

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised:

February 1, 2006

CATEGORICALLY NEEDY

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(16) Dental Services

- (1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.
- (2) Procedures which may be provided to recipients in the Child Health Services (EPSDT) Program without prior authorization are:
  - a. Initial radiographs taken in conjunction with preparation of a treatment plan.
  - b. **Periodic oral exam**, prophylaxis and topical flouride for children in the Child Health Services (EPSDT) Program.
  - c. Emergency treatment. One visit without prior authorization is payable for any emergency. Procedures payable without prior authorization when provided as emergency care include:
    1. All necessary radiographs.
    2. Extraction of up to three teeth for relief of pain or acute infections.
    3. Control of bleeding.
    4. Treatment for relief of pain resulting from injuries to the oral cavity or related services.
    5. Emergency services provided to patients in hospitals or long term care facilities.

All other procedures require prior authorization from the Medical Assistance Section. A full mouth radiograph is limited to once every five years. **Periodic oral exam, prophylaxis, fluoride treatment, and bite-wing X-rays are limited to once per every 6 (six) months plus 1 (one) day. Scaling is limited to one per state fiscal year (July 1 through June 30).** Periapical X-rays are limited to four (4) per recall visit. **Any limits will be exceeded based on medical necessity.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
Page 4c

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised:

February 1, 2006

CATEGORICALLY NEEDY

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10. Dental Services

Refer to Attachment 3.1-A, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.

**Dental services are available for Medicaid beneficiaries age 21 and over only when provided as a result of a life-threatening medical necessity. All adult dental services must be prior authorized.**

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SERVICES PROVIDED

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February 1, 2006

MEDICALLY NEEDY

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 4d

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised:

February 1, 2006

MEDICALLY NEEDED

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10. Dental Services

Refer to Attachment 3.1-B, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.

**Dental services are available for Medicaid beneficiaries age 21 and over only when provided as a result of a life-threatening medical necessity. All adult dental services must be prior authorized.**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: February 1, 2006

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found  
(Continued)

(18) Dental Services

- (a) Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. **State developed fee schedule rates are the same for both public and private provider of dental services. Effective for claims with dates of service on and after February 1, 2006, reimbursement rate maximums for Medicaid covered procedures are calculated at 95% of the 2006 Delta Dental Plan of Arkansas Inc.'s Premier rates as of January 16, 2006. Upon CMS approval, the reimbursement rates calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v. Reynolds) for its approval.**

**Medicaid dental rates will be adjusted as follows. The Division of Medical Services and the Arkansas State Dental Association shall meet on two year cycles beginning January 1, 2007, to evaluate the dental rates considering the factors set out in 42 U.S.C. Section 1396a(a)(30)(A) and shall review Delta Dental's then current Premier rates, identify rate adjustment to be made, and agree on the implementation methodology and date.**

**Procedure code D0350 (oral/facial photographic images) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the Medicaid maximum rate for procedure code D0350 is \$33.25. The rate is based on 47.5% of the \$70.00 2006 Delta Dental Plan of Arkansas Inc.'s Premier rate for procedure code D0340 as of January 16, 2006.**

**Procedure code D9248 (non-intravenous conscious sedation) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D9248 is \$96.74. The rate is based on 75% of the \$128.99 physician reimbursement maximum rate for procedure code 99143 (conscious sedation). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.**

**Procedure code D9310 (consultation, second opinion examination) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D9310 is \$40.13. The rate is based on 75% of the \$53.50 physician reimbursement maximum rate for procedure code 99241 (office visit, consultation). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.**

**Procedure code D1320 (tobacco counseling) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D1320 is \$25.00. The rate is based on 100% of the \$25.00 physician reimbursement maximum rate for procedure code 99212 (office or other outpatient visit). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.**

**Procedure code D9920 (behavior management tobacco) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D9920 is \$20.00. The rate is based on 80% of the \$25.00 physician reimbursement maximum rate for procedure code 99212 (office or other outpatient visit). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: February 1, 2006

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(b) Oral Surgeons

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

**For dates of service on and after February 1, 2006, oral surgeon rates for procedure codes that also may be billed by dentists shall be set in accordance with sub paragraph (a) above. Rates for other procedure codes are set as follows.**

For dates of service occurring April 1, 2004 and after:

- A. Reimbursement rates are increased by 10% up to a maximum or benchmark rate of 80% of the 2003 Arkansas Blue Cross/Blue Shield (BC/BS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than 80% of the 2003 BC/BS fee schedule rate, no increase will be given. A minimum rate or floor amount of 45% of the 2003 BC/BS fee schedule rate will be reimbursed. For those rates that after the 10 % increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.
- B. Reimbursement rates are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.
- C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:
  - (1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.
  - (2) Decreases: If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: February 1, 2006

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9. Clinic Services (Continued)

(5) End-Stage Renal Disease (ESRD) Facility Services

Reimbursement is made at the lower of: (a) the provider's actual charge for the service or (b) the allowable fee from the State's ESRD fee schedule based on reasonable charge.

