

Appendix XI – Dental Program Prior Authorizations (Section 26)

Denied Prior Authorizations July 1, 2015 – June 30, 2016

MCNA Code	Denial Reason Description	Diagnostic	Preventative	Restorative	Endodontics	Periodontics	Removable Prosthodontics	Maxillofacial Prosthetics	Implant Services	Fixed Prosthodontics	Oral & Maxillofacial Surgery	Orthodontics	Adjunctive General Services	Total
2	This request has been previously reported and an approval or denial was issued.	522	337	2,395	719	105	528	1	0	9	2,036	25	1,234	7,911
17	This a non covered service per the covered services outlined in your provider manual.	132	32	477	194	337	290	11	24	32	745	17	2,353	4,644
19	Payment for this procedure has been provided under a prior claim or procedure.	0	0	1	0	0	0	0	0	0	0	0	0	1
21	Coverage for this procedure is limited to once in a 6 month period per the covered benefits outlined in your provider manual.	95	102	0	0	0	0	0	0	0	1	0	5	203
23	Coverage for this procedure is limited to once in a 3 year period per the covered benefits outlined in your provider manual.	48	0	0	0	0	0	0	0	0	0	0	0	48
24	Charges for radiographs have been combined and an alternate benefit of a full month series considered.	1	0	0	0	0	0	0	0	0	0	0	0	1
27	Coverage for this procedure is limited to once in a 12 month period per the covered benefits in your provider manual.	38	30	137	0	10	15	0	0	0	0	0	3	233
28	This procedure is only covered in conjunction with preauthorized orthodontia.	4	4	0	0	4	0	0	0	0	934	1	2	949
36	Procedure is limited to once in a 5 year period per the covered benefits outlined in your provider manual.	0	0	0	0	9	11	0	0	6	0	0	0	26

80	Eruption of the permanent tooth will occur within 6 months which will naturally maintain the space.	0	56	1	1	0	0	0	0	0	0	0	0	58
88	Our records show that the member's tooth/teeth has already been pulled.	0	0	101	35	0	0	0	0	0	195	0	0	331
92	No benefit is provided for the extraction of non-infected primary teeth when normal loss is imminent. The member's condition does not meet MCNA's oral surgery guidelines.	1	0	5	1	0	0	0	0	0	119	0	0	126
111	The clinical reviewer has determined that the x-ray and/or photos submitted were not of diagnostic value. Please submit a diagnostic x-ray indicating the right and left sides and/or diagnostic quality photos.	8	23	1,018	348	26	28	0	0	0	417	2	7	1,877
120	The clinical reviewer has recommended an alternate procedure/benefit	12	214	258	94	465	57	0	0	3	1,876	22	4	3,005
121	This procedure can only be considered when reported and performed in conjunction with covered services.	7	0	1	0	0	0	0	0	0	0	0	1,641	1,649
122	Procedure is only covered on permanent teeth. Primary teeth are not covered.	0	7	34	51	0	0	0	0	0	3	0	0	95
150	The Dental director has advised that the x-rays received do not demonstrate the need for treatment submitted.	6	10	1,527	512	606	1	0	0	0	260	0	4	2,926
153	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	4	8	99	13	3	19	0	0	0	85	21	10	262

363	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.	0	2	0	0	0	0	0	0	0	0	0	31	33
384	Benefits for this service are limited to providers with a specialty in orthodontics.	0	0	0	0	0	0	0	0	0	0	15	0	15
400	Clinical criteria were not met.	32	158	2,599	409	60	430	2	0	24	165	42	858	4,779
405	Please submit a color photograph	0	0	300	128	15	3	0	0	0	51	5	5	507
406	Resubmit with the appropriate narrative to review this charge.	0	0	1	0	0	0	0	0	0	0	0	1	2
407	The combination of service submitted on this request for this member cannot be performed by the same provider on the same date of service.	20	3	0	0	15	0	0	0	0	0	0	11	49
410	According to our records, you are not certified or permitted to perform this level of anesthesia.	0	0	0	0	0	0	0	0	0	0	0	203	203
415	Sealants are not covered on teeth that have prior restorations.	0	3	0	0	0	0	0	0	0	0	0	0	3
416	Sealants are limited to posterior teeth only per the covered benefits outlined in your provider manual.	0	1	0	0	0	0	0	0	0	0	0	0	1
459	The Dental director requests diagnostic periodontal x-rays that show the bone loss to support the period charting received.	2	0	0	0	37	0	0	0	0	0	0	0	39
462	Please provide a narrative that documents the specific medical diagnosis regarding the patient's mental and/or physical health to make a medical necessity determination.	0	0	0	0	0	0	0	0	0	2	0	103	105
503	Please submit photos and rationale.	0	0	1	0	9	0	0	0	0	9	0	1	20
504	Please submit a correct CDT code.	52	37	577	180	21	89	0	0	3	57	36	58	1,110

