**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**Department of Health Care Finance**

**Office of the Director**

**DHCF Transmittal #09-29**

TO: District of Columbia Medicaid Providers of Fee-For-Service Dental Services

FROM: Julie Hudman, Ph.D.
Director

DATE: December 11, 2009

SUBJECT: **Transfer of Function: Prior Authorization Review Process for Fee-For-Service (FFS) Dental Services**

---

Effective January 11, 2010, the Department of Health Care Finance (DHCF) will transfer the performance of the prior authorization process for FFS dental services to the Delmarva Foundation for Medical Care, Inc., DHCF's Quality Improvement Organization (QIO). The Delmarva (or QIO) Prior Authorization Unit will conduct prior authorization reviews in accord with the attached Policies and Procedures to ensure that requested services are consistent with current DC Medicaid coverage policy. DHCF's Office of Utilization Management will provide monitoring and oversight of the process.

As a reminder, failure to obtain pre-authorization **will not** result in the Medicaid beneficiary being financially responsible for payment of any non-covered service or care. Treating providers incur financial liability when services are provided without prior authorization when needed.

Delmarva Foundation is hosting an orientation on the dental prior authorization process on **December 28, 2009, from 1-3 pm** at 825 North Capitol Street, NE, Washington, DC 20002. The orientation will be held in Room 3119. Providers who attend will meet the points of contact for the dental prior authorization process and gain clarity on the revised steps of the process, if needed. Please confirm your attendance at this orientation by contacting Peggy Chisolm of the Delmarva Foundation at 202-496-6572.

**If you have any questions regarding your submitted prior authorization request(s) on or after January 11, 2009, please contact Delmarva's Dental Coordinator at 202-496-6549. Questions may also be directed to Dr. Jennifer B. Campbell at Jennifer.campbell@dc.gov or Ms. Dorcas Jones, RN at dorcas.jones1@dc.gov .**

DHCF is committed to providing comprehensive, quality health care services. Thank you for assisting us in meeting the needs of the District of Columbia Medicaid beneficiaries.

Attachments:

(1) Contact List
(2) Policy and Procedures
(3) Dental Fee Schedule

# CONTACT LIST FOR ADDITIONAL INFORMATION AND GUIDANCE ON MEDICAID SERVICE AUTHORIZATIONS

**QIO PRIOR AUTHORIZATION UNIT**
**DELMARVA FOUNDATION FOR MEDICAL CARE, INC.**

| | |
|---|---|
| Contact | Dental Coordinator |
| Hours of Operation | Monday – Friday<br>8:00a.m. – 5:00 p.m. |
| Phone | 202-496-6549 |
| Fax | 1-866-906-3293 (*For the submission of all prior authorization requests, via the 719A Form)* |
| Address | Delmarva Foundation, Inc.<br>2175 K Street, NW, Suite 250<br>Washington, DC 20037-1845 |

Please contact Robin Revels-Fitzhugh, the Delmarva Director of DC Medicaid Programs, if inquiries are not adequately answered by the QIO Prior Authorization Unit or Dental Coordinator

Phone 202-496-6564
Email fitzhughr@dfmc.org

**AFFILIATED COMPUTER SERVICES (ACS)**
**PROVIDER RELATIONS DEPARTMENT**

**For training and guidance on completing the 719A Form and for billing questions**

| | |
|---|---|
| Hours of Operation | Monday – Friday<br>8:00a.m. – 5:00 p.m. |
| Phone | 202-906-8319 (inside DC Metro area)<br>1-866-752-9233 (outside DC Metro area) |

# DEPARTMENT OF HEALTH CARE FINANCE

| OFFICE OF UTILIZATION MANAGEMENT | POLICY AND PROCEDURES |
|---|---|

**SUBJECT**: Prior Authorization Process for Fee-for-Service Dental Services for District of Columbia Medicaid

| **Effective Date:** January 11, 2009 | **Last Date Revised** |
|---|---|

The District of Columbia Medicaid program covers dental services when they are prescribed by an actively-enrolled dentist or oral surgeon, and when they are covered in accordance with the DC Medicaid State Plan.

Prior authorization is required for certain dental services as indicated in the District of Columbia Medicaid Fee Schedule (available on-line at https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/1350).

DHCF contracts with a federally recognized Quality Improvement Organization (QIO) to verify the appropriateness of requested dental procedures. DHCF's QIO will execute the prior authorization process in advance of a dental provider supplying the service for a Medicaid beneficiary in accordance with the DC Medicaid State Plan.

Prior authorization for dental services will be requested via a 719A Form.

**Purpose:**
To help ensure that beneficiaries receive appropriate dental services and to make efficient use of recipient and DHCF resources.

**Procedures**:

***I. Provider Requests Approval:***

1. Every requesting dental provider is to complete fields 1-6, 8, 9, 13, 14, 15 A, and 15 B on the Form 719A. The requesting provider also completes fields 7, 10 and 11 of the 719A Form with appropriate American Dental Association (ADA) procedure code(s), quantity of units requested and estimated charges. Every provider is to insert its business name and DC Medicaid ID number in the upper right corner of the 719A Form.
2. The requesting provider faxes the 719A Form and the appropriate supporting documentation to the QIO Prior Authorization Unit.

## *II. QIO Prior Authorization Process and Timelines*

### *A. Written Prior Authorization Process*

1. **Beneficiary and provider eligibility verification.** The QIO Prior Authorization Unit verifies the:
    a. Beneficiary's Medicaid ID number (located in the MMIS Recipient Subsystem screen), including the beneficiary's active coverage period, as follows:
        - Date of services requested shall not exceed beneficiary's eligibility start and end dates;
        - If the beneficiary's eligibility end date is '999999', he or she is eligible for services indefinitely; and
        - Presence of appropriate Medicaid program eligibility codes.
    b. Provider's status as a Medicaid provider (located in the MMIS Provider Subsystem screen):
        i. Provider not enrolled in DC Medicaid program→ Not eligible to provide services;
        ii. Active Status (01)→Eligible to provide services; or
        iii. Inactive Status→ Not eligible to provide services.
    c. Requesting provider's signature and date on the 719A form.

2. **Administrative review.** The QIO Prior Authorization Unit will review the information contained on the 719A Form using the following criteria set forth below. Prior authorization requests will be denied if any of the standards below are not met:
    a. If the date of service precedes the date of request for prior authorization, the request for prior authorization will be denied.
    b. If the date of service precedes the date of the requesting provider's signature, the request for prior authorization will be denied.
    c. The date of the requesting provider's signature will be the first day of the six (6) month authorization time period, if authorization is granted.

3. **Clinical review.** The QIO Prior Authorization Unit will review the 719A Form and supporting documentation for the:
    a. Presence of appropriate diagnosis and procedure codes; and
    b. Written justification and supporting documentation.

    The QIO will use medical criteria approved by DHCF to approve or deny payment.

