APPENDIX XVIII - Dental Program, July 1, 2019 - June 30, 2020

Prior Authorization Denials, by PA denial code and procedure code

PA Denial Reason Code	Prior Authorization Denial Description	Diagnostic D0100-D0999	Preventive D1000-D1999	Restorative D2000-D2999	Endodontics D3000-D3999	Periodontics D4000-D4999	5000-5999 Removable/ Maxillofacial	6000-6999 Implant/Fixed	Oral & Maxillofacial Surgery D7000-D7999	Orhtodontics D8000-D8999	Adjunctive General Services D9000-D9999	Total
5	THE INFORMATION SUBMITTED ON THE CLAIM OR PRE-AUTHORIZATION SHOWS A CONFLICT IN THE PLACE OF SERVICE. COMPARE THE DESCRIPTION OF THE CDT CODE TO THE PLACE OF SERVICE INDICATED IN BOX 38 ON THE ADA CLAIM FORM			10					10		34	**54**
6	PROCEDURE DOES NOT MEET AGE REQUIREMENTS OF THE PLAN	2	124	90	7	8	3	2		30	18	**284**
16	DENIED BECAUSE THE PRE-AUTHORIZATION DOES NOT CONTAIN THE REQUIRED DOCUMENTATION .	39	448	1,152	542	143	137		876	37	110	**3,484**
18	THIS REQUEST HAS BEEN PREVIOUSLY REPORTED AND AN APPROVALDENIAL WAS ISSUED OR OUR RECORDS SHOW THAT THE MEMBER HAS ALREADY RECEIVED THIS SERVICE PLEASE SUBMITT DOCUMENTATION WITH YOUR CLAIM	383	183	1,517	452	59	599		2,056	25	1,309	**6,583**
31	THE SUBSCRIBER IS NOT CURRENTLY ACTIVE IN THE PROGRAM.	12	11	139	27	13	77		135	8	111	**533**
49	THIS PROCEDURE IS NOT COVERED IN CONJUNCTION WITH THE REPORTED SERVICE(S). PLEASE SUBMIT X-RAY(S) AND NARRATIVE WITH THIS REQUEST.	22	75	1,179	288	95	204		981	6	106	**2,956**
50	THE CLINICAL REVIEWER HAS DETERMINED THAT THE TREATMENT IS IN EXCESS OF THE MEMBER'S NEEDS.	92	77	530	117	15	26	2	370	12	2,255	**3,496**
55	THE PHOTOS RECEIVED DO NOT DEMONSTRATE THE NEED FOR THE TREATMENT REQUESTED.			17	7	43			39	2		**108**
56	THE DENTAL DIRECTOR HAS ADVISED THAT THE X-RAYS RECEIVED DO NOT DEMONSTRATE THE NEED FOR TREATMENT SUBMITTED.	6	3	807	447	928			9,844	1	17	**12,053**
58	TO BE ELIGIBLE FOR REIMBURSEMENT UNDER THE ADULT DENTURE PROGRAM, THE SERVICE MUST BE PERFORMED WITHIN 75 MILES OF THE PROVIDERS PRINCIPAL PLACE OF PRACTICE.						79					**79**
96	THIS PROCEDURE IS CONSIDERED NON-COVERED IN ACCORDANCE WITH EITHER THE PROGRAM BENEFITS OR THE FACILITY CONTRACT WITH MCNA	87	64	702	234	432	314	55	1,073	33	2,945	**5,939**
97	AS OUTLINED IN YOUR PROVIDER MANUAL, THE INITIAL PAYMENT FOR CDT D1510 AND D1515 INCLUDES ALL REPLACEMENT COSTS FOR 12 MONTHS FOLLOWING THE APPLIANCE PLACEMENT.		19									**19**
133	THIS TOOTH NEEDS TO BE EVALUATED BY AN ENDODONTIST.								4			**4**
151	THE ADULT DENTURE PROGRAM DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY						27					**27**
152	PLEASE SUBMIT THE ARCH LOCATION.	6	34	2	1	4	7		98	17	166	**335**
169	COVERAGE IS LIMITED TO THE MORE DEFINITIVE TREATMENT OR SERVICES PERFORMED. NITROUS OXIDE OR NON-INTRAVENOUS CONSCIOUS SEDATION WILL BE CONSIDERED ON THE SAME VISIT, BUT NOT BOTH. THE CLINICAL REVIEWER HAS RECOMMENDED AN ALTERNATE PROCEDURE/BENEFIT.		19	111	43	368	123		4,062	1	40	**4,767**
181	PLEASE SUBMIT A CORRECT CDT CODE.	26	290	526	168	37	175	3	308	29	78	**1,640**
186	THE ARCH REQUIRING THE PARTIAL DENTURE MUST BE MISSING TWO OR MORE MAXILLARY ANTERIOR TEETH, THREE OR MORE MANDIBULAR ANTERIOR TEETH, OR AT LEAST FOUR POSTERIOR TEETH IN A SINGLE QUADRANT WHEN THE PROSTHESIS WOULD RESTORE MASTICATORY FUNCTION AND BALANCE THE OCCLUSION.						58					**58**
204	THE ADULT DENTURE PROGRAM ONLY PROVIDES FOR ACRYLIC PARTIALS TO OPPOSE A FULL DENTURE THIS PROCEDURE IS NOT COVERED AT THE MEMBERS CURRENT BENEFIT LEVEL.						182					**182**
216	TREATMENT PERFORMED ON TEETH WITH POOR OR QUESTIONABLE PROGNOSIS IS NOT COVERED		3	680	277	1		1	5		3	**970**

