Appendix 15.XIII - Dental Program (Section 26)

SFY 15 Denied Prior Authorizations

Prior Authorizations Delineated by Reasons for Denial	Diagnostic D0100 - D0999	Preventive D1000 - D1999	Restorative (D2000 - D2999	Endodontics D3000 - D3999	Periodontics D4000 - D4999	Removable Prosthodontics D5000 - D5899	Maxillofacial Prosthetics D5900 - D5999	Implant Services D6000 - D6199	Fixed Prosthosdontics D6200 - D6999	Oral & Maxillofacial Surgery D7000 - D7999	Orhtodontics D8000 - D8999	Adjunctive General Services D9000 - D9999
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.	35	24	356	110	20	33	0	0	0	293	6	18
120 - THE CLINICAL REVIEWER HAS RECOMMENDED AN ALTERNATE PROCEDURE/BENEFIT.	0	2	2	0	8	1	0	0	0	7	0	0
121 - THIS PROCEDURE CAN ONLY BE CONSIDERED WHEN REPORTED AND PERFORMED IN CONJUNCTION WITH COVERED SERVICES.	4	1	0	0	0	0	0	0	0	0	0	1090
122 - PROCEDURE IS ONLY COVERED ON PERMANENT TEETH. PRIMARY TEETH ARE NOT COVERED.	0	0	2	4	0	0	0	0	0	1	0	0
123 - A PRIOR RESTORATION WAS COVERED WITHIN THE PAST TWELVE MONTHS ON THIS PRIMARY TOOTH.	0	0	1	0	0	0	0	0	0	0	0	0
12 - THE PATIENT CANNOT BE IDENTIFIED AS OUR MEMBER. PLEASE VERIFY THE PATIENT'S INFORMATION AND SUBMIT THE REQUEST WITH THE PATIENT'S FIRST AND LAST NAME AS WELL AS THE MEMBER ID NUMBER.	6	3	45	16	5	8	0	0	0	9	0	3

14 - THIS PROCEDURE HAS BEEN APPROVED AND WILL BE PAID ACCORDING TO YOUR CONTRACTED RATE. THE MEMBER IS NOT RESPONSIBLE FOR ANY AMOUNT EXCEEDING THE CONTRACTED RATE.	0	1	2	0	0	0	0	0	0	0	0	0
150 - THE DENTAL DIRECTOR HAS ADVISED THAT THE X-RAYS RECEIVED DO NOT DEMONSTRATE THE NEED FOR TREATMENT SUBMITTED.	0	21	519	254	428	1	0	0	0	124	0	4
151 - THE DENTAL DIRECTOR HAS REQUESTED THE RATIONALE FOR TREATMENT.IF APPLICABLE PLEASE ATTACH THIS INFORMATION WITH APPLICABLE X-RAY(S), CHARTING, OR NARRATIVE TO THIS DOCUMENT FOR REVIEW OF THIS CHARGE(S).	0	0	2	1	0	0	0	0	0	0	0	0
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 RENDERING PROVIDER. THE PROVIDER NAME SHOULD BE IN A LEGIBLE FORMAT.	2	1	4	5	0	6	0	0	0	12	2	1
157 - THE SUBSCRIBER IS NOT CURRENTLY ACTIVE IN THE PROGRAM.	9	1	47	16	8	19	0	0	0	96	1	30
159 - NITROUS OXIDE OR NON-INTRAVENOUS CONSCIOUS SEDATION WILL BE CONSIDERED ON THE SAME VISIT, BUT NOT BOTH.	0	0	0	0	0	0	0	0	0	0	0	3
160 - RESUBMIT A COPY OF THIS DOCUMENT LISTING WHICH TEETH THE SPACE MAINTAINER IS MAINTAINING SPACE FOR FURTHER REVIEW OF THIS CHARGE.	0	71	0	0	0	0	0	0	0	0	0	0

