New York State Workers' Compensation Board

RULE TEXT (12 NYCRR Part 444) and OFFICIAL NEW YORK WORKERS' COMPENSATION DENTAL FEE SCHEDULE, First Edition, March 1, 2009

RULE TEXT

12 NYCRR PART 444

DENTAL FEE SCHEDULE

Effective: March 1, 2009

The title to Subchapter M of Chapter V of Title 12 NYCRR is amended to read as follows:

M. Pharmacy, Durable Medical Goods, and Dental Fee Schedules and Appendices

Subchapter M of Chapter V. of Title 12 NYCRR is amended to add a new Part 444 to read as follows:

Part 444. Dental Fee Schedule

Section 444.1 Applicability

This dental fee schedule is applicable to dental treatment and procedures performed on or after, March 1, 2009, for the necessary care and treatment of an injured employee regardless of the date of accident or date of disablement. The date of service for dental treatment or for a dental procedure shall be the applicable date for reimbursement in accordance with this fee schedule. Dental treatment or procedures performed prior to March 1, 2009, shall be reimbursed at the usual and customary rate in the location where the claimant resides.

Section 444.2. Fee Schedule

(1) The dental fee schedule for all dental services shall be the *Official New York Workers' Compensation Dental Fee Schedule*, First Edition, March 1, 2009, prepared by the Chair and published by the Board, which is hereby incorporated by reference, except that the maximum reimbursement for dental services in cases in which the insurance carrier files or has filed a notice of controversy pursuant to Workers' Compensation Law section 25(2)(a) or (b) shall be twenty-five percent more than the fees set forth in the *Official New York Workers' Compensation Dental Fee Schedule*.

(2) The *Official New York Workers' Compensation Dental Fee Schedule* incorporated by reference herein may be examined at the office of the Department of State, 99 Washington Avenue, Suite 650, Albany, New York 12231, the Legislative Library, the libraries of the New York State Supreme Court, and the district offices of the Board in Albany, Binghamton, Brooklyn, Buffalo, Hauppauge, Hempstead, Manhattan,

Peekskill, Queens, Rochester and Syracuse. Copies may be obtained from the Board by writing to New York Workers' Compensation Dental Fee Schedule, Bureau of Health Management, New York State Workers' Compensation Board, 100 Broadway – Menands, Albany, New York 12241 or by telephone at 1-800-7812362 or by email at general_information@wcb.state.ny.us.

(3) The dental fee schedule shall be updated by the Chair as he or she deems warranted by changes in market rates. The dental fee schedule consists of a list of Current Dental Terminology (CDT) codes and descriptions of treatment services and procedures as published by the American Dental Association with a corresponding maximum fee to be charged by dental providers. Nothing shall prohibit a provider from charging a fee that is less than the fee schedule.

(4) Any treatment or procedure provided in connection with a work related injury not specifically contained in the dental fee schedule should be billed using CDT code D9999 "Unspecified Adjunctive Procedure By Report" (BR). The provider should establish a fee consistent in relativity with the other fees listed in the dental fee schedule. Any bill submitted by a dental provider which lists CDT Code D9999 shall be accompanied by a report providing the reasons why such procedure is necessary to treat the injured employee.

444.3 Payment of Bills and Reimbursement Requests.

(1) Bills submitted by a dental provider to the carrier or self-insured employer for payment or reimbursement shall be paid according to the fee schedule adopted under Workers' Compensation Law Section 13(a) within forty-five calendar days of receipt of the bill or reimbursement request.

(2) Where the liability of the self-insured employer or carrier for the claim has not been established or the treatment or procedure is not for a causally related condition, the self-insured employer or carrier shall pay any undisputed amount of the bill or reimbursement request and notify the Board, claimant and dental provider in writing using the form prescribed by the Chair for this purpose within forty-five calendar days of receipt of the

claim or reimbursement request: a) that the claim is not being paid and the reason for non-payment of the claim; or b) to request additional information needed to reasonably determine the self-insured employer's or carrier's liability for the claim or whether the dental treatment or procedure is causally related to the injury. Upon receipt of the information reasonably requested, the self-insured employer or carrier shall have thirty days to pay the bill or reimbursement request or provide written notice to the Board, claimant and dental provider using the form prescribed by the Chair for this purpose explaining why the bill is not being paid with copies of the additional information requested attached to the form to support the determination.

(3) Where the self-insured employer or carrier has failed to pay a bill or reimbursement request or make reasonable request for additional information within forty-five calendar days, the self-insured employer or carrier is deemed to have waived any objection to liability for the bill or reimbursement request and shall pay the bill or reimbursement request.

OFFICIAL NEW YORK

WORKERS' COMPENSATION

DENTAL FEE SCHEDULE

First Edition
March 1, 2009

Official New York Workers' Compensation Dental Fee Schedule, First Edition, March 1, 2009

Errata

Issued: March 1, 2011

Part 444 of Title 12 of the *New York Codes, Rules and Regulations* requires reimbursement for dental treatment and procedures performed on and after March 1, 2009, to be as set forth in the *Official New York Workers' Compensation Dental Fee Schedule, First Edition, March 1, 2009* (Dental Fee Schedule). The Dental Fee Schedule consists of a list of Current Dental Terminology (CDT) codes and descriptions[*] of treatment and services and procedures as published by the American Dental Association with a corresponding maximum fee to be charged by dental providers. The CDT codes and descriptions in the Dental Fee Schedule are from the American Dental Association reference manual, *CDT 2007/2008*.

When preparing the Dental Fee Schedule, the words "(UP TO AGE 21)" were mistakenly included with the description of CDT code D8090, rather than CDT code D8080. The words "(UP TO AGE 21)" are not part of the American Dental Association's description of CDT code D8090.