	D1110/D1120 in the last 12 month period.													
552	The payable amount for a complete or partial denture includes the cost of repairs incurred for the first 12 months following delivery of the appliance.	0	0	0	0	0	23	0	0	0	0	0	0	23
553	Please submit with the location and description of the fracture.	0	0	0	0	0	2	0	0	0	0	0	0	2
560	All treatment, per quadrant, must be performed on a single date of service. Simple restorations in a second quadrant must also be performed at the same appointment.	0	0	0	1	0	0	0	0	0	0	0	0	1
562	Coverage for this procedure is limited to once in a eight year period per the covered benefits outlined in your provider manual.	198	0	0	0	0	551	0	0	0	0	0	0	749
563	CDT D0150 is denied because the per-authorization does not contain the required radiographs, as described in your provider manual.	81	0	0	0	0	0	0	0	0	0	0	0	81
565	CDT D0150 must be submitted with CDT D02010, D0330, or D0240; As outlined in your provider manual.	4	0	0	0	0	0	0	0	0	0	0	0	4
567	As outlined in your provider manual, the initial payment for the denture includes all relines for the first 12 months after dentures seating.	0	0	0	0	4	45	0	0	0	0	0	0	49
568	A combination of relines and complete/partial dentures is allowed once in a eight year period, as outlined in your provider manual.	0	0	0	0	1	57	0	0	0	0	0	0	58
570	Alveoplasty is only covered when performed in conjunction with the	0	0	0	0	0	0	0	0	0	9	0	0	9

669	The member must be between the ages of 0-6 to receive this procedure.	0	1	0	0	0	0	0	0	0	0	0	1	2
670	The member must be between the ages of 0-16 to receive this procedure.	0	4	0	0	0	0	0	0	0	0	0	0	4
671	The member must be between the ages of 0-10 to receive this procedure.	0	10	0	0	0	0	0	0	0	0	0	0	10
672	The member must be between the ages of 0-4 to receive this procedure.	0	0	32	2	0	0	0	0	0	0	0	0	34
676	The member must be between the ages of 18-20 to receive this procedure.	0	0	0	0	0	2	0	0	0	0	0	0	2
680	The member must be between the ages of 5-8 to receive this procedure.	0	0	0	0	0	0	0	0	0	0	4	0	4
TOTAL		2,069	1,930	14,703	4,230	2,325	3,293	14	24	84	19,924	288	9,156	58,040

	Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.											
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)	1	0	0	0	0	1	0	0	1	0	3
46	This (these) service(s) is (are) not covered.	13	0	5	14	3	4	0	103	0	169	311
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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1	0	1	0	1	8	0	0	0	0	11
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	1	9	0	0	0	0	2	0	163	175
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	0	4	4	1	0	0	1	0	0	10
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	1	16	30	16	10	14	0	242	2	129	460
63	Correction to a prior claim.	0	0	3	0	0	0	0	0	0	0	3
86	Statutory Adjustment.	0	0	1	0	0	0	0	0	0	0	1
95	Plan procedures not followed.	0	0	2	123	0	0	0	0	0	0	125
125	Submission/billing error(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.)	2	3	15	7	0	9	0	15	0	19	70
138	Appeal procedures not followed or time limits not met.	0	0	0	2	0	0	0	0	0	0	2
140	Patient/Insured health identification number and name do not match.	0	0	0	0	0	0	0	4	0	3	7
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	3	14	80	106	2	43	0	21	0	86	355
169	Alternate benefit has been provided.	596	3	53	4	2	1	0	135	0	26	820
177	Patient has not met the required eligibility requirements.	0	0	2	0	0	4	0	0	0	0	6
181	Procedure code was invalid on the date of service.	0	0	7	3	0	4	0	2	0	6	22

193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	44	1	48	28	3	32	0	28	1	26	211
208	National Provider Identifier - Not matched.	3	1	12	12	0	10	0	88	1	36	163
242	Services not provided by network/primary care providers.	8	1	24	8	0	8	0	3	0	6	58
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).	0	0	3	1	0	1	0	4	0	2	11
252	An attachment/other documentation is required to adjudicate this claim/service. 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).	140	21	1,008	170	11	272	0	827	0	154	2,603
269	Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	0	0	0	0	0	0	1	0	186	187
272	Coverage/program guidelines were not met.	0	11	48	7	0	3	0	2	0	0	71
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	56	42	344	155	5	79	0	597	1	207	1,486
B14	Only one visit or consultation per physician per day is covered.	1	0	0	0	3	0	0	0	0	1	5
B20	Procedure/service was partially or fully furnished by another provider.	1	8	61	24	0	7	0	55	1	33	190
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	0	0	0	0	0	0	0	0	26	26
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	13	0	0	0	0	0	0	0	0	0	13
M51	Missing/incomplete/invalid procedure code(s).	6	2	25	18	1	11	3	41	7	69	183
M86	Service denied because payment already made for same/similar procedure within set time frame.	0	0	0	0	0	1	0	0	0	0	1

MA70	Missing/incomplete/invalid provider representative signature.	0	0	2	3	0	2	0	1	0	1	9
MA75	Missing/incomplete/invalid patient or authorized representative signature.	0	0	0	1	0	0	0	0	0	0	1
N20	Service not payable with other service rendered on the same date.	17	1	5	0	32	0	0	0	0	42	97
N292	Missing/incomplete/invalid service facility name.	4	0	2	1	0	6	0	6	0	3	22
N340	Missing/incomplete/invalid subscriber birth date.	0	0	0	0	0	6	0	4	0	1	11
N36	Claim must meet primary payer's processing requirements before we can consider payment.	4	0	1	1	0	6	0	3	0	12	27
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	0	0	1	0	0	0	0	19	0	0	20
N39	Procedure code is not compatible with tooth number/letter.	0	0	3	0	0	0	0	0	0	0	3
N640	Exceeds number/frequency approved/allowed within time period	50	82	22	2	4	20	0	0	0	6	186
N786	Benefit limitation for the orthodontic active and/or retention phase of treatment.	0	0	0	0	0	0	0	70	0	0	70
CARC not provided		557	15	708	92	42	237	0	269	5	113	2,038
Total		2,133	396	4,437	2,639	177	3,368	3	4,366	36	3,646	21,201