166 - THE CLINICAL REVIEWER HAS ADVISED THAT THE INCORRECT X-RAY WAS SUBMITTED, PLEASE SUBMIT THE CORRECT X-RAY FOR REVIEW.	28	19	130	43	0	40	0	0	0	80	2	3
176 - UPON COMPLETION OF ROOT CANAL, PLEASE SUBMIT PRE-OPERATIVE AND POST-OPERATIVE XRAY WITH YOUR CLAIM.	0	0	0	1	0	0	0	0	0	0	0	0
17 - THIS IS A NON-COVERED SERVICE PER THE COVERED SERVICES OUTLINED IN YOUR PROVIDER MANUAL.	84	28	257	79	157	239	2	10	26	627	22	242
180 - PLEASE SUBMIT A READABLE X-RAY.	7	7	70	20	2	15	0	0	0	232	2	13
18 - THE PAYMENT IS INCLUDED WITH ANOTHER SERVICE/PROCEDURE AND IS NOT PAYABLE SEPARATELY. THIS INCLUDES BUT IS NOT LIMITED TO FOLLOW-UP CARE.	0	0	1	0	1	0	0	0	0	0	0	0
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
212 - RESTORATIONS ARE LIMITED TO ONCE IN A TWELVE (12) MONTH PERIOD FOR THE SAME TOOTH NUMBER/LETTER AND SURFACE(S) PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	5	0	0	0	0	0	0	0	0	0
21 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A SIX MONTH PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	44	29	0	0	0	0	0	0	0	0	0	1

221 - UPON REVIEW OF THE X-RAY, THE TOOTH APPEARS TO BE MISSING.	0	0	5	2	0	0	0	0	0	27	0	0
228 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A 24 MONTH PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	10	0	4	0	0	0	0	0	0	0	0
236 - ALVEOPLASTY IS ONLY COVERED WHEN PERFORMED IN CONJUNCTION WITH FOUR OR MORE EXTRACTIONS IN A SINGLE QUADRANT.	0	0	0	0	0	0	0	0	0	4	0	0
23 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A THREE YEAR PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	36	0	0	0	0	0	0	0	0	0	0	0
241 - THIS PROCEDURE IS NOT COVERED IN CONJUNCTION WITH THE REPORTED SERVICE(S).	0	0	0	0	2	0	0	0	0	1	0	7
247 - SERVICE DID NOT MEET PLAN COVERAGE CRITERIA.	0	1	8	0	0	0	0	0	0	0	0	0
249 - THE NEA ATTACHMENT SUBMITTED IS INVALID, UNREADABLE AND/OR CONTAINS NO IMAGES. PLEASE SUBMIT THE ATTACHMENTS.	3	1	25	14	0	0	0	0	0	61	0	15
25 - ENDODONTIC TREATMENT IS INCLUSIVE OF ALL INTRA-OPERATIVE RADIOGRAPHS, PLACEMENT OF RUBBER DAM, AND TEMPORIZATION.	5	0	0	0	0	0	0	0	0	0	0	0
261 - PLEASE SUBMIT PERIODONTAL CHARTING.	0	0	0	0	97	0	0	0	0	0	0	0
264 - THE PAYMENT FOR THIS RESTORATION HAS RESULTED IN A REDUCTION DUE TO A PREVIOUSLY	0	0	0	0	1	0	0	0	0	0	0	0

PAID DUPLICATE SURFACE(S) THAT HAS BEEN PERFORMED WITHIN THE PRIOR TWELVE MONTHS.												
267 - PLEASE RESUBMIT THE ATTACHMENT IN A READABLE FORMAT.	0	0	4	3	0	0	0	0	0	0	0	0
270 - PLEASE PROVIDE FURTHER RATIONALE FOR TREATMENT.	14	23	89	54	28	219	0	0	11	178	38	40
271 - SUBSCRIBER RESIDES IN DUVAL COUNTY. ALL SUBSCRIBERS UNDER THIS PROGRAM RESIDING IN DUVAL COUNTY ARE REQUIRED TO BE SEEN BY THE DUVAL COUNTY HEALTH DEPARTMENT	0	0	0	0	1	0	0	0	0	0	0	0
27 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A TWELVE MONTH PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	8	2	38	1	4	4	0	0	0	0	0	3
28 - THIS PROCEDURE IS ONLY COVERED IN CONJUNCTION WITH PREAUTHORIZED ORTHODONTIA.	5	0	0	0	2	0	0	0	0	584	0	6
298 - THE SERVICE THAT YOUR DENTIST REQUESTED FOR YOU IS NOT COVERED ON THE TOOTH FOR WHICH IT WAS REQUESTED.	0	0	3	1	0	0	0	0	0	0	0	0
299 - PLEASE SUBMIT A PANORAMIC X-RAY.	0	0	0	0	0	0	0	0	0	8	2	0
2 - THIS REQUEST HAS BEEN PREVIOUSLY REPORTED AND AN APPROVAL OR DENIAL WAS ISSUED.	681	340	2149	849	194	893	0	0	3	2410	38	956
306 - THIS TOOTH NEEDS TO BE EVALUATED BY AN ENDODONTIST.	0	0	2	0	0	0	0	0	0	0	0	0
321 - THE CLINICAL REVIEWER HAS DETERMINED THAT THE TREATMENT IS IN EXCESS OF THE MEMBER'S NEEDS.	86	72	196	60	97	21	0	0	0	68	9	36