The Medicaid maximum is based on the 50<sup>th</sup> percentile of the Arkansas Medicare facility rates in effect March 1, 1988. Rates will be reviewed annually.

After discussion with CMS, it was determined that the Arkansas Medicare 75<sup>th</sup> percentile is considered the norm for Arkansas Medicare reimbursement. Since the State reimburses at Arkansas Medicare's 50<sup>th</sup> percentile, the reimbursement rates will not exceed Arkansas Medicare on the aggregate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

Effective for dates of service on and after October 1, 2004, the Arkansas Medicaid Program covers training in peritoneal self-dialysis for beneficiaries with end-stage renal disease.

Reimbursement for peritoneal self-dialysis and training has been established as follows.

The Arkansas Medicaid maximum allowable daily fee for training in continuous ambulatory peritoneal dialysis (CAPD) equals the maximum allowable daily fee (\$130) for a hemodialysis treatment plus \$12.00 per day. This is the same methodology used by Medicare to calculate their CAPD training reimbursement rate.

The Arkansas Medicaid maximum allowable daily fee for training in continuous cycling peritoneal dialysis (CCPD) equals the maximum allowable daily fee (\$130) for a hemodialysis treatment plus \$20.00 per day. This is the same methodology used by Medicare to calculate their CCPD training reimbursement rate.

10. Dental Services

Refer to Attachment 4.19-B, Item 4.b.(18).

**Reimbursement rate maximums are calculated at 95% of the 2006 Delta Dental Plan of Arkansas Inc.'s Premier rates as of January 16, 2006. Upon CMS approval, the reimbursement rates calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v. Reynolds) for its approval.**

**Medicaid dental rates will be adjusted as follows. The Division of Medical Services and the Arkansas State Dental Association shall meet on two year cycles beginning January 1, 2007, to evaluate the dental rates considering the factors set out in 42 U.S.C. Section 1396a(a)(30)(A) and shall review Delta Dental's then current Premier rates, identify rate adjustment to be made, and agree on the implementation methodology and date.**



# Arkansas Department of Health and Human Services

## Division of Medical Services



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**TO:** Arkansas Medicaid Health Care Providers – Dental

**DATE:** July 1, 2006

**SUBJECT:** Provider Manual Update Transmittal # 85

**REMOVE**

Section	Date
215.000	10-13-03
216.200	10-13-03
217.100	10-13-03
241.000	10-13-03
262.100	6-1-06

**INSERT**

Section	Date
215.000	7-1-06
216.200	7-1-06
217.100	7-1-06
241.000	7-1-06
262.100	7-1-06

**Explanation of Updates**

Section 215.000 has been included to advise that periodic dental screening exams are limited to two screening exams per every six (6) months plus one (1) day for individuals under age 21. The procedure was previously called the initial dental screen. The name of the interperiodic dental screen has been changed to the interperiodic dental screening exam for clarification of the procedure.

Section 216.200 has been included to advise providers that the periodic screening exam must include only two bitewings and is allowed every six (6) months plus one (1) day for individuals under age 21.

Section 217.100 has been revised to advise providers that prophylaxis and/or fluoride treatment may be performed on beneficiaries under age 21 every six (6) months plus one (1) day. The screening exam may be provided without prior authorization. Prior policy previously stated that the services could be provided once per state fiscal year.

Section 241.000 is being included to change the language regarding the Arkansas Medicaid reimbursement methodology. **Effective for dates of service on and after February 1, 2006, the Arkansas Medicaid Program will reimburse providers based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.**

Section 262.100 has been included to change the description of procedure code **D0120** to “CHS/EPSTD initial dental screening exam” and to change the description of procedure code **D0140** to “CHS/EPSTD interperiodic screening exam”. Obsolete information has been removed from the section.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website:

[www.medicaid.state.ar.us](http://www.medicaid.state.ar.us).

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

**215.000 Child Health Services (EPSDT) Dental Screening 7-1-06**

The Child Health Services (EPSDT) **periodic and interperiodic dental screening exams consist of** an inspection of the oral cavity by a licensed dentist. The purpose of the dental screening **exams** is to check for obvious dental abnormalities and to assure access to needed dental care. Regular screening **exams** should be performed in accordance with the recommendations of the Child Health Service (EPSDT) periodicity schedule.

The Child Health Services (EPSDT) **periodic dental screening exam** is limited to **two screening exams per every six (6) months plus one (1) day** for individuals under age 21. These benefits may be extended if documentation is provided that verifies medical necessity. See Section 262.100 to view the procedure code for **periodic dental screening exams**.