    If the 719A Form contains an imprecise procedure code, such as a miscellaneous "99" code, the QIO Prior Authorization Unit will request that the provider resubmit the 719A Form using more precise procedure code(s), if available. If a miscellaneous code continues to be used, the QIO will forward the prior authorization request to DHCF's Utilization Management unit who will discuss the miscellaneous coding with the dental

provider.

The QIO will utilize DC Medicaid claims history and any other accessible historical information on a beneficiary in its prior authorization request review and determination.

4. **Data submission to MMIS.** If the request for the dental service is approved, the QIO Prior Authorization Unit remotely and electronically enters approval data into the MMIS Prior Authorization Subsystem. Upon the entry of all necessary data, a prior authorization number is generated. The data entry process includes populating the following fields:
   a. approval status-→A (indicating approval)
   b. provider Letter Status-→Y (mail letter to provider)
   c. beneficiary's Medicaid ID number
   d. provider number
   e. approver ID Number
   f. dates of service range
   g. diagnosis code
   h. procedure code (see list)
   i. unit number (for each procedure code requested)
   j. tooth number(s)
   k. estimated charge; and
   l. prior authorization number is auto-assigned.

5. **Pricing.** If the request for dental service is approved, the QIO will adhere to the guidance below when entering data into the 'Approved Amount' field of the MMIS Prior Authorization Subsystem.
   a) If the estimated charge of the dental service is equal to or greater than the dollar amount included in the current DHCF fee schedule, the QIO will enter '00'.
   b) If the estimated charge of the dental service is less than the dollar amount included in the current DHCF fee schedule, the QIO will enter the estimated charge.

6. **Transmittal of notification to provider and beneficiary.** The QIO faxes to the provider written notification of the approval or denial determination related to the prior authorization request. Additionally, the beneficiary is mailed written notification of the approval or denial determination related to the prior authorization request.
   a. Notification of an approval will include a prior authorization number, approved dates of service range, approved HCPCS or CPT codes, approved reimbursement total, and approved units.
   b. Notification to a requesting provider of a denial will include the reason(s) for denial, denied service range, HCPCS codes, and units. Providers can not appeal decision
   c. Notification to the beneficiary of a denial will include instructions on how to appeal a denial.

***B. Timelines***

a. The QIO Prior Authorization Unit will return all incomplete 719A Forms to the provider via fax immediately. No action will be taken by the QIO until a complete 719A Form is received.

b. Within five (5) business days, the QIO Prior Authorization Unit will conduct a review of each complete 719A Form, and fax to the requesting provider a decision if the requested dental service is included within DHCF's fee schedule. If the service requires manual pricing, the request will be sent to DHCF within five (5) business days.

c. Authorization of a dental service is valid for a period of sixty (60) days.

d. Within three (3) business days of the determination, the QIO Prior Authorization Unit will fax written notification of denied services to the provider. Written notification including information on appeal rights will be mailed to the recipient.

**C. *Tracking***

The QIO will maintain a tracking log of all prior authorization requests and transactions, that includes the following:

1. beneficiary name and Medicaid ID number;
2. provider name and Medicaid ID number;
3. date of service;
4. the type of service requested;
5. date of determination; and
6. prior authorization number issued.

The tracking log will be updated monthly on the QIO's web portal, under 'Out Patient'.

***III. Provider Submits Claim to ACS***

All claims submitted to DHCF for payment must include the prior authorization number provided by the QIO (which is obtained and generated from the MMIS system) in Box 23 of the CMS 1500 as part of their claim submission.

***IV. Appeals Process (if needed):***

A. If the prior authorization is not granted, the beneficiary or the beneficiary's representative may fax a request for reconsideration to the QIO Prior Authorization Unit.

B. The QIO Prior Authorization Unit will:

1. Arrange for a reviewer, other than the reviewer who performed the initial review, to perform the reconsideration review; and
2. Issue the reconsideration decision within twenty-one (21) calendar days of the reconsideration request. Providers and beneficiaries will receive written notice within five (5) business days of the reconsideration

determination.

a. If approved, the QIO Prior Authorization Unit electronically and remotely enters the approval data into the Prior Authorization Subsystem of the MMIS.
b. If not approved, the QIO will provide written notification of denied services to the provider and the beneficiary. The notification to the beneficiary will include information on appeal rights.

C. If the beneficiary or the beneficiary's representative chooses to appeal the QIO's reconsideration decision, the beneficiary or the beneficiary's representative may request a fair hearing from the DC Office of Administrative Hearings. The beneficiary or the beneficiary's representative has ninety (90) days from the postmark date of the QIO reconsideration letter to ask for a fair hearing. Information on how to request a fair hearing will be included in the QIO denial letter.

***V. Customer Service***

A. The QIO Prior Authorization Unit will respond to provider and beneficiary inquiries regarding prior authorization requests.
B. If the QIO Prior Authorization Unit is unable to adequately answer provider and/or beneficiary inquiries, the QIO Director of DC Medicaid Programs will respond.
C. If neither the QIO Prior Authorization Unit, nor the QIO Director of DC Medicaid Programs, is able to adequately answer provider or beneficiary inquiries, the DHCF Contracting Officer's Technical Representative will respond.

| | |
|---|---|
| Responsible Approving Manager: Ann Page | Date: 12/11/09 |
| DHCF Approval: Joel McCarthy | Date: 12/11/09 |