329 - THIS REPRESENTS AN ADJUSTMENT TO THE ORIGINAL REQUEST.	0	0	1	0	0	0	0	0	0	0	0	1
335 - PEND CLAIM: RESUBMITTED CLAIM, CORRECTED CLAIM OR REMARKS INCLUDED WITH THE CLAIM. REQUIRES REVIEW.	0	0	0	0	0	0	0	0	0	2	0	0
339 - PLEASE SUBMIT A COMPLETED MAP 559 FORM OR A COPY OF THE PATIENTS CHART NOTES.	0	0	0	0	0	0	0	0	0	1	0	0
33 - RESTORATIONS ARE LIMITED TO ONCE IN A THREE YEAR PERIOD FOR THE SAME TOOTH NUMBER/LETTER AND SURFACE(S) PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	1	0	0	0	0	0	0	0	0	0
341 - THE DENTAL OFFICE ADVISED MCNA THAT THIS REQUEST WAS SUBMITTED IN ERROR.	20	15	98	43	1	21	0	0	1	90	4	29
347 - 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).	1	0	1	0	0	0	0	0	0	0	0	11
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	0	0	0	0	0	0	0	0	0	0	1
368 - APPEALS MUST BE SUBMITTED ACCORDING TO THE PLAN GUIDELINES OUTLINED IN YOUR PROVIDER MANUAL. PLEASE REFER TO YOUR PROVIDER MANUAL FOR	0	0	0	0	0	1	0	0	0	0	0	0

SUBMISSION GUIDELINES AND SUBMIT ACCORDINGLY.												
36 - PROCEDURE IS LIMITED TO ONCE IN A FIVE YEAR PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	0	0	22	0	0	0	0	0	0
377 - THIS CODE REQUIRES PRE-OPERATIVE X-RAYS TO BE SUBMITTED WITH THE CLAIM FOR CONSIDERATION. THE PROCEDURE WILL BE EVALUATED FOR MEDICAL NECESSITY DURING THE CLAIM REVIEW.	0	0	2	0	0	0	0	0	0	0	1	0
378 - AN INDIRECT PULP CAP PROCEDURE IS CONSIDERED A PART OF THE FINAL RESTORATION. CODE 3120 IS NOT SEPARATELY PAYABLE.	0	0	0	4	0	0	0	0	0	0	0	0
37 - RESTORATIVE SERVICES PERFORMED ON TEETH WITH POOR OR QUESTIONABLE PROGNOSIS ARE NOT COVERED.	0	12	193	73	0	1	0	0	12	0	0	0
384 - BENEFITS FOR THIS SERVICE ARE LIMITED TO PROVIDERS WITH A SPECIALTY IN ORTHODONTICS.	0	0	0	0	0	0	0	0	0	0	1	0
38 - COVERAGE FOR EXTRACTIONS AND ORAL SURGERY PROCEDURES IS INCLUSIVE OF LOCAL ANESTHETICS, SUTURING, MINOR SMOOTHING OF SOCKET BONE AND POST-OPERATIVE CARE.	0	0	0	0	0	0	0	0	0	1	0	0
399 - MCNA DOES NOT ISSUE RETROSPECTIVE AUTHORIZATIONS. REQUESTS FOR AUTHORIZATIONS AFTER WE HAVE PROCESSED THE CLAIM ARE NOT APPROVED.	169	57	296	90	5	63	0	0	0	221	1	70
400 - CLINICAL CRITERIA WERE NOT MET.	46	80	864	78	11	79	2	0	3	85	27	110

