APPENDIX XVII - Dental Program, July 1, 2020 - June 30, 2021

Prior Authorization Denials, by PA denial code and procedure code

DentaQuest

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	Blank	Total
3931	Per Dental Director review, removal of impacted tooth is denied. There is no sign of infection, pain beyond normal eruption, or that the tooth is in a position that will not let it break through the gum on its own.								4,500		13		**4,513**
3430	We have approved the amount of anesthesia that is normally needed to safely complete the services requested. Based on Dental Director review, the additional time requested is not medically necessary.										1,762		**1,762**
3307	Anesthetic services are only covered when the associated services are approved.										1,701		**1,701**
2040	Service is not covered. Please refer to your Office Reference Manual for definition of covered teeth/quad/arch, patient ages, and procedure codes.	5	6	351	49	200	262	54	121		105		**1,153**
3447	Sedation is only covered when the patient needs a lot of dental work done on the same day, four or more teeth pulled, or the patient is nervous about their treatment and a different drug has been tried and failed to help the patient relax during treatment.								1		694		**695**
3445	Per Dental Director review, the x-rays do not show the need for bone removal or sectioning of the tooth. This is needed for teeth that have formed abnormal or multiple roots or teeth with 75% of the clinical crown destroyed by decay. A less severe extraction code would be considered.								576				**576**
3799	Per Dental Director review, periodontal scaling and root planing is denied due to no evidence of significant bone loss.			2		417							**419**
4186	Per Dental Director review, removal of impacted tooth is denied due to incomplete root development.			1					367				**368**
2099	Services provided by an Out-of- Network or Non-contracted provider are not provided under this benefit program.	23	6	106	37	3	47		64		46		**332**
3782	Per Dental Director review, the x-rays do not support the code requested. A less severe extraction code would be considered. Please review the ADA code you requested and resubmit with the appropriate ADA code.								328				**328**
2021	The required tooth/quad/arch is invalid, was not submitted, or is not included in the member's benefit package for this procedure code. Please refer to your ORM and resubmit a claim with the appropriate information.		23	66	32	26	58		60		25		**290**
3443	Per Dental Director review, crown is denied. The tooth does not appear to have significant breakdown due to decay or trauma.			269					1				**270**
3577	Per Dental Director review, there does not appear to be a medical reason to allow dental services in a hospital setting or SPU.										165		**165**
4763	Per Dental Director review, partial is denied. Masticatory function does not appear to be severely impaired, demonstrated by missing 3 or more maxillary anterior teeth, 2 or more mandibular anterior teeth, 3 adjacent posterior teeth in a quadrant, 2 adjacent posterior tooth in both quadrants, or a combination of two or more anterior and at least 1 posterior tooth in the same arch.						160						**160**
3278	Service is denied for benefit limitations. This service is allowed once every 96 months. Our records show this service was completed less than 96 months ago.						145						**145**
3284	Per Dental Director review, treatment is denied. The information sent shows that exfoliation of this tooth is imminent.			8	2				129				**139**

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2101	Service not allowed. Patient history record indicates tooth was previously extracted.			10	11				107				**128**
2137	The ADA Code requested is not a benefit for this tooth/quad/arch. Please refer to your ORM for specific benefit information.			31	87		4						**122**
3800	Per Dental Director review, a full denture is denied. There does not appear to be a sign of infection or other medical reason for complete arch edentulation.						97						**97**
4629	Documentation must support a permanent tooth requiring a multi-surface restoration, with a good long-term prognosis.			89					2				**91**
2030	Subscriber is not eligible for services under this plan.	5	2	18	3	8	18		17	2	14		**87**
4647	Documentation must support a multiple rooted tooth or clinical crown is severely decayed.								84				**84**
3235	Per Dental Director review, it has been determined that a crown is			82									**82**
2093	Service exceeds benefit allowance. This service is allowed once every 8 years.	73											**73**
3428	Per Dental Director review, root canal treatment is denied. No decay approaching the nerve or periapical pathology.				72								**72**
4648	Documentation must support infection, pain beyond normal eruption, or aberrant tooth position. Tooth must also have root development.								64				**64**
3440	Per Dental Director review, treatment is denied due to subcrestal caries.			30	34								**64**
3149	Per Dental Director review, the submitted radiograph does not show the presence of this tooth.			3	1				57				**61**
4636	Documentation must support member is edentulous or the necessity of complete arch edentulation.						59						**59**
2031	Patient is over the age limit for this benefit.		4	20					30				**54**
4545	Per Dental Director review, documentation submitted fails to support necessity of dental examination beyond program limits. To qualify, evidence must be presented indicating restoration failure, recurrent decay, or changes to oral health.	48											**48**
4658	Documentation must support patient needs extensive dental work or patient is unable to tolerate treatment without sedation.								4		44		**48**
4632	Documentation must support decay approaching the nerve or periapical pathology and tooth has good long-term prognosis.				45								**45**
4175	Per Dental Director review, service is denied. Patient must have a significant amount of dental work that needs to be done on the same day; or the patient must have at least four or more teeth being extracted at once; or the patient must be extremely anxious about their dental treatment and other drugs have failed for anesthesia purposes; or the patient must have a diagnosed medical condition that requires anesthesia and monitoring for patient safety. Based on the information submitted with the request, the member does not meet any of these criteria.										43		**43**
3775	This service is included in the Special Procedure Unit (SPU) benefit.										40		**40**
3429	This service is considered part of another service.		12	1	14	1			5		5		**38**
3249	Per Dental Director review, a full mouth debridement is denied. There is no evidence of supragingival calculus on more than 50% of the teeth.					36							**36**
2100	Program guidelines require that the servicing provider have a current Medicaid License ID on file. We do not show a Medicaid License on file.		11	6	3			3	8		3		**34**