The description for CDT code D8090 is read:

COMPREHENSIVE ORTHO TRTMT OF ADULT DENTITION

Official New York Workers' Compensation Dental Fee Schedule
First Edition
March 1, 2009

Dental Procedure Codes and Fees.

(1) The maximum fees for dental services are as follows:

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D0120	PERIODIC ORAL EXAMINATION	34.25
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	62.50
D0150	COMPREHENSIVE ORAL EVALUATION - NEW/ESTABLISHED PATIENT	105.00
D0160	DETAILED & EXT ORAL EVAL-PROBLEM-FOCUSED	96.67
D0170	RE-EVAULATION	50.00
D0210	X-RAY INTRAORAL COMPLETE SERIES ALSO CODE 70320	112.00
D0220	X-RAY INTRAORAL PERIAPICAL ALSO CODE 70300	20.13
D0230	X-RAY INTRAORAL PERIAPICAL ADDITIONAL SEE CODE 70310	17.50
D0240	INTRAORAL-OCCLUSAL FILM	29.50
D0250	EXTRAORAL-FIRST FILM	35.00
D0260	EXTRAORAL-EACH ADDITIONAL FILM	29.00
D0270	BITEWING-SINGLE FILM	19.88
D0272	BITEWINGS-TWO FILMS	32.50
D0273	BITEWINGS-THREE FILMS	39.00
D0274	BITEWINGS - FOUR FILMS	50.13
D0277	VERTICAL BITEWINGS	63.00
D0290	POST/LAT SKULL AND FACIAL BON, SUR FLM	73.67
D0310	SIALOGRAPHY	220.00
D0320	TEMP-MANDIB JOINT ARTHROGRAM INC INS	375.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS(PER JOINT)	150.00
D0322	TOMOGRAPHIC SURVEY	162.00
D0330	X-RAY PANORAMIC FILM SEE ALSO CODE 70320	90.00
D0340	X-RAY, CEPHALOMETRIC	156.67
D0350	ORAL/FACIAL IMAGES (INC INTR AND EXTRAORAL IMAGES)	48.33
D0360	CONE BEAM CT	50.00
D0362	CONE BEAM CT - 2 DIMENSIONAL IMAGE	210.00
D0363	CONE BEAM CT - THREE DIMENSIONAL IMAGE	247.00
D0460	PULP VITALITY TESTS	43.50
D0470	DIAGNOSTIC CASTS	83.75
D1110	PROPHYLAXIS, ADULT	80.88
D1203	TOPICAL APPLICATION OF FLUORIDE (EXCLUDING PROPHYL	34.63
D1204	TOP APP/FLUORIDE (EXC-PROPHY) ADULT	33.33
D1351	SEALANT, PER TOOTH	45.88
D1510	SPACE MAINTAINER, FIXED-UNILATERAL	216.00
D1515	SPACE MAINTAINER, FIXED-BILATERAL	300.33
D1520	SPACE MAINTAINER REMOVABLE, UNILATERAL	310.00
D1525	SPACE MAINTAINER REMOVABLE, BILATERAL	315.00
D1550	RECEMENTATION OF SPACE MAINTAINER	33.25
D1555	REMOVAL OF FIXED SPACE MAINTAINER	52.80
D2140	AMALGAM; ONE SURFACE PRIMARY OR PERMANENT (SURF/TO	105.25
D2150	AMALGAM;TWO SURFACES PRIMARY OR PERMANENT (SUR/TOO	136.00
D2160	AMALGAM;THREE SURFACES PRIMARY OR PERMANENT (SUR/T	163.50
D2161	AMALGAM; FOUR OR MORE SURFACES PRIMARY OR PERMANET	194.75
D2330	RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR	110.50
D2331	RESIN-2 SURFACES, ANTERIOR	149.88
D2332	RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR	184.25
D2335	RESIN COMPOS - 4/MORE SURFACES/INVLV INCISAL ANG	225.25
D2390	RESIN-BASED COMPOSITE CROWN ANTERIOR (TOOTH)	228.75
D2391	RESIN-BASED COMPOSITE ONE SURF POSTERIOR (SURF/TOO	121.75