Department of Health Care Finance
2009 Fee Schedule
As of 09/01/2009

| Type of Procedure | Procedure Code | Description | Fee | P/A Ind | Type of Procedure | Procedure Code | Description | Fee | P/A Ind |
|---|---|---|---|---|---|---|---|---|---|
| DENTAL | D0120 | PERIODIC DENTAL SCREENING | $35.00 | N | DENTAL | D0140 | LIMIT ORAL EVAL PROBLM FO | $50.00 | N |
| DENTAL | D0150 | COMPREHENSVE ORAL EVALUAT | $77.50 | N | DENTAL | D0160 | EXTENSV ORAL EVAL PROB FO | $67.50 | Y |
| DENTAL | D0170 | RE-EVAL,EST PT,PROBLEM FO | $45.00 | N | DENTAL | D0180 | COMP PERIODONTAL EVALUATI | $77.50 | N |
| DENTAL | D0210 | INTRAOR COMPLETE FILM SER | $91.00 | N | DENTAL | D0220 | PERIAPICAL X RAY; FIRST F | $20.00 | N |
| DENTAL | D0230 | PERIAPICAL X RAY; EACH AD | $16.00 | N | DENTAL | D0240 | OCCLUSAL X RAY | $29.00 | N |
| DENTAL | D0270 | BITEWING,SINGLE,FIRST FIL | $21.00 | N | DENTAL | D0272 | DENTAL BITEWINGS TWO FILM | $40.00 | N |
| DENTAL | D0274 | DENTAL BITEWINGS FOUR FIL | $48.00 | N | DENTAL | D0290 | P.A. FILM | $314.00 | N |
| DENTAL | D0330 | PANOREX | $80.00 | N | DENTAL | D0340 | CEPHALOMETRIC FILM | $100.00 | N |
| DENTAL | D0350 | ORAL/FACIAL IMAGES | $59.00 | N | DENTAL | D0460 | PULP TEST | $39.00 | N |
| DENTAL | D0470 | STUDY MODELS | $75.00 | Y | DENTAL | D1110 | PREVENTIVE PROHYLAXIS (AD | $77.50 | N |
| DENTAL | D1120 | PREVENTIVE PHROPHYLAXIS ( | $47.00 | N | DENTAL | D1203 | TOPICAL APP FLUORIDE CHIL | $29.00 | N |
| DENTAL | D1204 | TOPICAL APP FLUORIDE ADUL | $26.00 | N | DENTAL | D1351 | DENTAL SEALANTS | $38.00 | N |
| DENTAL | D1510 | FIXED, BAND TYPE | $230.00 | N | DENTAL | D1515 | FIXED BILAT SPACE MAINTAI | $325.00 | N |
| DENTAL | D2140 | AMALGAM ONE SURFACE, PRIM | $90.00 | N | DENTAL | D2150 | AMALGAM TWO SURFACES, PRI | $115.00 | N |
| DENTAL | D2160 | AMALGAM THREE SURFACES, P | $139.00 | N | DENTAL | D2161 | AMALGAM FOUR SURFACES,PER | $165.00 | N |
| DENTAL | D2330 | RESIN-ONE SURFACE, ANTERI | $106.00 | N | DENTAL | D2331 | RESIN TWO SURFACES-ANTERI | $135.00 | N |
| DENTAL | D2332 | RESIN-THREE SURFACES, ANT | $165.00 | N | DENTAL | D2335 | RESIN-FOUR OR MORE SURFAC | $200.00 | N |
| DENTAL | D2391 | RESIN-BASED COMPOSITE - O | $120.00 | N | DENTAL | D2392 | RESIN-BASED COMPOSITE - T | $160.00 | N |
| DENTAL | D2393 | RESIN-BASED COMPOSITE - T | $200.00 | N | DENTAL | D2394 | RESIN-BASED COMPOSITE - F | $236.00 | N |
| DENTAL | D2710 | ACRYLIC JACKET | $400.00 | N | DENTAL | D2722 | CROWN RESIN W/ NOBLE META | $915.00 | N |
| DENTAL | D2750 | PORCELAIN WITH METAL | $500.00 | N | DENTAL | D2790 | GOLD(FULL CAST) | $600.00 | N |
| DENTAL | D2799 | PROVISIONAL CROWN | $375.00 | N | DENTAL | D2920 | RECEMENT CROWN | $75.00 | N |
| DENTAL | D2930 | PREFAB STNLSS STEEL CRWN | $300.00 | N | DENTAL | D2931 | PREFAB STNLSS STEEL CROWN | $102.40 | N |
| DENTAL | D2934 | PREFAB STEEL CROWN PRIMAR | $300.00 | N | DENTAL | D2970 | TEMP CROWN (FRACTURED TOO | $314.00 | Y |
| DENTAL | D3110 | PULP CAP DIRECT EXCLUDING | $55.00 | N | DENTAL | D3220 | PULPOTOMY | $134.00 | N |
| DENTAL | D3310 | END THXPY, ANTERIOR TOOTH | $498.00 | N | DENTAL | D3320 | END THXPY, BICUSPID TOOTH | $591.00 | N |
| DENTAL | D3330 | END THXPY, MOLAR | $728.00 | N | DENTAL | D3347 | RETREATMENT OF PREVIOUS R | $657.00 | Y |
| DENTAL | D3351 | APEXIFICATION/RECALC INIT | $248.00 | Y | DENTAL | D3426 | ROOT SURGERY EA ADD ROOT | $270.00 | N |
| DENTAL | D3430 | RETROGRADE AMALGAM | $180.00 | N | DENTAL | D4210 | GINGIVECTOMY/PLASTY PER Q | $446.00 | Y |
| DENTAL | D4211 | GINGIVECTOMY/PLASTY PER T | $160.00 | Y | DENTAL | D4240 | GINGIVAL FLAP PROC W/ PLA | $125.00 | N |
| DENTAL | D4241 | GNGVL FLAP W ROOTPLAN 1-3 | $125.00 | N | DENTAL | D4249 | CROWN LENGTHEN HARD TISSU | $496.00 | N |
| DENTAL | D4263 | BONE REPLCE GRAFT FIRST S | $452.00 | Y | DENTAL | D4264 | BONE REPLCE GRAFT EACH AD | $339.00 | Y |
| DENTAL | D4341 | PERIODONTAL SCALING AND R | $181.00 | Y | DENTAL | D4355 | FULL MOUTH DEBRIDEMENT | $130.00 | N |
| DENTAL | D5110 | COMPLETE UPPER DENTURE | $1,120.00 | N | DENTAL | D5120 | COMPLETE LOWER DENTURE | $1,125.00 | N |
| DENTAL | D5211 | DENTURES MAXILL PART RESI | $838.00 | N | DENTAL | D5212 | DENTURES MAND PART RESIN | $1,200.00 | Y |
| DENTAL | D5213 | DENTURES MAXILL PART META | $1,200.00 | N | DENTAL | D5214 | DENTURES MANDIBL PART MET | $1,200.00 | N |
| DENTAL | D5610 | REPAIR BROKEN COMPLETE DE | $145.00 | N | DENTAL | D5640 | REPLACE FX BROKEN & TOOTH | $125.00 | N |
| DENTAL | D5982 | SURGICAL STENT | $380.00 | Y | DENTAL | D7140 | EXTRACTION ERUPTED TOOTH/ | $110.00 | N |
| DENTAL | D7210 | SURGICAL REMOVAL OF ERUPT | $192.00 | N | DENTAL | D7220 | REMOVAL OF IMPACTED TOOTH | $210.00 | N |
| DENTAL | D7230 | REMOVAL OF IMPACTED TOOTH | $285.00 | N | DENTAL | D7240 | REMOVAL OF IMPACTED TOOTH | $350.00 | N |
| DENTAL | D7241 | IMPACT TOOTH REM BONY W/C | $0.00 | N | DENTAL | D7250 | ROOT TIPS | $350.00 | N |