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4760	Documentation must support masticatory function is severely impaired and that the remaining teeth in the arch have a good long-term prognosis. Documentation must demonstrate 3 or more missing maxillary anterior teeth, 2 or more missing mandibular anterior teeth, 3 adjacent missing posterior teeth in a quadrant, 2 adjacent missing posterior teeth in both quadrants, or a combination of 2 or more anterior teeth along with 1 posterior tooth missing in the same arch.						32						32
2018	The submitted information is either not valid or is illegible. The procedure code must be a current valid ADA code and the fee requested must be legible. For benefit consideration, please make any necessary corrections and resubmit.		9				10				6	7	32
4177	Per Dental Director review, service is denied. The tooth does not appear to have significant breakdown due to decay or trauma.			32									32
3434	Per Dental Director review, documentation submitted does not support the need for a frenulectomy due to labial/buccal frenum.								29				29
3438	Per Dental Director review, crown is denied. There is no evidence of decay or missing crown to support the need for replacement.			29									29
3936	Outpatient (SPU) request can only be approved if the associated services are approved.										28		28
2096	Service exceeds benefit allowance. Service is limited to one per every 12 months.	23		4									27
3515	This service is included as part of the surgical extraction of an adjacent impacted tooth.								27				27
4659	Documentation must support a medical reason or need to perform dental services in a hospital setting or SPU.										25		25
2022	The required surface(s) is/are invalid or missing for this procedure code. Please submit a corrected claim with the valid procedure and the valid surface(s).			23									23
2023	This procedure requires a specific number of surfaces. The submitted surface coding does not match the procedure code. Please submit a corrected claim with the corrected procedure code or the corrected surface coding.			21									21
4121	Per Dental Director review, the documentation received fails to indicate any specific needs or conditions that preclude use of a removable prosthesis.							21					21
4635	Documentation must support significant bone loss requiring periodontal scaling and root planing.					20							20
4631	Documentation must support pulpal or apical pathology and tooth has good long-term prognosis.				20								20
3631	Immediate dentures are only covered when the extractions are performed on the same day. Documentation received indicates this member is already edentulous.						20						20
3210	Denture relines and adjustments are included with the denture benefit when performed within six months of denture placement.						19						19
3426	Per Dental Director review, crown is denied due to a clinically unacceptable root canal fill.			19									19
4033	Per Dental Director review, service is denied. Narrative submitted does not support x-rays could not be received from previous dentist or that the additional x-rays are required for proper diagnosis and/or treatment.	19											19
4762	Documentation must support the presence of ectopically erupting teeth, isolated dental crossbite, or recovery of recent minor space loss, leading to a handicapping malocclusion.									19			19
2060	Provider record is not active or no provider contract is in effect for the date of service.			1	1				12		3		17
4774	Documentation must support the tooth is present and requires removal.								17				17

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3220	Per Dental Director review, the loss of bone demonstrated radiographically does not meet the benefit criteria for a bone graft.					17							17
3512	This service is included as part of the extraction benefit.								16				16
4061	Per Dental Director review, a panorex or full mouth series of radiographs, labeled with the member's full name, date film(s) taken (mm/dd/yyyy), and identify the patients left and right side, is needed in order to review this request.			1			3		7		5		16
3219	Per Dental Director review, the tissue levels do not indicate the need for this service based on the submitted information.					15							15
4016	Per Dental Director review, treatment on primary teeth is only considered when the permanent tooth is congenitally missing.			14									14
3441	Per Dental Director review, service is denied. A partial denture would adequately replace the missing teeth if treatment meets criteria for partial benefit.							12	2				14
3519	Per Dental Director review, the information received does not indicate that additional time, materials, techniques or staff are necessary for the behavior management of this patient.										13		13
3102	This periodontal surgery is denied. There is no history of periodontal scaling or root planing.					12							12
3449	Per Dental Director review, treatment is denied due to furcation involvement.			4	8								12
3550	Per Dental Director review, service is denied. There is no sign of pain or infection due to the current condition of the tooth. A filling on this tooth is not medically necessary.			10									10
3798	The treatment related to this service was not approved so this service is not approved.								1		9		10
3454	Per Dental Director review, the documentation submitted does not demonstrate the need for the use of fluoride.		10										10
3726	Hospital calls are only allowable when there is an approved SPU on file.										9		9
2089	Service exceeds benefit allowance. Service is limited to one per every 60 months.						9						9
4634	Documentation must support plaque below the gum line causing pockets.					9							9
2024	This procedure code requires a specific tooth. The submitted tooth does not match the procedure code or is invalid. If this is a supernumerary tooth, please refer to the CDT for information regarding the appropriate numbering system.								8				8
4766	Per Dental Director review, documentation fails to support necessity of orthodontic treatment. There must be craniofacial anomaly or other severe craniofacial deformity resulting in a physically handicapping malocclusion.									8			8
4643	Documentation must support completion of a service or there is no other more appropriate ADA code for the service.	1	2		1		1		3				8
4660	Documentation must support drugs requested are anti-inflammatories, steroids, or anti-biotics.										8		8
4767	Per Dental Director Review, harmful habit appliances are only benefited when the maxillary permanent incisors are actively erupting. Documentation does not support active eruption.									8			8
2272	Full mouth debridement within 12 months of a cleaning or oral or periodontal evaluations.					8							8
4791	Per Dental Director review, service is denied. This drug is only allowed in conjunction with an impaction.										8		8
4795	Documentation must indicate name of drug and support this service is in conjunction with an impaction.										8		8
4801	Reconsiderations are allowed when the initial decision was based on medical necessity. The service you are requesting was not initially denied because of medical necessity, and therefore does not qualify for a reconsideration. Please submit an appeal.								4		4		8