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D2392	RESIN-BASED COMPOSITE - TWO SURFACES POSTERIOR	174.50
D2393	RESIN-BASED COMPOSITE - THREE SURFACES POSTERIOR	211.75
D2394	RESIN COMPOS - FOUR OR MORE SURFACES POSTERIOR	233.00
D2710	CROWN RESIN INDIRECT (LAB)(TOOTH)	552.17
D2712	CROWN 3/4 RESIN BASED COMPOSITE	787.00
D2720	CROWN-RESIN W/HIGH NOBLE METAL	760.00
D2721	CROWN-RESIN W/PREDOMINANTLY BASE METAL	760.00
D2722	CROWN-RESIN W/NOBLE METAL	760.00
D2740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	899.25
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	887.00
D2751	CROWN-PORCELAIN FUSED TO PREDOMIN BASE METAL	823.25
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	883.75
D2780	CROWN 3/4 CAST HIGH NOBLE METAL	987.50
D2781	CROWN 3/4 CAST PREDOMINATELY BASE METAL	878.33
D2782	CROWN 3/4 CAST NOBLE METAL	878.33
D2783	CROWN 3/4 PORC/CERAMIC	878.33
D2790	CROWN-FULL CAST HIGH NOBLE METAL	897.50
D2791	CROWN-FULL CAST PREDOMIN BASE METAL	745.25
D2792	CROWN-FULL CAST NOBLE METAL	843.00
D2794	CROWN TITANIUM	843.00
D2799	PROVISIONAL CROWN	305.00
D2910	RECEMENT INLAY, ONLAY OR PARTIAL RESTORATION	82.00
D2915	RECEMENT CAST OR PRE-FABRICATED POST & CORE	85.00
D2920	RECEMENT CROWN	76.56
D2930	PREFAB STAIN STEEL CROWN-PRIM TOOTH	185.00
D2931	PREFAB STAIN STEEL CROWN-PERM TOOTH	215.75
D2932	PREFABRICATED RESIN CROWN (PERMANENT)	204.67
D2933	PREFAB STAINLESS STEEL CROWN W RESIN WINDOW	228.67
D2934	PREFAB ESTHETIC CODED STAINLESS STEEL CROWN-PRIM	228.67
D2940	SEDATIVE FILLING	87.75
D2950	CORE BUILDUP INCLUDING ANY PINS	196.00
D2951	PIN RETENTION-PER TOOTH IN ADD TO RESTORE	54.33
D2952	CAST POST AND CORE IN ADD TO CROWN	338.00
D2953	ADDITIONAL INDIRECTLY FABRICATED POST	173.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	283.38
D2955	POST REMOVAL (NOT IN CONJUNCT W/ENDODON THERAPY)	172.67
D2957	EACH ADDITIONAL PRE-FABRICATED POST	116.70
D2960	LABIAL VENEER-CHAIRSIDE	396.50
D2961	LABIAL VENEER-LAB	806.25
D2962	LABIAL VENEER-LAB	838.25
D2970	TEMPORARY CROWN (FX TOOTH)	271.00
D2975	COPING	186.25
D2980	CROWN REPAIR	186.25
D3110	PULP CAP-DIRECT	51.75
D3120	PULP CAP - INDIRECT	52.25
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORE)	132.00
D3221	PULPAL DEBRIDEMENT	150.00
D3230	PUPAL TX (RESORB FILING) ANTER PRIM (EXC FIN RESTO	204.67
D3240	PUPAL TX (RESORB FILING) POST,PRIM (EXC FIN RESTOR	263.67
D3310	RCT ANTERIOR (EXCLUDE FINAL RESTOR)	564.75
D3320	RCT BICUSPID (EXCLUD FINAL RESTORE)	676.00
D3330	RCT MOLAR (EXCLUDING FINAL RESTORE)	833.75
D3331	RCT OBSTRUCTION	369.00
D3332	INCOMPLETE ENDO THERAPY; INOPERABLE	296.00
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	180.00
D3346	RETREAT PREV ROOT CANAL TX ANTERIOR	559.00
D3347	RETREAT PREV ROOT CANAL TX BICUSPID	706.33
D3348	RETREAT PREV ROOT CANAL TX MOLAR	850.00
D3351	APEXIFICATION (INITIAL VISIT)	208.33
D3352	APEXIFICATION INTERIM MED REPLACEMENT	131.67
D3353	APEXIFICATION (FINAL VISIT)	243.33
D3410	APICOECTOMY-ANTERIOR (PER TOOTH)	517.75
D3421	APICOECTOMY-BICUSPID (FIRST ROOT)	510.00
D3425	APICOECTOMY-MOLAR (FIRST ROOT)	592.00
D3426	APICOECTOMY (PER TOOTH)-EACH ADDITION ROOT	192.50
D3430	RETROGRADE FILLING-PER ROOT	156.33
D3450	ROOT AMP	338.50
D3460	ENDODONTIC ENDOSSEOUS IMPLANT	1,138.52
D3470	INTENTIONAL REIMPLANTATION	689.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D3920	HEMISECTION	403.00
D3950	CANAL PREP AND FITTING OF PREFORMED POST	169.00
D4210	GINGIVECTOMY OR GINGIVOPLASTY- PER QUAD	363.67
D4211	GINGIVECTOMY 1-3 CONTIGUOUS TEETH PER QUAD	242.60
D4230	ANATOMICAL CROWN EXPOSURE-4 OR MORE CONT TEETH PER QUAD	410.40
D4231	ANATOMICAL CROWN EXPOSURE-1-3 TEETH PER QUAD	396.00
D4240	GINGIVAL FLAP 4 OR MORE CONT. TEETH	695.00
D4241	GINGIVAL FLAP 1-3 CONT TEETH	495.00
D4245	APICALLY POSITIONED FLAP	623.00
D4249	CROWN LENGHTENING	603.00
D4260	OSSEOUS SURGERY 4 OR MORE CONT. TEETH	786.67
D4261	OSSEOUS SURGERY 1-3 CONT. TEETH	523.00
D4263	BONE REPLACEMENT GRAFT-FIRST SITE	450.00
D4264	BONE REPLACEMENT GRAFT-EACH ADD. SITE IN QUAD	375.00
D4265	BIOLOGIC MATERIALS	350.00
D4266	GUIDED TISSUE REGENERATION-RESORABLE BARRIER	691.35
D4267	GUIDED TISSUE REGENERATION-NON RESORABLE BARRIER	520.00
D4268	SURGICAL REVISION PROCEDURE	630.00
D4270	PEDICLE SOFT TISSUE GRAFT	685.00
D4271	FREE SOFT TISSUE GRAFT	623.00
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT	810.00
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	528.00
D4275	SOFT TISSUE ALLOGRAFT	810.00
D4276	COMBINED CONNECTIVE TISSUE & DBLE PEDICLE GRAFT	912.00
D4320	PROVISIONAL SPLINTING INTRACORONAL	352.00
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	314.00
D4910	PERIODONTAL MAINTENANCE	96.50
D4920	UNSCHEDULED DRESSING CHANGE	78.00
D5110	DENTURE-COMPLETE UPPER	1,185.00
D5120	DENTURE-COMPLETE LOWER	1,185.00
D5130	IMMEDIATE DENTURE MAXILLARY	1,430.00
D5140	IMMEDIATE DENTURE MANDIBULAR	1,430.00
D5211	UPPER PARTIAL-RESIN BASE W CLASPS + RESTS	937.00
D5212	LOWER PARTIAL-RESIN BASE W CLASPS + RESTS	941.25
D5213	UPPER PARTIAL CAST BASE W RESIN SADS CLASP + REST	1,353.75

