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|  | ***Commonwealth of Massachusetts***  ***Executive Office of Health and Human Services*** Office of Medicaid *www.mass.gov/masshealth* |

MassHealth

Transmittal Letter DEN-109

January 2021

**TO:** Dental Providers Participating in MassHealth

**FROM:** Daniel Tsai, Assistant Secretary for MassHealth [signature of Daniel Tsai]

**RE:** *Dental* *Manual* (Expanded Coverage of Adult Dental Benefits)

**Updates to Subchapter 6 of the MassHealth Dental Manual**

This letter transmits changes to the service codes and descriptions in Subchapter 6 of the MassHealth *Dental Manual* to reflect covered service codes for members age 21 and older. These changes are being made to reflect expanded coverage of adult dental benefits, including certain endodontic, prosthodontic, and oral surgery services, effective January 1, 2021, as required pursuant to the Fiscal Year 2021 General Appropriations Act, Chapter 227 of the Acts of 2020.

These updates are being made notwithstanding that certain of these services are not currently listed as covered services in 130 CMR 420.000: *Dental Services*. As described below, MassHealth expects to formally amend 130 CMR 420.000 in the near future to reflect this expanded coverage of adult dental benefits. These updates do not impact MassHealth members under age 21.

**Please hold all claims for the dental service codes below for members age 21 and older for dates of service beginning January 1, 2021, until the system is ready.**

DentaQuest will notify you as soon as the system is ready to process claims for these codes via the red bell and notification on the MassHealth Provider Web Portal at <https://provider.masshealth-dental.net/mh_provider_login>.

The following is a summary of the changes.

**Subchapter 6 Code Changes**

Effective for dates of service on or after January 1, 2021, MassHealth is adding coverage for members age 21 and older for the dental service codes below. These services were already covered for members under age 21, and in certain cases for clients over the age of 21 who are served by the Massachusetts Department of Developmental Services (DDS). Please see Subchapter 6 for limitations, prior authorization requirements, report requirements, and notations.

| **Code** | **Description** |
| --- | --- |
| D2751 | porcelain crown fused to predominantly base metal |
| D2910 | re-cement or re-bond inlay, onlay, veneer or partial coverage restoration |
| D2920 | recement crown |
| D2951 | pin retention in addition restoration |
| D2954 | post & core |
| D2980 | crown repair, by report |
| D2999 | unspecified restorative procedure, by report |
| D3310 | root canal therapy- anterior |
| D3320 | root canal therapy- bicuspid |
| D3330 | root canal therapy- molar |
| D3346 | retreatment of root canal therapy- anterior |
| D3347 | retreatment of root canal therapy- bicuspid |
| D3348 | retreatment of root canal therapy- molar |
| D3410 | apicoectomy- anterior |
| D3421 | apicoectomy- bicuspid |
| D3425 | Apicoectomy- molar |
| D3426 | apicoectomy- each additional root |
| D6999 | Unspecified fixed prosthodontic procedure, by report |
| D7340 | Vestibuloplasty- ridge extension (second epithelialization) |
| D7350 | Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) |
| D7410 | Excision of benign lesion up to 1.25 cm |
| D7411 | Excision of benign lesion greater than 1.25 cm |
| D7450 | Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm |
| D7451 | Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm |
| D7460 | Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm |
| D7461 | Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm |
| D7471 | Removal of lateral exostosis (maxilla or mandible) |
| D7472 | Removal of torus palatinus |
| D7473 | Removal of torus mandibularis |
| D7961 | Frenulectomy- buccal/labial |
| D7962 | Frenulectomy- lingual |
| D7963 | Frenuloplasty |
| D7970 | Excision of hyperplastic tissue - per arch |
| D7999 | Unspecified oral surgery procedure, by report |
| D9999 | Unspecified adjunctive procedure, by report |

**Upcoming Updates to 130 CMR 420.000**

MassHealth intends to make corresponding updates to 130 CMR 420.000 as soon as possible, to reflect this coverage of adult dental benefits including certain endodontic, prosthodontic, and oral surgery services. MassHealth expects that the following (or substantially similar) revised language will be included in 130 CMR 420.000: *Dental Services* with respect to members age 21 and older.

**Crown**

The MassHealth agency pays for porcelain fused to predominantly base metal crown and prefabricated posts and cores for members. The MassHealth agency pays for reinforcing pins only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. Commercial amalgam bonding systems are included in this category.

**Root Canal Therapy**

The MassHealth agency pays for root-canal therapy only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition.