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3647	Per Dental Director review, the tooth is non-restorable due to large areas of decay.			7	1								8
3175	Per Dental Director review, it has been determined that there is no medical necessity for dental sealants on bicuspid teeth. There is no evidence-based clinical information available to support the need for this service.		7										7
3490	Please refer to your ORM for the appropriate ADA code, no information was received showing evidence of pain, swelling, bleeding or external trauma.	7											7
4642	Documentation must support present of occlusal wear, bruxism, clenching, masseter pain, or bone breakdown.										7		7
3306	Per Dental Director review, please refer to the CDT for the appropriate procedure code. There appears to be a valid ADA code that is more appropriate for the treatment as described.										7		7
2397	Per Dental Director review, the requested documentation and/or additional information to help us fairly examine the member's need and make a decision for the requested service was not received within the time frame allowed. Please resubmit with ADA form and all required information necessary to make a decision for medical necessity.			3	3				1				7
2273	Partial denture or services relating to a partial denture in an arch with history of a full denture.						7						7
4663	Documentation must support the need for appliance therapy due to a harmful habit, such as thumb sucking or tongue thrusting, that cause the teeth to move over time.									6			6
2145	Restorations are not allowable on a tooth with an existing crown.			6									6
4066	Per Dental Director review, a periapical radiograph, labeled with the member's full name, date film(s) taken (mm/dd/yyyy), and identify the patients left and right side, is needed in order to review this request.			1	4								5
3722	Nitrous can only be considered when the associated services are approved.										5		5
2025	This procedure code requires a specific surface(s); the submitted surface(s) does not match the procedure code. Please submit a corrected claim with the correct surface code.			5									5
2104	Service Does Not Meet Benefit Criteria.	1					3				1		5
4074	Per Dental Director review, the x-ray submitted does not appear to be for the tooth or area requested. A diagnostic quality labeled x-ray showing the entire tooth or area labeled with the member's full name, date film(s) taken (mm/dd/yyyy), and identify the patients left and right side is required in order to review this request.			3							1		4
3513	This service is included as part of the surgery benefit.					4							4
3496	Please refer to your ORM for the appropriate ADA code, this request is for the replacement of primary teeth and requires a different code.						4						4
3788	An additional prophylaxis is only considered for members with special needs.		4										4
3483	Please refer to your ORM for the appropriate ADA code. There are less than four extractions in the quadrant that require alveoloplasty.								4				4
4068	Per Dental Director review, the name of the drug is needed in order to review this request.										4		4
4768	Per Dental Director review, there is no evidence ectopically erupting teeth, isolated dental crossbite, or recovery of recent minor space loss, leading to a handicapping malocclusion.									4			4
3488	Please refer to your ORM for the appropriate ADA code, the tooth is not impacted.								3				3

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3451	Per Dental Director review, the documentation submitted does not show thumb sucking or pressing the tongue against the teeth over and over. The documentation submitted does not support the need for a harmful habit appliance.									3			3
3431	Our records indicate that there is no previous history of periodontal treatment.					2					1		3
4120	Per Dental Director review, service is denied. There is no need to replace existing restoration. To approve replacing the restoration, there must be a failing restoration, recurrent or new decay, marginal/cuspal integrity compromised, or a lost restoration.			3									3
4761	Documentation must support the presence of a craniofacial anomaly or other severe craniofacial deformity resulting in a physically handicapping malocclusion.									3			3
3958	Per Dental Director review, service is denied. The documentation received does not support the necessity of exceeding the annual maximum benefit.								3				3
3489	Please refer to your ORM for the appropriate ADA code, the tooth has not been surgically exposed and requires a different code.								3				3
3446	Per Dental Director review, gingivectomy is denied. The documentation does not support plaque below the gum line causing pockets.					3							3
3055	This service was previously approved for a different provider.						3						3
3334	Per Dental Director review, service is denied. There is no sign of infection or other medical reason for tooth removal.								3				3
4299	Per Dental Director review, documentation submitted fails to support the presence of occlusal wear, bruxism, clenching, masseter pain, or bone breakdown.										3		3
4515	Per Dental Director review, documentation received does not indicate occlusal disharmony with high spots or pain upon closing.										3		3
3628	Per Dental Director review, the information received does not indicate that nitrous oxide is medically necessary.										3		3
3629	Nitrous oxide is covered as part of the approved anesthesia benefit.										3		3
2087	Service exceeds benefit allowance. Service is limited to one per every 24 months.		1		2								3
3282	Per Dental Director review, surgical exposure is denied. The information sent shows that the tooth should erupt on its own.								2				2
3514	This service is included as part of the crown preparation or other restoration.					2							2
4097	Per Dental Director review, a diagnostic quality x-ray showing the entire coronal tooth structure is required in order to review this request.			1	1								2
4641	Documentation must support the member is tongue tied, has a diastema in conjunction to orthodontic treatment, loss of attached gingiva, or the frenulectomy is needed for the construction of a denture.								2				2
3634	This code is not appropriate for the removal of a space maintainer or braces.								2				2
3635	There is no information indicating the consultation was requested by the primary dentist, therefore this is denied.										2		2
4775	Documentation must support the presence of recurrent decay, new decay, or failing existing restoration.			2									2