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D5214	LOWER PARTIAL CAST BASE W RESIN SADS CLASP+REST	1,362.50
D5225	MAX PARTIAL DENTURE FLEX BASE	1,183.00
D5226	MAND PARTIAL DENTURE FLEX BASE	1,183.00
D5281	REMOVE UNILAT PART DENTURE	628.33
D5410	ADJUST COMPLETE DENTURE MAXILLARY	62.50
D5411	ADJUST COMPLETE DENTURE MANDIBULAR	67.50
D5421	ADJUST PARTIAL DENTURE MAXILLARY	62.50
D5422	ADJUST PARTIAL DENTURE MANDIBULAR	62.50
D5510	REPAIR BROKEN COMPLT DENTURE BASE	153.75
D5520	REPLACE MISS/BROKEN TEETH-COMPL DENT EACH TOOTH	121.50
D5610	REPAIR RESIN SADDLE OR BASE	149.25
D5620	REPAIR CAST FRAMEWORK	203.75
D5630	REPAIR OR REPLACE BROKEN CLASP	181.25
D5640	REPLACE BRKN TEETH-PER TOOTH	127.50
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	153.75
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	180.13
D5670	REPLACE TEETH ON ACRYLIC CAST METAL FRAMEWORK (MAX)	374.00
D5671	REPLACE TEETH ON ACRYLIC CAST METAL FRAMEWORK (MAND)	391.33
D5710	REBASE COMPLETE UPPER DENTURE	398.75
D5711	REBASE COMPLETE LOWER DENTURE	398.00
D5720	REBASE UPPER PARTIAL DENTURE	361.75
D5721	REBASE LOWER PARTIAL DENTURE	351.25
D5730	RELINE UP COMPL DENTURE CHAIRSIDE	277.75
D5731	RELINE COMPL LOWER DENTURE CHAIRSIDE	277.75
D5740	RELINE UPPER PART DENTURE CHAIRSIDE	258.00
D5741	RELINE LOWER PART DENTURE CHAIRSIDE	263.75
D5750	RELINE UPPER COMPL DENTURE LAB	398.75
D5751	RELINE LOWER COMPL DENTURE LAB	401.00
D5760	RELINE UPPER PART DENTURE LAB	342.50
D5761	RELINE LOWER PART DENTURE LAB	381.25
D5810	INTERIM COMPLETE DENTURE MAX	532.75
D5811	INTERIM COMPLETE DENTURE MAND	532.75
D5820	INTERIM PARTIAL DENTURE	456.25
D5821	TEMP PART-STAYPLATE DENT LOWER	358.33
D5850	TISSUE CONDITIONING-UPPER-PER DENTURE UNIT	103.33
D5851	TISSUE CONDITIONING-LOWER-PER DENTURE UNIT	95.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D5860	OVERDENTURE COMPLETE	1,397.00
D5861	OVERDENTURE PARTIAL	1,354.00
D5862	PERCISION ATTACHMENT	452.00
D5867	REPLACE SEMI PRECISION OR PRECISION ATTACHMENT	246.00
D5875	MODIFICATION OF REMOVAL PROSTH FOLLOWING IMPLANT SURGERY	279.00
D5911	FACIAL MOULAGE (SECTIONAL)	300.00
D5912	FACIAL MOULAGE (COMPLETE)	400.00
D5913	NASAL PROSTHESIS BY RPT	1,175.00
D5914	AURICULAR PROSTHESIS BY RPT	1,175.00
D5915	ORBITAL PROSTHESIS	1,195.00
D5916	OCULAR PROSTHESIS	1,195.00
D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	450.00
D5937	TRISMUS APPLIANCE NOT (TMD)	559.00
D5958	PALATAL LIFT PROSTHESIS-INTERIM	1,000.00
D5986	FLUORIDE GEL CARRIER, PER ARCH	115.00
D5987	COMMISSURE SPLINT	300.00
D5988	SURGICAL SPLINT	312.50
D6010	SURG PLACEMENT ENDOSTEAL IMPLANT	1,800.00
D6012	SURG PLACEMENT INTRIM IMPLANT BODY FOR TRANS PROSTH	853.00
D6040	SURG PLACEMENT EPOSTEAL IMPLANT 21245	11,665.00
D6050	SURG PLACEMENT TRANSOSTEAL IMPLANT 21244	6,050.00
D6053	IMPL/ABUT DENTUR CMPL ENDTULS ARCH	2,866.67
D6055	DENTAL IMPLANT SUPP CONNECTING BAR	963.50
D6056	PREBABRICATED ABUTEMENT	554.00
D6057	CUSTOM ABUTMENT	628.33
D6058	ABUT SUPP PORC/CERAMIC CROWN	1,170.00
D6059	ABUT PORC TO METAL CROWN HI NOBLE METAL	1,131.67
D6060	ABUT PORC TO METAL CROWN BASE METAL	1,500.00
D6061	ABUT PORC TO METAL CROWN NOBLE METAL	1,180.00
D6062	ABUT SUPP CAST MTL CROWN HIGH NOBLE METAL	1,060.00
D6063	ABUT SUPP CAST MTL CROWN BASE METAL	1,500.00
D6064	ABUT SUPP CAST MTL CROWN NOBLE METAL	1,180.00
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	1,172.00
D6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	1,169.00
D6067	IMPLANT SUPPORTED METAL CROWN	1,246.67
D6068	ABUT SUPP RETAIN PORC/CERAM FPD	1,083.33