**Apicoectomy**

The MassHealth agency pays for an apicoectomy as a separate procedure following root canal therapy when the canal cannot be retreated through reinstrumentation. Payment by the MassHealth agency for an apicoectomy with root canal filling includes payment for the filling of the canal or canals and removing the pathological periapical tissue and any retrograde filling in the same period of treatment.

**Vestibuloplasty**

The MassHealth agency pays for vestibuloplasty ridge extension for all members.

**Frenulectomy**

The MassHealth agency pays for frenulectomy procedures for all members. Frenulectomies may be performed to excise the frenum when the tongue has limited mobility, to aid in the closure of diastemas, and as a preparation for prosthetic surgery. If the purpose of the frenulectomy is to release the tongue, a written statement by a physician or primary care clinician and a speech pathologist clearly stating the problem must be maintained in the member’s dental record. The MassHealth agency does not pay for labial frenulectomies performed before the eruption of the permanent cuspids, unless orthodontic documentation that clearly justifies the medical necessity for the procedure is maintained in the member’s dental record.

**Excision of Hyperplastic Tissue**

The MassHealth agency pays for excision of hyperplastic tissue by report for all members. The MassHealth agency does not pay separately for the excision of hyperplastic tissue when performed in conjunction with an extraction. This procedure is generally reserved for the preprosthetic removal of such lesions as fibrous epuli or benign palatal hyperplasia.

**Excision of Benign Lesion**

The MassHealth agency pays for excision of soft-tissue lesions for all members.

**Removal of Exostosis and Tori**

The MassHealth agency pays for removal of exostosis and tori once per arch for all members.

As a reminder, dental providers may request prior authorization for any medically necessary service payable in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions set forth in 130 CMR 450.144, 42 U.S.C.1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than age 21. This applies even if the service is not listed in Subchapter 6 of the *Dental Manual*.

**Fee Schedule**

If you wish to obtain a fee schedule for dental services, you may download the Executive Office of Health and Human Services regulations at no cost at [www.mass.gov/service-details/eohhs-regulations](https://www.mass.gov/service-details/eohhs-regulations). The regulation title for dental services is [101 CMR 314.00: *Dental Services*](https://www.mass.gov/regulations/101-CMR-31400-dental-services).

**MassHealth Website**

This transmittal letter and attached pages are available on the MassHealth website at [www.mass.gov/masshealth-transmittal-letters](http://www.mass.gov/masshealth-transmittal-letters).

To sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins, send a blank email to [join-masshealth-provider-pubs@listserv.state.ma.us](mailto:join-masshealth-provider-pubs@listserv.state.ma.us). No text in the body or subject line is needed.

**Questions**

If you have questions about this transmittal letter, please contact MassHealth Dental Customer Service at (800) 207-5019, or email your inquiry to [inquiries@masshealthdental.net](mailto:inquiries@masshealthdental.net).

For additional information, please see the *MassHealth* *Dental Program Office Reference Manual* (available at <http://www.masshealth-dental.net/>).

NEW MATERIAL

(The pages listed here contain new or revised language.)

Dental Manual

Pages 6-1 through 6-28

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Dental Manual

Pages 6-1 through 6-30 — transmitted by Transmittal Letter DEN-107

601 Introduction

Dental providers who bill using Current Dental Terminology (CDT) codes must refer to the current version of the American Dental Association’s (ADA) code book for the service descriptions for codes listed in Subchapter 6 of the *Dental Manual*. Dentists who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7) must refer to the current version of the American Medical Association’s (AMA) Current Procedural Terminology (CPT) code book for the service descriptions for codes listed in Subchapter 6 of the *Dental Manual*.

MassHealth pays for dental services as described in MassHealth regulations at 130 CMR 420.000 and 450.000. A dental provider may request prior authorization for any medically necessary service payable in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions set forth in 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member under the age of 21. This applies even if the service is not listed in Subchapter 6 of the *Dental* *Manual*. For each dental service code, the description indicates any limitations, such as age and frequency, and if prior authorization is required for the member.

Dentists Who Are Specialists in Oral Surgery

A dentist who is a specialist in oral surgery in accordance with 130 CMR 420.405(A)(7) must submit all requests for prior authorization and claims containing CPT codes directly to MassHealth rather than to any third-party administrator or other MassHealth vendor, as described in 130 CMR 420.000.

When billing for multiple surgeries performed during the same operative session or on the same day, dental providers who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7), are reminded that Modifier 51 must be added to the second, third, and subsequent lines as appropriate. The primary procedure must be on line 1.

Modifiers

The following modifiers are for Provider Preventable Conditions (PPCs) that are National Coverage Determinations (NDCs).