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4148	Per Dental Director review, the narrative received does not show the need for hard tissue removal to allow for denture placement.								2				2
4679	Documentation must support vertical bone loss requiring bone graft.					2							2
2086	Service exceeds benefit allowance. Service is limited to one per lifetime per patient.				1		1						2
3765	This service is included as part of the comprehensive ortho treatment.									2			2
3303	Per Dental Director review, a narrative regarding the treatment is needed in order to review this request.					1			1				2
4764	Per Dental Director Review, partial is denied. Masticatory function does not appear to be severely impaired, demonstrated by missing 1 or more maxillary anterior tooth, 2 or more mandibular anterior teeth, or three or more teeth in the same arch, one of which is an anterior tooth.						2						2
3316	Per Dental Director review, osseous surgery is denied. There is no evidence of significant bone loss.					2							2
4142	Per Dental Director review, the information received does not support the need to remove only part of the tooth due to root proximity to the nerve or jaw fracture.								2				2
2155	This code is either an invalid ADA code or may be considered a medical procedure (CPT code) and should be submitted to the member's medical carrier.										2		2
3286	Per Dental Director review, apexification is denied. The information sent shows that the roots are fully formed.				2								2
4144	Per Dental Director review, service is denied. The information submitted fails to support the presence of cranio-facial anomalies, implants or skeletal fracture.	2											2
2029	This procedure is a duplicate of a service previously processed.				1				1				2
2144	The claim needs to include the procedure code, the encounter code and corresponding fee to reflect your affiliation with a Federally Qualified Health Center.	1											1
3664	Per Dental Director review, documentation fails to indicate sinus floor at a level in relation to bone requiring addition of bone to support prosthesis. Existing bone level can support a dental implant body without perforation of sinus.								1				1
3927	Per Dental Director review, study models, labeled with the date models were made (mm/dd/yyyy) and member's full name, are needed in order to review this request.									1			1
3739	This service is a duplicate of the same service on another line.										1		1
4792	Documentation must indicate name of drug and support this drug was dispensed for home use.										1		1
3969	Outpatient services (SPU) cannot be approved. Narrative indicates services have been previously performed. Outpatient services must be prior-authorized.										1		1
3925	Double abutments are not a covered benefit under this plan.							1					1
3764	Per Dental Director review, a treatment plan is needed in order to review this request.										1		1
3223	Per Dental Director review, it has been determined that there is no medical necessity for dental sealants on anterior teeth or third molar teeth. There is no evidence-based clinical information available to support the need of this service.		1										1
4162	Per Dental Director review, service is denied. The information received does not show damage to the facial hard/soft tissue requiring prosthetic repair.						1						1
2146	Service exceeds benefit allowance. Service is limited to one per date of service.					1							1

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2090	Service exceeds benefit allowance. This service is allowed once every 6 months.										1		1
4637	Documentation must support missing anterior teeth or less than 8 teeth in occlusion, and the remaining teeth have good long-term prognosis.						1						1
4651	Documentation must support the presence of a soft tissue lesion.								1				1
4557	Per Dental Director review, documentation submitted fails to support evidence of tooth breakdown indicating the need for surgical exposure of additional tooth structure for rubber dam isolation/placement.				1								1
4653	Documentation must support temporomandibular pain or non-surgical treatment.		1										1
3516	This service is included as part of the restorative procedure.			1									1
2109	Service Denied Due To Appropriate Care Review-Patient History Does not Support Service.			1									1
4765	Per Dental Director review, it has been determined that a partial denture is necessary, however the type of partial denture requested is being denied because there is a less costly adequate and equally effective partial denture available.						1						1
4184	Crown is denied. Per the ORM, the crown benefit is limited to 5 crowns performed on one date of service, except when services are being performed under sedation or in a hospital setting.								1				1
3526	This service is included as part of the final placement of a permanent fixed bridge, partial or complete denture.						1						1
3172	This service must be performed with braces. We do not show a history of braces, therefore, this service is denied.								1				1
3528	DentaQuest does not coordinate outpatient benefits for this health plan. Please contact the health plan for the short procedure unit (SPU) request.										1		1
3677	Per Dental Director review, long term prognosis is limited due to radiographic evidence of root resorption.			1									1
3283	Per Dental Director review, radiographs received show permanent tooth about to erupt.		1										1
4669	Documentation must support the presence of a cleft palate, anterior crossbite, posterior crossbite, or severe traumatic deviations.									1			1
2365	We have received a medical code (CPT) for the requested service. Please submit the appropriate dental code (CDT) for the requested service. For non-dental related CPT codes, please submit to the member's health plan.											1	1
2105	Service allowance included as part of another covered benefit.	1											1
4757	Per Dental Director review, documentation submitted needs to demonstrate presence of a soft tissue lesion requiring removal and testing.								1				1
3655	Per Dental Director review, documentation submitted fails to support fracture of facial bones and necessity to repair.								1				1
TOTALS		**209**	**100**	**1,285**	**436**	**789**	**968**	**91**	**6,686**	**57**	**4,834**	**8**	**15,463**

