

**ATTACHMENT A-1  
TEXAS MEDICAID FEE SCHEDULE  
SCHEDULE OF ALLOWABLE FEES**

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Procedure Code	Procedure Description	Fee
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	\$28.85
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	\$18.78
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	\$142.07
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	\$35.32
D0160	DETAILED AND EXTENSIVE ORAL EVAL- PROBLEM FOCUSED, BY REPORT	\$14.95
D0170	RE-EVALUATION, LIMITED PROBLEM FOCUSED	\$16.54
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	\$7.86
D0210	INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES	\$70.64
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	\$12.56
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	\$11.51
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$9.80
D0250	EXTRA-ORAL – 2D PROJECTION RADIOGRAPHIC IMAGE CREATED USING A STATIONARY RADIATION SOURCE, AND DETECTOR	\$18.38
D0260	EXTRAORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE	\$12.25
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$4.90
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$23.38
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$29.01
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$34.61
D0277	VERTICAL BITEWINGS – 7 TO 8 FILMS	\$31.12
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY RADIOGRAPHIC IMAGE	\$33.08
D0310	SIALOGRAPHY	\$44.10
D0320	TEMPOROMANDIBULAR JOINT ARTHOGRAM, INCLUDING INJECTION	\$73.50
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT	\$34.30
D0322	TOMOGRAPHIC SURVEY	\$33.08
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$63.78
D0340	CEPHALOMETRIC RADIOGRAPHIC IMAGE	\$33.08
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY	\$18.38
D0360	CONE BEAM CT - CRANIOFACIAL DATA CAPTURE	\$282.98
D0362	CONE BEAM – TWO DIMENSIONAL IMAGE	\$169.79
D0363	CONE BEAM – THREE DIMENSIONAL IMAGE	\$226.38
D0367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM	\$226.38
D0415	BACTERIOLOGIC STUDIES	\$24.50

Procedure Code	Procedure Description	Fee
D0460	PULP VITALITY TESTS	\$12.25
D0470	DIAGNOSTIC CASTS	\$22.05
D0502	OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT	\$56.35
D1110	PROPHYLAXIS - ADULT	\$54.88
D1120	PROPHYLAXIS - CHILD	\$36.75
D1203	TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - CHILD	\$14.70
D1204	TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - ADULT	\$14.70
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	\$14.70
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	\$14.70
D1330	ORAL HYGIENE INSTRUCTIONS	\$12.25
D1351	SEALANT - PER TOOTH	\$28.24
D1352	PREVENTIVE RESIN RESTORATION IS A MOD. TO HIGH CARIES RISK	\$37.44
D1510	SPACE MAINTAINER-FIXED- UNILATERAL	\$156.80
D1516	SPACE MAINTAINER-FIXED- BILATERAL, MAXILLARY	\$232.75
D1517	SPACE MAINTAINER-FIXED- BILATERAL, MANDIBULAR	\$232.75
D1520	SPACE MAINTAINER-REMOVABLE- UNILATERAL	\$73.50
D1526	SPACE MAINTAINER-REMOVABLE- BILATERAL, MAXILLARY	\$104.13
D1527	SPACE MAINTAINER-REMOVABLE- BILATERAL, MANDIBULAR	\$104.13
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER- MAXILLARY	\$18.38
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER- MANDIBULAR	\$18.38
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER – PER QUADRANT	\$13.79
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER – PER QUADRANT	\$36.75
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY	\$49.00
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR	\$49.00
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED - UNILATERAL	\$200.00
D2140	AMALGAM - ONE SURFACE, PERMANENT	\$62.80
D2140	AMALGAM - ONE SURFACE, PRIMARY	\$60.75
D2150	AMALGAM - TWO SURFACES, PERMANENT	\$83.57
D2150	AMALGAM - TWO SURFACES, PRIMARY	\$81.24
D2160	AMALGAM - THREE SURFACES, PERMANENT	\$106.46