Department of Health Care Finance
2009 Fee Schedule
As of 09/01/2009

| Type of Procedure | Procedure Code | Description | Fee | P/A Ind | Type of Procedure | Procedure Code | Description | Fee | P/A Ind |
|---|---|---|---|---|---|---|---|---|---|
| DENTAL | D7270 | REPLANTATION OF TOOTH WIT | $375.00 | N | DENTAL | D7280 | SURGICAL EXPOSURE OF BONE | $341.00 | N |
| DENTAL | D7282 | MOBILIZE ERUPTED/MALPOS T | $352.00 | N | DENTAL | D7285 | BIOPSY OF ORAL TISSUE HAR | $359.00 | Y |
| DENTAL | D7286 | BIOPSY OF ORAL TISSUE S | $201.00 | N | DENTAL | D7310 | ALVEOLOPLASTY IN CONJUNCT | $200.00 | Y |
| DENTAL | D7320 | ALVEOLOPLASTY NOT IN CONJ | $295.00 | Y | DENTAL | D7340 | STOMATOPLASTY PER ARCH UN | $635.00 | Y |
| DENTAL | D7350 | STOMATOPLASTY,COMPLICATED | $2,050.00 | Y | DENTAL | D7410 | EXCISION OF BENIGN LESION | $0.00 | N |
| DENTAL | D7412 | EXCISION BENIGN LESION CO | $0.00 | N | DENTAL | D7413 | EXCISION MALIG LESION<=1. | $0.00 | N |
| DENTAL | D7414 | EXCISION MALIG LESION>1.2 | $0.00 | N | DENTAL | D7415 | EXCISION MALIG LES COMPLI | $0.00 | N |
| DENTAL | D7451 | REMOVAL ODONTOGENIC CYST, | $593.00 | Y | DENTAL | D7460 | EXCISION OF RANULA | $330.00 | Y |
| DENTAL | D7471 | REM EXOSTOSIS ANY SITE | $556.00 | Y | DENTAL | D7472 | REMOVAL OF TORUS PALATINU | $685.00 | Y |
| DENTAL | D7473 | REMOVE TORUS MANDIBULARIS | $645.00 | Y | DENTAL | D7510 | INCISION DRAINAGE ABSCESS | $155.00 | N |
| DENTAL | D7520 | INCISION & DRAINAGE EXTRA | $250.00 | N | DENTAL | D7530 | CURETTAGE OF FISTULOUS TR | $247.00 | N |
| DENTAL | D7610 | FX,OPEN REDUCTION MAXILLA | $0.00 | N | DENTAL | D7620 | FX,CLOSED REDUCTION MAXIL | $0.00 | N |
| DENTAL | D7630 | FX,OPEN REDUCTION MANDIBL | $0.00 | N | DENTAL | D7640 | FX,CLOSED REDUCTION MANDI | $0.00 | N |
| DENTAL | D7650 | FX, OPEN REDUCTION ZYGOMA | $0.00 | N | DENTAL | D7820 | CLOSED REDUCTION OF DISLO | $112.50 | N |
| DENTAL | D7840 | CONDYLECTOMY | $675.00 | Y | DENTAL | D7850 | MENISCECTOMY | $630.00 | Y |
| DENTAL | D7860 | ARTHROTOMY | $450.00 | Y | DENTAL | D7870 | ARTHROCENTESIS | $36.00 | N |
| DENTAL | D7910 | SUTURES | $190.00 | N | DENTAL | D7911 | DEBRIDEMENT & REPAIR OF S | $307.00 | N |
| DENTAL | D7940 | OSTEOPLASTY(PROGNATHISM,M | $2,000.00 | Y | DENTAL | D7950 | OSTEOPERIOSTEAL,CARTILAGE | $2,890.00 | Y |
| DENTAL | D7953 | BONE REPLACEMENT GRAFT | $581.25 | Y | DENTAL | D7960 | FRENULECTOMY | $313.00 | Y |
| DENTAL | D7972 | SURG REDCT FIBROUS TUBERO | $675.00 | Y | DENTAL | D8050 | INTERCEP DENTAL TX PRIMAR | $0.00 | N |
| DENTAL | D8080 | COMPRE DENTAL TX ADOLESCE | $5,000.00 | Y | DENTAL | D8090 | COMPRE DENTAL TX ADULT | $5,000.00 | Y |
| DENTAL | D8210 | REMOVABLE APPLIANCE THERA | $552.00 | N | DENTAL | D8220 | FIXED OR CEMENTED | $677.00 | N |
| DENTAL | D8680 | ORTHODONTIC RETENTION | $557.00 | N | DENTAL | D8999 | ORTHODONTIC PROCEDURE | $1,200.00 | Y |
| DENTAL | D9110 | PALLIATIVE TREATMENT OF D | $85.00 | N | DENTAL | D9220 | GENERAL ANESTHESIA | $260.00 | Y |
| DENTAL | D9221 | GENERAL ANESTHESIA EA AD | $112.00 | Y | DENTAL | D9230 | ANALGESIA | $46.00 | N |
| DENTAL | D9310 | CONSULTATION | $112.50 | N | DENTAL | D9420 | HOSPITAL VISIT | $33.00 | Y |
| DENTAL | D9430 | CONSULTANT EVALUATION EXA | $67.50 | N | DENTAL | D9940 | OCCLUSAL GUARDS, BY REPOR | $476.00 | Y |
| DENTAL | D9951 | LIMITED OCCLUSAL ADJUSTME | $116.00 | N | DENTAL | D9952 | COMPLETE OCCLUSAL ADJUSTM | $474.00 | N |
| DENTAL | J0120 | TETRACYCLINE 250MG/VIAL | $12.67 | N | DENTAL | J0170 | INJECTION,ADRENALIN,EPINE | $1.37 | N |
| DENTAL | J0280 | INJECTION,AMINOPHYLLIN, U | $1.61 | N | DENTAL | J0290 | INJECTION,AMPICILLIN, UP | $3.52 | N |
| DENTAL | J0460 | ATROPINE SULFATE 1MG/ML | $2.66 | N | DENTAL | J0780 | INJECTION, COMPAZINE, UP | $5.41 | N |
| DENTAL | J1020 | METHYLPREDNISOLONE ACETAT | $2.40 | N | DENTAL | J1030 | METHYLPREDNISOLONE ACETAT | $6.35 | N |
| DENTAL | J1040 | METHYLPREDNISOLONE ACETAT | $10.90 | N | DENTAL | J1170 | HYDROMORHONE 1MG | $1.49 | N |
| DENTAL | J1710 | HYDROCORTISONE 50MG/ML | $3.47 | N | DENTAL | J1720 | HYDROCORTISONE 100MG | $3.77 | N |
| DENTAL | J1940 | FUROSEMIDE 20MG/2ML | $1.60 | N | DENTAL | J2270 | MORPHINE SULFATE 10MG/ML | $1.10 | N |
| DENTAL | J2510 | PENICILLIN PROCAINE 600,0 | $1.05 | N | DENTAL | J2540 | INJECTION PFIZERPEN, UP T | $1.05 | N |
| DENTAL | J2550 | PROMETHAZINE HCL 50MG/ML | $1.08 | N | DENTAL | J2560 | PHENOBARBITAL 120MG | $1.94 | N |
| DENTAL | J2920 | INJECTION,SOLU MEDROL , U | $2.50 | N | DENTAL | J3070 | PENTOZOCAINE 30MG/ML | $1.98 | N |
| DENTAL | J3100 | OXYTETRACYCLINE 50MG/ML | $1.25 | N | DENTAL | J3360 | DIAZEPAM 5MG/ML | $2.10 | N |
| DENTAL | J3430 | INJECTION, VITAMIN K, UP | $3.77 | N | DENTAL | J3480 | INJECTION,XYLOCAINE | $1.05 | N |
| DENTAL | J7060 | 5% DEXTROSE/WATER (500ML | $7.21 | N | DENTAL | 10060 | INCISION AND DRAINAGE ABS | $12.00 | N |