Source: DentaQuest Report 188 Prior Authorization Reports

APPENDIX XVII - Dental Program, July 1, 2020 - June 30, 2021

Prior Authorization Denials, by PA denial code and procedure code

MCNA

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
56	THE DENTAL DIRECTOR HAS ADVISED THAT THE X-RAYS RECEIVED DO NOT DEMONSTRATE THE NEED FOR TREATMENT SUBMITTED.			391	68	782			4,910		3	**6,154**
18	THIS REQUEST HAS BEEN PREVIOUSLY REPORTED AND AN APPROVAL OR DENIAL WAS ISSUED.	224	195	1,048	268	76	399		1,304	6	883	**4,403**
96	THIS PROCEDURE IS CONSIDERED NON-COVERED IN ACCORDANCE WITH EITHER THE PROGRAM BENEFITS OR THE FACILITY CONTRACT WITH MCNA	61	258	458	133	301	249	41	950	8	881	**3,340**
169	THE CLINICAL REVIEWER HAS RECOMMENDED AN ALTERNATE PROCEDURE/BENEFIT.		4	55	26	242	46		2,592		20	**2,985**
272	CLINICAL CRITERIA WERE NOT MET.	521	46	229	59	37	922	11	839	63	213	**2,940**
50	THE CLINICAL REVIEWER HAS DETERMINED THAT THE TREATMENT IS IN EXCESS OF THE MEMBER'S NEEDS.	27	50	284	94	28	23	1	207	4	1,769	**2,487**
49	PLEASE SUBMIT X-RAY(S) AND NARRATIVE WITH THIS REQUEST.	10	40	811	163	40	164		718	3	50	**1,999**
252	PLEASE SUBMIT A TREATMENT PLAN.	2	29	266	75	196	205	1	403	10	746	**1,933**
31	THE SUBSCRIBER IS NOT CURRENTLY ACTIVE IN THE PROGRAM.	57	44	365	109	50	212		606	7	277	**1,727**
16	PLEASE SUBMIT THE PATIENT CHART NOTES. CHART NOTES SHOULD INCLUDE THE DATE OF SERVICE, SERVICES RENDERED, NECESSARY DETAILS TO SERVICE AND THE NAME OF THE RENDERING PROVIDER. THE PROVIDER NAME SHOULD BE IN A LEGIBLE FORMAT.	14	234	454	181	77	122	1	364	19	54	**1,520**
18	THIS REQUEST HAS BEEN PREVIOUSLY REPORTED AND AN APPROVAL OR DENIAL WAS ISSUED.	76	44	285	114	29	128		503	1	197	**1,377**
269	THIS PROCEDURE CAN ONLY BE CONSIDERED WHEN REPORTED AND PERFORMED IN CONJUNCTION WITH COVERED SERVICES.										1,342	**1,342**
56	THE DENTAL DIRECTOR HAS ADVISED THAT THE XRAY AND/OR PHOTO IMAGING DO NOT DEMONSTRATE THE MEDICAL NECESSITY FOR THE TREATMENT SUBMITTED.	1		50	9	148	2		1,073		1	**1,284**
181	PLEASE SUBMIT A CORRECT CDT CODE.	6	111	443	155	16	151	3	210	17	25	**1,137**
251	THE NEA ATTACHMENT SUBMITTED IS INVALID, UNREADABLE AND/OR CONTAINS NO IMAGES. PLEASE SUBMIT THE ATTACHMENTS.	1	11	524	60	21	32	5	267		9	**930**
96	THIS PROCEDURE IS CONSIDERED NON-COVERED IN ACCORDANCE WITH EITHER THE PROGRAM BENEFITS OR THE FACILITY CONTRACT	22	14	77	26	46	54	4	546		112	**901**
50	THE CLINICAL REVIEWER HAS DETERMINED THAT THE TREATMENT IS IN EXCESS OF THE MEMBER'S NEEDS.	17	10	107	32	41	14	10	93	3	446	**773**
259	COVERAGE FOR THIS PROCEDURE IS LIMITED TO THREE TIMES IN A TWELVE MONTH PERIOD.			1					722			**723**
272	CLINICAL CRITERIA WERE NOT MET.	95	7	51	7	7	309	3	218	13	7	**717**
169	THE CLINICAL REVIEWER HAS RECOMMENDED AN ALTERNATE PROCEDURE/BENEFIT.	1	3	18		52	5		612	2		**693**
P7	OUR RECORDS SHOW THAT THE MEMBER HAS ALREADY RECEIVED THIS SERVICE. PLEASE SUBMIT THE REQUIRED DOCUMENTATION WITH THE CLAIM	83	67	190	44	4	15		173		91	**667**
276	THIS SERVICE IS ONLY PAYABLE ON A TOOTH THAT HAS HAD ENDODONTIC TREATMENT.			593	1							**594**
259	COVERAGE FOR THIS PROCEDURE IS LIMITED TO THREE TIMES IN A TWELVE MONTH PERIOD.								502			**502**
49	PLEASE SUBMIT X-RAY(S) AND NARRATIVE WITH THIS REQUEST.	4	10	153	31	5	58		219		5	**485**
31	THE SUBSCRIBER IS NOT CURRENTLY ACTIVE IN THE PROGRAM.	8	12	120	33	12	97		147	7	38	**474**
16	PLEASE SUBMIT THE PATIENT CHART NOTES. CHART NOTES SHOULD INCLUDE THE DATE OF SERVICE, SERVICES RENDERED, NECESSARY DETAILS TO SERVICE AND THE NAME OF THE RENDERING PROVIDER. THE PROVIDER NAME SHOULD BE IN A LEGIBLE FORMAT.	3	46	100	56	34	29		157	4	17	**446**