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D2160	AMALGAM - THREE SURFACES, PRIMARY	\$88.20
D2161	AMALGAM - FOUR OR MORE SURFACES, PERMANENT	\$121.88
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY	\$90.01
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	\$75.81
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	\$100.46
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	\$131.17
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	\$162.80
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR, PERMANENT	\$147.00
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR, PRIMARY	\$85.00
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR - PERMANENT	\$80.34
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR - PRIMARY	\$75.45
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR - PERMANENT	\$105.30
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR - PRIMARY	\$97.01
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR - PERMANENT	\$115.00
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR - PRIMARY	\$100.25
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR - PERMANENT	\$125.00
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR - PRIMARY	\$105.75
D2410	GOLD FOIL - 1 SURFACE	\$73.50
D2420	GOLD FOIL - 2 SURFACES	\$122.50
D2430	GOLD FOIL - 3 SURFACES	\$122.50
D2510	INLAY - METALLIC - 1 SURFACE	\$173.19
D2520	INLAY-METALLIC-2 SURFACES	\$252.25
D2530	INLAY-METALLIC-3+ SURFACES	\$252.25
D2542	ONLAY - METALLIC - TWO SURFACES	\$252.25
D2543	ONLAY-METALLIC-3 SURFACES	\$252.25
D2544	ONLAY-METALLIC-4+ SURFACES	\$252.25
D2610	INLAY-PORCE/CERAMIC-1SURFACE	\$258.72
D2620	INLAY-PORCELAIN/CERAMIC-2 SURFACES	\$258.72
D2630	INLAY-PORC/CERAMIC 3+ SURFACES	\$258.72
D2642	ONLAY-PORCELAIN/CERAMIC-2 SURFACES	\$258.72
D2643	ONLAY-PORCELAIN/CERAMIC-3 SURFACES	\$258.72
D2644	ONLAY-PORCELAIN/CERAMIC-4+ SURFACES	\$258.72
D2650	INLAY-COMPOSITE/RESIN 1SURFACE	\$252.25
D2651	INLAY-COMPOSITE/RESIN-2 SURFACES	\$252.25
D2652	INLAY-COMPOSITE/RESIN-3+ SURFACES	\$252.25
D2662	ONLAY-COMPOSITE/RESIN-2 SURFACES	\$252.25
D2663	ONLAY-COMPOSITE/RESIN-3 SURFACES	\$252.25

Procedure Code	Procedure Description	Fee
D2664	ONLAY-COMPOSITE/RESIN-4+ SURFACES	\$252.25
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	\$252.25
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$252.25
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	\$252.25
D2722	CROWN - RESIN WITH NOBLE METAL	\$252.25
D2740	CROWN - PORCELAIN/CERAMIC	\$252.25
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$504.50
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$504.50
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	\$504.50
D2780	CROWN - ¾ CAST HIGH NOBLE METAL	\$252.25
D2781	CROWN - ¾ CAST PREDOMINANTLY BASE METAL	\$252.25
D2782	CROWN - ¾ CAST NOBLE METAL	\$252.25
D2783	CROWN - ¾ PORCELAIN/CERAMIC	\$252.25
D2790	CROWN - FULL CAST HIGH NOBLE METAL	\$504.50
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	\$252.25
D2792	CROWN - FULL CAST NOBLE METAL	\$252.25
D2794	CROWN - TITANIUM	\$252.25
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	\$17.92
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	\$17.92
D2920	RE-CEMENT OR RE-BOND CROWN	\$19.11
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	\$149.12
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	\$155.27
D2932	PREFABRICATED RESIN CROWN	\$65.70
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	\$149.12
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	\$149.12
D2940	PROTECTIVE RESTORATION	\$34.95
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	\$43.00
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	\$11.94
D2952	CAST POST AND CORE IN ADDITION TO CROWN	\$83.61
D2953	EACH ADDITIONAL CAST POST - SAME TOOTH	\$41.81
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	\$71.66
D2955	POST REMOVAL (NOT IN CONJUNCTION WITH ENDODONTIC THERAPY)	\$71.66
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	\$35.83
D2960	LABIAL VENEER (LAMINATE)-CHAIR	\$107.49

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Procedure Code	Procedure Description	Fee
D2961	LABIAL VENEER (RESIN LAMINATE) - LABORATORY	\$173.19
D2962	LABIAL VENEER (PORC LAMINATE) - LABORATORY	\$203.04
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER PARTIAL DENTURE FRAMEWORK	\$107.49
D2980	CROWN REPAIR, BY REPORT	\$47.78
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	\$0.00
D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	\$15.53
D3120	PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)	\$28.67
D3220	THERAPEUTIC PULPOTOMY	\$84.05
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH	\$37.03
D3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH	\$42.02
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH	\$340.14
D3320	ENDODONTIC THERAPY, PREMOLAR TOOTH	\$394.14
D3330	ENDODONTIC THERAPY, MOLAR TOOTH	\$596.48
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	\$149.30
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - PREMOLAR	\$197.08
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	\$262.76
D3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT	\$71.66
D3352	APEXIFICATION/RECALCIFICATION - INTERIM MEDICATION REPLACEMENT	\$47.78
D3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	\$95.55
D3354	PULPAL REGENERATION	\$98.00
D3410	APICOECTOMY - ANTERIOR	\$125.41
D3421	APICOECTOMY - PREMOLAR (FIRST ROOT)	\$155.27
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	\$155.27
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	\$71.66

