Dental Supplement

Denturist

BRITISH COLUMBIA

Ministry of
Social Development
and Poverty Reduction

Ministry of
Social Development
and Poverty Reduction

TABLE OF CONTENTS

Part A - Preamble - Dental Supplements - Denturist

The overall intent of the Ministry of Social Development and Poverty Reduction (Ministry) Dental Supplements is to provide coverage for basic dental and emergency dental services to eligible individuals who receive assistance through the BC Employment and Assistance (BCEA) Program and children in low-income families. The attached Part B - *Schedule of Fee Allowances - Denturist* outlines the eligible services and fees associated with the Ministry's Dental Supplements and the provision of basic dental services. It contains the rules, frequency and financial limits associated with each service. All frequency limitations also include services performed by a dentist.

The following information provides details on the Ministry's Dental Supplements, how to confirm eligibility and obtain payment for services rendered.

Eligibility for Dental Supplements

It is important to note that the Ministry provides varying levels of benefits and some individuals may have coverage for basic dental services with a 2-year limit while others are limited to coverage of emergency dental services only. To ensure active coverage is in place and to confirm the type and amount of coverage available, eligibility must be confirmed for all patients prior to proceeding with any treatment. Procedures for confirming eligibility for your patients are outlined on page (iv) under the Eligibility Information section.

BCEA Adults

Adults who are eligible for basic dental services under Ministry Dental Supplements are eligible for a $1,000 limit every 2-year period beginning on January 1st of every odd numbered year. The applicable fees for services provided to adult patients are listed in the *Schedule of Fee Allowances – Dentist* under the column marked "Adult".

BCEA Children

Children (under 19 years of age) covered under the Ministry Dental Supplement are eligible for a $2,000 limit for basic dental services every 2-year period beginning on January 1st of every odd numbered year.

Healthy Kids

Children (under 19 years of age) eligible for Supplementary Benefits through the Medical Services Plan (MSP) are eligible for dental supplements through the Healthy Kids Program. Children covered under the Healthy Kids Program have a $2,000 limit for basic dental services every 2-year period beginning on January 1st of every odd numbered year.

The applicable fees for services provided to BCEA Children and Healthy Kids patients are listed in the *Schedule of Fee Allowances – Dentist* under the column marked "Child".

Emergency Dental Supplements

For Ministry clients who are not eligible for the previously noted 2-year limit or those who have exhausted their limit, some short-term assistance may be available through Emergency Dental Supplements. Children covered under the Healthy Kids program are also eligible for Emergency Dental Supplements. Emergency Dental allows for treatment of an eligible person who needs immediate attention to relieve pain, or to control infection or bleeding or if a person's health or welfare is otherwise immediately jeopardized.

Specific and comprehensive information regarding allowable emergency services along with their associated fees, rules and restrictions and billing information can be found under Part C - *Preamble - Emergency Dental Supplements – Denturist* and Part D - *Schedule of Fee Allowances – Emergency Dental – Denturist*.

Note: Emergency services must be billed on a separate claim form (paper or electronic) and clearly marked as "Emergency".

Denture Policy

Initial Placement – Complete Denture(s)

All Ministry clients, including those with Emergency Dental Supplement coverage only, are eligible for a single complete denture (upper or lower), or complete dentures if the dentures are required as a result of extractions for the relief of pain resulting in full clearance of the arch/arches. This clearance must have taken place in the preceding six months. If extractions were completed in the hospital, a comment must be noted on the claim form that indicates date and place of surgery. To ensure active coverage is in place, eligibility must be confirmed for all patients prior to proceeding with any treatment. Procedures for confirming eligibility for your patients are outlined on page (iv) under the Eligibility Information section.

The number of extractions required is not limited, but the extractions must result in full clearance and either be completed using the patient's basic dental limit or under the Emergency Dental Supplements.

The denture fee items are restricted to 31310, 31311, 31320, and 31321.

For those patients that have a 2-year limit, funds still available within that limit will be utilized to pay for the denture(s) with the remaining balance for the denture(s) paid over limit.

Note: Coverage for dentures is normally limited to once per arch every five years, however, payment of a **partial** denture within the past five years will not preclude provision of a complete denture as a result of full clearance. Conversely, partial dentures should not be used as provisional or temporary appliances.