402 - THIS PLAN REQUIRES THE MEMBER TO HAVE ALL SERVICES PROVIDED BY THEIR MAIN DENTAL HOME PROVIDER AND/OR FACILITY UNLESS A REFERRAL REFERRAL OR AUTHORIZATION ON FILE FOR THE SERVICE(S) YOU HAVE SUBMITTED.	0	0	0	0	0	0	0	0	0	17	0	10
405 - PLEASE SUBMIT A COLOR PHOTOGRAPH.	0	0	26	1	6	0	0	0	0	33	2	9
406 - RESUBMIT WITH THE APPROPRIATE NARRATIVE TO REVIEW THIS CHARGE.	0	0	1	0	0	0	0	0	0	1	0	0
408 - DOCUMENTATION INDICATES THE ROOT CANAL TREATMENT WAS NOT COMPLETED TO AN ACCEPTABLE STANDARD OF CARE.	0	0	3	0	0	0	0	0	0	0	0	0
40 - COVERAGE IS LIMITED TO THE MORE DEFINITIVE TREATMENT OR SERVICES PERFORMED.	0	0	0	0	5	0	0	0	0	0	0	0
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	3
457 - THE X-RAY RECEIVED DOES NOT DEMONSTRATE EVIDENCE OF GROSS CALCULUS TO SUPPORT THIS PROCEDURE. PLEASE SUBMIT A PHOTO TO VERIFY PRESENCE OF GROSS CALCULUS	0	0	0	0	2	0	0	0	0	0	0	0
459 - THE DENTAL DIRECTOR REQUESTS DIAGNOSTIC PERIODONTAL X-RAYS THAT SHOW THE BONE LOSS TO SUPPORT THE PERIO CHARTING RECEIVED	0	0	0	0	75	0	0	0	0	0	0	0
462 - PLEASE PROVIDE A NARRATIVE THAT DOCUMENTS THE SPECIFIC MEDICAL DIAGNOSIS REGARDING THE PATIENT'S MENTAL AND/OR	0	0	0	0	0	4	0	0	0	0	0	16

PHYSICAL HEALTH TO MAKE A MEDICAL NECESSITY DETERMINATION.												
463 - MCNA WILL REVIEW THIS PROCEDURE ONCE ENDODONTIC THERAPY IS COMPLETED TO AN ACCEPTABLE STANDARD OF CARE AS OUTLINED IN MCNA'S UTILIZATION REVIEW A PRE-PAYMENT REVIEW OF THE PRE- AND POST-OP X-RAYS.	0	0	30	0	0	0	0	0	0	0	0	0
46 - SERVICES PERFORMED BY A NON-PARTICIPATING PROVIDER ARE NOT COVERED.	29	11	38	4	11	31	0	0	0	54	4	17
48 - PLEASE SUBMIT X-RAY(S) AND NARRATIVE WITH THIS REQUEST.	85	59	818	283	48	315	0	0	7	799	21	58
502 - PLEASE SUBMIT PHOTOS, X-RAYS, AND A NARRATIVE.	0	0	7	0	4	0	0	0	0	0	1	4
503 - PLEASE SUBMIT PHOTOS AND RATIONALE.	0	0	2	0	11	0	0	0	0	7	0	1
504 - PLEASE SUBMIT A CORRECT CDT CODE.	7	22	130	40	20	53	0	0	2	39	45	4
50 - SUBMIT YOUR REQUEST WITH THE APPLICABLE TOOTH NUMBER, TOOTH SURFACE, QUADRANT OR ARCH LOCATION.	0	7	0	0	1	0	0	0	0	2	1	0
511 - PLEASE SUBMIT THE CORRECT TOOTH NUMBER.	2	2	148	76	0	4	0	0	0	102	0	4
512 - PLEASE SUBMIT THE CORRECT TOOTH SURFACE.	0	1	50	0	0	0	0	0	0	0	0	0
513 - PLEASE SUBMIT THE APPLICABLE QUADRANT.	2	73	0	0	25	0	0	0	0	8	0	0
514 - PLEASE SUBMIT THE ARCH LOCATION.	5	73	0	0	0	14	0	0	0	19	8	72
515 - PLEASE SUBMIT A PATHOLOGY REPORT.	0	0	0	0	0	0	0	0	0	1	0	0
516 - PLEASE SUBMIT A TREATMENT PLAN.	2	0	0	0	0	0	0	0	0	0	0	1