Department of Health Care Finance
2009 Fee Schedule
As of 09/01/2009

| Type of Procedure | Procedure Code | Description | Fee | P/A Ind | Type of Procedure | Procedure Code | Description | Fee | P/A Ind |
|---|---|---|---|---|---|---|---|---|---|
| DENTAL | 10061 | INCISION AND DRAINAGE ABS | $18.00 | N | DENTAL | 10080 | I & D PILONIDAL CYST SIMP | $12.00 | N |
| DENTAL | 10081 | I & D PILONIDAL CYST, COM | $18.00 | N | DENTAL | 10120 | INCISION/REMOVAL FOREIGN | $24.00 | N |
| DENTAL | 10121 | INCISION/REMOVAL FOREIGN | $42.00 | N | DENTAL | 10140 | INCISION AND DRAINAGE HEM | $12.00 | N |
| DENTAL | 10160 | PUNCTURE ASPIR./ABSCESS,H | $12.00 | N | DENTAL | 11200 | EXCISION SKIN TAGS,ANY AR | $54.00 | N |
| DENTAL | 11440 | EXCISION/OTHER BENIGN LES | $45.00 | N | DENTAL | 11441 | EXCISION BENIGN LESION 0. | $51.00 | N |
| DENTAL | 11442 | EXCISION BEGNIGN LESION 1 | $63.00 | N | DENTAL | 11443 | EXCISION BENIGN LESION 2. | $99.00 | N |
| DENTAL | 11444 | EXCISION BENIGN LESION 3. | $99.00 | N | DENTAL | 11446 | EXCISION BENIGN LESION OV | $99.00 | N |
| DENTAL | 12011 | SIMPLE REP./SUPERF.WOUNDS | $18.00 | N | DENTAL | 12013 | SIMPLE REPAIR WOUNDS/2.6 | $30.00 | N |
| DENTAL | 12014 | SIMPLE REPAIR WOUNDS 5.1C | $30.00 | N | DENTAL | 12015 | SIMPLE REPAIR WOUND 7.6 1 | $30.00 | N |
| DENTAL | 12016 | SIMPLE REPAIR WOUND 12.6 | $30.00 | N | DENTAL | 12017 | SIMPLE REPAIR WOUND 20.1 | $30.00 | N |
| DENTAL | 12018 | SIMPLE WOUND REPAIR OVER | $30.00 | N | DENTAL | 12020 | RX. SUPERF. WOUND DEHISCE | $30.00 | N |
| DENTAL | 12021 | RX. SUPERF. WOUND DEHISCE | $45.00 | N | DENTAL | 12051 | LAYER CLOSURE OF WOUNDS 2 | $18.00 | N |
| DENTAL | 12052 | LAYER CLOSURE WOUNDS 2.6 | $30.00 | N | DENTAL | 12053 | LAYER CLOSURE WOUND 5.1CM | $30.00 | N |
| DENTAL | 12054 | LAYER CLOSURE WOUND 7.6 C | $30.00 | N | DENTAL | 12055 | LAYER CLOSURE WOUND 12.6 | $30.00 | N |
| DENTAL | 12056 | LAYER CLOSURE WOUND 20.1 | $30.00 | N | DENTAL | 12057 | LAYER CLOSURE WOUND OVER | $30.00 | N |
| DENTAL | 13131 | COMPLEX REPAIR 1.1 2.5 CM | $120.00 | N | DENTAL | 13132 | COMPLEX WOUND REPAIR 2.6 | $150.00 | N |
| DENTAL | 13150 | COMPLEX WOUND REPAIR 1.0 | $120.00 | N | DENTAL | 13151 | COMPLEX REPAIR 1.1CM 2.5 | $120.00 | N |
| DENTAL | 13152 | COMPLEX WOUND REPAIR 2.6 | $150.00 | N | DENTAL | 13160 | SEC. CLOSURE/SUR.WOUND/DE | $200.00 | N |
| DENTAL | 15120 | SPLIT GRAFT/MOUTH/100 SQ. | $135.00 | N | DENTAL | 15121 | SPLIT GRAFT/ MOUTH /EACH | $67.00 | N |
| DENTAL | 20005 | INCISION OF SOFT TISSUE A | $66.00 | N | DENTAL | 20670 | REMOVAL OF IMPLANT;SUPERF | $90.00 | N |
| DENTAL | 20680 | REMOVAL OF IMPLANT DEEP | $180.00 | N | DENTAL | 20999 | UNLISTED PROCEDURE MUSCUL | $200.00 | N |
| DENTAL | 21010 | ARTHROTOMY TMJ UNILATERAL | $300.00 | N | DENTAL | 21030 | EXCISE BENIGN TUMOR OF FA | $187.50 | N |
| DENTAL | 21034 | EXCISE MALIGNANCY OF FACI | $251.00 | N | DENTAL | 21040 | EXCISE BENIGN CYST;MANDIB | $187.50 | N |
| DENTAL | 21044 | EXCISE MALIGNANT TUMOR; M | $187.50 | N | DENTAL | 21045 | RADICAL RESECTION OF MAND | $480.00 | N |
| DENTAL | 21050 | TEMPRORMANDIBULAR ARTHREC | $300.00 | N | DENTAL | 21060 | TEMPOROMANDIBULAR MENISCE | $420.00 | N |
| DENTAL | 21070 | CORONOIDECTOMY; UNILATERA | $187.50 | N | DENTAL | 21100 | MAXILLOFACIAL FIXATION | $42.00 | N |
| DENTAL | 21110 | INTERDENTAL FIXATION | $60.00 | N | DENTAL | 21206 | OSTEOPLASTY; MAXILLA, SEG | $375.00 | N |
| DENTAL | 21208 | OSTEOPLASTY WITH AUTOGRAF | $800.00 | N | DENTAL | 21210 | BONE GRAFT; NASAL, MAXILL | $750.00 | N |
| DENTAL | 21215 | BONE GRAFT, MANDIBLE | $600.00 | N | DENTAL | 21230 | RIB CARTILAGE GRAFT, AUTO | $600.00 | N |
| DENTAL | 21235 | EAR CARTILAGE GRAFT; AUTO | $480.00 | N | DENTAL | 21240 | TEMPOROMANDIBULAR ARTHROP | $480.00 | N |
| DENTAL | 21244 | RECONSTRUCTION OF MANDIBL | $1,000.00 | N | DENTAL | 21245 | RECONSTRUCTION MANDIBULAR | $1,000.00 | N |
| DENTAL | 21248 | RECONSTRUCTION MAXILLARY/ | $480.00 | N | DENTAL | 21260 | ORBITAL REVISION; EXTRACR | $600.00 | N |
| DENTAL | 21261 | REVISE ORBIT; INTRA/EXTRA | $900.00 | N | DENTAL | 21263 | REVISE ORBIT; ADVANCE FOR | $900.00 | N |
| DENTAL | 21267 | REPOSITION ORBIT; EXTRACR | $600.00 | N | DENTAL | 21268 | REPOSITION ORBIT; INTRA/E | $900.00 | N |
| DENTAL | 21270 | RECONSTRUCT ORBITOFACIAL | $900.00 | N | DENTAL | 21275 | ORBITOCRANIOFACIAL RECONS | $600.00 | N |
| DENTAL | 21310 | TREATMENT OF NASAL FRACTU | $135.00 | N | DENTAL | 21315 | DIGITAL MANIPULATION OF N | $54.00 | N |
| DENTAL | 21320 | MANIPULATE NASAL FX; INST | $150.00 | N | DENTAL | 21325 | OPEN TREATMENT NASAL FX | $225.00 | N |
| DENTAL | 21330 | TREATMENT NASAL FX, COMPL | $360.00 | N | DENTAL | 21335 | OPEN TREATMENT FX NASAL S | $360.00 | N |
| DENTAL | 21337 | TREAT OF CLOSED NASAL SEP | $112.50 | N | DENTAL | 21338 | OPEN TREAT NASOETH FX,W/O | $180.00 | N |
| DENTAL | 21339 | OPEN TREATMENT NASOETH FX | $210.00 | N | DENTAL | 21340 | TREAT NASOETHMOID COMPLEX | $510.00 | N |
| DENTAL | 21345 | TREAT NASOMAXILLARY COMPL | $300.00 | N | DENTAL | 21346 | OPEN TREATMENT NASOMAXILL | $300.00 | N |