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222	COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A 24 MONTH PERIOD. . . COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A SIX MONTH PERIOD. . . COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A THREE YEAR PERIOD. . . COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A TWELVE MONTH PERIOD. . . PROCEDURE IS LIMITED TO ONCE IN A FIVE YEAR PERIOD. . . RESTORATIONS ARE LIMITED TO ONCE IN A TWELVE (12) MONTH PERIOD FOR THE SAME TOOTH NUMBER/LETTER AND SURFACE(S). . . THIS PROCEDURE IS LIMITED TO THREE (3) UNITS PER DATE OF SERVICE. . . . . .PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL. THE ORIGINAL BILLING PROVIDER, GROUP, OR FACILITY IS RESPONSIBLE FOR THE REPLACEMENT OF THE ORIGINAL RESTORATION WITHIN THE FIRST 12 MONTHS AFTER INITIAL PLACEMENT.	57	130	294	7	4	27		1		157	**677**
233	DATA ENTRY ADVISED THE REFERRAL OR PREAUTHORIZATION WAS ENTERED IN ERROR	3	6	5		2	1		593		823	**1,433**
236	CHARGE HAS BEEN REVIEWED UTILIZING THE CORRECT ADA PROCEDURE CODE. PERIODONTAL ROOT PLANING AND SCALING IS NOT COVERED WHEN PERFORMED ON THE SAME DATE OF SERVICE AS A PROPHYLAXIS.		30									**30**
242	SERVICES PERFORMED BY A NON-PARTICIPATING FACILITY ARE NOT COVERED. SERVICES PERFORMED BY A NON-PARTICIPATING PROVIDER ARE NOT COVERED.	4		10	2		11		27		12	**66**
251	PERIAPICAL X-RAY NEEDS TO INCLUDE APEX OF THE SUBMITTED TOOTH FOR REVIEW. PLEASE RESUBMIT THIS PRE-AUTHORIZATION WITH ALL DOCUMENTATION REQUIRED AS PART OF YOUR CORRECTIVE ACTION PLAN. THE CLINICAL REVIEWER HAS DETERMINED THAT THE X-RAY AND/OR PHOTOS SUBMITTED WERE NOT OF DIAGNOSTIC VALUE. PLEASE RESUBMIT A DIAGNOSTIC X-RAY INDICATING RIGHT AND LEFT SIDES AND/OR DIAGNOSTIC QUALITY PHOTOS MARKED WITH THE CORRECT TOOTH ID NUMBER OR LETTER. THE NEA ATTACHMENT SUBMITTED IS INVALID, UNREADABLE AND/OR CONTAINS NO IMAGES. PLEASE SUBMIT THE ATTACHMENTS.	3	11	917	222	77	35		436		16	**1,717**
252	ALL MISSING TEETH OR TEETH TO BE EXTRACTED MUST BE INDICATED ON THE PRE-AUTHORIZATION REQUEST. PLEASE SUBMIT . . . additional documentation requested	36	69	548	269	216	376	3	745	33	1,585	**3,880**
269	THIS PROCEDURE CAN ONLY BE CONSIDERED WHEN REPORTED AND PERFORMED IN CONJUNCTION WITH COVERED SERVICES.										2,414	**2,414**
272	Multiple descriptions	579	93	399	166	92	1,509	24	1,433	116	700	**5,111**
274	THE PAYMENT IS INCLUDED WITH ANOTHER SERVICE/PROCEDURE AND IS NOT PAYABLE SEPARATELY. THIS INCLUDES BUT IS NOT LIMITED TO FOLLOW-UP CARE.						2					**2**
276	THIS SERVICE IS ONLY PAYABLE ON A TOOTH THAT HAS HAD ENDODONTIC TREATMENT.			1,294					2			**1,296**
B13	OUR RECORDS SHOW THAT THE MEMBER'S TOOTH/TEETH HAS ALREADY BEEN REMOVED. SERVICES HAVE BEEN PAID AT THE FEDERALLY QUALIFIED HEALTH CENTER (FQHC) RATE FOR THIS FACILITY.			68	27				332			**427**