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D6069	ABUT RETN PORC METAL FPD HIGH NOBLE METAL	1,158.33
D6070	ABUT RETN PORC METAL FPD BASE METAL	1,687.50
D6071	ABUT SUPP RETN PORC FUSED METL FPD	1,800.00
D6072	ABUT SUPP RETN CAST METAL FPD	1,275.00
D6073	ABUT RETN CAST METAL FPD BASE METAL	1,350.00
D6074	ABUT RETN CAST METAL FPD NOBLE METAL	1,800.00
D6075	IMPLANT SUPP RETAIN CERAMIC FPD	1,350.00
D6076	IMPLANT SUPP RETAIN PORC FUSED METAL FPD	1,484.00
D6077	IMPLANT SUPP RETAIN CAST METAL FPD	1,534.00
D6080	IMPLANT MAINTENANCE PROCEDURES	207.00
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS BY REPORT	567.00
D6091	REPLACE SEMI PRECISION OR PRECISION ATTACHMENT	470.00
D6092	RECEMENT IMPLANT/ABUTEMENT SUPPORTED CROWN	119.00
D6093	RECEMENT IMPLANT/ABUTEMENT SUPPORTED FIXED PARTIAL	123.00
D6100	IMPLANT REMOVAL	250.00
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX	600.00
D6210	BRIDGE PONTICS-CAST HIGH NOBLE METAL	898.33
D6211	BRIDGE PONTICS -CAST PREDOM BASE METAL	708.33
D6212	BRIDGE PONTIC-CAST NOBLE METAL	911.25
D6214	PONTIC-TITANIUM	824.00
D6240	PONTIC-PORCELAIN TO HIGH NOBLE METAL	875.00
D6241	PONTIC-PORCELAIN TO PREDOM BASE METAL	726.67
D6242	PONTIC-PORCELAIN TO NOBLE METAL	831.25
D6245	PONTIC PORCELAIN/CERAMIC	876.67
D6250	PONTIC-RESIN W HIGH NOBLE METAL	755.00
D6251	PONTIC-RESIN W PREDOM BASE METAL	673.33
D6252	PONTIC RESIN W/NOBLE METAL	681.25
D6253	PROVISIONAL PONTIC	441.67
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHES	342.50
D6710	CROWN-INDIRECT RESIN BASED COMPOSITE	838.00
D6720	CROWN-RESIN W/HIGH NOBLE METAL	900.00
D6721	CROWN-RESIN PREDOMIN BASE METAL	950.00
D6722	CROWN RESIN NOBLE METAL	900.00
D6740	CROWN-PORCELAIN/CERAMIC	863.33
D6750	CROWN-PORCELAIN TO HIGH NOBLE METAL	958.75
D6751	CROWN PORCELAIN TO PREDOM BASE METAL	825.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D6752	CROWN-PORCELAIN TO NOBLE METAL	847.50
D6780	CROWN-3/4 CAST HIGH NOBLE METAL	950.00
D6781	CROWN-3/4 CAST PREDOM BASE METAL	802.00
D6782	CROWN-3/4 CAST NOBLE METAL	827.00
D6783	CROWN-3/4 PORCELAIN/CERAMIC	855.00
D6790	CROWN-FULL CAST HIGH NOBLE METAL	866.67
D6791	CROWN-FULL CAST PREDOM BASE METAL	866.67
D6792	CROWN-FULL CAST NOBLE METAL	850.00
D6793	PROVISIONAL RETAINER CROWN	327.50
D6794	CROWN TITANIUM	375.00
D6920	CONNECTOR BAR	303.33
D6930	RECEMENT BRIDGE	117.00
D6940	STRESS BREAKER	361.67
D6950	PRECISION ATTACHMENT	425.00
D6970	CAST POST & CORE IN ADD TO BRIDGE RETAINER	328.33
D6972	PREFAB POST & CORE IN ADD TO BRIDGE RETAINER	267.33
D6973	CORE BUILDUP FOR RETAINER	210.00
D6975	COPING/METAL	540.00
D6976	EACH ADD INDIRECTLY FABRICATED POST-SAME TOOTH	213.00
D6977	EACH ADD PREFABRICATED POST-SAME TOOTH	126.00
D6980	BRIDGE REPAIR-PER UNIT (SEVERING PER QUADRANT)	197.50
D7111	EXTRACTION CORONAL REMNANTS DECID TOOTH	100.00
D7140	EXTRACTION ERUPTED TOOTH/EXPOSED ROOT ETC (TOOTH)	122.50
D7210	SURG REMV ERUPTED TOOTH RQR ELEV FLP&REMV BONE	221.50
D7220	REMOVAL IMPACTED TOOTH-SOFT TISSUE	268.75
D7230	REMOVAL IMPACTED TOOTH PARTIALLY BONY	331.25
D7240	REMOVAL IMPACTED TOOTH COMPLETELY BONY	412.50
D7241	REM IMPACT TOOTH-COMP BONY W SURG COMP	472.50
D7250	SURG REMOVE OF RESID TOOTH ROOTS CUTTING PROC	227.50
D7260	ORAL ANTRAL FISTULA CLOSURE	1,742.50
D7261	PRIMARY CLOSURE OF SINUS PERFORATION	1,811.00
D7270	TOOTH REIMPL STABLE ACCID EVULSED/DISPL TOOTH/ALVE	371.25
D7272	TOOTH TRANS (INCL REIMP ONE SITE TO OTHER/SPLNTNG)	615.00
D7285	BIOPSY OF ORAL TISSUE-HARD	415.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D7286	BIOPSY OF ORAL TISSUE-SOFT	259.50
D7290	SURGICAL REPOSITION OF TEETH	525.00
D7291	TRANSEPTAL FIBEROTOMY	231.00
D7292	SURGICAL PLACEMENT:TEMP ANCHORAGE DEVICE	1,610.00
D7293	SURGICAL PLACEMENT:TEMP ANCHORAGE DEVICE	1,181.00
D7294	SURGICAL PLACEMENT:TEMP ANCHORAGE DEVICE W/O SURG FLAP	884.00
D7310	ALVEOLOPLASTY W EXTRACT PER QUAD 4 OR MORE TEETH	216.00
D7311	ALVEOLOPLASTY W EXTRACT PER QUAD 1-3 TEETH	200.50
D7320	ALVEOPLASTY W/O EXTRACTION PER QUAD 4 PLUS TEETH	371.25
D7321	ALVEOPLASTY NOT IN CONJUNCTION W/EXTRACTIONS 1-3 TEETH	293.00
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITH)	1,087.00
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INC SOFT TISSUE GRAFTS)	2,369.00
D7410	EXCISION OF BENIGN LESION ; UP TO 1.25 CM	400.75
D7411	EXC BENIGN LESION GRATER THAN 1.25 CM	653.25
D7412	EXC BENIGN LESION ; COMPLICATED	550.00
D7413	EXC MALIGNANT LESION UP TO 1.25 CM	1,125.00
D7414	EXC MALIGNANT LESION GREATER THAN 1.25CM	2,000.00
D7415	EXC MALIGNANT LESION COMPLICATED	4,500.00
D7440	EXCIS MALIGNANT TUMOR-LES DIAM UP TO 1.25 CM	1,400.00
D7441	EXCIS OF MALIGNANT TUMOR LES OVER 1.25 CM	1,000.00
D7450	REMOVE ODONTOGENIC CYST LES DIAM UP TO 1.25 CM	582.75
D7451	REMOVE ODONTOGENIC CYST LES DIAM OVER 1.25 CM	911.25
D7460	REMOVE NONODONTOGENIC CYST SIZE UP TO 1.25 CM	416.67
D7461	REMOVE NONODONTOGENIC CYST SIZE OVER 1.25 CM	797.67
D7465	DESTRUCTION LESION(S)/PHYSICAL OR CHEMICAL METHODS	465.00
D7471	REMOVAL LAT. EXOSTOSIS MAXILLA OR MANDIBLE	479.67
D7472	REMOVAL TORUS PALATINUS	627.00
D7473	REMOVAL TORUS MANDIBULARIS	491.67
D7485	SURGICAL REDUCTION OSSEOUS TUBEROSITY	512.00
D7490	RADICAL RESECTION MANDIBLE W BONE GRAFT	6,500.00
D7510	SURG INCIS DRAINAGE ABSCESS INTRAORAL	193.75