517 - PLEASE SUBMIT A COMPLETED COPY OF THE ANESTHESIA TIME RECORD FOR REVIEW WITH YOUR CLAIM. THIS DOCUMENT MUST INCLUDE THE NAME OF THE RENDERING PROVIDER FOR THE ANESTHESIA. THE PROVIDER NAME MUST BE LEGIBLE.	0	0	0	0	0	0	0	0	6	1	0	12
51 - THIS REQUEST IS DENIED AS IT DOES NOT MEET COVERAGE CRITERIA	0	0	0	0	0	0	0	0	0	0	2	0
527 - THE TREATMENT RENDERED WAS NOT COMPLETED TO AN ACCEPTABLE STANDARD OF CARE.	2	0	1	1	0	0	0	0	0	0	0	0
528 - THE PHOTOS RECEIVED DO NOT DEMONSTRATE THE NEED FOR THE TREATMENT REQUESTED.	0	0	10	0	24	0	0	0	0	0	0	0
529 - PLEASE SUBMIT COLOR PHOTOS SHOWING UPPER ANTERIOR FACIAL AND LOWER ANTERIOR FACIAL AND LINGUAL VIEWS.	0	0	0	0	18	0	0	0	0	0	0	0
530 - SERVICES ARE DENIED BECAUSE THIS PROGRAM IS NO LONGER ACTIVE WITH MCNA.	0	0	4	0	0	0	0	0	0	0	0	1
534 - PERIAPICAL X-RAY NEEDS TO INCLUDE APEX OF THE SUBMITTED TOOTH FOR REVIEW.	0	0	119	15	0	0	0	0	0	14	0	0
535 - NO BENEFIT IS PROVIDED FOR THE EXTRACTION OF ASYMPTOMATIC TEETH WHICH SHOW NO SIGNS OF INFECTION; INCLUDING BUT NOT LIMITED TO THE REMOVAL OF THIRD MOLARS. THE MEMBER'S CONDITION DOES NOT MEET MCNA'S ORAL SURGERY GUIDELINES.	2	0	2	0	0	0	0	0	0	978	0	4
548 - AS OUTLINED IN YOUR PROVIDER MANUAL, THE INITIAL	0	2	0	0	0	0	0	0	0	0	0	0

PAYMENT FOR CDT D1510 AND D1515 INCLUDES ALL REPLACEMENT COSTS FOR 12 MONTHS FOLLOWING THE APPLIANCE PLACEMENT.												
549 - PLEASE SUBMIT WITH THE PRE-OPERATIVE AND POST-OPERATIVE COLOR PHOTOGRAPHS	0	0	0	0	1	0	0	0	0	1	0	0
550 - CDT D4355 IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR CDT D1110/D1120 IN THE LAST 12 MONTH PERIOD	0	0	0	0	4	0	0	0	0	0	0	0
553 - PLEASE RESUBMIT WITH THE LOCATION AND DESCRIPTION OF THE FRACTURE	0	0	0	0	0	4	0	0	0	0	0	0
558 - PLEASE SUBMIT THE MCNA BEHAVIOR MANAGEMENT REPORT FORM WITH THE CLAIM.	0	0	0	0	0	0	0	0	0	0	0	2
562 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A EIGHT YEAR PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	53	0	3	0	0	463	0	0	0	0	0	0
567 - AS OUTLINED IN YOUR PROVIDER MANUAL, THE INITIAL PAYMENT FOR THE DENTURE INCLUDES ALL RELINES FOR THE FIRST 12 MONTHS AFTER DENTURE SEATING.	0	0	0	0	0	24	0	0	0	0	0	0
568 - A COMBINATION OF RELINES OR RELINES AND COMPLETE/PARTIAL DENTURES IS ALLOWED ONCE IN A EIGHT YEAR PERIOD, AS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	0	0	21	0	0	0	0	0	0
569 - AS OUTLINED IN YOUR PROVIDER MANUAL, COVERAGE FOR A SPACE MAINTAINER IS LIMITED TO THE NECESSARY MAINTENANCE OF A POSTERIOR SPACE. SPACE FOR AN	0	1	0	0	0	0	0	0	0	0	0	0

ANTERIOR TOOTH AND IS THEREFORE, NOT COVERED.												
571 - COVERAGE IS LIMITED TO THE PLAN GUIDELINES AS SPECIFIED IN YOUR PROVIDER MANUAL.	921	45	273	84	47	1188	0	0	16	1195	123	803
587 - EXAMINATION AND X-RAYS ARE PAYABLE ONLY IN CONJUNCTION WITH COMPLETE DENTURE OR PARTIAL	25	0	0	0	0	0	0	0	0	0	0	0
588 - IF MORE THAN 6 TEETH REMAIN, THE PROVIDER MUST CERTIFY BY STATEMENT IN THE REMARKS SECTION THAT 6 OR FEWER TEETH WILL REMAIN IN THE FINAL IMPRESSION	0	0	0	0	0	1	0	0	0	0	0	0
589 - THE ADULT DENTURE PROGRAM ONLY PROVIDES FOR ACRYLIC PARTIALS TO OPPOSE A FULL DENTURE AND DOES NOT PROVIDE 2 PARTIAL DENTURES IN THE SAME ORAL CAVITY	2	0	0	0	0	16	0	0	0	0	0	0
591 - THIS PROCEDURE WAS ALREADY APPROVED FOR ANOTHER PROVIDER	0	0	0	0	0	2	0	0	0	0	0	0
59 - INVALID OR NO INFORMATION RELATING TO THE TOOTH NUMBER/LETTER, QUADRANT, SURFACE(S), OR ARCH WAS REPORTED FOR THIS PROCEDURE CODE. NUMBER/LETTER, QUADRANT, SURFACE(S), OR ARCH. RESUBMIT WITH THE CORRECT INFORMATION.	1	0	1	0	0	0	0	0	0	4	4	0
606 - THIS PLAN REQUIRES A REFERRAL FOR SPECIALTY SERVICES	0	0	0	0	0	0	0	0	0	4	0	4
619 - PLEASE SUBMIT THE TMJ SUMMARY FORM	0	0	0	0	0	0	0	0	0	0	0	2