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
252	PLEASE SUBMIT A TREATMENT PLAN.	2	8	14	2	37	51		92		195	**401**
222	THE ORIGINAL BILLING PROVIDER, GROUP, OR FACILITY IS RESPONSIBLE FOR THE REPLACEMENT OF THE ORIGINAL RESTORATION WITHIN THE FIRST 12 MONTHS AFTER INITIAL PLACEMENT.	70	57	103	1		6				152	**389**
216	TREATMENT PERFORMED ON TEETH WITH POOR OR QUESTIONABLE PROGNOSIS IS NOT COVERED		5	274	77		1	4	3			**364**
B13	OUR RECORDS SHOW THAT THE MEMBER'S TOOTH/TEETH HAS ALREADY BEEN REMOVED.			20	6				303			**329**
181	PLEASE SUBMIT A CORRECT CDT CODE.	7	33	128	32	13	34		51	3	27	**328**
N130	THE ADULT DENTURE PROGRAM DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY						282					**282**
251	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, WHICH MUST INCLUDE THE PATIENTS NAME AND/OR DIAGNOSTIC QUALITY PHOTOS MARKED WITH THE CORRECT TOOTH ID NUMBER OR LETTER.	1	1	180	23	23			49		2	**279**
269	THIS PROCEDURE CAN ONLY BE CONSIDERED WHEN REPORTED AND PERFORMED IN CONJUNCTION WITH COVERED SERVICES.	1									246	**247**
B7	ACCORDING TO OUR RECORDS, YOU ARE NOT CERTIFIED OR PERMITTED TO PERFORM THIS LEVEL OF ANESTHESIA.										232	**232**
152	PLEASE SUBMIT THE ARCH LOCATION.	10	7				4		51	10	140	**222**
6	THE MEMBER MUST BE BETWEEN THE AGES OF 5 - 8 TO RECEIVE THIS PROCEDURE	4	111	40	4	4	4	2		19	8	**196**
204	THE ADULT DENTURE PROGRAM ONLY PROVIDES FOR ACRYLIC PARTIALS TO OPPOSE A FULL DENTURE						173					**173**
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.						169					**169**
276	THIS SERVICE IS ONLY PAYABLE ON A TOOTH THAT HAS HAD ENDODONTIC TREATMENT.			166								**166**
233	DATA ENTRY ADVISED THE REFERRAL OR PREAUTHORIZATION WAS ENTERED IN ERROR	4	13	28	10		1		19		18	**93**
204	THE ADULT DENTURE PROGRAM ONLY PROVIDES FOR ACRYLIC PARTIALS TO OPPOSE A FULL DENTURE						85					**85**
216	TREATMENT PERFORMED ON TEETH WITH POOR OR QUESTIONABLE PROGNOSIS IS NOT COVERED			54	18							**72**
55	THE PHOTOS RECEIVED DO NOT DEMONSTRATE THE NEED FOR THE TREATMENT REQUESTED.			24		35			10			**69**
242	SERVICES PERFORMED BY A NON-PARTICIPATING FACILITY ARE NOT COVERED.	1	4	10	4	6	6		22		11	**64**
119	THIS PROCEDURE HAS BEEN APPROVED CONTINGENT UPON AVAILABILITY OF THE MEMBER'S ANNUAL BENEFIT MAXIMUM	26	32		3	1					1	**63**
222	THE ORIGINAL BILLING PROVIDER, GROUP, OR FACILITY IS RESPONSIBLE FOR THE REPLACEMENT OF THE ORIGINAL RESTORATION WITHIN THE FIRST 12 MONTHS AFTER INITIAL PLACEMENT.			29							27	**56**
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.						52					**52**
152	PLEASE SUBMIT THE ARCH LOCATION.	1							22		27	**50**
233	DATA ENTRY ADVISED THE REFERRAL OR PREAUTHORIZATION WAS ENTERED IN ERROR	1	3	15	7	4			10		7	**47**

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.										46	**46**
236	CHARGE HAS BEEN REVIEWED UTILIZING THE CORRECT ADA PROCEDURE CODE.		8						34		1	**43**
119	COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A TWELVE MONTH PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	20	19				1				1	**41**
242	SERVICES PERFORMED BY A NON-PARTICIPATING FACILITY ARE NOT COVERED.	2	1	2		4	1		19		9	**38**
107	OUR RECORDS SHOW THAT THE MEMBER HAS RECEIVED A FULL DENTURE, COMPLETE OR IMMEDIATE, IN THIS ARCH. THE EXTRACTIONS REPORTED REQUIRE THE PRESENCE OF NATURAL TEETH IN ORDER TO BE APPROVED.								29			**29**
150	MUST BE MISSING ONE (1) OR TWO (2) MAXILLARY PERMANENT ANTERIOR TEETH OR, MISSING TWO (2) MANDIBULAR PERMANENT ANTERIOR TEETH OR, MISSING THREE (3) OR MORE PERMANENT TEETH IN THE SAME ARCH (OF WHICH AT LEAST ONE MUST BE ANTERIOR)						23					**23**
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.										20	**20**
6	THE MEMBER MUST BE BETWEEN THE AGES OF 5 - 8 TO RECEIVE THIS PROCEDURE	1	8	7						2		**18**
55	THE PHOTOS RECEIVED DO NOT DEMONSTRATE THE NEED FOR THE TREATMENT REQUESTED.			8		4			6			**18**
236	CHARGE HAS BEEN REVIEWED UTILIZING THE CORRECT ADA PROCEDURE CODE.		1						15			**16**
151	THE ADULT DENTURE PROGRAM DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY						14					**14**
151	THE ADULT DENTURE PROGRAM DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY						10					**10**
97	THIS PROCEDURE IS NOT COVERED WHEN PERFORMED ON THE SAME DATE OF SERVICE AS A MORE DEFINITIVE TREATMENT OR IN CONJUNCTION WITH THE REPORTED SERVICE(S).		9									**9**
59	THIS CODE REQUIRES PRE-OPERATIVE DOCUMENTATION (X-RAYS, PERIO CHARTING, AND/OR PHOTOS) TO BE SUBMITTED WITH THE CLAIM FOR CONSIDERATION. THE PROCEDURE WILL BE EVALUATED FOR MEDICAL NECESSITY DURING THE CLAIM REVIEW.			7								**7**
107	OUR RECORDS SHOW THAT THE MEMBER HAS RECEIVED A FULL DENTURE, COMPLETE OR IMMEDIATE, IN THIS ARCH. THE EXTRACTIONS REPORTED REQUIRE THE PRESENCE OF NATURAL TEETH IN ORDER TO BE APPROVED.								6			**6**
97	AS OUTLINED IN YOUR PROVIDER MANUAL, THE INITIAL PAYMENT INCLUDES ALL REPLACEMENT COSTS FOR 12 MONTHS FOLLOWING THE APPLIANCE PLACEMENT.		4							1		**5**
206	NO TIN OR NPI NUMBER WAS INCLUDED WITH THIS CLAIM OR THE TIN/NPI NUMBER SUBMITTED DOES NOT MATCH OUR RECORDS. WE ARE DENYING THIS CLAIM BECAUSE WE CANNOT PROPERLY IDENTIFY THE PROVIDER AND/OR FACILITY.						4		1			**5**
59	THIS CODE REQUIRES PRE-OPERATIVE DOCUMENTATION (X-RAYS, PERIO CHARTING, AND/OR PHOTOS) TO BE SUBMITTED WITH THE CLAIM FOR CONSIDERATION. THE PROCEDURE WILL BE EVALUATED FOR MEDICAL NECESSITY DURING THE CLAIM REVIEW.			4								**4**