PA Surgical or other invasive procedure on wrong body part

PB Surgical or other invasive procedure on wrong patient

PC Wrong surgery or other invasive procedure on patient

For more information on the use of these modifiers, see [Appendix V](https://www.mass.gov/doc/appendix-v-masshealth-billing-instructions-for-provider-preventable-conditions-3/download) of your provider manual.

Public Health Dental Hygienists

Public health dental hygienists may claim payment for service codes D0190, D0191, D0220, D0230, D0272, D0273, D0274, D1110, D1120, D1206, D1208, D1351, D1354, D4341, D4342, D9110, and D9410.

602Explanation of Abbreviations and Service Code Requirements

The following abbreviations are used in Subchapter 6 with certain services that may require special reporting, as described next.

1. Prior Authorization.
2. “PA” indicates that service-specific prior authorization is required (see 130 CMR 420.410). The provider must include in any request for prior authorization sufficiently detailed, clear information documenting the medical necessity of the service requested and, where specified, the information described in this Subchapter 6.
3. The MassHealth agency may require any additional information it deems necessary. If prior authorization is not required, the provider must maintain in the member’s dental record, all information necessary to disclose the medical necessity for the services provided. Pursuant to 130 CMR 420.410(B)(3), prior authorization may be requested for any exception to a limitation on a service otherwise covered for that member. (For example, MassHealth limits prophylaxis to two per member per calendar year, but pays for additional prophylaxis for a member within a calendar year if medically necessary.)

(B) Individual Consideration. “IC” indicates that the claim will receive individual consideration to determine payment. A descriptive report must accompany the claim (see 130 CMR 420.412) and be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the services provided. The reports must include the following where applicable.

1. amount of time required to perform the service;
2. degree of skill required to perform the service;
3. severity and complexity of the member’s disease, disorder, or disability; and
4. any extenuating circumstances or complications.

603 Service Codes: Diagnostic Services

See 130 CMR 420.422 for service descriptions and limitations.

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- |
| D0120 | Twice per calendar year | Yes | Yes | Yes |  |
| D0140 | Twice per calendar year | Yes | Yes | Yes |  |
| D0145 | Twice per calendar year | Yes (IC) | No | No | See 602(B) above. |
| D0150 | Once per member per dentist | Yes | Yes | Yes |  |
| D0180 | Once per calendar year | Yes | Yes | Yes |  |
| D0190 | Twice per calendar year | Yes | Yes | Yes | Payable only to a Public Health Hygienist |
| D0191 | Once per calendar year | Yes | Yes | Yes | Payable only to Public Health Hygienist |

604 Service Codes: Radiographs

See 130 CMR 420.423 and *Dental Manual* [Appendix E](https://www.mass.gov/doc/appendix-e-intraoral-complete-series-of-radiographic-images/download) for service descriptions and limitations.

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- |
| D0210 | Once every three calendar years | Yes | Yes | Yes |  |
| D0220 |  | Yes | Yes | Yes |  |
| D0230 |  | Yes | Yes | Yes |  |
| D0240 | Twice per calendar year | Yes | No | No |  |
| D0270 | Twice per calendar year | Yes | Yes | Yes |  |
| D0272 | Twice per calendar year | Yes | Yes | Yes |  |
| D0273 | Twice per calendar year | Yes (IC) | Yes (IC) | Yes (IC) | See 602(B) above. |
| D0274 | Twice per calendar year | Yes | Yes | Yes |  |
| D0330 | Once every three calendar years | Yes | Yes | Yes |  |
| D0340 |  | Yes | Yes | Yes |  |

605 Service Codes: Preventive Services

See 130 CMR 420.424 for service descriptions and limitations.

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- |
| D1110 | Twice per calendar year | Yes  (Use this code for ages 14- 21.) | Yes | Yes |  |
| D1120 | Twice per calendar year | Yes  (Use this code for ages up to 14.) | No | No |  |

605 Service Codes: Preventive Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements, Report Requirements, and Notations** | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D1206 |  | Yes | No\* | No\* | | | *\* Exception for members who have a medical or dental condition that significantly interrupts the flow of saliva  (PA required). See 602(A) above and 130 CMR 420.424(B)(1)(b).* |
| D1208 |  | Yes | No\* | No\* | | | *\* Exception for members who have a medical or dental condition that significantly interrupts the flow of saliva  (PA required). See 602(A) above and 130 CMR 420.424(B)(1)(b).* |
| **Other Preventive Services** | | | | | | | |
| D1351 | Permanent first, second, and third noncarious, nonrestored molars | Yes | No | No |  | | |
| **Space Maintenance (Passive Appliances)** | | | | | | | |
| D1510 | Twice per lifetime | Yes | No | No |  | | |
| D1354 | Twice per tooth’s lifetime | Yes | Yes | Yes |  | | |
|  |  |  |  |  |  | | |
| D1516 |  | Yes | No | No |  | | |
| D1517 |  | Yes | No | No |  | | |
| D1520 | Twice per lifetime | Yes | No | No |  | | |
|  |  |  |  |  |  | | |
| D1526 |  | Yes | No | No |  | | |
| D1527 |  | Yes | No | No |  | | |