62 - PROCEDURE DOES NOT MEET AGE REQUIREMENTS OF THE PLAN.	5	30	105	9	260	6	0	0	1	7	49	93
65 - SERVICES PERFORMED BY A NON-PARTICIPATING FACILITY ARE NOT COVERED.	54	11	55	11	15	85	0	0	0	61	1	14
75 - SEALANTS ARE NOT COVERED ON TEETH THAT HAVE PRIOR OCCLUSAL RESTORATIONS.	0	3	0	0	0	0	0	0	0	0	0	0
76 - RESUBMIT CLAIM WITH PRE AND POST OPERATIVE X-RAYS.	0	0	2	0	0	0	0	0	0	0	0	0
77 - PLEASE SUBMIT X-RAYS, PERIODONTAL CHARTING AND RATIONALE INDICATING TREATMENT.	0	0	0	0	184	0	0	0	0	0	0	0
80 - ERUPTION OF THE PERMANENT TOOTH WILL OCCUR WITHIN 6 MONTHS WHICH WILL NATURALLY MAINTAIN THE SPACE.	0	32	0	0	0	0	0	0	0	1	0	0
88 - OUR RECORDS SHOW THAT THE MEMBER'S TOOTH/TEETH HAS ALREADY BEEN PULLED.	0	0	18	10	0	0	0	0	0	190	0	1
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	3	0	0	0	0	0	0	94	0	2

SFY 15 Denials after Prior Authorization Approved

Prior Authorizations Delineated by Reasons for Denial	Diagnostic D0100 - D0999	Preventive D1000 - D1999	Restorative (D2000 - D2999	Endo-dontics D3000 - D3999	Periodontics D4000 - D4999	Removable Prosthodontics D5000 - D5899	Maxillofacial Prosthetics D5900 - D5999	Implant Services D6000 - D6199	Fixed Prosthodontics D6200 - D6999	Oral & Maxillofacial Surgery D7000 - D7999	Ortho-dontics D8000 - D8999	Adjunctive General Services D9000 - D9999
11 - CLAIMS MUST BE FILED WITHIN TWELVE MONTHS OF THE DATE OF SERVICE PER THE CLAIMS AND PAYMENT SECTION OF YOUR PROVIDER MANUAL.	25	0	33	21	1	13	0	0	0	23	0	15
110 - CHARGE HAS BEEN REVIEWED UTILIZING THE CORRECT ADA PROCEDURE CODE.	2	0	1	0	0	0	0	0	0	0	0	0
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.	0	1	11	65	0	0	0	0	0	0	0	0
115 - THIS CLAIM/PROCEDURE HAS BEEN PREVIOUSLY REPORTED WITH A DIFFERENT DATE OF SERVICE. PLEASE SUBMIT THE PATIENT CHART NOTES FOR DATE OF SERVICE CONFIRMATION.	186	10	111	92	9	129	0	0	0	73	11	35
117 - UNBUNDLED PROCEDURES FOR INDIVIDUAL RESTORATIONS ON THE SAME TOOTH PERFORMED ON THE SAME DATE OF SERVICE HAVE BEEN COMBINED AND THE APPROPRIATE CDT CODE CONSIDERED.	0	0	35	0	0	0	0	0	0	0	0	0
12 - THE PATIENT CANNOT BE IDENTIFIED AS OUR MEMBER. PLEASE VERIFY THE PATIENT'S INFORMATION AND SUBMIT THE REQUEST WITH THE PATIENT'S FIRST AND LAST NAME AS WELL AS THE MEMBER ID NUMBER.	0	0	0	0	0	2	0	0	0	0	0	0
120 - THE CLINICAL REVIEWER HAS RECOMMENDED AN ALTERNATE PROCEDURE/BENEFIT.	0	0	2	2	0	0	0	0	0	73	0	1