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
177	MUST BE MISSING ONE (1) OR MORE ADJACENT MAXILLARY ANTERIOR TEETH, OR MISSING TWO (2) OR MORE ADJACENT MANDIBULAR ANTERIOR TEETH, OR MISSING AT LEAST THREE (3) ADJACENT POSTERIOR PERMANENT TEETH IN A SINGLE QUADRANT WHEN THE PROSTHESIS WOULD RESTORE MASTICATORY FUNCTION (THIRD MOLARS NOT CONSIDERED FOR REPLACEMENT), OR MISSING AT LEAST TWO (2) ADJACENT POSTERIOR PERMANENT TEETH IN BOTH QUADRANTS OF THE SAME ARCH WHEN THE PROSTHESIS WOULD RESTORE MASTICATORY FUNCTION IN AT LEAST ONE (1) QUADRANT (THIRD MOLARS NOT CONSIDERED FOR REPLACEMENT).						4					**4**
133	PENDING CLAIM: NEEDS INTERNAL AUTH/PRE-DETERMINATION REVIEW.			3							1	**4**
206	NO TIN OR NPI NUMBER WAS INCLUDED WITH THIS CLAIM OR THE TIN/NPI NUMBER SUBMITTED DOES NOT MATCH OUR RECORDS. WE ARE DENYING THIS CLAIM BECAUSE WE CANNOT PROPERLY IDENTIFY THE PROVIDER AND/OR FACILITY.			2							1	**3**
177	MISSING THREE (3) OR MORE MAXILLARY ANTERIOR TEETH, OR MISSING TWO (2) OR MORE MANDIBULAR ANTERIOR TEETH, OR MISSING AT LEAST THREE (3) ADJACENT POSTERIOR PERMANENT TEETH IN A SINGLE QUADRANT WHEN THE PROSTHESIS WOULD RESTORE MASTICATORY FUNCTION (THIRD MOLARS NOT CONSIDERED FOR REPLACEMENT), OR MISSING AT LEAST TWO (2) ADJACENT POSTERIOR PERMANENT TEETH IN BOTH QUADRANTS OF THE SAME ARCH WHEN THE PROSTHESIS WOULD RESTORE MASTICATORY FUNCTION IN AT LEAST ONE QUADRANT (THIRD MOLARS NOT CONSIDERED FOR REPLACEMENT) OR, MISSING A COMBINATION OF TWO (2) OR MORE ANTERIOR AND AT LEAST ONE POSTERIOR TOOTH (EXCLUDING WISDOM TEETH AND THE SECOND MOLAR) IN THE SAME ARCH.						2					**2**
24	THE PREAUTHORIZATION IS APPROVED CONTINGENT UPON EVIDENCE OF EXTRACTIONS BEING COMPLETED PRIOR TO THE DELIVERY DATE OF THE CONVENTIONAL DENTURE OR ON THE SAME DATE OF THE IMMEDIATE DENTURE.						1					**1**
274	THE PAYMENT IS INCLUDED WITH ANOTHER SERVICE/PROCEDURE AND IS NOT PAYABLE SEPARATELY. THIS INCLUDES BUT IS NOT LIMITED TO FOLLOW-UP CARE.				1							**1**
116	THE MEMBER'S CURRENT DENTITION STAGE IS NOT APPROPRIATE FOR TREATMENT REQUESTED. PLEASE SUBMIT THE APPROPRIATE CDT CODE FOR THIS MEMBER'S DENTITION'S STAGE									1		**1**
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.						1					**1**
149	COVERAGE IS LIMITED TO ONCE PER LIFETIME PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.									1		**1**
273	THIS PROCEDURE IS NOT REIMBURSABLE TO THE SAME BILLING PROVIDER, FACILITY, OR GROUP THAT BILLED THE ORIGINAL D1510, D1516, AND 1517.		1									**1**
35	SERVICES FOR CODE 0145 ARE LIMITED TO 10 PER LIFETIME. BENEFITS FOR THIS SERVICE HAVE BEEN EXHAUSTED.			1								**1**
9	MEMBER IS OUTSIDE THE AGE RANGE FOR THIS OFFICE								1			**1**
TOTALS		**1,384**	**1,560**	**8,192**	**1,932**	**2,375**	**4,165**	**86**	**19,078**	**204**	**8,358**	**47,334**