606 Service Codes: Restorative Services

See 130 CMR 420.425 for service descriptions and limitations.

| **Service Code and Limitations** | | | | **Covered Under Age 21?** | | | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | | | | **Prior-Authorization Requirements, Report Requirements, and Notations** | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Amalgam Restorations (Including Polishing)** | | | | | | | | | | | | | | |
| D2140 | Once per calendar year per tooth | | | Yes | | Yes | | | Yes | | |  | | |
| D2150 | Once per calendar year per tooth | | | Yes | | Yes | | | Yes | | |  | | |
| D2160 | Once per calendar year per tooth | | | Yes | | Yes | | | Yes | | |  | | |
| D2161 | Once per calendar year per tooth | | | Yes | | Yes | | | Yes | | |  | | |
| **Resin-Based Composite Restorations** | | | | | | | | | | | | | | |
| D2330 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| D2331 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| D2332 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| D2335 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| D2390 | | | Once per calendar year per tooth | | Yes | No | | | | | No | | |  |
| D2391 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| D2392 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| D2393 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| D2394 | | | Once per calendar year per tooth | | Yes | Yes | | | | | Yes | | |  |
| **Crowns – Single Restoration Only** | | | | | | | | | | | | | | |
| D2710 | | Once per 60 months per tooth | | | Yes | No | | | | No | | |  | |
| D2740 | | Once per 60 months per tooth | | | Yes | No | | | | No | | |  | |
| D2750 | | Once per 60 months per tooth | | | Yes | No | | | | No | | |  | |

606 Service Codes: Restorative Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- |
| D2751 | Once per 60 months per tooth | Yes | Yes | | Yes | Maintain pre-treatment and post-treatment film of the tooth. |
| D2752 | Once per 60 months per tooth | Yes | No | | No |  |
| D2790 | Once per 60 months per tooth | Yes | No | | No |  |
| **Other Restorative Services** | | | | | | |
| D2910 |  | Yes | Yes | | Yes |  |
| D2920 |  | Yes | Yes | | Yes |  |
| D2930 |  | Yes | No | | No |  |
| D2931 |  | Yes | No\* | | No\* | *\* Exception for members with undue medical risk. See  130 CMR 420.425(C)(2).* |
| D2932 | Primary anterior teeth only | Yes | No | | No |  |
| D2934 |  | Yes | No | | No |  |
| D2951 |  | Yes | Yes | | Yes |  |
| D2954 |  | Yes | | Yes | Yes | Maintain pre-treatment and post-treatment film of the tooth. |
| D2980 | Chairside | Yes | | Yes | Yes |  |
| D2999 | Outside laboratory | Yes  (PA)  (IC) | | Yes (PA) (IC) | Yes (PA)  (IC) | Include documentation to substantiate why the repair could not be done chairside. See 602(A) and (B) above and  130 CMR 420.425(E). |

607 Service Codes: Endodontic Services

See 130 CMR 420.426 for service descriptions and limitations.

| **Service Code and Limitations** | | | | **Covered Under Age 21?** | | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pulpotomy** | | | | | | | | | |
| D3220 |  | | | Yes | | No | No | |  |
| **Root Canal Therapy (Including Pre- and Post-Treatment Radiographs and Follow-up Care)** | | | | | | | | | |
| D3310 | Once per lifetime per tooth | | | Yes | | Yes | Yes | |  |
| D3320 | Once per lifetime per tooth | | | Yes | | Yes | Yes | |  |
| D3330 | Once per lifetime per tooth | | | Yes | | Yes | Yes | |  |
| D3346 |  | | | Yes | | Yes | Yes | |  |
| D3347 |  | | | Yes | | Yes | Yes | |  |
| **Endodontic Retreatment** | | | | | | | | | | |
| D3348 | |  | Yes | | Yes | | | Yes |  | |
| **Apicoectomy/Periradicular Services** | | | | | | | | | | |
| D3410 | | Per tooth. Includes retrograde filling. Once per lifetime per tooth | Yes | | Yes | | | Yes | Maintain periapical film of the tooth and date of the original root canal treatment. | |
| D3421 | | Once per lifetime per tooth | Yes | | Yes | | | Yes | Maintain periapical film of the tooth and date of the original root canal treatment. | |
| D3425 | | First root. Once per lifetime per tooth | Yes | | Yes | | | Yes | Maintain periapical film of the tooth and date of the original root canal treatment. | |

