	$88.00	1 per 12 months
D5750		RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	$128.70	$128.70	1 per 12 months
D5751		RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	$128.70	$128.70	1 per 12 months
D5820		INTERIM PARTIAL DENTURE (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY	$319.80	$319.80	1 per 5 years
D5821		INTERIM PARTIAL DENTURE (INCLUDING, RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR	$336.70	$336.70	1 per 5 years
D5913		NASAL PROSTHESIS	$2,036.00	$2,036.00	
D5914		AURICULAR PROSTHESIS	$1,881.00	$1,881.00	
D5919		FACIAL PROSTHESIS	$3,408.00	$3,408.00	
D5931		OBTURATOR PROSTHESIS , SURGICAL	$1,121.90	$1,121.90	
D5932		OBTURATOR PROSTHESIS, DEFINITIVE	$1,992.00	$1,992.00	
D5934		MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE	$1,660.00	$1,660.00	
D5952		SPEECH AID PROSTHESIS, PEDIATRIC	$2,036.00	n/c	
D5953		SPEECH AID PROSTHESIS, ADULT	n/c	$2,036.00	
D5954		PALATAL AUGMENTATION PROSTHESIS	$1,550.00	$1,550.00	
D5955		PALATAL LIFT PROSTHESIS, DEFINITIVE	$1,836.00	$1,836.00	
D5988		ORAL SURGICAL SPLINT	$896.00	$896.00	
D5999		UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	manually priced	manually priced	Requires prepayment review to determine if requirements in 907 KAR 1:026 have been met prior to authorizing payment
D6010	Tooth numbers 1-32, A-T	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	$2,001.07	$2,001.07	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6056	Tooth numbers 1-32, A-T	PREFABRICATED ABUTMENT-INCLUDES MODIFICATION AND PLACEMENT	$600.29	$600.29	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D6057	Tooth numbers 1-32, A-T	CUSTOM FABRICATED ABUTMENT-INCLUDES PLACEMENT	$729.95	$729.95	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6058	Tooth numbers 1-32, A-T	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,076.11	$1,076.11	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6059	Tooth numbers 1-32, A-T	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$1,324.39	$1,324.39	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6065	Tooth numbers 1-32, A-T	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$1,400.93	$1,400.93	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6066	Tooth numbers 1-32, A-T	IMPLANT SUPPORTED CROWN-PORCELAIN FUSED TO HIGH NOBLE ALLOYS	$1,057.00	$1,057.00	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6190	Tooth numbers 1-32, A-T	SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE	$411.87	$411.87	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6103	Tooth numbers 1-32, A-T	BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT-DOES NOT INCLUDE FLAP ENTRY AND CLOSURE	$263.86	$263.86	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6081	Tooth numbers 1-32, A-T	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	$238.35	$238.35	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6104	Tooth numbers 1-32, A-T	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	$288.65	$288.65	prior authorization required. An implant must be based on last resort (dentures cause damage or not wearable due to medical reasons) once per tooth per lifetime
D6211	Tooth numbers 1-32, A-T	PONTIC-CAST PREDOMINANTLY BASE METAL	$341.00	$341.00	1 per 5 years
D6240	Tooth numbers 1-32, A-T	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	$483.00	$483.00	1 per 5 years
D6241	Tooth numbers 1-32, A-T	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$341.00	$341.00	1 per 5 years
D6242	Tooth numbers 1-32, A-T	PONTIC-PORCELAIN FUSED TO NOBLE METAL	$412.00	$412.00	1 per 5 years
D6750	Tooth numbers 1-32, A-T	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$553.96	$553.96	1 per 5 years
D6751	Tooth numbers 1-32, A-T	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$341.00	$341.00	1 per 5 years
D6752	Tooth numbers 1-32, A-T	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	$412.00	$412.00	1 per 5 years

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D6930	Tooth numbers 1-32, A-T	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	$77.00	$77.00	
D7111	Tooth numbers 1-32, A-T	EXTRACTION, CORONAL REMNANTS-PRIMARY TOOTH	$72.25	$72.25	1 per lifetime per tooth per member regardless of provider
D7140	Tooth numbers 1-32, A-T	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL	$82.50	$82.50	1 per lifetime per tooth per member regardless of provider
D7210	Tooth numbers 1-32, A-T	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$148.50	$148.50	1 per lifetime per tooth per member regardless of provider
D7220	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE)	$127.40	$98.00	1 per lifetime per tooth per member regardless of provider
D7230	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	$179.40	$138.00	1 per lifetime per tooth per member regardless of provider
D7240	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	$215.80	$166.00	1 per lifetime per tooth per member regardless of provider
D7241	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY WITH UNUSUAL SURGICAL COMPLICATIONS	$222.30	$171.00	1 per lifetime per tooth per member regardless of provider
D7250	Tooth numbers 1-32, A-T	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$142.00	$142.00	1 per lifetime per tooth per member regardless of provider
D7251	Tooth numbers 1-32, A-T	CORONECTOMY-INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY	$466.37	$466.37	1 per lifetime per tooth
D7260		ORAL ANTRAL FISTULA CLOSURE	$135.20	$104.00	
D7270	Tooth numbers 1-32, A-T	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	$200.00	$200.00	
D7280	Tooth numbers 1-32, A-T	EXPOSURE OF AN UNERUPTED TOOTH	$434.25	$434.25	Per 907 KAR 1:026 Coverage of surgical access of an unerupted tooth shall: (a) Be limited to exposure of the tooth for orthodontic treatment; and (b) Require prepayment review.