Procedure Code	Procedure Description	Fee
D3430	RETROGRADE FILLING - PER ROOT	\$47.78
D3450	ROOT AMPUTATION - PER ROOT	\$71.66
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	\$203.04
D3470	INTENTIONAL REIMPLANTATION	\$119.44
D3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	\$17.92
D3920	HEMISECTION	\$77.64
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	\$47.78
D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	\$0.00
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	\$155.27
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	\$47.78
D4230	ANATOMICAL CROWN EXPOSURE - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TOOTH SPACES PER QUADRANT	\$155.27
D4231	ANATOMICAL CROWN EXPOSURE - ONE TO THREE TEETH OR BOUNDED TOOTH SPACES PER QUADRANT	\$93.16
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	\$173.19
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	\$52.55
D4245	APICALLY POSITIONED FLAP	\$173.19
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	\$155.27
D4260	OSSEOUS SURGERY FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	\$214.99
D4261	OSSEOUS SURGERY ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	\$64.02
D4266	GUIDED TISSUE REGENERATE- RESORBABLE BARRIER, PER SITE, PER TOOTH	\$262.76
D4267	GUIDED TISSUE REGENERATION - NONRESORBABLE BARRIER, PER SITE, PER TOOTH	\$310.54
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	\$185.13
D4271	FREE SOFT TISSUE GRAFT PROCEDURE	\$202.13
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURE	\$214.99
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	\$119.44

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Procedure Code	Procedure Description	Fee
D4275	SOFT TISSUE ALLOGRAFT	\$214.99
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT	\$214.99
D4277	FREE SOFT TISSUE GRAFT PROCEDURE FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT	\$65.70
D4278	FREE SOFT TISSUE GRAFT PROCEDURE EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	\$65.70
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE- EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	\$65.70
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE - EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	\$65.70
D4320	PROVISION SPLINTING - INTRACORONAL	\$59.72
D4321	PROVISION SPLINTING - EXTRACORONAL	\$95.55
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	\$53.75
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	\$6.69
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE ORAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	\$71.66
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS	\$28.67
D4910	PERIODONTAL MAINTENANCE PROCEDURES	\$35.83
D4920	UNSCHEDULED DRESSING CHANGE	\$23.89
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	\$0.00
D5110	COMPLETE DENTURE - MAXILLARY	\$358.31
D5120	COMPLETE DENTURE - MANDIBULAR	\$358.31
D5130	IMMEDIATE DENTURE - MAXILLARY	\$370.26
D5140	IMMEDIATE DENTURE - MANDIBULAR	\$370.26
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	\$262.76
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	\$262.76
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	\$382.20
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	\$382.20
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$17.92
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$17.92
D5421	ADJUST PARTIAL DENTURE-MAXILLARY	\$17.92
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$17.92
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	\$68.00
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	\$68.00

Procedure Code	Procedure Description	Fee
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	\$41.81
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	\$68.00
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	\$68.00
D5630	REPAIR OR REPLACE BROKEN CLASP	\$47.78
D5640	REPLACE BROKEN TEETH-PER TOOTH	\$41.81
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	\$47.78
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	\$59.72
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	\$167.21
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	\$167.21
D5710	REBASE COMPLETE MAXILLARY DENTURE	\$131.38
D5711	REBASE COMPLETE MANDIBULAR DENTURE	\$131.38
D5720	REBASE MAXILLARY PARTIAL DENTURE	\$131.38
D5721	REBASE MANDIBULAR PARTIAL DENTURE	\$131.38
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	\$77.64
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	\$77.64
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	\$71.66
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	\$71.66
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	\$113.47
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	\$113.47
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	\$113.47
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	\$113.47
D5810	INTERIM COMPLETE DENTURE-MAXILLARY	\$191.10
D5811	INTERIM COMPLETE DENTURE-MANDIBULAR	\$191.10
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	\$155.27
D5821	INTERIM PARTIAL DENTURE-MANDIBULAR	\$155.27
D5850	TISSUE CONDITIONING, MAXILLARY	\$35.83
D5851	TISSUE CONDITIONING,MANDIBULAR	\$35.83
D5860	OVERDENTURE - COMPLETE, BY REPORT	\$379.75
D5861	OVERDENTURE - PARTIAL, BY REPORT	\$379.75

