APPENDIX XVI - DBPM Denied Claims, July 1, 2020 - June 30, 2021[1]

by claims adjustment reason code (CARC), emergency vs. non-emergency[2]

CARC		Emergency			Non-Emergency			DBPM Total
		DentaQuest	MCNA	Total	DentaQuest	MCNA	Total	
96	Non-covered charge(s).	.	61	61	.	93,426	93,426	93,487
18	Exact duplicate claim/service	.	138	138	12,493	48,103	60,596	60,734
169	Alternate benefit has been provided.	.	94	94	.	53,388	53,388	53,482
27	Expenses incurred after coverage terminated.	.	28	28	.	42,996	42,996	43,024
204	This service/equipment/drug is not covered under the patient's current benefit plan	.	.	.	20,774	1	20,775	20,775
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	.	17	17	.	20,005	20,005	20,022
6	The procedure/revenue code is inconsistent with the patient's age.	.	8	8	.	19,020	19,020	19,028
22	This care may be covered by another payer per coordination of benefits.	.	75	75	1,945	12,342	14,287	14,362
252	An attachment/other documentation is required to adjudicate this claim/service.	.	149	149	.	13,370	13,370	13,519
119	Benefit maximum for this time period or occurrence has been reached.	.	3	3	2,225	8,315	10,540	10,543
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.	.	72	72	.	7,770	7,770	7,842
242	Services not provided by network/primary care providers.	.	6	6	.	6,381	6,381	6,387
16	Claim/service lacks information or has submission/billing error(s).	.	76	76	1,303	5,006	6,309	6,385
272	Coverage/program guidelines were not met.	.	54	54	.	5,985	5,985	6,039
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	.	31	31	.	4,798	4,798	4,829
243	Services not authorized by network/primary care providers.	.	.	.	4,761	.	4,761	4,761
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	.	20	20	.	3,669	3,669	3,689
9	The diagnosis is inconsistent with the patient's age.	.	.	.	.	3,470	3,470	3,470
150	Payer deems the information submitted does not support this level of service.	.	.	.	2,853	362	3,215	3,215
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.	.	2	2	.	2,910	2,910	2,912
181	Procedure code was invalid on the date of service.	.	12	12	2,111	669	2,780	2,792
206	National Provider Identifier - missing.	.	.	.	.	2,497	2,497	2,497
29	The time limit for filing has expired.	.	10	10	.	2,448	2,448	2,458
269	Anesthesia not covered for this service/procedure.	.	25	25	.	2,116	2,116	2,141
261	The procedure or service is inconsistent with the patient's history.	.	1	1	79	1,400	1,479	1,480
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	.	2	2	.	1,239	1,239	1,241
B14	Only one visit or consultation per physician per day is covered.	.	1	1	.	1,235	1,235	1,236
B20	Procedure/service was partially or fully furnished by another provider.	.	15	15	.	1,221	1,221	1,236

CARC		Emergency			Non-Emergency			DBPM Total
		DentaQuest	MCNA	Total	DentaQuest	MCNA	Total	
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.	.	22	22	.	1,096	1,096	1,118
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	.	7	7	.	1,108	1,108	1,115
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.	.	16	16	.	901	901	917
197	Precertification/authorization/notification/pre-treatment absent.	.	.	.	903	.	903	903
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	.	23	23	.	797	797	820
200	Expenses incurred during lapse in coverage	.	2	2	.	744	744	746
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	.	4	4	.	708	708	712
31	Patient cannot be identified as our insured.	.	1	1	616	21	637	638
5	The procedure code/type of bill is inconsistent with the place of service.	.	1	1	.	544	544	545
149	Lifetime benefit maximum has been reached for this service/benefit category.	.	.	.	.	369	369	369
40	Charges do not meet qualifications for emergent/urgent care.	.	34	34	.	279	279	313
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	.	.	.	284	.	284	284
152	Payer deems the information submitted does not support this length of service.	.	8	8	.	128	128	136
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	.	.	.	.	112	112	112
216	Based on the findings of a review organization	.	1	1	.	86	86	87
95	Plan procedures not followed.	.	6	6	.	71	71	77
26	Expenses incurred prior to coverage.	.	.	.	.	66	66	66
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	.	2	2	.	57	57	59
146	Diagnosis was invalid for the date(s) of service reported.	.	.	.	.	42	42	42
259	Additional payment for Dental/Vision service utilization.	.	.	.	.	37	37	37
185	The rendering provider is not eligible to perform the service billed.	.	.	.	.	35	35	35
199	Revenue code and Procedure code do not match.	.	1	1	.	30	30	31
32	Our records indicate the patient is not an eligible dependent.	.	.	.	25	2	27	27
177	Patient has not met the required eligibility requirements.	.	.	.	.	15	15	15
107	The related or qualifying claim/service was not identified on this claim.	.	.	.	.	14	14	14
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	.	3	3	.	8	8	11
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	.	.	.	.	9	9	9
133	The disposition of this service line is pending further review.	.	.	.	.	8	8	8
14	The date of birth follows the date of service.	.	.	.	.	8	8	8
253	Sequestration - reduction in federal payment	.	1	1	.	7	7	8
173	Service/equipment was not prescribed by a physician.	.	.	.	.	6	6	6

CARC		Emergency			Non-Emergency			DBPM Total
		DentaQuest	MCNA	Total	DentaQuest	MCNA	Total	
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	.	.	.	.	6	6	6
140	Patient/Insured health identification number and name do not match.	.	.	.	.	5	5	5
276	Services denied by the prior payer(s) are not covered by this payer.	.	.	.	.	5	5	5
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	.	.	.	.	5	5	5
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been	.	.	.	.	4	4	4
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	.	.	.	.	3	3	3
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	.	.	.	.	3	3	3
273	Coverage/program guidelines were exceeded.	.	.	.	.	3	3	3
144	Incentive adjustment, e.g. preferred product/service.	.	.	.	.	2	2	2
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	.	.	.	.	2	2	2
104	Managed care withholding.	.	.	.	.	1	1	1
167	This (these) diagnosis(es) is (are) not covered.	.	.	.	.	1	1	1
182	Procedure modifier was invalid on the date of service.	.	.	.	.	1	1	1
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	.	.	.	.	1	1	1
39	Services denied at the time authorization/pre-certification was requested.	.	.	.	.	1	1	1

Source: 173 Denied Claims Report

[1]Inpatient hospital denied claim counts are reported at the header level. Denied claims counts for all other provider types are reported at the line level. Excludes pharmacy claims which are reported in the second table this appendix.
[2]Each claim denied may have mutliple CARC codes therefore totals includes duplication. Emergency services are defined as claim type 03 with revenue codes 450, 459, or 981 (outpatient hosptial) and claim type 04 with procedure codes 99281 through 99285 (professional).