Denture Policy, continued

Initial Placement – Partial Denture(s) in excess of the 2-year basic dental limit

It is important to note that not all Ministry clients qualify for partial dentures. Eligibility for this service must be confirmed prior to beginning treatment. See the Eligibility Information section on page (iv).

For eligible patients, partial dentures will be considered in excess of their 2-year limit, if all of the following conditions apply:

1. At least one extraction is required for relief of pain and the extraction has been done in the preceding six months,
2. The extraction(s) must result in 3 or more adjacent/contiguous missing teeth on the same arch, and
3. The Ministry has not paid for a denture on the same arch within the past five years.

Fee items will be restricted to fee codes 41610, 41612, 41620, 41622 as outlined in the *Ministry Schedule of Fee Allowances - Denturist*. No cast dentures will be covered in excess of the patient's limit.

Funds still available within the patient's limit will be utilized first with the remaining balance for denture(s) paid over limit. It is expected that the patient's basic dental treatment (extractions, filling, etc.) will have been accomplished by the patient's dentist within the confines of the patient's limit or under Emergency Dental Supplements.

Replacement Dentures (partial or complete) in excess of the 2-year basic dental limit

It is important to note that not all Ministry clients qualify for replacement dentures. Eligible clients must have 2 years continuous Ministry coverage. Eligibility for this service must be confirmed prior to beginning treatment. See the Eligibility Information section on page (iv).

The Ministry will pay for denture(s) only once every five years.

Note: an exception to this would be if the current denture(s) was a partial and the replacement denture(s) is complete in conjunction with full clearance of teeth (see above under Initial Placement – Complete Dentures).

Fee items will be restricted to fee codes 31310, and 31320 for complete dentures and 41610, 41612, 41620, 41622 for partial dentures outlined in the *Schedule of Fee Allowances - Denturist*. No cast dentures will be covered in excess of the patient's 2-year limit. Funds still available within the patient's limit will be utilized first with the remaining balance for denture(s) paid over limit.

Relines, Rebases and other denture related treatment

No other denture treatment will be considered over the patient's 2-year limit as urgent needs can be met through the Emergency Dental Supplements.

Eligibility Information

Eligibility must be confirmed for all patients prior to treatment, including those covered by the Emergency Dental Supplement. We recommend you request picture identification in addition to their Personal Health Number (PHN) from new patients.

You must confirm that there are sufficient funds available within your patient's limit to pay for scheduled services and previous dental history should be checked for time-limited procedures. Treatment involving more than one practitioner or a specialist should be coordinated to ensure sufficient funds are available for all services planned.

To ensure that your patient has active Ministry sponsored coverage and to determine the level of this coverage, eligibility must be confirmed immediately prior to providing service, as coverage can change from month to month.

Steps to confirm a patient's eligibility:

1. **Obtain the patient's Personal Health Number (PHN) from their CareCard, BC Driver's Licence or BC Services Card.**
2. **Access PROVIDERnet at www.providernet.ca to confirm active coverage and look up plan limits available for services, or contact Pacific Blue Cross at:**

Vancouver: 1-604-419-2780 All other Communities: 1-800-665-1297

If Ministry clients or parents of children covered through the Healthy Kids Program have questions related to their coverage, they should be referred to the Ministry's Dental Information Line at 1-866-866-0800.

Payment Process

Claims under the Ministry's Dental Supplements will be paid in accordance with the *Schedule of Fee Allowances - Denturist* and these fees represent the maximum amount the Ministry can pay for the services billed.

Claim Submission:

Denturists can submit claims electronically to Pacific Blue Cross via CDAnet for services provided under a patient's Basic Coverage (2-year limit) or under a patient's Emergency Coverage.