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D5862	PRECISION ATTACHMENT, BY REPORT	\$155.27
D5863	OVERDENTURE - COMPLETE MAXILLARY	\$370.26
D5864	OVERDENTURE - PARTIAL MAXILLARY	\$370.26
D5865	OVERDENTURE - COMPLETE MANDIBULAR	\$370.26
D5866	OVERDENTURE - PARTIAL MANDIBULAR	\$370.26
D5911	FACIAL MOULAGE (SECTIONAL)	\$47.78
D5912	FACIAL MOULAGE (COMPLETE)	\$86.00
D5913	NASAL PROSTHESIS	\$836.06
D5914	AURICULAR PROSTHESIS	\$836.06
D5915	ORBITAL PROSTHESIS	\$836.06
D5916	OCULAR PROSTHESIS	\$537.47
D5919	FACIAL PROSTHESIS	\$1,074.94
D5922	NASAL SEPTAL PROSTHESIS	\$133.77
D5923	OCULAR PROSTHESIS, INTERIM	\$322.48
D5924	CRANIAL PROSTHESIS	\$418.03
D5925	FACIAL AUGMENT IMPLANT PROSTHESIS	\$358.31
D5926	NASAL PROSTHESIS, REPLACEMENT	\$429.98
D5927	AURICULAR PROSTHESIS, REPLACE	\$429.98
D5928	ORBITAL PROSTHESIS, REPLACE	\$429.98
D5929	FACIAL PROSTHESIS, REPLACEMENT	\$859.95
D5931	OBTURATOR PROSTHESIS, SURGICAL	\$358.31
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	\$1,242.15
D5933	OBTURATOR PROSTHESIS, MODIFICATION	\$268.74
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE	\$537.47
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE	\$537.47
D5936	OBTURATOR PROSTHESIS, INTERIM	\$597.19
D5937	TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)	\$250.82
D5951	FEEDING AID	\$133.77
D5952	SPEECH AID PROSTHESIS, PEDIATRIC	\$806.21
D5953	SPEECH AID PROSTHESIS, ADULT	\$806.21

Procedure Code	Procedure Description	Fee
D5954	PALATAL AUGMENT PROSTHESIS	\$424.01
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE	\$214.99
D5958	PALATAL LIFT PROSTHESIS, INTERIM	\$214.99
D5959	PALATAL LIFT PROSTHESIS, MODIFICATION	\$95.55
D5960	SPEECH AID PROSTHESIS, MODIFICATION	\$95.55
D5982	SURGICAL STENT	\$107.49
D5983	RADIATION CARRIER	\$155.27
D5984	RADIATION SHIELD	\$155.27
D5985	RADIATION CONE LOCATOR	\$155.27
D5986	FLUORIDE GEL CARRIER	\$47.78
D5987	COMMISSURE SPLINT	\$125.41
D5988	SURGICAL SPLINT	\$107.49
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT	\$268.74
D5993	MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS.	\$1,979.16
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	\$0.00
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	\$1,102.50
D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLNT	\$1,960.00
D6055	CONNECTING BAR - IMPLANT SUPPORTED OR ABUTMENT SUPPORTED	\$294.00
D6056	PREFABRICATED ABUTMENT	\$343.00
D6057	CUSTOM ABUTMENT	\$343.00
D6080	IMPLANT MAINTENANCE PROCEDURE	\$42.88
D6090	REPAIR IMPLANT PROSTHESIS	\$134.75
D6092	RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	\$45.91
D6093	RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE	\$45.91
D6095	REPAIR IMPLANT ABUTMENT	\$171.50
D6100	IMPLANT REMOVAL, BY REPORT	\$220.50
D6210	PONTIC - CAST HIGH NOBLE METAL	\$252.25
D6211	PONTIC-CAST BASE METAL	\$252.25
D6212	PONTIC - CAST NOBLE METAL	\$252.25
D6240	PONTIC-PORCELAIN FUSED-HIGH NOBLE	\$252.25