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B7	ACCORDING TO OUR RECORDS, YOU ARE NOT CERTIFIED OR PERMITTED TO PERFORM THIS LEVEL OF ANESTHESIA. OUR RECORDS INDICATE THAT THIS PROCEDURE HAS BEEN EXCLUDED FROM PAYMENT AS YOU WERE NOT CREDENTIALED TO PERFORM THIS SERVICE ON MCNA MEMBERS.								3		355	**358**
N130	THE ADULT DENTURE PROGRAM DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY THE ADULT DENTURE PROGRAM ONLY PROVIDES FOR ACRYLIC PARTIALS TO OPPOSE A FULL DENTURE						209					**209**
P7	OUR RECORDS SHOW THAT THE MEMBER HAS ALREADY RECEIVED THIS SERVICE. PLEASE SUBMIT THE REQUIRED DOCUMENTATION WITH THE CLAIM	83	22	183	56		29		193		96	**662**
TOTALS		**1,440**	**1,711**	**11,180**	**3,359**	**2,537**	**4,210**	**90**	**23,626**	**350**	**13,350**	**61,853**

Source: MCNA Report 188 Prior Authorization Reports

APPENDIX XVIII - Dental Program, July 1, 2019 - June 30, 2020

Claims that denied after prior authorization, by denial code and procedure code

CARC	Claims Adjustment Reason Code (CARC) Description	A-Diagnostic D0100-D0999	B-Preventive D1000-D1999	C-Restorative D2000-D2999	D-Endodontics D3000-D3999	E-Periodontics D4000-D4999	F-Removable Prosthodontics D5000-D5899	I-Fixed Prosthosdontics D6200-D6999	J-Oral & Maxillofacial Surgery D7000-D7999	K-Orhtodontics D8000-D8999	L-Adjunctive General Services D9000-D9999	Total
18	Exact duplicate claim/service	152	177	856	291	25	327	.	2,212	9	1,403	**5,452**
252	An attachment/other documentation is required to adjudicate this claim/service.	2	.	542	512	1	655	.	38	2	868	**2,620**
16	Claim/service lacks information or has submission/billing error(s).	36	48	101	56	5	55	8	409	10	556	**1,284**
269	Anesthesia not covered for this service/procedure.	.	.	.	.	.	.	.	.	.	1,111	**1,111**
22	This care may be covered by another payer per coordination of benefits.	25	13	122	46	.	201	.	349	4	310	**1,070**
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	12	30	263	88	4	28	.	379	4	134	**942**
272	Coverage/program guidelines were not met.	65	15	113	30	9	83	.	257	2	125	**699**
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	.	4	70	16	9	4	.	402	.	44	**549**
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	13	7	22	13	8	2	.	71	.	361	**497**
169	Alternate benefit has been provided.	49	1	13	2	.	4	.	263	.	38	**370**
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.	.	.	51	10	1	.	.	256	.	.	**318**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	2	2	291	1	5	9	.	3	1	1	**315**
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	60	173	42	3	.	5	.	.	.	5	**288**
181	Procedure code was invalid on the date of service.	.	.	2	1	.	252	.	4	.	3	**262**
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	2	1	9	.	.	1	.	3	1	189	**206**
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	.	.	14	165	.	1	.	13	.	2	**195**
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	2	.	20	18	1	24	.	30	.	76	**171**
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	4	1	12	7	.	17	.	36	.	43	**120**
206	National Provider Identifier - missing.	4	4	7	10	.	6	.	47	.	37	**115**
6	The procedure/revenue code is inconsistent with the patient's age.	1	54	6	.	14	.	.	18	.	1	**94**
216	Based on the findings of a review organization	2	.	40	27	.	3	.	3	.	4	**79**
27	Expenses incurred after coverage terminated.	2	.	10	5	.	25	.	15	.	12	**69**
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	.	.	4	.	.	.	.	.	.	62	**66**
95	Plan procedures not followed.	.	.	.	66	.	.	.	.	.	.	**66**