Detailed information on how to submit claims through PROVIDERnet is outlined in Pacific Blue Cross' Dental Provider Reference Guide which can be found on their website: https://www.pac.bluecross.ca/

Some exclusions from CDAnet are:

1. **Submissions that require explanations on the claim form (e.g.: certain denture claims, ie: initial denture with no record of extractions), and/or,**
2. **Submissions that require supporting documentation (e.g.: lab slips, clinical descriptions, diagnoses, radiographs, photographs, etc.)**

Payment Process, continued

Claims, including previously noted claims excluded from CDAnet process, may also be submitted on a standard dental claim form and sent to:

Pacific Blue Cross – Ministry Dental Program PO Box 65339 Vancouver, BC V5N 5P3

Note: Treatment completed under the Emergency Dental Supplements must be submitted on a separate claim form from treatment under Basic Coverage and will be paid in accordance with the *Schedule of Fee Allowances Emergency Dental – Denturist.* This applies to both manual paper claims and electronic claims.

To facilitate payment, it is essential that the submitted claim form be completed as accurately and thoroughly as possible using the patient's name and PHN. Where a claim form is correctly completed and the service provided is an eligible service covered by the Ministry, payment can be expected within 30 days of receipt of the claim. Rebilling within 30 days may not only hold up payment of the original claim but will also delay the processing of subsequent claims. Claims requiring review by a dental consultant may take longer to process.

All claims are processed on a "first come, first served" basis therefore timely submission is encouraged. Claims must be submitted within one year of the date of service. No payment will be made on any claim received later than one year from the date of service. If there is an error on your billing, subsequent claims may jeopardize the payment of your rebilling.

The denturist must bill the actual service(s) rendered. An alternative fee item number should not be substituted. All claims must be submitted under the payment number of the denturist performing the service(s). Claims, resubmissions and adjustment requests sent by paper must bear the denturist's signature. This confirms the work was completed and accurately billed. The denturist remains solely responsible for all claims submitted.

Every time a claim is submitted, electronically or by paper, it indicates the dental practitioners understanding of, and agreement with the terms, conditions and guidelines set out in this fee schedule. The Ministry will not pay for services rendered by a dental practitioner who is not registered to practice in BC, or provides services outside their scope of practice, or outside of limits and conditions on their practice.

Where payment of a claim has been adjusted or refused, the remittance statement will include an explanation code.

MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION

Schedule of Fee Allowances – Denturist
Effective September 1, 2017

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
	EXAMINATIONS		
Note:	New patient and recall exams have a combined limit of two per calendar year. Only those practitioners who have successfully completed the oral pathology requirement may bill 10010 and/or 10105		
10010	New Patient Exam	24.00	66.75
Note:	Limited to once per patient per denturist. All new patient examinations must include a detailed prosthetic history including visual and digital examination of the oral structures, TMJ, lips, oral mucosa and tongue.		
10105	Recall Exam (Annual)	19.00	37.00
Note:	Limited to once per patient per calendar year.		
10104	Specific Exam	16.00	29.75
Note:	Specific exams are limited to a combination of two per calendar year and are limited to examination and evaluation of a specific condition in a localized area.		
	COMPLETE DENTURES		
Note:	Dentures are an eligible item once every five years. The replacement of dentures within five years of original insertion will normally not be paid by the Ministry. Refer to Denture Policy in Part A – Preamble to Dental Supplements - Denturist. Any lab costs are included in the stated fee. Complete denture fees include: – Impressions, initial and final jaw relation records – Try-in; evaluation – Records check – Insertion – Adjustments and 6 months post-insertion care including tissue conditioning		
31310	Complete Maxillary Denture	581.25	1007.00
31311	Immediate Complete Maxillary Denture	675.00	1280.00
Note:	Denturists without Oral Pathology must wait 21 days prior to provision of service.		

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
31320	Complete Mandibular Denture	581.25	1007.00
31321	Immediate Complete Mandibular Denture	675.00	1280.00
	RELINES AND REBASES – COMPLETE DENTURES		
Note:	Relines and rebases are limited to a combined maximum of once per arch in a two-year period and are not billable within the six-month post-insertion period. Any lab costs are included in the stated fee.		
	Processed Reline – Complete Denture		
32110	Maxillary	160.00	284.50
32120	Mandibular	160.00	284.50
code change	Chairside/Direct Reline – Complete Denture		
32418	Maxillary	72.00	123.75
32428	Mandibular	72.00	123.75
code change	Processed Rebase – Complete Denture		
33117	Maxillary	184.00	346.25
33127	Mandibular	184.00	346.25
	REPAIRS – COMPLETE DENTURES		
Note:	The amounts listed are the maximum that will be paid. Should the lab fee be less for a specific procedure, this should be reflected in the amount billed. Lab slips must be available upon request.		
	Repair without Impression – Complete Denture		
36110	Maxillary	35.00 + L(37.00) = 72.00	48.00 + L(51.00) = 99.00
36120	Mandibular	35.00 + L(37.00) = 72.00	48.00 + L(51.00) = 99.00
	Repair with Impression – Complete Denture		
36210	Maxillary	50.00 + L(42.00) = 92.00	74.00 + L(62.00) = 136.00
36220	Mandibular	50.00 + L(42.00) = 92.00	74.00 + L(62.00) = 136.00