**ATTACHMENT A-1  
TEXAS MEDICAID FEE SCHEDULE  
SCHEDULE OF ALLOWABLE FEES**

**\*\* PLEASE REFER TO OFFICE REFERENCE MANUAL ON DENTAQUEST'S WEBSITE FOR COVERED SERVICES\*\***

Procedure Code	Procedure Description	Fee
D6241	PONTIC-PORCELAIN FUSED TO BASE METAL	\$252.25
D6242	PONTIC-PORCELAIN FUSED-NOBLE METAL	\$252.25
D6245	PROSTHODONTICS FIXED, PONTIC - PORCELAIN/CERAMIC	\$252.25
D6250	PONTIC-RESIN WITH HIGH NOBLE METAL	\$252.25
D6251	PONTIC-RESIN WITH BASE METAL	\$252.25
D6252	PONTIC-RESIN WITH NOBLE METAL	\$252.25
D6545	RETAINER - CAST METAL FIXED	\$257.40
D6548	PROSTHODONTICS FIXED, RETAINER - PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHODONTIC	\$258.72
D6549	RESIN RETAINER-FOR RESIN BONDED FIXED PROSTHESIS	\$252.25
D6720	CROWN-RESIN WITH HIGH NOBLE METAL	\$252.25
D6721	CROWN-RESIN WITH BASE METAL	\$252.25
D6722	CROWN-RESIN WITH NOBLE METAL	\$252.25
D6740	RETAINER CROWN – PORCELAIN/CERAMIC	\$252.25
D6750	CROWN-PORCELAIN FUSED HIGH NOBLE	\$252.25
D6751	CROWN-PORCELAIN FUSED TO BASE METAL	\$252.25
D6752	CROWN-PORCELAIN FUSED NOBLE METAL	\$252.25
D6780	CROWN-3/4 CST HIGH NOBLE METAL	\$252.25
D6781	PROSTHODONTICS FIXED, CROWN ¾ CAST PREDOMINANTLY BASED METAL	\$252.25
D6782	PROSTHODONTICS FIXED, CROWN ¾ CAST NOBLE METAL	\$252.25
D6783	PROSTHODONTICS FIXED, CROWN ¾ PORCELAIN/CERAMIC	\$252.25
D6790	CROWN-FULL CAST HIGH NOBLE	\$252.25
D6791	CROWN - FULL CAST BASE METAL	\$252.25
D6792	CROWN - FULL CAST NOBLE METAL	\$252.25
D6920	CONNECTOR BAR	\$128.99
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	\$35.83
D6940	STRESS BREAKER	\$83.61
D6950	PRECISION ATTACHMENT	\$131.38
D6970	CAST POST/CORE AND FIXED RETAIN	\$98.00
D6972	PREFABRICATED POST AND CORE + RETAINER	\$79.63
D6973	CORE BUILD RETAINER WITH PINS	\$55.13

Procedure Code	Procedure Description	Fee
D6975	COPING - METAL	\$122.50
D6976	PROSTHODONTICS FIXED, EACH ADDITIONAL CAST POST-SAME TOOTH	\$49.00
D6977	PROSTHODONTICS FIXED, EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	\$39.82
D6980	FIXED PARTIAL DENTURE REPAIR	\$65.70
D7111	EXTRACTION, CORONAL REMNANTS - PRIMARY TOOTH	\$11.47
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	\$64.06
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH	\$98.23
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	\$150.49
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	\$171.99
D7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$286.65
D7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	\$149.30
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	\$88.38
D7260	OROANTRAL FISTULA CLOSURE	\$131.38
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$131.38
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	\$105.11
D7272	TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER)	\$143.33
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	\$59.72
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	\$59.72
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	\$23.89
D7285	INCISIONAL BIOPSY OF ORAL TISSUE-HARD (BONE, TOOTH)	\$71.66
D7286	INCISIONAL BIOPSY OF ORAL TISSUE-SOFT	\$59.72
D7290	SURGICAL REPOSITIONING OF TEETH	\$131.38
D7291	TRANSSEPTAL FIBEROTOMY, BY REPORT	\$47.78
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	\$53.75
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	\$71.66
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	\$119.44
D7350	VESTIBULOPLASTY - RIDGE EXTENSION	\$238.88
D7410	RADICAL EXCISION - LESION DIAMETER UP TO 1.25CM	\$95.55
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	\$143.33
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	\$95.55

