Appendix XI - Dental Program, July 1, 2017 - June 30, 2018

Denied prior authorization by denial code and procedure code catergory

MCNA Code	Description of Authorization Denial Code	Diagnostic D0100 - D0999	Preventive D1000 - D1999	Restorative D2000 - D2999	Endodontics D3000 - D3999	Periodontics D4000 - D4999	Removable Prosthodontics D5000 - D5899	Implant Services D6000 - D6199	Fixed Prosthosdontics D6200 - D6999	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)	252	124	1,167	575	24	379	-	-	1,744	12	1,061	5,338
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).	10	1	542	714	-	1,146	-	-	18	1	1,283	3,715
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	52	24	304	147	4	93	-	-	708	5	205	1,542
22	This care may be covered by another payer per coordination of benefits.	59	14	169	70	-	174	-	-	476	14	282	1,258
272	Coverage/program guidelines were not met.	385	5	321	24	10	105	-	1	160	5	160	1,176
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	58	27	247	117	8	62	-	1	202	21	206	949
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.	3	-	296	83	24	-	-	-	521	-	9	936
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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7	-	16	12	1	6	1	-	43	-	536	622
181	Procedure code was invalid on the date of service.	2	-	2	1	-	430	-	-	8	-	14	457
169	Alternate benefit has been provided.	158	-	32	1	-	5	-	-	187	-	19	402
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. 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.)	11	1	41	23	1	127	-	-	22	1	89	316

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97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	10	8	245	4	2	15	-	-	9	-	10	303
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.	-	-	2	-	-	-	-	-	1	-	275	278
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.	-	-	32	6	1	-	-	-	5	3	204	251
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	70	67	38	9	-	-	-	-	-	-	31	215
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).	-	-	23	119	-	1	-	-	14	-	-	157
29	The time limit for filing has expired.	18	-	19	6	-	44	-	-	34	-	36	157
27	Expenses incurred after coverage terminated.	3	1	20	8	2	40	-	-	46	-	30	150
B20	Procedure/service was partially or fully furnished by another provider.	-	2	26	22	-	4	-	-	37	1	33	125
206	National Provider Identifier - missing.	14	4	23	12	1	13	-	-	34	2	12	115
216	Based on the findings of a review organization	-	-	51	40	-	-	-	-	-	-	1	92
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	8	-	17	5	2	17	-	-	13	3	22	87
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	5	-	26	5	-	12	-	-	25	1	13	87
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	-	-	-	-	-	-	-	-	84	-	-	84
138	Appeal procedures not followed or time limits not met.	7	1	19	3	-	7	-	-	27	3	13	80
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.	-	-	36	13	3	-	-	-	18	-	-	70

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5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	-	-	-	-	-	-	-	-	-	-	69	69
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2	31	4	3	-	-	-	-	17	1	4	62
242	Services not provided by network/primary care providers.	-	1	19	10	-	6	-	-	9	-	2	47
39	Services denied at the time authorization/pre-certification was requested.	-	-	18	-	-	-	-	-	20	-	8	46
152	Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	-	6	-	-	-	1	-	-	31	-	5	43
31	Patient cannot be identified as our insured.	-	1	5	1	-	1	-	-	13	-	1	22
95	Plan procedures not followed.	-	-	-	14	-	-	-	-	-	-	-	14
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	-	-	9	4	-	-	-	-	-	-	-	13
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	11	-	-	-	-	-	-	-	-	-	-	11
200	Expenses incurred during lapse in coverage	-	-	1	1	-	-	-	-	4	-	5	11
177	Patient has not met the required eligibility requirements.	-	-	-	-	-	-	-	-	4	-	5	9
199	Revenue code and Procedure code do not match.	-	-	-	-	-	-	-	-	8	-	-	8
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.	-	-	-	-	2	-	-	-	4	-	2	8
14	The date of birth follows the date of service.	-	-	-	-	-	6	-	-	-	-	-	6
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.	-	-	-	-	-	-	-	-	-	-	6	6
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	-	-	4	1	-	-	-	-	-	-	-	5
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	-	1	-	-	-	-	-	-	-	-	-	1

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23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	1	-	-	-	-	-	-	-	-	-	-	1
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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	-	-	-	-	-	-	-	1
276	Services denied by the prior payer(s) are not covered by this payer.	-	-	1	-	-	-	-	-	-	-	-	1
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	-	-	-	-	-	1	-	-	-	-	-	1
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	-	-	-	-	-	-	-	-	1	-	-	1
B14	Only one visit or consultation per physician per day is covered.	1	-	-	-	-	-	-	-	-	-	-	1
Total		**1,147**	**319**	**3,775**	**2,054**	**85**	**2,695**	**1**	**2**	**4,547**	**73**	**4,651**	**19,349**