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
	TISSUE CONDITIONING – COMPLETE DENTURES		
Note:	Fee items 37110 and 37120 are billable twice per arch per year only before a reline/rebase or the fabrication of a replacement denture.		
37110	Maxillary	39.20	107.50
37120	Mandibular	39.20	107.50
	ADJUSTMENTS – COMPLETE DENTURES		
Note:	Adjustments (fee items 38110 and 38120) are limited to one per arch per date of service to a total of two per arch in a calendar year. Adjustments are not payable during the 6-month post-insertion period or within one week of repairs with or without impression.		
38110	Maxillary	20.00	26.00
38120	Mandibular	20.00	26.00
	PARTIAL DENTURES		
Note:	Partial dentures are an eligible item once every five years. Any lab costs are included in the stated fee. Temporary or provisional appliances are not covered.		
	Partial denture fees include: – Diagnostic models, analysis and suggested design – Proposed tooth preparation, selection and master impression – Bite-registration, mold selection and shade – Try-in – Insertion and occlusal equilibration – Adjustments and 6 months post-insertion care – Patient referral back to prescribing dentist for post-insertion examination of prosthetic		
	Cast Frame		
	Free End, Cast Frame		
41114	Maxillary	787.50	1181.00
41124	Mandibular	787.50	1181.00
	Tooth Borne, Cast Frame		
41254	Maxillary	787.50	1181.00
41264	Mandibular	787.50	1181.00
	Acrylic Base		
41610	Maxillary- Acrylic Base with Clasps	450.00	841.00
41620	Mandibular - Acrylic Base with Clasps	450.00	841.00

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Acrylic Base, continued		
41612	Maxillary - Acrylic Base without Clasps	375.00	630.00
41622	Mandibular - Acrylic Base without Clasps	375.00	630.00
	RELINES AND REBASES – PARTIAL DENTURES		
Note:	Relines and rebases are limited to a combined maximum of once per arch in a two-year period and are not billable within the six-month post-insertion period. Any lab costs are included in the stated fee.		
code change	Processed Reline – Partial Denture		
42116	Maxillary	156.80	284.50
42126	Mandibular	156.80	284.50
code change	Chairside/Direct Reline – Partial Denture		
42418	Maxillary	68.80	123.75
42428	Mandibular	68.80	123.75
code change	Processed Rebase – Partial Denture		
43116	Maxillary	161.60	346.25
43126	Mandibular	172.00	346.25
	REPAIRS AND ADDITIONS – PARTIAL DENTURES		
Note:	The amounts listed are the maximum that will be paid. Should the lab fee be less for a specific procedure, this should be reflected in the amount billed. Lab slips must be available upon request.		
	Repair without Impression – Partial Denture		
46110	Maxillary	35.00 + L(37.00) = 72.00	48.00 + L(51.00) = 99.00
46120	Mandibular	35.00 + L(37.00) = 72.00	48.00 + L(51.00) = 99.00
	Repair with Impression – Partial Denture		
46210	Maxillary	50.00 + L(42.00) = 92.00	74.00 + L(62.00) = 136.00
46220	Mandibular	50.00 + L(42.00) = 92.00	74.00 + L(62.00) = 136.00