**ATTACHMENT A-1  
TEXAS MEDICAID FEE SCHEDULE**

**SCHEDULE OF ALLOWABLE FEES**

\*\* PLEASE REFER TO OFFICE REFERENCE MANUAL ON DENTAQUEST'S WEBSITE FOR COVERED SERVICES\*\*

Procedure Code	Procedure Description	Fee
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM	\$143.33
D7440	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER UP TO 1.25CM	\$173.19
D7441	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER GREATER THAN 1.25CM	\$226.93
D7450	REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25CM	\$113.47
D7451	REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION GREATER THAN 1.25CM	\$155.27
D7460	REMOVAL OF NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25CM	\$113.47
D7461	REMOVAL OF NONODONTOGENIC CYST OR TUMOR - LESION GREATER THAN 1.25CM	\$155.27
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT	\$65.70
D7472	REMOVAL OF TORUS PALATINUS	\$152.88
D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	\$35.83
D7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE	\$119.44
D7530	REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE	\$47.78
D7540	REMOVAL OF REACTION-PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM	\$95.55
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE	\$101.53
D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY	\$119.44
D7670	ALVEOLUS STABILIZATION OF TEETH, CLOSED REDUCTION SPLINTING	\$77.64
D7820	CLOSED REDUCTION DISLOCATION	\$77.64
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	\$133.77
D7910	SUTURE SMALL WOUNDS UP TO 5 CM	\$71.66
D7911	COMPLICATED SUTURE-UP TO 5 CM	\$77.64
D7912	COMPLEX SUTURE - GREATER THAN 5CM	\$155.27
D7960	FRENULECTOMY	\$100.33
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	\$107.49
D7971	EXCISION OF PERICORONAL GINGIVA	\$41.81
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	\$41.81
D7980	SURGICAL SIALOLITHOTOMY	\$185.13
D7983	CLOSURE OF SALIVARY FISTULA	\$155.27

Procedure Code	Procedure Description	Fee
D7997	APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCHBAR	\$47.78
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT	\$0.00
D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	\$435.00
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$435.00
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$697.00
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	\$697.00
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	\$697.00
D8210	REMOVABLE APPLIANCE THERAPY	\$250.00
D8220	FIXED APPLIANCE THERAPY	\$250.00
D8660	PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT	\$14.70
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	\$66.74
D8680	ORTHODONTIC RETENTION	\$697.00
D8690	ORTHODONTIC TREATMENT	\$19.60
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT	\$115.24
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN - MINOR PROCEDURE	\$17.92
D9120	FIXED PARTIAL DENTURE SECTIONING	\$19.11
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	\$11.94
D9211	REGIONAL BLOCK ANESTHESIA	\$17.92
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	\$29.86
D9215	LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	\$12.25
D9220	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 30 MINUTES	\$125.00
D9221	DEEP SEDATION/GENERAL ANESTHESIA - EACH ADDITIONAL 15 MINUTES	\$35.00
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	\$58.50
D9223	DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	\$43.88
D9230	INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS	\$27.11
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA- FIRST 15 MINUTES	\$57.04
D9241	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 30 MINUTES	\$125.00

**ATTACHMENT A-1  
TEXAS MEDICAID FEE SCHEDULE**

**SCHEDULE OF ALLOWABLE FEES**

**\*\* PLEASE REFER TO OFFICE REFERENCE MANUAL ON DENTAQUEST'S WEBSITE FOR COVERED SERVICES\*\***

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>Fee</b>
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA- FIRST 15 MINUTES	\$57.04
D9241	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 30 MINUTES	\$125.00
D9242	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH ADDITIONAL 15 MINUTES	\$35.00
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	\$42.78
D9248	NON-INTRAVENOUS MODERATE (CONSCIOUS) SEDATION	\$121.88
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN	\$14.58
D9410	HOUSE/EXTENDED CARE FACILITY CALL	\$23.89
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	\$36.31
D9430	OFFICE VISIT FOR OBSERVATION - NO OTHER SERVICES PERFORMED	\$14.33
D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	\$29.86
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	\$17.92
D9612	THERAPEUTIC DRUG INJECTION - 2 OR MORE MEDICATIONS BY REPORT	\$35.83
D9630	OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT	\$8.60
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	\$11.94
D9920	BEHAVIOR MANAGEMENT, BY REPORT	\$47.78
D9930	TREATMENT OF COMPLICATIONS (POST-SURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT	\$23.89
D9944	OCCLUSAL GUARD – HARD APPLIANCE, FULL ARCH	\$113.47
D9950	OCCLUSION ANALYSIS-MOUNTED CASE	\$53.75
D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$35.83
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$143.33
D9970	ENAMEL MICROABRASION	\$53.75
D9974	INTERNAL BLEACHING - PER TOOTH	\$53.75
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT	\$0.00