Source: MCNA Report 188 Prior Authorization Reports

APPENDIX XVII - Dental Program, July 1, 2020 - June 30, 2021

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

DentaQuest

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
22	This care may be covered by another payer per coordination of benefits.	6	1	4	2	.	.	.	3	.	.	**16**
31	Patient cannot be identified as our insured.	.	.	.	.	.	7	.	.	.	.	**7**
197	Precertification/authorization/notification/pre-treatment absent.	.	.	.	.	.	.	.	.	4	.	**4**
Total		**6**	**1**	**4**	**2**	**-**	**7**	**-**	**3**	**4**	**-**	**27**

Source: Report 173 Denied Claims

APPENDIX XVII - Dental Program, July 1, 2020 - June 30, 2021

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

MCNA

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	116	106	682	241	13	279	.	1,178	4	661	**3,280**
252	An attachment/other documentation is required to adjudicate this claim/service.	5	6	520	478	2	874	.	108	3	772	**2,768**
22	This care may be covered by another payer per coordination of benefits.	22	12	88	33	6	208	.	252	2	254	**877**
272	Coverage/program guidelines were not met.	118	11	70	13	4	111	.	254	.	89	**670**
27	Expenses incurred after coverage terminated.	4	9	117	34	3	117	.	207	1	85	**577**
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	11	11	98	49	2	34	.	221	2	100	**528**
96	Non-covered charge(s).	3	216	21	10	4	5	2	30	.	203	**494**
16	Claim/service lacks information or has submission/billing error(s).	22	23	78	49	2	53	.	94	7	108	**436**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	2	1	345	1	.	2	.	9	.	.	**360**
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	3	.	4	3	.	1	.	4	.	274	**289**
181	Procedure code was invalid on the date of service.	3	.	3	2	.	248	.	20	.	1	**277**
150	Payer deems the information submitted does not support this level of service.	.	.	.	.	.	.	.	.	.	273	**273**
169	Alternate benefit has been provided.	55	.	13	.	.	2	.	152	.	34	**256**
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.	.	.	10	7	4	.	.	208	.	.	**229**
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	6	2	21	27	1	92	.	17	.	27	**193**
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.	.	.	17	169	.	.	.	2	.	.	**188**
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.	2	.	46	13	5	2	.	45	.	63	**176**
269	Anesthesia not covered for this service/procedure.	.	.	2	.	.	.	.	2	.	141	**145**
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	3	7	19	8	1	7	.	41	.	36	**122**
29	The time limit for filing has expired.	7	2	19	16	.	24	.	33	.	15	**116**
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	28	42	32	.	.	2	.	2	.	6	**112**
206	National Provider Identifier - missing.	1	1	1	.	.	8	.	54	.	38	**103**
B20	Procedure/service was partially or fully furnished by another provider.	.	3	17	8	.	3	.	25	.	26	**82**
95	Plan procedures not followed.	.	.	2	54	.	.	.	.	.	.	**56**
119	Benefit maximum for this time period or occurrence has been reached.	12	17	1	1	.	3	.	.	.	.	**34**
6	The procedure/revenue code is inconsistent with the patient's age.	2	19	5	7	.	.	.	.	.	.	**33**

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
152	Payer deems the information submitted does not support this length of service.	.	.	.	.	.	.	.	28	.	1	**29**
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	.	.	.	.	.	.	.	.	.	17	**17**
199	Revenue code and Procedure code do not match.	.	.	1	1	.	2	.	11	.	.	**15**
200	Expenses incurred during lapse in coverage	.	.	.	1	.	2	.	6	1	4	**14**
216	Based on the findings of a review organization	.	.	8	6	.	.	.	.	.	.	**14**
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	1	2	1	.	.	.	.	.	.	8	**12**
5	The procedure code/type of bill is inconsistent with the place of service.	.	.	.	.	.	.	.	.	.	12	**12**
261	The procedure or service is inconsistent with the patient's history.	5	.	.	.	.	.	.	2	.	.	**7**
107	The related or qualifying claim/service was not identified on this claim.	.	.	.	.	.	.	.	6	.	.	**6**
242	Services not provided by network/primary care providers.	.	.	.	.	.	4	.	.	.	1	**5**
259	Additional payment for Dental/Vision service utilization.	.	.	.	.	.	.	.	4	.	.	**4**
276	Services denied by the prior payer(s) are not covered by this payer.	.	.	3	.	.	.	.	.	.	.	**3**
B14	Only one visit or consultation per physician per day is covered.	.	.	.	.	.	.	.	.	.	3	**3**
32	Our records indicate the patient is not an eligible dependent.	.	.	1	1	.	.	.	.	.	.	**2**
185	The rendering provider is not eligible to perform the service billed.	.	.	1	.	.	.	.	.	.	.	**1**
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.	.	.	.	.	.	.	.	1	.	.	**1**
253	Sequestration - reduction in federal payment	.	.	.	1	.	.	.	.	.	.	**1**
273	Coverage/program guidelines were exceeded.	.	.	.	.	.	.	.	.	.	1	**1**
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	.	.	.	.	.	.	.	1	.	.	**1**
9	The diagnosis is inconsistent with the patient's age.	.	.	.	.	.	.	.	.	.	1	**1**
Total		**431**	**490**	**2,246**	**1,233**	**47**	**2,083**	**2**	**3,017**	**20**	**3,254**	**12,823**

Source: Report 173 Denied Claims