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D7511	SURG INCIS DRAINAGE ABSCESS INTRAORAL COMPLICATED	292.50
D7520	SURG INCIS DRAINAGE ABSCESS EXTRAORAL	572.50
D7521	SURG INCIS DRAINAGE ABSCESS EXTRAORAL COMPLICATED	572.50
D7530	REMOVAL FB MUCOSA SKIN OR SUBQ ALVEOLAR TISSUE	466.67
D7540	REMOVE FOREIGN BODY MUSCULOSKELETAL	744.33
D7550	SEQUESTRECTOMY-OSTEO INC GUTTERING OR SAUCERIZATIO	725.00
D7560	SURG INCIS MAXILLARY SINUSOTOMY	1,016.67
D7610	TREAT FRAC MAXILLA OPEN REDUCTION	3,535.75
D7620	TREAT FRAC MAXILLA CLOSED REDUCTION	2,409.25
D7630	TREAT FRAC MANDIBLE OPEN REDUCTION	3,681.25
D7640	TREAT FRAC MANDIBLE CLOSED REDUCTION	2,173.75
D7650	MALAR/ZYGOMATIC ARCH, OPEN REDUCTION	2,221.75
D7660	MALAR/ZYGOMATIC ARCH CLOSED REDUCTION	1,427.50
D7670	ALVEOLUS CL REDUCTION MAY INC STABILIZATION TEETH	1,262.50
D7671	ALVEOLUS OPEN REDUCT MAY INC STABILIZATION TEETH	1,950.00
D7680	FRACTURE FACIAL BONES-COMPLICATED ETC	4,428.33
D7710	TREAT FRAC MAXILLA-OPEN REDUCTION	3,575.00
D7720	TREAT FRAC MAXILLA-CLOSED REDUCTION	2,775.00
D7730	TREAT FRAC MANDIBLE-OPEN REDUCTION	4,031.25
D7740	TREAT FRAC MANDIBLE CLOSED REDUCTION	2,352.75
D7750	MALAR/ZYGOMATIC ARCH, OPEN REDUCTION	3,402.50
D7760	MALAR/ZYGOMATIC ARCH, OPEN REDUCTION	1,350.00
D7770	ALVEOLUS-STAB OF TEETH, OPEN REDUCT SPLINTING	1,777.50
D7771	ALVEOLUS CLOSED REDUCT STABILIZATION OF TEETH	1,716.67
D7780	FRACTURE FACIAL BONES-COMPLICATED	6,500.00
D7810	OPEN REDUCTION OF DISLOCATION	3,300.00
D7820	CLOSED REDUCTION OF DISLOCATION	641.25
D7830	MANIPULATION UNDER ANESTHESIA	941.67
D7840	CONDYLECTOMY	3,846.67
D7850	SURGICAL DISCECTOMY;WITH/WITHOUT IMPLANT	3,566.67
D7852	DISC REPAIR	2,500.00
D7854	SYNOVECTOMY	2,150.00
D7856	MYOTOMY	2,500.00
D7858	JOINT RECONSTRUCTION	5,750.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D7860	ARTHROTOMY	2,250.00
D7865	ARTHOPLASTY	2,750.00
D7870	ARTHROCENTESIS	902.00
D7872	ARTHROSCOPY-DX-W/WO BIOPSY	975.00
D7873	ARTHROSCOPY-SURG-LAVAGE/LYSIS OF ADHESIONS	1,700.00
D7874	ARTHROSCOPY-SURGICAL: DISC REPOSITIONING & STABILIZATION	2,400.00
D7875	ARTHROSCOPY-SURGICAL: SYNOVECTOMY	2,400.00
D7876	ARTHROSCOPY-SURGICAL: DISCECTOMY	2,400.00
D7877	ARTHROSCOPY-SURGICAL: DEBRIDEMENT	2,250.00
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	800.00
D7910	SUTURE OF SMALL WOUNDS UP TO 5 CM	600.00
D7911	COMPLICATED SUTURE-UP TO 5 CM	1,186.67
D7912	COMPLICATED SUTURE-GREATER THAN 5 CM	1,937.50
D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION & TYPE OF GRAFT))	2,000.00
D7940	OSTEOPLASTY-ORTHOGNATHIC DEFORMITIES	5,000.00
D7941	OSTEOTOMY-MANDIBULAR RAMI	5,633.33
D7943	OSTEOTOMY-MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT	4,800.00
D7944	OSTEOTOMY - SEGMENTED OR SUBAPICAL, PER SEXTANT OR QUADRANT	2,900.00
D7945	OSTEOTOMY-BODY OF MANDIBLE	5,666.67
D7946	LEFORT I (MAXILLA-TOTAL)	5,300.00
D7947	LEFORT I (MAXILLA-SEGMENTED)	5,333.33
D7948	LEFORT II/III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) - WITHOUT BONE GRAFT	5,500.00
D7949	LEFORT II/III WITH BONE GRAFT	6,500.00
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES-AUTOGENOUS OR NONAUTOGENOUS, BY REPORT	2,500.00
D7960	FRENULECTOMY (FRENECTOMY/FRENOTOMY) SEPARATE PROCEDURE	502.50
D7963	FRENULOPLASTY	377.00
D7970	EXCISION OF HYPERPLASTIC TISSUE, PER ARCH	553.67
D7971	EXCISION OF PERICORONAL GINGIVA	190.00
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	490.00
D7980	SIALOLITHOTOMY	946.00
D7981	EXCISION OF SALIVARY GLAND, BY REPORT	969.00