**ATTACHMENT A-2  
TEXAS CHIP FEE SCHEDULE**



**SCHEDULE OF ALLOWABLE FEES**

\*\* PLEASE REFER TO OFFICE REFERENCE MANUAL ON DENTAQUEST'S WEBSITE FOR COVERED SERVICES\*\*

Procedure Code	Procedure Description	Fee
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	\$28.85
D0140	LIMITED ORAL EVALUATION- PROBLEM FOCUSED	\$18.78
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	\$35.32
D0210	INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES	\$70.64
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	\$12.56
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	\$11.51
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$4.90
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$23.38
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$34.61
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$63.78
D1110	PROPHYLAXIS - ADULT	\$54.88
D1120	PROPHYLAXIS - CHILD	\$36.75
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	\$14.70
D1351	SEALANT - PER TOOTH	\$28.24
D1510	SPACE MAINTAINER-FIXED- UNILATERAL	\$156.80
D1515	SPACE MAINTAINER - FIXED - BILATERAL	\$232.75
D1516	SPACE MAINTAINER --FIXED-- BILATERAL, MAXILLARY	\$232.75
D1517	SPACE MAINTAINER --FIXED-- BILATERAL, MANDIBULAR	\$232.75
D1520	SPACE MAINTAINER-REMOVABLE- UNILATERAL	\$73.50
D1525	SPACE MAINTAINER-REMOVABLE- BILATERAL	\$104.13
D1526	SPACE MAINTAINER -- REMOVABLE--BILATERAL, MAXILLARY	\$104.13
D1527	SPACE MAINTAINER -- REMOVABLE--BILATERAL, MANDIBULAR	\$104.13
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED - UNILATERAL	\$200.00
D2140	AMALGAM - ONE SURFACE - PERMANENT	\$62.80
D2140	AMALGAM - ONE SURFACE - PRIMARY	\$61.25
D2150	AMALGAM - TWO SURFACES - PERMANENT	\$83.57
D2150	AMALGAM - TWO SURFACES - PRIMARY	\$81.75
D2160	AMALGAM - THREE SURFACES - PERMANENT	\$106.46
D2160	AMALGAM - THREE SURFACES - PRIMARY	\$88.75
D2161	AMALGAM - FOUR OR MORE SURFACES -PERMANENT	\$121.88
D2161	AMALGAM - FOUR OR MORE SURFACES - PRIMARY	\$90.01
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	\$75.81

Procedure Code	Procedure Description	Fee
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	\$100.46
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	\$131.17
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	\$162.80
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR - PERMANENT	\$80.34
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR - PRIMARY	\$76.25
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR - PERMANENT	\$105.30
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR - PRIMARY	\$97.75
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR - PERMANENT	\$117.98
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR - PRIMARY	\$121.00
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR - PERMANENT	\$131.63
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR - PRIMARY	\$135.00
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	\$252.25
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$252.25
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	\$252.25
D2722	CROWN - RESIN WITH NOBLE METAL	\$252.25
D2740	CROWN - PORCELAIN/CERAMIC	\$252.25
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	\$504.50
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$504.50
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	\$504.50
D2790	CROWN - FULL CAST HIGH NOBLE METAL	\$504.50
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	\$252.25
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	\$149.12
D2931	PREFABRICATED STAINLESS STEEL CROWN- PERMANENT TOOTH	\$155.27
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	\$149.12
D3220	THERAPEUTIC PULPOTOMY - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	\$84.05
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH	\$37.03
D3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH	\$42.02
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH	\$340.14
D3320	ENDODONTIC THERAPY, PREMOLAR TOOTH	\$394.14
D3330	ENDODONTIC THERAPY, MOLAR TOOTH	\$596.48
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	\$155.27