607 Service Codes: Endodontic Services (cont.)

| **Service Code and Limitations** | | | **Covered Under Age 21?** | | **Covered DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D3426 | Each additional root | Yes | | Yes | | Yes | | Maintain periapical film of the tooth and date of the original root canal treatment. |

608 Service Codes: Periodontal Services

See 130 CMR 420.427 for service descriptions and limitations.

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- |
| **Surgical Services (Including Usual Postoperative Services)** | | | | | |
| D4210 | Once per quadrant per 3 calendar years | Yes | Yes (PA) | Yes  (PA) | Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member’s periodontal condition. See 602(A) above and 130 CMR 420.427(A). |

608 Service Codes: Periodontal Services (cont.)

| **Service Code and Limitations** | | | **Covered Under Age 21?** | | **Covered DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D4211 | Once per quadrant per 3 calendar years | | Yes | | Yes (PA) | | Yes  (PA) | | Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member’s periodontal condition. See 602(A) above and 130 CMR 420.427(A). |
| D4341 | | Once per quadrant per 3 calendar years | | Yes | | Yes (PA) | | Yes  (PA) | Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member’s periodontal condition. See 602(A) above and 130 CMR 420.427(B). |

608 Service Codes: Periodontal Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | | **Covered DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements, Report Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- |
| D4342 | Once per quadrant per 3 calendar years | | Yes | Yes  (PA) | Yes  (PA) | Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member’s periodontal condition. See 602(A) above and 130 CMR 420.427(B). |

609 Service Codes: Prosthodontic (Removable) Services

See 130 CMR 420.428 for service descriptions and limitations.

| **Service Code and Limitations** | | | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report**  **Requirements, and Notations** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Complete Dentures (Including Routine Post-Delivery Care)** | | | | | | | | |
| D5110 | | Once per 84 months | | Yes | Yes | Yes |  | |
| D5120 | | Once per 84 months | | Yes | Yes | Yes |  | |
| D5130 | |  | | Yes | No | No |  | |
| D5140 | |  | | Yes | No | No |  | |
| **Partial Dentures (Including Routine Post-Delivery Care)** | | | | | | |
| D5211 | | Once per 84 months | Yes | Yes | Yes |  |
| D5212 | | Once per 84 months | Yes | Yes | Yes |  |

609 Service Codes: Prosthodontic (Removable) Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements,**  **Report**  **Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- |
| **Partial Dentures (Including Routine Post-Delivery Care)** | | | | | | |
| D5213 | Once per 84 months | Yes | No | No |  | |
| D5214 | Once per 84 months | Yes | No | No |  | |
| D5225 | Once per 84 months | Yes | No | No |  | |
| D5226 | Once per 84 months | Yes | No | No |  | |
| **Repairs to Complete Dentures** | | | | | | | | |
| D5511 | |  | Yes | Yes | Yes |  | | |
| D5512 | |  | Yes | Yes | Yes |  | | |
| D5520 | |  | Yes | Yes | Yes |  | | |
| **Repairs to Partial Dentures** | | | | | | | | |
| D5611 | |  | Yes | Yes | Yes |  | | |
| D5612 | |  | Yes | Yes | Yes |  | | |
| D5621 | |  | Yes | Yes | Yes |  | | |
| D5622 | |  | Yes | Yes | Yes |  | | |
| D5630 | |  | Yes | Yes | Yes |  | | |
| D5640 | |  | Yes | Yes | Yes |  | | |
| D5650 | |  | Yes | Yes | Yes |  | | |
| D5660 | |  | Yes | Yes | Yes |  | | |
| **Denture Reline Procedures** | | | | | | | | |
| D5730 | | Once per 24 months per arch | Yes | Yes | Yes |  | | |
| D5731 | | Once per 24 months per arch | Yes | Yes | Yes |  | | |
| D5740 | | Once per 24 months per arch | Yes | No | No |  | | |
| D5741 | | Once per 24 months per arch | Yes | No | No |  | | |
| D5750 | | Once per 24 months per arch | Yes | Yes | Yes |  | | |
| D5751 | | Once per 24 months per arch | Yes | Yes | Yes |  | | |