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D7982	SIALODOCHOPLASTY	1,500.00
D7983	CLOSURE OF SALIVARY FISTULA	1,650.00
D7990	EMERGENCY TRACHEOTOMY	1,233.33
D7991	CORONOIDECTOMY	2,275.00
D7997	APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCHBAR	564.00
D8060	INTERCEPTIVE ORTHO TRTMT OF THE TRANSITIONAL DENTITION	850.00
D8070	COMPREHENSIVE ORTHO TRTMT OF THE TRANSITIONAL DENTITION	985.00
D8080	COMPREHENSIVE ORTHO TRTMT OF ADOLESCENT DENTITION	985.00
D8090	COMPREHENSIVE ORTHO TRTMT OF ADULT DENTITION ~~(UP TO AGE 21)~~	985.00
D8210	REMOVABLE APPLIANCE THERAPY	375.00
D8660	PRE ORTHO TREATMENT VISIT	40.00
D8670	PERIODIC ORTHO TREATMENT VISIT (AS PART OF CONTRACT)	235.00
D8680	ORTHO RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION & PLACEMENT OF RETAINERS	235.00
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	285.00
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN - MINOR PROCEDURE	70.00
D9120	FIXED PARTIAL DENTURE SECTIONING	196.00
D9210	LOCAL ANESTHESIA	53.00
D9220	DEEP SEDATION/GEN ANESTH FIRST 30 MIN	330.00
D9221	DEEP SEDATION/GEN ANESTH EACH ADD 15 MINUTES	80.00
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE	89.00
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA-FIRST 30 MIN	277.33
D9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA-EACH ADD 15 MIN	53.50
D9248	NON INTRAVENOUS CONSCIENCE SEDATION	126.67
D9310	CONSULT-DX SERVICE BY DDS OTHER THAN DDS DOING TX	128.33
D9410	HOUSE/EXTENDED CARE FACILITY CALL	117.33
D9420	HOSPITAL CALL	172.50
D9430	OFFICE VISIT/OBSERVATION (NO OTHER SERVICES PERFORMED)	54.33

WORKERS' COMPENSATION DENTAL FEES		
Code*	**Description**	**Fee**
D9440	OFFICE VISIT AFTER REGULARLY SCHEDULED HOURS	115.50
D9450	CASE PRESENTATION	99.00
D9610	THERAPEUTIC PARENTERAL DRUG/SINGLE ADMIN	135.00
D9612	THERAPEUTIC PARENTERAL DRUGS/2 OR MORE ADMIN DIF MEDS	180.00
D9630	OTHER DRUGS AND/OR MEDICAMENTS BY REPORT	31.00
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	35.00
D9911	APPLICATION OF DESENSITIZING RESIN	44.00
D9920	BEHAVIOR MANAGEMENT, BY REPORT	51.33
D9930	TREATMENT OF COMPLICATIONS POST SURGICAL BY REPORT	105.00
D9940	OCCLUSAL GUARD, BY REPORT	475.00
D9942	REPAIR OR REALLIGN OF OCCULSAL GUARD	175.00
D9950	OCCULSION ANALYSIS MOUNTED CASE	250.00
D9951	OCCULSIAL ADJUSTMENT LIMITED	125.00
D9952	OCCULSAL ADJUSTMENT COMPLETE	468.00
D9971	ODONTOPLASTY 1-2 TEETH	125.00
D9973	EXTERNAL BLEACHING PER TOOTH	180.00
D9974	INTERNAL BLEACHING PER TOOTH	214.00
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE BY REPORT	BR

(2) The maximum reimbursement for dental services in claims in which the insurance carrier files or has filed a notice of controversy pursuant to Workers' Compensation Law section 25(2)(a) or (b) shall be twenty-five percent more than the fees set forth above in paragraph (1).