**ATTACHMENT A-2  
TEXAS CHIP FEE SCHEDULE  
SCHEDULE OF ALLOWABLE FEES**

\*\* PLEASE REFER TO OFFICE REFERENCE MANUAL ON DENTAQUEST'S WEBSITE FOR COVERED SERVICES\*\*

Procedure Code	Procedure Description	Fee
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	\$53.75
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE ORAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	\$71.66
D5110	COMPLETE DENTURE - MAXILLARY	\$358.31
D5120	COMPLETE DENTURE - MANDIBULAR	\$358.31
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$262.76
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$262.76
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$382.20
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	\$382.20
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	\$64.06
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	\$98.23
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	\$150.49
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	\$171.99
D7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$286.65
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	\$435.00
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$435.00
D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	\$435.00
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$435.00
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$697.00
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	\$697.00
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	\$697.00
D8210	REMOVABLE APPLIANCE THERAPY (INCLUDES APPLIANCES FOR THUMB SUCKING AND TONGUE THRUSTING)	\$250.00
D8220	FIXED APPLIANCE THERAPY (INCLUDES APPLIANCES FOR THUMB SUCKING AND TONGUE THRUSTING)	\$250.00
D8660	PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT	\$14.70
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	\$66.74

Procedure Code	Procedure Description	Fee
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES)	\$697.00
D8690	ORTHODONTIC TREATMENT (ALTERNATIVE BILLING TO A CONTRACT FEE)	\$19.60

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**TEXAS ORTHODONTIC FEE SCHEDULE  
DENTAL PANEL REIMBURSEMENT**

- 1.00** Provider shall be reimbursed for Covered Services rendered to Members administered by DentaQuest at the lesser of billed charges or one hundred percent (100%) of the Attached Fees as shown in paragraphs 6.00 and 7.00.
- 2.00** Provider agrees to practice cost effective dentistry. Provider acknowledges that improper billing or the rendering of dental care that is determined to be unnecessary or inappropriate by DentaQuest, shall not be compensated and will constitute sufficient basis for termination of this agreement or other measures as described in paragraph 3.00.
- 3.00** Provider acknowledges that fee-for-service dental reimbursement can only be maintained with the cooperation and commitment of all dental panel members to practice cost effective, quality dentistry. Providers, whose practice patterns deviate from the norms of the DentaQuest dental panel, may be subject to notice of probationary status and/or possible termination, subject to the appropriate notice and appeal procedures as stated herein.
- 4.00** DentaQuest shall pay Provider within thirty (30) calendar days of receipt of clean claims for dental services rendered to Members. Provider agrees to accept electronic payment and electronic remittances if/when available. DentaQuest will pay Providers interest at a rate of 1.5 % per month (18% per annum) on all clean claims not adjudicated within 30 days.
- 5.00** Provider reimbursement requires receipt of a clean claim. A claim shall be considered clean only if the claim requires no further information, documentation, adjustment or alteration by Provider to be adjudicated by DentaQuest. DentaQuest shall deny claims that are not clean claims within thirty (30) calendar days of receipt. Any dispute regarding payment shall be deemed waived unless Provider submits written notification of the reasons for the dispute within one hundred twenty (120) days of receipt of the payment, statement of denial or adjustment. Provider agrees that DentaQuest can adjust future payments or request Provider refund an amount equal to any payment made to Provider in error by DentaQuest including but not limited to an overpayment, duplicate payment, an ineligible member or for any other reason for which payment should not have initially been made.

**6.00 Payment Schedule**

**Level I (Must be completed in 12 months)**

D8010 or D8020 limited ortho –primary or transitional	\$435.00
D8670 periodic orthodontic treatment visit	\$66.74

**Level II (Must be completed in 24 months)**

D8050 or D8060 interceptive –primary or transitional	\$435.00
D8070 or D8080 or D8090 comprehensive – transitional, adolescent or adult	\$697.00
D8670 periodic orthodontic treatment visit	\$66.74

- 7.00 Additional Services:** There may be extenuating circumstances that warrant additional treatment, including but not limited to craniofacial anomalies and cleft palate. In the event that the Member requires additional treatment, the Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the patient or extenuating circumstances. Each case will be reviewed and evaluated on a case by case basis for medical necessity. Level III and Level IV described below are the clinical criteria that must be met in order to qualify for additional services.

- 7.01** To submit for additional services, the provider must complete the following:
- A. Submit a prior authorization on a 2006 or greater ADA claim form with the appropriate code(s) being requested
  - B. If the provider is requesting additional monthly adjustments, the code D8670 must be utilized
  - C. Recent radiographs (x-rays) showing the progress made to current
  - D. Photographs
  - E. Treatment plan

### Other Orthodontic Services

D8210	removable appliance therapy	\$250.00
D8220	fixed appliance therapy	\$250.00
D8680	orthodontic retention (removal of appliances) New and Transfer cases	\$697.00
D8691	repair of orthodontic appliance	\$75.00
D8692	replacement of lost/broken retainer	\$125.00
D8693	rebond/cement/repair retainer	\$50.00