APPENDIX XIII - Dental Program, July 1, 2018 - June 30, 2019

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										37	**37**
6	PROCEDURE DOES NOT MEET AGE REQUIREMENTS OF THE PLAN	4	174	166	42	12	4	6		44	21	**473**
16	DENIED BECAUSE THE PRE-AUTHORIZATION DOES NOT CONTAIN THE REQUIRED DOCUMENTATION . . .	47	566	1,334	494	159	165	1	654	33	70	**3,523**
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	585	291	1,654	510	78	959		1,837	23	1,220	**7,157**
22	PEND: DETERMINE COB ORDER OF BENEFITS. PLEASE SUBMIT THE PRIMARY CARRIER'S BENEFIT STATEMENT AND ANY PREVIOUS EXPLANATION OF BENEFITS.								5			**5**
31	THE SUBSCRIBER IS NOT CURRENTLY ACTIVE IN THE PROGRAM.	30	18	177	51	14	69		122	3	83	**567**
40	COVERAGE FOR THIS CODE IS LIMITED TO EMERGENCY SERVICES ONLY. WHEN SUBMITTING A CLAIM WITH THIS SERVICE, THE FACILITY MUST SUBMIT A NARRATIVE OF THE PROCEDURE ACTUALLY BEING PERFORMED. THE CLAIM FORM DID NOT INDICATE THIS WAS AN EMERGENCY.										7	**7**
49	THIS PROCEDURE IS NOT COVERED IN CONJUNCTION WITH THE REPORTED SERVICE(S). PLEASE SUBMIT X-RAY(S) AND NARRATIVE WITH THIS REQUEST.	16	72	804	160	48	95		512	2	28	**1,737**
50	THE CLINICAL REVIEWER HAS DETERMINED THAT THE TREATMENT IS IN EXCESS OF THE MEMBER'S NEEDS.	30	59	628	116	23	31		253	1	2,274	**3,415**
55	THE PHOTOS RECEIVED DO NOT DEMONSTRATE THE NEED FOR THE TREATMENT REQUESTED.			62	2	56			5			**125**
56	THE DENTAL DIRECTOR HAS ADVISED THAT THE X-RAYS RECEIVED DO NOT DEMONSTRATE THE NEED FOR TREATMENT SUBMITTED.	3	3	1,293	665	1,109			8,832		8	**11,913**

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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.	2					133					**135**
96	THIS PROCEDURE IS CONSIDERED NON-COVERED IN ACCORDANCE WITH EITHER THE PROGRAM BENEFITS OR THE FACILITY CONTRACT WITH MCNA	116	126	1,151	469	376	275	66	1,690	5	3,823	**8,097**
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.		31	1	1							**33**
133	THIS TOOTH NEEDS TO BE EVALUATED BY AN ENDODONTIST.				1							**1**
147	THIS CDT CODE IS APPROVED BUT THE RATE HAS NOT BEEN SET BY HHSC. PAYMENT OF THE APPROPRIATE RATE WILL BE MADE ONCE THE RATE HEARING PROCESS IS COMPLETE.						2					**2**
151	THE ADULT DENTURE PROGRAM DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY						43					**43**
152	PLEASE SUBMIT THE ARCH LOCATION.	11	206			5	2		153	24	129	**530**
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.	1	47	176	71	440	122		3,744	3	56	**4,660**
181	PLEASE SUBMIT A CORRECT CDT CODE.	18	241	690	226	27	358		133	24	252	**1,969**
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.	2					143					**145**
216	TREATMENT PERFORMED ON TEETH WITH POOR OR QUESTIONABLE PROGNOSIS IS NOT COVERED		2	396	116				9			**523**

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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). . .	127	102	377	22	9	12				79	**728**
233	DATA ENTRY ADVISED THE REFERRAL OR PREAUTHORIZATION WAS ENTERED IN ERROR	6	4	36	5		12		461	4	587	**1,115**
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.		249			1	1				1	**252**
242	SERVICES PERFORMED BY A NON-PARTICIPATING FACILITY ARE NOT COVERED. SERVICES PERFORMED BY A NON-PARTICIPATING PROVIDER ARE NOT COVERED.	7	9	54	11	3	15		57		29	**185**
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.	1	28	1,898	289	74	54		470	2	5	**2,821**
252	ALL MISSING TEETH OR TEETH TO BE EXTRACTED MUST BE INDICATED ON THE PRE-AUTHORIZATION REQUEST. PLEASE SUBMIT . . . additional documentation requested	30	165	1,417	444	306	658		1,230	37	868	**5,155**
269	THIS PROCEDURE CAN ONLY BE CONSIDERED WHEN REPORTED AND PERFORMED IN CONJUNCTION WITH COVERED SERVICES.			2					1		2,734	**2,737**
272	Multiple descriptions	869	114	1,960	274	88	2,090	17	3,203	82	1,485	**10,182**