609 Service Codes: Prosthodontic (Removable) Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report**  **Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- |
| D5760 | Once per 24 months per arch | Yes | No | No |  |
| D5761 | Once per 24 months per arch | Yes | No | No |  |

610 Service Codes: Prosthodontic (Fixed) Services

See 130 CMR 420.429 for service descriptions and limitations.

| **Service Code and Limitations** | | **Covered Under Age 21?** | | **Covered**  **DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements,**  **Report**  **Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Fixed Partial Denture Pontics** | | | | | | | | |
| D6241 | Once per 60 months per tooth | Yes | No | | No | |  | |
| D6751 | Once per 60 months per tooth | Yes | No | | No | |  | |
| **Other Fixed Partial Denture Services** | | | | | | | | |
| D6930 |  | Yes | No | | No | |  | |
| D6980 |  | Yes | No | | No | | . | |

611 Service Codes: Oral Surgery (Exodontic) Services

See 130 CMR 420.430 for service descriptions and limitations.

| **Service Code and Limitations** | | | | **Covered Under Age 21?** | | | **Covered**  **DDS**  **Clients Aged 21 and Older?** | | | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report**  **Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D6999 | |  | | Yes  (PA) (IC) | | | Yes (PA)  (IC) | | | Yes  (PA)  (IC) | Include documentation to substantiate why the repair could not be done chairside. See 602(A) and (B) above and  130 CMR 420.429(B). |
| **Extractions (Includes Local Anesthesia and Routine Postoperative Care)** | | | | | | | | | | | |
| D7111 | | |  | Yes | | Yes | | | Yes | |  |
| D7140 | | |  | Yes | | Yes | | | Yes | |  |
| D7210 | | |  | Yes | | Yes | | | Yes | |  |
| D7220 | | |  | Yes | | Yes | | | Yes | |  |
| D7230 | | |  | Yes | | Yes | | | Yes | |  |
| D7240 | | |  | Yes  (PA) | | Yes (PA) | | | Yes  (PA) | | Include Panorex film. See 602(A) above and 130 CMR 420.430(D). |
| D7250 | | |  | Yes | | Yes | | | Yes | |  |
| D7270 | | |  | Yes | | Yes | | | Yes | |  |
| D7280 | | | Including orthodontic attachments | Yes | | No | | | No | |  |
| D7283 | | |  | Yes | | No | | | No | |  |
| **Surgical Procedures** | | | | | | | | | | | |
| D7310 | Once per 6 months per quadrant | | | Yes | Yes | | | Yes | | |  |
| D7311 | Once per 6 months per quadrant | | | Yes | Yes | | | Yes | | |  |
| D7320 | Once per 6 months per quadrant | | | Yes | Yes | | | Yes | | |  |
| D7321 | Once per 6 months per quadrant | | | Yes | Yes | | | Yes | | |  |

611 Service Codes: Exodontic Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report**  **Requirements, and Notations** |
| --- | --- | --- | --- | --- | --- |
| D7340 |  | Yes  (PA) | Yes  (PA) | Yes  (PA) | Include justification of the surgical procedure designed to increase alveolar ridge height. See 602(A) above and 130 CMR 420.430(F). |
| D7350† |  | Yes | Yes  (PA) | Yes  (PA) | † Payable only to a dental provider with a specialty in oral surgery. In accordance with  130 CMR 420.405(A)(7). See 602(A) above and  130 CMR 420.430(F). |
| D7410 |  | Yes | Yes | Yes |  |
| D7411 |  | Yes | Yes | Yes |  |
| D7450 |  | Yes | Yes | Yes |  |
| D7451 |  | Yes | Yes | Yes |  |
| D7460 |  | Yes | Yes | Yes |  |
| D7461 |  | Yes | Yes | Yes |  |

611 Service Codes: Exodontic Services (cont.)

| **Service Code and Limitations** | | | **Covered Under Age 21?** | | **Covered**  **DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements,**  **Report**  **Requirements, and Notations** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D7471† | Once per lifetime per arch | | Yes | | Yes | | Yes | | † Payable only to a dental provider with a specialty in oral surgery in accordance with  130 CMR 420.405(A)(7).  See 602(A) above. | |
| D7472† | Once per lifetime per arch | | Yes | | Yes | | Yes | | † Payable only to a dental provider with a specialty in oral surgery in accordance with  130 CMR 420.405(A)(7).  See 602(A) above. | |
| D7473† | Once per lifetime per arch | | Yes | | Yes | | Yes | | † Payable only to a dental provider with a specialty in oral surgery in accordance with  130 CMR 420.405(A)(7).  See 602(A) above. | |
|  |  | |  | |  | |  | |  | |
| D7961 |  | | Yes | | Yes | | Yes | |  | |
| D7962 |  | | Yes | | Yes | | Yes | |  | |
| D7963 |  | | Yes | | Yes | | Yes | |  | |
| D7970 |  | | Yes | | Yes | | Yes | |  | |
| D7999 |  | | Yes  (PA) (IC) | | Yes  (PA) (IC) | | Yes  (PA)(IC) | | See 602(A) and (B) above. | |