D7310	Quadrant 10, 20, 30, 40	ALVEOPLASTY IN CONJUNCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	$189.49	$189.49	Be limited to one (1) per quadrant, per lifetime, per recipient; Require a minimum of a four (4) tooth area within the same quadrant.
D7320	Quadrant 10, 20, 30, 40	ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	$189.49	$189.49	
D7410		EXCISION OF BENIGN LESION LESS THAN 1.25 CM	$87.10	$67.00	
D7411		EXCISION OF BENIGN TISSUE LESION GREATER THAN 1.25 CM	$87.10	$67.00	
D7471	Arch number 01, 02	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	$101.40	$78.00	
D7472		REMOVAL OF TORUS PALATINUS	$302.47	$302.47	1 per lifetime
D7473		REMOVAL OF TORUS MANDIBULARIS	$209.28	$209.28	1 per quadrant per lifetime

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D7510		INCISION & DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	$67.60	$52.00	
D7520		INCISION & DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	$80.60	$62.00	
D7530		REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE	$201.50	$201.50	
D7880		OCCLUSAL ORTHOTIC APPLIANCE	$424.00	$424.00	Requires prior authorization - 1 per lifetime
D7910		SUTURE OF RECENT SMALL WOUND UP TO 5CM	$67.60	$52.00	
D7961		BUCCAL/LABIAL FRENECTOMY	$167.60	$167.60	2 per date of service @ $167.60 each
D7962		LINGUAL FRENECTOMY	$167.60	$167.60	2 per date of service @ $167.60 each
D8210		REMOVABLE APPLIANCE THERAPY	$362.00	n/c	Requires prior authorization
D8220		FIXED APPLIANCE THERAPY	$259.00	n/c	Requires prior authorization
D8698		RE-CEMENT OR RE-BOND FIXED RETAINER-MAXILLARY	$75.00	n/c	
D8699		RE-CEMENT OR RE-BOND FIXED RETAINER MANDIBULAR	$75.00	n/c	
D8701		REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT-MAXILLARY	$25.00	n/c	1 per 4 years
D8702		REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT-MANDIBULAR	$25.00	n/c	1 per 4 years
D8703		REPLACEMENT OF LOST/BROKEN RETAINER-MAXILLARY	$93.64	n/c	1 per 4 years
D8704		REPLACEMENT OF LOST/BROKEN RETAINER MANDIBULAR	$93.64	n/c	1 per 4 years
D9110		PALLIATIVE TREATMENT OF DENTAL PAIN-PER VISIT	$61.95	$61.95	1 per date of service
D9222		DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTE INCREMENT	$75.00	$75.00	Effective date 01/01/2018 Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service
D9223		DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	$75.00	$75.00	Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service
D9230		INHALATION OF NITROUS OXIDE/AXIOLYSIS ANALGESIA	$39.00	$39.00	
D9239		INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA-FIRST 15 MINUTES	$138.78	138.78	Requires Dentists to have anesthesia certification on file in their office for auditing purposes
D9243		INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA-EACH SUBSEQUENT 15 MINUTE INCREMENT	$138.78	$138.78	Requires Dentists to have anesthesia certification on file in their office for auditing purposes
D9248		NON-INTRAVENOUS CONCIOUS SEDATION	$39.00	$39.00	Requires Dentists to have anesthesia certification on file in their office for auditing purposes
D9410		HOUSE/EXTENDED CARE FACILITIES CALL	$67.60	$52.00	
D9420		HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	$67.60	$52.00	
D9944		OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH	$150.00	$150.00	1 per 2 years
D9945		OCCLUSAL GUARD-SOFT APPLIANCE, FULL ARCH	$250.00	$250.00	1 per 2 years
D9946		OCCLUSAL GUARD-HARD APPLIANCE, PARTIAL ARCH	$100.00	$100.00	1 per 2 years
D9986		MISSED APPOINTMENT	n/c	n/c	
D9987		CANCELLED APPOINTMENT	n/c	n/c	

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
Oral Pathology Procedures and Fee Schedule					
D0472		ACCESSION OF TISSUE GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$43.71	$43.71	Covered for adults effective 1/1/2023