Department of Health Care Finance
2009 Fee Schedule
As of 09/01/2009

| Type of Procedure | Procedure Code | Description | Fee | P/A Ind | Type of Procedure | Procedure Code | Description | Fee | P/A Ind |
|---|---|---|---|---|---|---|---|---|---|
| DENTAL | 21347 | OPEN TREATMENT NASOMAXILL | $420.00 | N | DENTAL | 21355 | MANIPULATE FX OF MALAR AR | $300.00 | N |
| DENTAL | 21360 | TREAT DEPRESSED MALAR FRA | $375.00 | N | DENTAL | 21365 | TREAT COMPLICATED FX MALA | $637.50 | N |
| DENTAL | 21385 | TREAT ORBITAL FX; TRANSAN | $450.00 | N | DENTAL | 21386 | TREAT ORBITAL FX; PERIORB | $360.00 | N |
| DENTAL | 21387 | TREAT ORBITAL FX; COMBINA | $525.00 | N | DENTAL | 21390 | TREAT ORBITAL FX WITH IMP | $562.50 | N |
| DENTAL | 21395 | TREAT ORBITAL FX WITH BON | $600.00 | N | DENTAL | 21400 | TREAT FX OF ORBIT W/O MAN | $120.00 | N |
| DENTAL | 21401 | TREAT FX OF ORBIT WITH MA | $180.00 | N | DENTAL | 21406 | TREAT OPEN FX OF ORBIT W/ | $300.00 | N |
| DENTAL | 21407 | TREAT OPEN FX OF ORBIT WI | $562.50 | N | DENTAL | 21421 | TREAT PALATAL/ ALVEOLAR R | $300.00 | N |
| DENTAL | 21422 | OPEN TREATMENT OF PALATE/ | $510.00 | N | DENTAL | 21431 | TREAT CRANIOFACIAL SEPARA | $180.00 | N |
| DENTAL | 21432 | OPEN RX CRANIOFACIAL SEPA | $510.00 | N | DENTAL | 21433 | COMPLICATED RX CRANIOFACI | $637.50 | N |
| DENTAL | 21435 | COMPLICATED TX CRANIOFACI | $637.50 | N | DENTAL | 21440 | MANIPULATE ALVEOLAR RIDGE | $180.00 | N |
| DENTAL | 21445 | OPEN TREATMENT ALVEOLAR R | $180.00 | N | DENTAL | 21450 | TREAT CLOSED OR OPEN MAND | $225.00 | N |
| DENTAL | 21451 | OPEN OR CLOSE TREAT MANDI | $210.00 | N | DENTAL | 21452 | OPEN TREAT MANDIBULAR FX; | $180.00 | N |
| DENTAL | 21453 | OPEN TREATMENT MANDIBULAR | $262.50 | N | DENTAL | 21454 | OPEN TREAT OF CLOSED/OPEN | $210.00 | N |
| DENTAL | 21461 | TREAT MANDIBULAR FX W/O/ | $275.00 | N | DENTAL | 21462 | TREAT MANDIBULAR FX WITH | $343.75 | N |
| DENTAL | 21480 | TX TEMPOROMANDIBULAR DISL | $60.00 | N | DENTAL | 21485 | TEMPOROMANDIBULAR MANIPUL | $60.00 | N |
| DENTAL | 21490 | TX TEMPOROMANDIBULAR DISL | $60.00 | N | DENTAL | 21495 | TREATMENT HYOIDFRACTURE | $180.00 | N |
| DENTAL | 21497 | INTERDENTAL WIRING | $214.55 | N | DENTAL | 21499 | UNLISTED PROCEDURE, HEAD | $300.00 | N |
| DENTAL | 23930 | INCISION AND DRAINAGE | $60.00 | N | DENTAL | 30580 | REPAIR FISTULA/OROMAXILLA | $174.00 | N |
| DENTAL | 30600 | REPAIR FISTULA; ORONASAL | $225.00 | N | DENTAL | 31000 | LAVAGE BY CANNULATION/MAX | $90.00 | N |
| DENTAL | 31002 | LAVAGE BY CANNULATION/SPH | $90.00 | N | DENTAL | 31020 | SINUSOTOMY, MAX.; INTRANA | $90.00 | N |
| DENTAL | 31030 | SINUSOTOMY,RAD./UNI./S RE | $252.00 | N | DENTAL | 31032 | SINUSOTOMY;RAD./UNI./C RE | $252.00 | N |
| DENTAL | 40490 | BIOPSY OF LIP | $45.00 | N | DENTAL | 40500 | VERMILLIONECTOMY C MUCOSA | $240.00 | N |
| DENTAL | 40510 | EXCISION LIP;TRANS.WEDGE | $90.00 | N | DENTAL | 40520 | EXC. LIP; V EXC.C PRI. DI | $90.00 | N |
| DENTAL | 40525 | EXC. LIP;FULL THICK./RECO | $350.00 | N | DENTAL | 40527 | EXC. LIP; CROSS LIP FLAP | $800.00 | N |
| DENTAL | 40530 | RESECTION OF LIP,+ONE FOU | $180.00 | N | DENTAL | 40650 | REPAIR LIP; FULL THICK. V | $180.00 | N |
| DENTAL | 40652 | REPAIR LIP UP TO HALF VER | $180.00 | N | DENTAL | 40654 | REPAIR LIP,OVER ONE HALF | $240.00 | N |
| DENTAL | 40700 | PLASTIC REPAIR OF CLEFT L | $420.00 | N | DENTAL | 40701 | PLASTIC REPAIR CLEFT LIP/ | $480.00 | N |
| DENTAL | 40702 | PLASTIC REPAIR CLEFT LIP/ | $360.00 | N | DENTAL | 40720 | PLASTIC REPAIR CLEFT LIP, | $300.00 | N |
| DENTAL | 40761 | REPAIR CLEFT LIP C CROSS | $480.00 | N | DENTAL | 40799 | UNLISTED PROCEDURE, LIPS | $480.00 | N |
| DENTAL | 40800 | DRAINAGE OF ABSCESS, CYST | $30.00 | N | DENTAL | 40801 | DRAINAGE OF ABSCESS,CYST, | $45.00 | N |
| DENTAL | 40804 | REMOVAL EMBEDDED FOREIGN | $30.00 | N | DENTAL | 40805 | REMOVAL EMBEDDED FOREIGN | $45.00 | N |
| DENTAL | 40806 | INCISION OF LABIAL FRENUM | $15.00 | N | DENTAL | 40808 | BIOPSY,VESTIBULE OF MOUTH | $18.00 | N |
| DENTAL | 40810 | EXCISE LESION/MUCOSA/SUBM | $36.00 | N | DENTAL | 40812 | EXCISION LESION/MUCOSA/SU | $48.00 | N |
| DENTAL | 40814 | EXCISE LESION MUCOSA/SUBM | $78.00 | N | DENTAL | 40816 | EXCISE LESION/MUCOSA/SUUB | $114.00 | N |
| DENTAL | 40818 | EXCISION MUCOSA AS DONOR | $60.00 | N | DENTAL | 40819 | EXCISION OF FRENUM,LABIAL | $66.00 | N |
| DENTAL | 40830 | CLOSRE OF LACERATION 2.5 | $48.00 | N | DENTAL | 40831 | CLOSURE OF LACERATION OVE | $82.00 | N |
| DENTAL | 40840 | VESTIBULOPLASTY; ANTERIOR | $400.00 | N | DENTAL | 40842 | VESTIBULOPLASTY,POSTERIOR | $400.00 | N |
| DENTAL | 40843 | VESTIBULOPLASTY;POSTERIOR | $400.00 | N | DENTAL | 40844 | VESTIBULOPLASTY;ENTIRE AR | $600.00 | N |
| DENTAL | 40845 | VESTIBULOPLASTY; COMPLEX | $576.00 | N | DENTAL | 40899 | UNLISTED PROC.VESTIBULE O | $400.00 | N |
| DENTAL | 41000 | INTRAORAL INCISION AND DR | $30.00 | N | DENTAL | 41005 | INTRAORAL INCISION AND DR | $37.50 | N |
| DENTAL | 41006 | INTRAORAL I&D,SUBLINGUAL, | $36.00 | N | DENTAL | 41007 | INTRAORAL INCISION AND DR | $36.00 | N |