Individuals under age 21 enrolled in the EPSDT Program may receive an interperiodic dental screening **exam** as often as **is** medically necessary. Prior authorization from the Division of Medical Services Dental Care Unit is required for this service and must be requested on the ADA Claim Form. [View or print form ADA-J510](#). See Section 262.100 for the interperiodic dental screening **exam** procedure code.

Infant oral health care examinations must be based on the recommendations of the American Academy of Pediatric Dentistry. Essential elements of an infant oral health care visit are a thorough medical and dental history, oral examination, parental counseling, preventive health education and determination of appropriate periodic re-evaluation. See Section 201.500 for information regarding the dentist's role in the EPSDT Program.

**216.200 Bitewing Radiographs in the EPSDT Intraoral Examination 7-1-06**

The EPSDT **periodic screening** exam must include two bitewing films that cover the distal of the cuspids to the distal of the most posterior tooth.

The EPSDT **periodic screening** exam must include only two bitewings and is allowed **every six (6) months plus one (1) day for individuals under age 21**. See Section 262.100 for the appropriate procedure code.

**217.100 Dental Prophylaxis and Fluoride Treatment 7-1-06**

Dental prophylaxis and a fluoride treatment for patients under age 21 are preventive treatments covered by Medicaid. Prophylaxis and/or fluoride treatments may be performed on patients under age 21 **every six (6) months plus one (1) day**. If more frequent treatment is needed due to severe periodontal problems, the provider should request prior authorization with a brief narrative.

Medicaid does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis and sealants unless other procedures are performed at the same time.

A provider may generally perform the following procedures without prior authorization:

- A. **periodic EPSDT screening exam**
- B. prophylaxis and fluoride
- C. periapical X-rays, amalgam-composite restorations (except four or more surfaces)
- D. pulpotomies
- E. chrome crowns on deciduous teeth

See Section 262.100 for applicable codes.

**241.000 Method of Reimbursement 7-1-06**

**Arkansas Medicaid reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.**

**262.100 ADA Procedure Codes Payable to Beneficiaries Under Age 21**

7-1-06

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for beneficiaries under the age of 21.

Beside each code is a reference chart that indicates whether X-rays are required and when prior authorization (PA) is required for the covered procedure code. If a concise report is required, this information is included in the PA column.

\* Revenue code

\*...( ) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service.

\*\* Prior authorization is required for panoramic x-rays performed on children under six years of age. (See section 216.100)

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
<b>Child Health Services (EPSDT) Dental Screening</b> (See section 215.000)			
D0120	CHS/EPSDT Dental <b>Screening</b> Exam	No	No
D0140	CHS/EPSDT Interperiodic Dental <b>Screening</b> Exam	Yes, and requires report	No
<b>Radiographs</b> (See sections 216.000 – 216.300)			
D0210	Intraoral – complete series (including bitewings)	No	No
D0220	Intraoral – periapical – first film	No	No
D0230	Intraoral – periapical – each additional film	No	No
D0240	Intraoral – occlusal film	No	No
D0250	Extraoral – first film	No	No
D0260	Extraoral – each additional film	No	No
D0272	Bitewings – two films	No	No
D0330	Panoramic film	No**	No
D0340	Cephalometric film	Yes	No
<b>Tests and Laboratory</b>			
D0470	Diagnostic casts	Yes	No
D0350	Diagnostic photographs	Yes	No
<b>Preventive</b>			
<b>Dental Prophylaxis</b> (See section 217.100)			
D1120	Prophylaxis – child (ages 0-9)	No	No
D1110	Prophylaxis – adult (ages 10-20)	No	No
<b>Topical Fluoride Treatment (Office Procedure)</b> (See Section 217.100)			
D1201	Topical application of fluoride (including prophylaxis)	No	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
<b>Dental Sealants</b> (See section 217.200)			
D1351	Sealant per tooth (1st and 2nd permanent molars only)	No	No
<b>Space Maintainers</b> (See section 218.000)			
D1510	Space maintainer – fixed – unilateral	Yes	Yes
D1515	Space maintainer – fixed – bilateral	Yes	Yes
D1525	Space maintainer – removable-bilateral	Yes	Yes
<b>Restorations</b> (See sections 219.000 – 219.200)			
<b>Amalgam Restorations (including polishing)</b> (See section 219.100)			
D2140	Amalgam – one surface	No	No
D2150	Amalgam – two surfaces	No	No
D2160	Amalgam – three surfaces	No	No
D2161	Amalgam – four or more surfaces	No	No
<b>Composite Resin Restorations</b> (See section 219.200)			
D2330	Resin – one surface, anterior, permanent	No	No
D2331	Resin – two surfaces, anterior, permanent	No	No
D2332	Resin – three surfaces, anterior, permanent	No	No
D2335	Resin – four or more surfaces or involving incisal angle, permanent	Yes	Yes
<b>Crowns – Single Restoration Only</b> (See section 220.000)			
D2710	Crown – resin (laboratory)	Yes	Yes
D2752	Crown – porcelain-ceramic substrate	Yes	Yes
D2920	Re-cement crown	No	Yes
D2930	Prefabricated stainless steel crown – primary	No	No
D2931	Prefabricated stainless steel crown – permanent	Yes	Yes
<b>Endodontia</b> (See section 221.000)			
<b>Pulpotomy</b>			
D3220	Therapeutic pulpotomy (excluding final restoration)	No	No
D3221	Gross pulpal debridement, primary and permanent teeth	Yes	No
<b>Root canal therapy (including treatment plan, clinical procedures and follow-up care)</b>			
D3310	One canal (excluding final restoration)	Yes	Yes
D3320	Two canals (excluding final restoration)	Yes	Yes
D3330	Three canals (excluding final restoration)	Yes	Yes