D0473		ACCESSION OF TISSUE GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$61.81	$61.81	Covered for adults effective 1/1/2023
D0474		ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$152.38	$152.38	Covered for adults effective 1/1/2023
D0486		DECALCIFICATION PROCEDURE (ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)	$35.44	$35.44	Covered for adults effective 1/1/2023
D0475		SPECIAL STAINS FOR MICROORGANISMS (ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)	$12.57	$12.57	Covered for adults effective 1/1/2023
D0476		SPECIAL STAINS NOT FOR MICROORGANISMS (ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)	$71.03	$71.03	Covered for adults effective 1/1/2023
D0477		IMMUNOHISTOCHEMICAL STAINS (ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)	$71.03	$71.03	Covered for adults effective 1/1/2023
D0478		TISSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$71.97	$71.97	Covered for adults effective 1/1/2023
D0479		DIRECT IMMUNOFLUORESCENCE *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$55.43	$55.43	Covered for adults effective 1/1/2023
D0482		CONSULTATION ON SLIDES PREPARED ELSEWHERE *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$52.09	$52.09	Covered for adults effective 1/1/2023
D0484		CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL SUPPLIED BY REFERRING SOURCE *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$52.09	$52.09	Covered for adults effective 1/1/2023
D0485		LABORATORY ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMLE MICROSCOPIC EXAMINATION AND PREPARATION AND TRANSMISSION OF WRITTEN REPORT *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$88.10	$88.10	Covered for adults effective 1/1/2023
D0486		LABORATORY ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMLE MICROSCOPIC EXAMINATION AND PREPARATION AND TRANSMISSION OF WRITTEN REPORT *(ONLY COVERED IF PROVIDED BY AN ORAL PATHOLOGIST)*	$35.44	$35.44	Covered for adults effective 1/1/2023

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
Orthodontic Procedures and Fee Schedule					
D8660		**PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT**	**$112.00 ***	**n/c**	**Requires prior authorization - and only if individual ultimately not approved for orthodontic treatment. Age 0 - 21 only**
D8670		**PERIODIC ORTHODONTIC TREATMENT VISIT**	*****	**n/c**	**Requires prior authorization. Age 0 - 21 only**
D8999		**UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT**	*****	**n/c**	**Requires prior authorization. Age 0 - 21 only**
Oral Surgeon Procedures and Fee Schedule					
D0330		PANORAMIC RADIOGRAPHIC IMAGE	$73.70	$73.70	A panoramic film shall: a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and b. Require prior authorization in accordance with Section 15(1), (2), and (3) of this administrative regulation for a recipient under the age of six (6) years;
D3410	Tooth numbers 1-32, A-T	APICOECTOMY-ANTERIOR	$363.00	$363.00	1 per tooth per lifetime
D3421	Tooth numbers 1-32, A-T	APICOECTOMY-PREMOLAR FIRST ROOT	$294.50	$294.50	1 per tooth per lifetime
D3425	Tooth numbers 1-32, A-T	APICOECTOMY-MOLAR FIRST ROOT	$294.50	$294.50	1 per tooth per lifetime
D3426	Tooth numbers 1-32, A-T	APICOECTOMY-PER TOOTH EACH ADDITIONAL ROOT	$197.00	$197.00	1 per tooth per lifetime
D7111	Tooth numbers 1-32, A-T	EXTRACTION, CORONAL REMNANTS-PRIMARY TOOTH	$72.25	$72.25	1 per lifetime per tooth
D7140	Tooth numbers 1-32, A-T	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL	$82.50	$82.50	1 per lifetime per tooth
D7210	Tooth numbers 1-32, A-T	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	$148.50	$148.50	1 per lifetime per tooth
D7220	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE)	$187.00	$187.00	1 per lifetime per tooth