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($)	
		Adult	**Child**
	TISSUE CONDITIONING – PARTIAL DENTURE		
Note:	Fee items 47110 and 47120 are billable twice per arch per year only before a reline/rebase or the fabrication of a replacement denture.		
47110	Maxillary	39.20	107.50
47120	Mandibular	39.20	107.50
	ADJUSTMENTS – PARTIAL DENTURES		
Note:	Adjustments (fee items 48110 and 48120) are limited to one per arch per date of service to a total of two per arch in a calendar year. Adjustments are not payable during the 6-month post-insertion period or within one week of repairs with or without impression.		
48110	Maxillary	20.00	26.00
48120	Mandibular	20.00	26.00
70020	Home and Institutional Visit	25.60	50.00
Note:	Fee item 70020 is billable only when treating a patient who resides in a hospital or institutional facility. The name and address of the institution must be noted on the claim form. It is not billable if the patient is admitted to the hospital specifically for the purpose of dental services. Limited to two per patient per calendar year. This fee may be billed only once per institution per day, regardless of the number of patients seen.		
73008	Processed Soft Liner	104.00	297.00
Note:	Fee item 73008 will only be considered when done in conjunction with fabrication of new complete or partial dentures or reline/rebase of complete or partial dentures. Arch code required.		
code change			
73050	Name and Date of Production Insertion per denture	20.00	25.00
Note:	Fee item 73050 is limited to one per upper and one per lower prosthesis in a five year period for persons 65 years of age and older and persons in institutional care. Arch code required.		

Note: All frequency limitations in this schedule also include services performed by a dentist.

Part C - Preamble - Emergency Dental Supplements - Denturist

Emergency Dental and Denture Supplements is available for all eligible Ministry of Social Development and Poverty Reduction clients, including those who do not have a 2-year limit under the Ministry's Dental Supplements or those who have exhausted their limit. Children covered under the Healthy Kids program are also eligible for Emergency Dental Supplements. Emergency Dental allows for treatment of an eligible person who needs immediate attention to relieve pain, or to control infection or bleeding or if a person's health or welfare is otherwise immediately jeopardized.

The attached Part D - *Schedule of Fee Allowances – Emergency Dental – Denturist* outlines the allowable services and fees associated with the Ministry's Emergency Dental Supplements. It contains the rules, frequency and financial limits associated with each service. All frequency limitations also include services performed by a dentist.

Each emergency visit is restricted to the procedures and limitations outlined in this schedule. Services outside this schedule (i.e., dentures, processed relines and rebases, exceeding time-limited procedures, etc.) will not be covered and any work beyond the immediate relief of pain will not be considered. Frequency of emergencies (i.e., individual patients with multiple visits) and treatment provided will be monitored by the Ministry. Where concerns arise, Ministry staff will address these issues with the denturist.

The following information provides details on how to confirm eligibility and obtain payment for services rendered.

Eligibility Information

Eligibility must be confirmed for all patients prior to treatment. We recommend you request picture identification in addition to their Personal Health Number (PHN) from new patients.

You must confirm that there is active coverage and previous dental history should be checked for time-limited procedures. Treatment involving more than one practitioner or a specialist should be coordinated to ensure no duplicated services are planned.

To ensure that your patient has active Ministry sponsored coverage and to determine the level of this coverage, eligibility must be confirmed immediately prior to providing service, as coverage can change from month to month.

Steps to confirm a patient's eligibility:

1. **Obtain the patient's Personal Health Number (PHN) from their CareCard, BC Driver's Licence or BC Services Card.**
2. **Access PROVIDERnet at www.providernet.ca to confirm active coverage and look up any plan limits available for services, or contact Pacific Blue Cross at:**

Vancouver: 1-604-419-2780 All other Communities: 1-800-665-1297

If Ministry clients or parents of children covered through the Healthy Kids Program have questions related to their coverage, they should be referred to the Dental Information Line at 1-866-866-0800.

Payment Process

Claims for any treatment completed under the Emergency Dental Supplements must be submitted on a separate claim form and you must clearly indicate that the services were provided for the immediate relief of pain or as an emergency.

Claims under the Ministry's Dental Supplements will be paid in accordance with the *Schedule of Fee Allowances – Emergency Dental - Denturist* and these fees represent the maximum amount the Ministry can pay for the services billed.

Claim Submission:

Denturists can submit claims electronically to Pacific Blue Cross via CDAnet for services provided under a patient's Emergency Coverage.