612 Service Codes: Orthodontic Services

See 130 CMR 420.431 for service descriptions and limitations.

| **Service Code and Limitations** | | **Covered Under Age 21?** | | | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Orthodontic Diagnosis and Full Orthodontic Treatment** | | | | | | | |
| D8050 |  | | Yes  (PA)  (IC) | | No | No | Include the number of adjustment visits required in conjunction with the type of interceptive appliance.  See 602(A) and (B) above and  130 CMR 420.431. |
| D8060† |  | | | Yes  (PA) (IC) | No | No | Include the number of adjustment visits required in conjunction with the type of interceptive appliance.  See 602(A) and (B) above, 130 CMR 420.431, and *Dental Manual* [Appendix F](https://www.mass.gov/doc/appendix-f-authorization-for-interceptive-orthodontic-treatment/download).  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). |

612 Service Codes: Orthodontic Services (cont.)

| **Service Code and Limitations** | | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- | --- |
| D8070† | Once per lifetime for either D8070, D8080, or D8090. | Yes  (PA) | No | No | Include the x-ray, photographic prints, completed copy of the Handicapping Labio-Lingual Deviations (HLD), Form and medical necessity narrative, if applicable. See 602(A) and (B) above,130 CMR 420.431, and *Dental Manual* [Appendix D](https://www.mass.gov/doc/appendix-d-authorization-form-for-comprehensive-orthodontic-treatment-0/download).  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). |

612 Service Codes: Orthodontic Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- |
| D8080† | Once per lifetime for either D8070, D8080, or D8090. | Yes  (PA) | No | No | Include the x-ray, photographic prints, a completed copy of the Handicapping Labio-Lingual Deviations (HLD) Form and a medical necessity narrative, if applicable. See 602(A) above and  130 CMR 420.431 and *Dental Manual* [Appendix D](https://www.mass.gov/doc/appendix-d-authorization-form-for-comprehensive-orthodontic-treatment-0/download).  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). |

612 Service Codes: Orthodontic Services (cont.)

| **Service Code and Limitations** | | | **Covered Under Age 21?** | | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D8090† | Once per lifetime for either D8070, D8080 or D8090. | Yes  (PA) | | No | | No | Include the x-ray, photographic prints, a completed copy of the Handicapping Labio-Lingual Deviations (HLD) Form and a medical necessity narrative, if applicable. See 602(A) above and  130 CMR 420.431 and *Dental Manual* [Appendix D](https://www.mass.gov/doc/appendix-d-authorization-form-for-comprehensive-orthodontic-treatment-0/download).  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). | |

612 Service Codes: Orthodontic Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| D8670† | As part of contract; billed once per quarter (90 days) on the first date of service beginning with the calendar month following the calendar month during which appliance(s) were placed | Yes (PA) | | No\* | | No\* | Submit authorization request for the first two years of treatment. Include photographic prints, radiographs (lateral and occlusal views) & HLD Form.  *\* Exception for members whose comprehensive orthodontic treatment began by age 21.*  *See 130 CMR 420.431(A).*  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). |
| D8660† | Consultation - once per 6 months | Yes | | No | | No | † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). |

612 Service Codes: Orthodontic Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- |
| D8680† |  | Yes | No\* | No\* | *\* Exception for members whose comprehensive orthodontic treatment began by age 21. PA required.*  *See  130 CMR 420.431(A)(1).*  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6).  Include the date of the initial banding and a narrative of the reason(s) for removal of the orthodontic appliance. See 602(A) above. |
| D8690† |  | Yes  (PA) | No | No | † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6).  See 602(A) above. |

612 Service: Orthodontic Services (cont.)

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- |
| D8703† |  | Yes  (PA) | No | No | See 602(A) above.  See  130 CMR 420.431(C)(5).  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). |
| D8704† |  | Yes  (PA) | No | No | See 602(A) above.  See  130 CMR 420.431(C)(5).  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6). |
| D8999† |  | Yes  (PA)  (IC) | No\* | No\* | *\* Exception for members whose comprehensive orthodontic treatment began by age 21.* PA required. *See  130 CMR 420.431(A).*  † Payable only to a dental provider who is a specialist in orthodontics in accordance with  130 CMR 420.405(A)(6).  See 602(A) and (B) above. |