Department of Health Care Finance
2009 Fee Schedule
As of 09/01/2009

| Type of Procedure | Procedure Code | Description | Fee | P/A Ind | Type of Procedure | Procedure Code | Description | Fee | P/A Ind |
|---|---|---|---|---|---|---|---|---|---|
| DENTAL | 41008 | INTRAORAL I&D SUBMANDIBUL | $30.00 | N | DENTAL | 41009 | INTRAORAL I&D ABSCESS/MAS | $37.00 | N |
| DENTAL | 41010 | INCISION OF LINGUAL FRENU | $15.00 | N | DENTAL | 41015 | EXTRAORAL I&D/FLOOR OF MO | $30.00 | N |
| DENTAL | 41016 | EXTRALORAL I&D/FLOOR/MOUT | $36.00 | N | DENTAL | 41017 | EXTRAORAL I&D/FLOOR/MOUTH | $36.00 | N |
| DENTAL | 41018 | EXTRAORAL I&D/FLOOR/MOUTH | $37.00 | N | DENTAL | 41100 | BIOPSY OF TONQUE;ANTERIOR | $22.50 | N |
| DENTAL | 41105 | BIOPSY OF TONGUUE;POSTERI | $27.00 | N | DENTAL | 41108 | BIOPSY OF FLOOR OF MOUUTH | $18.00 | N |
| DENTAL | 41110 | EXC. LESION OF TONGUE S C | $36.00 | N | DENTAL | 41112 | EXCISION OF TONGUE LESION | $54.00 | N |
| DENTAL | 41113 | EXCISION OF LESION/TONGUE | $54.00 | N | DENTAL | 41114 | EXC. LESION/TONGUE/LOCAL | $76.00 | N |
| DENTAL | 41115 | EXCISION OF LINGUAL FRENU | $45.00 | N | DENTAL | 41116 | EXCISION ,LESION,FLOOR OF | $45.00 | N |
| DENTAL | 41120 | GLOSSECTOMY,LESS THAN 1/2 | $216.00 | N | DENTAL | 41130 | HEMIGLOSSECTOMY | $216.00 | N |
| DENTAL | 41250 | REPAIRL LACERATION/MOUTH | $50.00 | N | DENTAL | 41252 | REPAIR LACERATION/POST. 1 | $75.00 | N |
| DENTAL | 41500 | FIXATION OF TONGUE,MECHAN | $75.00 | N | DENTAL | 41520 | FRENOPLASTY | $150.00 | N |
| DENTAL | 41599 | UNLISTED PROC./FLOOR OF M | $150.00 | N | DENTAL | 41800 | DRAINAGE OF ABSCESS,CYST, | $18.00 | N |
| DENTAL | 41805 | REMOVAL IMBEDDED FOREIGN | $18.00 | N | DENTAL | 41806 | REMOVAL EMBEDDED FOREIGN | $30.00 | N |
| DENTAL | 41820 | GINGIVECTOMY EXCISION GIN | $125.00 | N | DENTAL | 41821 | OPERCULECTOMY,EXC. PERICO | $200.00 | N |
| DENTAL | 41822 | EXCISION OF FIBROUS TUBER | $50.00 | N | DENTAL | 41823 | EXCISION OF OSSEOUS TUUBE | $106.00 | N |
| DENTAL | 41825 | EXCISION OF OTHER LESION | $50.00 | N | DENTAL | 41826 | EXCISION OF TUMOR/LESION/ | $72.00 | N |
| DENTAL | 41827 | EXCISION LESION/TUMOR COM | $108.00 | N | DENTAL | 41828 | EXC. HYPERPLASTIC ALVEOLA | $125.00 | N |
| DENTAL | 41830 | ALVEOLECTOMY,INC. CURETTA | $55.00 | N | DENTAL | 41850 | DESTRUCTION OF LESION DEN | $55.00 | N |
| DENTAL | 41870 | PERIODONTAL MUCOSAL GRAFT | $360.00 | N | DENTAL | 41872 | GINGIVOPLASTY | $360.00 | N |
| DENTAL | 41874 | ALVEOPLASTY | $360.00 | N | DENTAL | 41899 | UNLISTED PROCEDURE, DENTO | $360.00 | N |
| DENTAL | 42000 | DRAINAGE OF ABSCESS/PALAT | $37.50 | N | DENTAL | 42100 | BIOPSY OF PALATE, UVULA | $18.00 | N |
| DENTAL | 42104 | EXCISION/LESION/PALATE/UV | $37.50 | N | DENTAL | 42106 | EXCISION/LESION/PALATE/UV | $52.50 | N |
| DENTAL | 42120 | RESECTION OF PALATE/EXTEN | $360.00 | N | DENTAL | 42140 | UVULECTOMY, RESECTION OF | $360.00 | N |
| DENTAL | 42145 | PALATOPHARYNGOPLASTY | $750.00 | N | DENTAL | 42160 | DESTRUCT. LESION, PALATE/ | $36.00 | N |