(3) The dental fee schedule consists of a list of Current Dental Terminology (CDT) codes and descriptions of treatment services and procedures as published by the American Dental Association with a corresponding maximum fee to be charged by dental providers. Nothing shall prohibit a provider from charging a fee that is less than the fee schedule.

(4) Any treatment or procedure provided in connection with a work related injury not specifically contained in the dental fee schedule should be billed using CDT code D9999 "Unspecified Adjunctive Procedure By Report" (BR). The provider should establish a fee consistent in relativity with the other fees listed in the dental fee schedule. Any bill submitted by

a dental provider which lists CDT Code D9999 shall be accompanied by a report providing the reasons why such procedure is necessary to treat the injured employee.

Official New York Workers' Compensation Dental Fee Schedule, First Edition, March 1, 2009

Errata

Issued: October 26, 2013

Part 444 of Title 12 of the *New York Codes, Rules and Regulations* requires reimbursement for dental treatment and procedures performed on and after March 1, 2009, to be as set forth in the *Official New York Workers' Compensation Dental Fee Schedule, First Edition, March 1, 2009* (Dental Fee Schedule). The Dental Fee Schedule consists of a list of Current Dental Terminology (CDT) codes and descriptions* of treatment and services and procedures as published by the American Dental Association with a corresponding maximum fee to be charged by dental providers. The CDT codes and descriptions in the Dental Fee Schedule are from the American Dental Association reference manual, *CDT 2007/2008*.

Since issuing the Dental Fee Schedule, the following errors were detected and are hereby corrected:

CODE	CURRENT DESCRIPTION	DESCRIPTION CORRECTION
D0210	X-RAY INTRAORAL COMPLETE SERIES ALSO CODE 70320	X-RAY INTRAORAL COMPLETE SERIES
D0220	X-RAY INTRAORAL PERIAPICAL ALSO CODE 70300	X-RAY INTRAORAL PERIAPICAL
D0230	X-RAY INTRAORAL PERIAPICAL ADDITIONAL SEE CODE 70310	X-RAY INTRAORAL PERIAPICAL
D6040	SURG PLACEMENT EPOSTEAL IMPLANT 21245	SURG PLACEMENT EPOSTEAL IMPLANT
D6050	SURG PLACEMENT TRANSOSTEAL IMPLANT 21244	SURG PLACEMENT TRANSOSTEAL IMPLANT
D8090	COMPREHENSIVE ORTHO TRTMT OF ADULT DENTITION (UP TO AGE 21)	COMPREHENSIVE ORTHO TRTMT OF ADULT DENTITION

CODE	CURRENT DESCRIPTION	CURRENT FEE	FEE CORRECTION
D6059	ABUT PORC TO METAL CROWN HI NOBLE METAL	1,131.67	1,500.00
D6060	ABUT PORC TO METAL CROWN BASE METAL	1,500.00	1,131.67
D6062	ABUT SUPP CAST MTL CROWN HIGH NOBLE METAL	1,060.00	1,500.00
D6063	ABUT SUPP CAST MTL CROWN BASE METAL	1,500.00	1,060.00
D6069	ABUT RETN PORC METAL FPD HIGH NOBLE METAL	1,158.33	1,687.50
D6070	ABUT RETN PORC METAL FPD BASE METAL	1,687.50	1,158.33
D6210	BRIDGE PONTICS-CAST HIGH NOBLE METAL	898.33	911.25
D6212	BRIDGE PONTIC-CAST NOBLE METAL	911.25	898.33
D6720	CROWN-RESIN W/HIGH NOBLE METAL	900.00	950.00
D6721	CROWN-RESIN PREDOMIN BASE METAL	950.00	900.00
D6791	CROWN-FULL CAST PREDOM BASE METAL	866.67	850.00
D6792	CROWN-FULL CAST NOBLE METAL	850.00	866.67

Official New York Workers' Compensation Dental Fee Schedule
First Edition, March 1, 2009

Errata

Issued: March 1, 2011

Part 444 of Title 12 of the New York Codes, Rules and Regulations requires reimbursement for dental treatment and procedures performed on and after March 1, 2009, to be as set forth in the Official New York Workers' Compensation Dental Fee Schedule, First Edition, March 1, 2009 (Dental Fee Schedule). The Dental Fee Schedule consists of a list of Current Dental Terminology (CDT) codes and descriptions of treatment and services and procedures as published by the American Dental Association with a corresponding maximum fee to be charged by dental providers. The CDT codes and descriptions in the Dental Fee Schedule are from the American Dental Association reference manual, CDT 2007/2008.

When preparing the Dental Fee Schedule, the words "(UP TO AGE 21)" were mistakenly included with the description of CDT code D8090, rather than CDT code D8080. The words "(UP TO AGE 21)" are not part of the American Dental Association's description of CDT code D8090.

The description for CDT code D8090 is read:

COMPREHENSIVE ORTHO TRTMT OF ADULT DENTITION