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273	SERVICES IN A MOBILE SETTING OR SCHOOL BASED SETTING MUST BE WITHIN 20 MILES OF THE PROVIDER'S PRINCIPAL PLACE OF PRACTICE FOR URBAN AREAS, AND 40 MILES OF THE PROVIDER'S PRINCIPAL PLACE OF PRACTICE FOR RURAL AREAS.										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.	2		2			1					**5**
276	THIS SERVICE IS ONLY PAYABLE ON A TOOTH THAT HAS HAD ENDODONTIC TREATMENT.			84								**84**
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.			58	18		1		368			**445**
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.			1							243	**244**
N130	THE ADULT DENTURE PROGRAM DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY THE ADULT DENTURE PROGRAM ONLY PROVIDES FOR						264				12	**276**
P7	OUR RECORDS SHOW THAT THE MEMBER HAS ALREADY RECEIVED THIS SERVICE. PLEASE SUBMIT THE REQUIRED DOCUMENTATION WITH THE CLAIM	274	114	264	83	2	23		190		101	**1,051**
TOTALS		**2,181**	**2,621**	**14,685**	**4,070**	**2,830**	**5,532**	**90**	**23,929**	**287**	**14,153**	**70,378**

Source: MCNA Report 188 Prior Authorization Reports

APPENDIX XIII - Dental Program, July 1, 2018 - June 30, 2019

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

CARC	Claims Adjustment Reason Code (CARC) Description	Diagnostic D0100-D0999	Preventive D1000-D1999	Restorative D2000-D2999	Endodontics D3000-D3999	Periodontics D4000-D4999	Removable Prosthodontics D5000-D5899	Oral & Maxillofacial Surgery D7000-D7999	Orhtodontics D8000-D8999	Adjunctive General Services D9000-D9999	Total
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	218	124	1,435	588	30	446	1,584	10	1,083	**5,518**
252	An attachment/other documentation is required to adjudicate this claim/service.	6	5	594	606	1	879	35	1	1,001	**3,128**
16	Claim/service lacks information or has submission/billing error(s).	105	43	144	85	9	72	358	12	299	**1,127**
22	This care may be covered by another payer per coordination of	40	16	139	48	5	227	329	5	239	**1,048**
272	Coverage/program guidelines were not met.	176	8	306	40	8	81	280		56	**955**
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.	13	1	152	21	17	3	645		22	**874**
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.)	14	3	18	9	3	2	42		653	**744**
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	7	18	200	74		16	284	5	113	**717**
181	Procedure code was invalid on the date of service.	1	1	11	3		405	12	1	18	**452**
169	Alternate benefit has been provided.	111	2	18		4	3	241		23	**402**
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.			110	23			163			**296**
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	2	5	258		3	8			4	**280**
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).		1	22	210			6		5	**244**
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.			36	3			2		189	**230**
6	The procedure/revenue code is inconsistent with the patient's age.	2	47	6		1		148		4	**208**
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	52	91	33	1	1	12			10	**200**
269	Anesthesia not covered for this service/procedure.			2						187	**189**
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	10		13	29		26	14		46	**138**
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	5	2	24	9	3	6	34	1	50	**134**
B20	Procedure/service was partially or fully furnished by another provider.		1	40	10		1	46		32	**130**
216	Based on the findings of a review organization	3	1	56	36		2	20		4	**122**
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	4	1	6	10		19	38	2	36	**116**
27	Expenses incurred after coverage terminated.			13	4		38	35		23	**113**
29	The time limit for filing has expired.	11		15	10		30	33		11	**110**
206	National Provider Identifier - missing.		1	19	7		9	41		9	**86**

CARC	Claims Adjustment Reason Code (CARC) Description	Diagnostic D0100-D0999	Preventive D1000-D1999	Restorative D2000-D2999	Endodontics D3000-D3999	Periodontics D4000-D4999	Removable Prosthodontics D5000-D5899	Oral & Maxillofacial Surgery D7000-D7999	Orhtodontics D8000-D8999	Adjunctive General Services D9000-D9999	Total
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.		70							1	**71**
5	The procedure code/type of bill is inconsistent with the place of					1				60	**61**
95	Plan procedures not followed.				50						**50**
152	Payer deems the information submitted does not support this length of service.	1	2					26		1	**30**
39	Services denied at the time authorization/pre-certification was	2		3	1		1	10		6	**23**
B14	Only one visit or consultation per physician per day is covered.	2				4	2			9	**17**
242	Services not provided by network/primary care providers.	4		3			2	2		4	**15**
14	The date of birth follows the date of service.							8		6	**14**
199	Revenue code and Procedure code do not match.			6				6			**12**
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.			11							**11**
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.									11	**11**
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.	1						4		1	**6**
261	The procedure or service is inconsistent with the patient's history.	5									**5**
31	Patient cannot be identified as our insured.							3		1	**4**
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.			3							**3**
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.						1			1	**2**
185	The rendering provider is not eligible to perform the service billed.							1			**1**
26	Expenses incurred prior to coverage.				1						**1**
40	Charges do not meet qualifications for emergent/urgent care.									1	**1**
Totals		**795**	**443**	**3,696**	**1,878**	**90**	**2,291**	**4,450**	**37**	**4,219**	**17,899**

Source: Report 173 Denied Claims