| DENTAL | 42180 | REPAIR LACER. OF PALATE, | $45.00 | N | DENTAL | 42182 | REPAIR LACERATION OF PALA | $90.00 | N |
| DENTAL | 42200 | PALATOPLASTY FOR CLEFT PA | $420.00 | N | DENTAL | 42205 | PALATOPLASTY FOR CLEFT PA | $420.00 | N |
| DENTAL | 42210 | PALATOPLASTY WITH BONE GR | $650.00 | N | DENTAL | 42215 | PALATOPLASTY; MAJOR REVIS | $650.00 | N |
| DENTAL | 42220 | PALATOPLASTY,SECOND. LENG | $525.00 | N | DENTAL | 42225 | PALATOPLASTY ATTACH. PHAR | $525.00 | N |
| DENTAL | 42226 | LENGTHENING OF PALATE AND | $800.00 | N | DENTAL | 42227 | LENGTHENING OF PALATE C I | $800.00 | N |
| DENTAL | 42235 | REPAIR OF ANTERIOR PALATE | $600.00 | N | DENTAL | 42260 | REPAIR OF NASOLABIAL FIST | $120.00 | N |
| DENTAL | 42280 | MAXILLARY IMPRESS. FOR PA | $150.00 | N | DENTAL | 42281 | INSERTION OF PINRETAINED | $150.00 | N |
| DENTAL | 42299 | UNLISTED PROC./PALATE,UVU | $300.00 | N | DENTAL | 42550 | INJECTION PROCEDURE/SIALO | $27.00 | N |
| DENTAL | 42600 | CLOSURE SALIVARY FISTULA | $150.00 | N | DENTAL | 42650 | DILATION SALIVARY DUCT | $12.00 | N |
| DENTAL | 42660 | DILATION/CATHETERIZATION/ | $12.00 | N | DENTAL | 42665 | LIGATION SALIVARY DUCT, I | $75.00 | N |
| DENTAL | 42699 | UNLISTED PROCEDURE, SALIV | $150.00 | N | DENTAL | 42720 | INCISION AND DRAINAGE ABS | $60.00 | N |
| DENTAL | 42725 | INCISION AND DRAINAGE ABS | $187.50 | N | DENTAL | 70100 | RADIIOLOGIC EXAM, MANDIBL | $13.50 | N |
| DENTAL | 70110 | RADIOLOGIC EXAM, MANDIBLE | $13.50 | N | DENTAL | 70140 | RADIOLOGIC EXAM, FACIAL B | $18.00 | N |
| DENTAL | 70150 | RADIOLOGIC EXAM, FACIAL B | $18.00 | N | DENTAL | 70160 | RADIOLOGIC EXAM, NASAL BO | $11.70 | N |
| DENTAL | 70170 | DACRYOCYSTOGRAPHY,NASOLAC | $7.43 | N | DENTAL | 70210 | RADIOLOGICAL EXAM, SINUSE | $18.00 | N |
| DENTAL | 70220 | RADIOLOGIC EXAM,SINUSES,P | $18.00 | N | DENTAL | 70300 | RADIOLOGIC EXAM, TEETH,SI | $4.50 | N |
| DENTAL | 70310 | RADIOLOGIC EXAM, TEETH; P | $9.00 | N | DENTAL | 70320 | RADIOLOGIC EXAM TEETH COM | $18.00 | N |

Department of Health Care Finance
2009 Fee Schedule
As of 09/01/2009

| Type of Procedure | Procedure Code | Description | Fee | P/A Ind | Type of Procedure | Procedure Code | Description | Fee | P/A Ind |
|---|---|---|---|---|---|---|---|---|---|
| DENTAL | 70328 | RADIOLOGIC EXAM,TMJ,UNILA | $18.00 | N | DENTAL | 70330 | RADIOLOGIC EXAM, TMJ, BIL | $22.50 | N |
| DENTAL | 70332 | TMJ ARTHROTOMOGRAPHY; SUP | $20.00 | N | DENTAL | 70350 | CEPHALOGRAM, ORTHODONTIC | $36.20 | N |
| DENTAL | 70355 | ORTHOPANTOGRAM | $22.00 | N | DENTAL | 70390 | SIALOGRAPHY, SUPERVISION | $8.91 | N |
| DENTAL | 76499 | UNLISTED DIAGNOSTIC RADIO | $45.00 | N | DENTAL | 97010 | PHYSICAL MEDICINE RX TO O | $13.75 | N |
| DENTAL | 97024 | PHYSICAL MEDICINE RX; DIA | $6.00 | N | DENTAL | 97039 | PHYSICAL MEDICINE RX; SPE | $13.75 | N |
| DENTAL | 97110 | PHYS. MED. RX. ONE AREA; | $6.00 | N | DENTAL | 97112 | PHYS. MED. NEUROMUSC. REE | $6.00 | N |
| DENTAL | 99000 | SPECIMEN HANDLING, OFFICE | $1.00 | N | DME REN | A4480 RR | VABRA ASPIRATOR | $38.00 | Y |