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
<b>Periapical Services</b>			
D3410	Apicoectomy (per tooth) – first root	Yes	Yes
<b>Periodontal Procedures</b> (See section 222.000)			
<b>Surgical Services (including usual postoperative services)</b>			
D4341	Periodontal scaling and root planing	Yes	Yes
D4910	Periodontal maintenance procedures (following active therapy)	Yes	Yes
<b>Complete dentures (Removable Prosthetics Services)</b> (See section 223.000)			
D5110	Complete denture – maxillary	Yes	Yes
D5120	Complete denture – mandibular	Yes	Yes
<b>Partial Dentures (Removable Prosthetic Services)</b> (See section 223.000)			
D5211	Upper partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
D5212	Lower partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
<b>Repairs to Partial Denture</b> (See section 223.000)			
D5610	Repair acrylic saddle or base	Yes	No
D5620	Repair cast framework	Yes	No
D5640	Replace broken teeth – per tooth	Yes	No
D5650	Add tooth to existing partial denture	Yes	No
<b>Fixed Prosthodontic Services</b> (See section 224.000)			
D6930	Re-cement bridge	Yes	No
<b>Oral Surgery</b> (See section 225.000)			
<b>Simple Extractions (includes local anesthesia and routine postoperative care)</b> (See section 225.100)			
D7111	Extraction, coronal remnants-deciduous tooth	No	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	No
<b>Surgical Extractions (includes local anesthesia and routine postoperative care)</b> (See section 225.200)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes	Yes
D7220	Removal of impacted tooth – soft tissue	Yes	Yes
D7230	Removal of impacted tooth – partially bony	Yes	Yes
D7240	Removal of impacted tooth – completely bony	Yes	Yes

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes	Yes
<b>Other Surgical Procedures</b>			
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	Yes	Yes
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	Yes	Yes
D7285	Biopsy of oral tissue – hard	Yes	Yes
D7286	Biopsy of oral tissue – soft	Yes	Yes
<b>Osteoplasty for Prognathism, Micrognathism or Apertognathism</b>			
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes	No
<b>Frenulectomy</b>			
D7960	Frenulectomy (Frenectomy or Frenotomy) Separate procedure	Yes	Yes
<b>Orthodontics (See section 226.000)</b>			
<b>Minor Treatment of Control Harmful Habits</b>			
D8210	Removable appliance therapy	Yes	Yes
D8220	Fixed appliance therapy	Yes	Yes
<b>Comprehensive Orthodontic Treatment – Permanent Dentition</b>			
D8070	Class I Malocclusion	Yes	Yes
D8080	Class II Malocclusion	Yes	Yes
D8090	Class III Malocclusion	Yes	Yes
<b>Other Orthodontic Devices</b>			
D8999	Unspecified orthodontic procedure, by report	Yes	Yes
<b>Anesthesia</b>			
D9220	General Anesthesia – first 30 minutes	Yes	Yes
D9221	General Anesthesia – each 15 minutes	Yes	No
D9230	Analgesia N <sub>2</sub> O	No, but requires report for request for more than 1 unit per day	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D9248	Non-I.V. Conscious Sedation	Yes and requires report	No
<b>Consultations</b> (See section 214.000)			
D9310	** (Second opinion examination) Consultation, diagnostic service provided by dentist or physician other than practitioner providing treatment	Yes	No
<b>Outpatient Hospital Services</b> (See section 228.200)			
0361*	Outpatient hospitalization – for hospital only	Yes	No
0360*	Outpatient hospitalization – for hospital only	Yes	No
0369*	Outpatient hospitalization – for hospital only	Yes	No
0509*	Outpatient hospitalization – for hospital only	Yes	No
<b>Smoking Cessation</b>			
D1320	Tobacco counseling for the control and prevention of oral disease	No	No
D9220	Behavior management, by report (tobacco counseling)	No	No
<b>Unclassified Treatment</b>			
D9110	Palliative treatment with dental pain	Yes	No