Detailed information on how to submit emergency claims through PROVIDERnet is outlined in Pacific Blue Cross' Dental Provider Reference Guide which can be found on their website: https://www.pac.bluecross.ca/

Some exclusions from CDAnet are:

1. **Submissions that require explanations on the claim form (e.g.: certain denture claims, ie: initial denture with no record of extractions), and/or,**
2. **Submissions that require supporting documentation (e.g.: lab slips, clinical descriptions, diagnoses, radiographs, photographs, etc.)**

Claims, including previously noted claims excluded from CDAnet process, may also be submitted on a standard dental claim form and sent to:

Pacific Blue Cross - Ministry Dental Program PO Box 65339 Vancouver, BC V5N 5P3

To facilitate payment, it is essential that the submitted claim form be completed as accurately and thoroughly as possible using the patient's name and PHN. Where a claim form is correctly completed and the service provided is an eligible service covered by the Ministry, payment can be expected within 30 days of receipt of the claim. Rebilling within 30 days may not only hold up payment of the original claim, but will also delay the processing of subsequent claims.

Note: Claims requiring review by a dental consultant may take longer to process.

All claims are processed on a "first come, first served" basis therefore timely submission is encouraged. Claims must be submitted within one year of the date of service. No payment will be made on any claim received later than one year from the date of service. If there is an error on your billing, subsequent claims may jeopardize the payment of your rebilling.

Payment Process, continued

The denturist must bill the actual service(s) rendered. An alternative fee item number should not be substituted. All claims must be submitted under the payment number of the denturist performing the service(s). Claims, resubmissions and adjustment requests sent by paper must bear the denturist's signature. This confirms the work was completed and accurately billed. The denturist remains solely responsible for all claims submitted.

Every time a claim is submitted, electronically or by paper, it indicates the dental practitioners understanding of, and agreement with the terms, conditions and guidelines set out in this fee schedule. The Ministry will not pay for services rendered by a dental practitioner who is not registered to practice in BC, or provides services outside their scope of practice, or outside of limits and conditions on their practice.

Where payment of a claim has been adjusted or refused, the remittance statement will include an explanation code.

MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION

Schedule of Fee Allowances – Emergency Dental - Denturist
Effective September 1, 2017

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
10104	Specific Exam	16.00	29.75
Note:	Specific exams are limited to a combination of two per calendar year and are limited to examination and evaluation of a specific condition in a localized area.		
	Chairside/Direct Reline – Complete Denture		
Note:	Relines are limited to once per arch in a two-year period and are not billable within the six-month post insertion period.		
code change			
32418	Maxillary	72.00	123.75
32428	Mandibular	72.00	123.75
	Repair without Impression – Complete Denture		
Note:	The amounts listed are the maximum that will be paid. Should the lab fee be less for a specific procedure, this should be reflected in the amount billed. Lab slips must be available upon request.		
36110	Maxillary	35.00 +L(37.00) = 72.00	48.00 +L(51.00) = 99.00
36120	Mandibular	35.00 +L(37.00) = 72.00	48.00 +L(51.00) = 99.00
	Chairside/Direct Reline – Partial Denture		
Note:	Relines are limited to once per arch in a two-year period and are not billable within the six-month post insertion period.		
code change			
42418	Maxillary	68.80	123.75
42428	Mandibular	68.80	123.75

FEE NO.	FEE DESCRIPTION	FEE AMOUNT ($) Adult	Child
	Repair without Impression – Partial Denture		
Note:	The amounts listed are the maximum that will be paid. Should the lab fee be less for a specific procedure, this should be reflected in the amount billed. Lab slips must be available upon request.		
46110	Maxillary	35.00 +L(37.00) = 72.00	48.00 +L(51.00) = 99.00
46120	Mandibular	35.00 +L(37.00) = 72.00	48.00 +L(51.00) = 99.00
	Adjustment to Denture		
Note:	Adjustments are limited to one per arch per date of service to a total of two per arch in a calendar year. Adjustments are not payable during the 6-month post insertion period or within one week of repairs with or without impression.		
38110	Complete Maxillary	20.00	26.00
38120	Complete Mandibular	20.00	26.00
48110	Partial Maxillary	20.00	26.00
48120	Partial Mandibular	20.00	26.00

Note: All frequency limitations in this schedule also include services performed by a dentist.