D7230	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	$236.50	$236.50	1 per lifetime per tooth
D7240	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	$295.00	$295.00	1 per lifetime per tooth
D7241	Tooth numbers 1-32, A-T	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY WITH UNUSUAL SURGICAL COMPLICATIONS	$333.00	$333.00	1 per lifetime per tooth
D7250	Tooth numbers 1-32, A-T	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	$142.00	$142.00	1 per lifetime per tooth
D7260		ORAL ANTRAL FISTULA CLOSURE	$370.50	$370.50	
D7270	Tooth numbers 1-32, A-T	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	$200.00	$200.00	

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D7280	Tooth numbers 1-32, A-T	EXPOSURE OF AN UNERUPTED TOOTH	$434.25	$434.25	Per 907 KAR 1:026 Coverage of surgical access of an unerupted tooth shall: (a) Be limited to exposure of the tooth for orthodontic treatment; and (b) Require prepayment review.
D7285		INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	$210.50	$210.50	
D7286		INCISIONAL BIOPSY OF ORAL TISSUE - SOFT	$172.59	$172.59	
D7310	Quadrant 10, 20, 30, 40	ALVEOPLASTY IN CONJUNCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	$189.49	$189.49	
D7320	Quadrant 10, 20, 30, 40	ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	$189.49	$189.49	
D7410		EXCISION OF BENIGN LESION LESS THAN 1.25 CM	$102.50	$102.50	
D7411		EXCISION OF BENIGN TISSUE LESION GREATER THAN 1.25 CM	$431.00	$431.00	
D7471	Arch number 01, 02	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	$204.00	$204.00	
D7472		REMOVAL OF TORUS PALATINUS	$403.50	$403.50	1 per lifetime
D7473		REMOVAL OF TORUS MANDIBULARIS	$409.00	$409.00	1 per lifetime
D7510		INCISION & DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	$112.24	$112.24	
D7520		INCISION & DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	$144.00	$144.00	
D7530		REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE	$201.50	$201.50	
D7550		PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE	$231.00	$231.00	
D7880		OCCLUSAL ORTHOTIC APPLIANCE	$424.00	$424.00	Requires prior authorization - 1 per lifetime
D7910		suture of recent small wounds up to 5 cm	$121.47	$121.47	
D7961		BUCCAL/LABIAL FRENECTOMY -FIRST PROCEDURE	$167.60	$167.60	
D7961		BUCCAL/LABIAL FRENECTOMY-SECOND PROCEDURE	$167.60	$167.60	
D7962		LINGUAL FRENECTOMY	$167.60	$167.60	2 per date of service @ $167.60 each
D9110		PALLIATIVE TREATMENT OF DENTAL PAIN-PER VISIT	$61.95	$61.95	1 per date of ervice
D9222		DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTE INCREMENT	$138.75	$138.75	Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service
D9223		DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	$138.75	$138.75	Allow any combination of CDT D9222 and D9223 for a maximum of four times per date of service
D9230		INHALATION OF NITROUS OXIDE/AXIOLYSIS ANALGESIA	$39.00	$39.00	
D9239		INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA-FIRST 15 MINUTES	$138.78	$138.78	Must have anesthesia certification on file in their office for auditing purposes

Proc Code	Requirements	Procedure Description	UNDER AGE 21 Rate	21 and OVER Rate	Notes
D9243		INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA-EACH SUBSEQUENT 15 MINUTE INCREMENT	$138.78	$138.78	Must have anesthesia certification on file in their office for auditing purposes
D9248		NON-INTRAVENOUS CONCIOUS SEDATION	$39.00	$39.00	Must have anesthesia certification on file in their office for auditing purposes
D9410		HOUSE/EXTENDED CARE FACILITIES CALL	$67.60	$67.60	
D9420		HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	$67.60	$67.60	
D9610		THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION	$42.28	$42.28	