CARC	Claims Adjustment Reason Code (CARC) Description	A-Diagnostic D0100-D0999	B-Preventive D1000-D1999	C-Restorative D2000-D2999	D-Endodontics D3000-D3999	E-Periodontics D4000-D4999	F-Removable Prosthodontics D5000-D5899	I-Fixed Prosthosdontics D6200-D6999	J-Oral & Maxillofacial Surgery D7000-D7999	K-Orhtodontics D8000-D8999	L-Adjunctive General Services D9000-D9999	Total
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	1	3	16	6	.	14	.	16	.	8	**64**
B20	Procedure/service was partially or fully furnished by another provider.	2	.	15	5	2	.	.	21	.	13	**58**
5	The procedure code/type of bill is inconsistent with the place of service.	.	.	.	.	.	.	.	.	.	47	**47**
29	The time limit for filing has expired.	8	.	7	6	.	12	.	9	.	3	**45**
242	Services not provided by network/primary care providers.	.	.	6	2	.	3	.	11	.	13	**35**
152	Payer deems the information submitted does not support this length of service.	1	.	.	.	1	.	.	19	.	1	**22**
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	.	.	.	.	.	.	.	.	.	20	**20**
199	Revenue code and Procedure code do not match.	.	.	1	.	.	6	.	7	.	.	**14**
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	.	.	7	3	.	.	.	.	.	.	**10**
26	Expenses incurred prior to coverage.	.	.	1	.	.	.	.	4	.	5	**10**
200	Expenses incurred during lapse in coverage	.	.	.	1	.	2	.	.	.	5	**8**
B14	Only one visit or consultation per physician per day is covered.	1	.	.	.	.	.	.	.	.	6	**7**
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	.	5	.	.	.	.	.	.	.	.	**5**
133	The disposition of this service line is pending further review. (Use only with Group Code OA).	.	.	.	2	.	.	.	.	.	2	**4**
261	The procedure or service is inconsistent with the patient's history.	2	1	1	.	.	.	.	.	.	.	**4**
173	Service/equipment was not prescribed by a physician.	.	3	.	.	.	.	.	.	.	.	**3**
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	.	.	2	.	.	.	.	.	.	1	**3**
107	The related or qualifying claim/service was not identified on this claim.	.	.	.	.	.	.	.	2	.	.	**2**
9	The diagnosis is inconsistent with the patient's age.	.	.	2	.	.	.	.	.	.	.	**2**
253	Sequestration - reduction in federal payment	.	.	1	.	.	.	.	.	.	.	**1**
276	Services denied by the prior payer(s) are not covered by this payer.	.	.	1	.	.	.	.	.	.	.	**1**
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	.	.	1	.	.	.	.	.	.	.	**1**
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	.	.	1	.	.	.	.	.	.	.	**1**
Total		**448**	**542**	**2,672**	**1,392**	**85**	**1,739**	**8**	**4,897**	**33**	**5,509**	**17,325**

Source: Report 173 Denied Claims