613 Service Codes: General Anesthesia and IV Sedation Services

See 130 CMR 420.452 for service descriptions and limitations.

| **Service Code and Limitations** | | **Covered Under Age 21?** | **Covered**  **DDS**  **Clients Aged 21 and Older?** | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- |
| D9222 |  | Yes | Yes | Yes |  |
| D9223 |  | Yes | Yes | Yes |  |
| D9230 |  | Yes | Yes | Yes |  |
| D9239 |  | Yes | Yes | Yes |  |
| D9243 |  | Yes | Yes | Yes |  |
| D9248 |  | Yes | Yes | Yes |  |

614 Service Codes: Adjunctive Services

See 130 CMR 420.456 for service descriptions and limitations.

| **Service Code and Limitations** | | | **Covered Under Age 21?** | | **Covered**  **DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Unclassified Treatment** | | | | | | | | |
| D9110 | | Other nonemergency medically necessary treatment may be provided during the same visit; that is, nonemergency codes may be billed in conjunction with D9110. | Yes | Yes | | Yes | |  |
| **Professional Visits** | | | | | | | | |
| D9410 |  | | Yes | Yes | | Yes | | A visit to a nursing facility, chronic disease and rehabilitation hospital, hospice facility, school, or other licensed educational facility, once per facility per day. Bill in addition to any medically necessary MassHealth-covered service provided during the same visit. Code may be billed once per facility per day. See  130 CMR 420.456(F). |

614 Service Codes: Adjunctive Services (cont.)

| **Service Code and Limitations** | | | | **Covered Under Age 21?** | | **Covered**  **DDS**  **Clients Aged 21 and Older?** | | **Covered Aged 21 and Older?** | **Prior-Authorization Requirements,**  **Report Requirements,**  **and Notations** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Treatment of Physically or Developmentally Disabled Members** | | | | | | | | | |
| D9920 | | Once per member per day | Yes  (PA) | | Yes (PA) | | Yes  (PA) | | Include a description of the member’s illness or disability, and types of services to be furnished.  See 602(A) above and  130 CMR 420.456(B). |
| **Miscellaneous Services** | | | | | | | | | |
| D9930 |  | | Yes  (IC) | | Yes  (IC) | | Yes  (IC) | | Include with the claim the date, the location of the original surgery, and the type of procedure. See 602(A) above. |
| D9945 |  | | Yes  (PA) | | No | | No | | Include documented evidence of the need for the appliance. See 602(A) above. |
| D9941 |  | | Yes | | No | | No | |  |
| D9999 |  | | Yes  (PA), (IC) | | Yes  (PA), (IC) | | Yes  (PA)  (IC) | | See 602(A) and (B) above. |

615 Service Codes: Oral and Maxillofacial Surgery Services

See 130 CMR 420.453 and 420.455 for service descriptions and limitations.

The following all-numeric service codes may be used only by dental providers who are specialists in oral surgery, in accordance with 130 CMR 420.405(A)(7).

CPT Service Codes

10060

10061

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11043

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14001

14020

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14041

14060

14061

14301

14302

15040

15100

15110

15111

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17999 (IC)

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20240

20245

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20525

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20605

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615 Service Codes: Oral and Maxillofacial Surgery Services(cont.)

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21088 (IC)

21089 (IC)

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21137 (PA)

21138 (PA)

21139 (PA)

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21146 (PA)

21147 (PA)

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21155 (PA)

21159 (PA)

21160 (PA)

21172 (PA)

21175 (PA)

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21188 (PA)

21193 (PA)

21194 (PA)

21195 (PA)

21196 (PA)

21198 (PA)

21206 (PA)

21208 (PA)

21209 (PA)

21210 (PA)

21215 (PA)

21230 (PA)

21235 (PA)

21240 (PA)

21242 (PA)

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21247 (PA)

21255 (PA)

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21299 (PA),   
(IC)

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21499 (IC)

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29800 (PA)

29804 (PA)

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31299 (IC)

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31575

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31603

31605

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31615

31622

35500

35572

35681

35682

35701

35800

35860

35875

35876

37609

38500

38505

38510

38542

38550

38555

38700

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38790

38792

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40500

615 Service Codes: Oral and Maxillofacial Surgery Services(cont.)

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40702

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40843 (PA)

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40845 (PA)

40899 (IC)

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41820 (IC), (PA)

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41899 (IC)

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42999 (IC)

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615 Service Codes: Oral and Maxillofacial Surgery Services(cont.)

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