121 - THIS PROCEDURE CAN ONLY BE CONSIDERED WHEN REPORTED AND PERFORMED IN CONJUNCTION WITH COVERED SERVICES.	0	0	1	0	0	0	0	0	0	0	0	150
122 - PROCEDURE IS ONLY COVERED ON PERMANENT TEETH. PRIMARY TEETH ARE NOT COVERED.	0	0	1	0	0	0	0	0	0	0	0	0
125 - THE MAXIMUM BENEFIT HAS BEEN RELEASED.	0	0	0	0	0	0	0	0	0	0	1	0
13 - CLAIMS PAYMENT DENIED. SERVICES WERE DENIED AT THE TIME PRE-AUTHORIZATION WAS REQUESTED.	0	0	6	3	0	0	0	0	0	0	0	1
14 - THIS PROCEDURE HAS BEEN APPROVED AND WILL BE PAID ACCORDING TO YOUR CONTRACTED RATE. THE MEMBER IS NOT RESPONSIBLE FOR ANY AMOUNT EXCEEDING THE CONTRACTED RATE.	0	0	1	0	0	0	0	0	0	0	0	1
145 - THE DENTAL DIRECTOR HAS ADVISED THERE IS NO EVIDENCE OF DECAY IN THE PULP CHAMBER.	0	0	0	8	0	0	0	0	0	0	0	0
150 - THE DENTAL DIRECTOR HAS ADVISED THAT THE X-RAYS RECEIVED DO NOT DEMONSTRATE THE NEED FOR TREATMENT SUBMITTED.	0	0	1	1	0	0	0	0	0	0	0	0
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 RENDERING PROVIDER. THE PROVIDER NAME SHOULD BE IN A LEGIBLE FORMAT.	51	0	9	4	0	113	0	0	0	10	0	4
159 - NITROUS OXIDE OR NON-INTRAVENOUS CONSCIOUS SEDATION WILL BE CONSIDERED ON THE SAME VISIT, BUT NOT BOTH.	0	0	0	0	0	0	0	0	0	0	0	13
166 - THE CLINICAL REVIEWER HAS ADVISED THAT THE INCORRECT X-RAY WAS SUBMITTED, PLEASE SUBMIT THE CORRECT X-RAY FOR REVIEW.	0	0	4	15	0	0	0	0	0	5	0	0

167 - THIS INFORMATION HAS PREVIOUSLY BEEN REQUESTED.	12	1	7	36	0	22	0	0	0	7	0	39
17 - THIS IS A NON-COVERED SERVICE PER THE COVERED SERVICES OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	0	0	0	0	0	0	0	0	1
173 - THE CLINICAL REVIEWER HAS ADVISED THE PROGNOSIS IS POOR OR QUESTIONABLE. BENEFITS RELEASED TOWARD RESTORATIVE SERVICES WILL BE DEDUCTED FROM ANY FUTURE EXTRACTION CHARGES WITHIN 12 MONTHS.	0	0	3	2	0	0	0	0	0	0	0	0
176 - UPON COMPLETION OF ROOT CANAL, PLEASE SUBMIT PRE-OPERATIVE AND POST-OPERATIVE XRAY WITH YOUR CLAIM.	0	0	4	42	0	0	0	0	0	0	0	0
178 - PLEASE INDICATE WHETHER SERVICES WERE INCURRED DUE TO AN ACCIDENTAL INJURY. IF SO, PLEASE PROVIDE A DESCRIPTION OF THE ACCIDENT.	0	0	2	0	0	0	0	0	0	0	0	0
18 - THE PAYMENT IS INCLUDED WITH ANOTHER SERVICE/PROCEDURE AND IS NOT PAYABLE SEPARATELY. THIS INCLUDES BUT IS NOT LIMITED TO FOLLOW-UP CARE.	21	2	3	0	5	9	0	0	0	0	0	7
180 - PLEASE SUBMIT A READABLE X-RAY.	0	0	0	6	0	0	0	0	0	0	0	0
182 - THE MAXIMUM ALLOWABLE REIMBURSEMENT HAS BEEN APPLIED.	1	0	1	0	0	0	0	0	0	0	0	0
19 - PAYMENT FOR THIS PROCEDURE HAS BEEN PROVIDED UNDER A PRIOR CLAIM OR PROCEDURE.	146	82	583	256	23	154	1	0	0	598	8	213
197 - THIS PROCEDURE IS ONLY COVERED IN CONJUNCTION WITH ROOT CANAL THERAPY.	0	0	644	3	0	0	0	0	0	0	0	0
199 - SUBSCRIBER WAS NOT ELIGIBLE ON DATE OF SERVICE.	0	0	0	0	0	0	0	0	0	4	0	1
2 - THIS REQUEST HAS BEEN PREVIOUSLY REPORTED AND AN APPROVAL OR DENIAL WAS ISSUED.	554	114	1672	988	49	334	2	0	1	1293	15	635
21 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A SIX MONTH PERIOD	55	7	1	0	0	0	0	0	0	0	0	7

PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.												
212 - RESTORATIONS ARE LIMITED TO ONCE IN A TWELVE (12) MONTH PERIOD FOR THE SAME TOOTH NUMBER/LETTER AND SURFACE(S) PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	3	0	0	0	0	0	0	0	0	0
224 - CLAIMS/PREAUTHORIZATIONS MUST BE FILED WITH THE MCNA SUBSCRIBER ID NUMBER.	0	0	0	0	0	0	0	0	0	4	0	1
227 - THIS PROCEDURE IS COVERED ONCE PER FIVE YEARS.	0	0	0	0	0	1	0	0	0	0	0	0
228 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A 24 MONTH PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	25	0	13	0	0	0	0	0	0	0	0
23 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A THREE YEAR PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	15	0	0	0	0	0	0	0	0	0	0	0
230 - SERVICE IS ONLY COVERED TWICE IN A TWELVE MONTH PERIOD.	0	0	0	0	0	0	0	0	0	0	0	3
231 - COVERAGE IS LIMITED TO ONCE PER LIFETIME PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	0	0	0	0	0	0	0	2	0
235 - THE FREQUENCY RESTRICTION OF THIS PROCEDURE/SERVICE HAS BEEN REACHED ON THE SAME DATE OF SERVICE.	14	0	1	0	2	0	0	0	0	0	0	23
237 - CLAIM DENIED AS CLAIM DOES NOT HAVE A SUBSCRIBER SIGNATURE IN BOX 36 OF THE CLAIM FORM RECEIVED.	7	0	10	5	1	3	0	0	0	4	0	3
24 - CHARGES FOR RADIOGRAPHS HAVE BEEN COMBINED AND AN ALTERNATE BENEFIT OF A FULL MOUTH SERIES CONSIDERED.	309	0	0	0	0	0	0	0	0	0	0	0
241 - THIS PROCEDURE IS NOT COVERED IN CONJUNCTION WITH THE REPORTED SERVICE(S).	27	0	9	0	25	0	0	0	0	0	0	152

245 - PLEASE CHANGE THE DATE OF SERVICE ON THE CLAIM FORM TO REFLECT THE SEATING DATE OF THE DENTURE AND RESUBMIT THE CLAIM.	3	0	0	0	0	170	0	0	0	0	0	0
247 - SERVICE DID NOT MEET PLAN COVERAGE CRITERIA.	1	0	580	8	2	0	0	0	0	0	0	15
249 - THE NEA ATTACHMENT SUBMITTED IS INVALID, UNREADABLE AND/OR CONTAINS NO IMAGES. PLEASE SUBMIT THE ATTACHMENTS.	0	0	5	8	0	0	0	0	0	0	0	3
25 - ENDODONTIC TREATMENT IS INCLUSIVE OF ALL INTRA-OPERATIVE RADIOGRAPHS, PLACEMENT OF RUBBER DAM, AND TEMPORIZATION.	2	0	0	0	0	0	0	0	0	0	0	0
252 - NOT MEDICALLY NECESSARY.	0	0	0	0	0	0	0	0	0	0	0	3
262 - RESTORATIONS ARE LIMITED TO ONCE IN A TWELVE (12) MONTH PERIOD FOR THE SAME TOOTH NUMBER/LETTER AND SURFACE PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	2	0	0	0	0	0	0	0	0	0
267 - PLEASE RESUBMIT THE ATTACHMENT IN A READABLE FORMAT.	2	0	0	0	0	0	0	0	0	0	0	0
268 - MCNA WILL DEEM A CLAIM PAID IN FULL WHEN THE PRIMARY INSURANCE PAYMENT MEETS OR EXCEEDS MCNA'S REIMBURSEMENT RATES.	0	0	0	0	0	0	0	0	0	3	0	1
27 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A TWELVE MONTH PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	3	0	1	0	11	10	0	0	0	0	0	0
270 - PLEASE PROVIDE FURTHER RATIONALE FOR TREATMENT.	0	0	1	3	0	0	0	0	0	2	0	112
28 - THIS PROCEDURE IS ONLY COVERED IN CONJUNCTION WITH PREAUTHORIZED ORTHODONTIA.	0	0	0	0	0	0	0	0	0	2	0	0
286 - THE DATE OF BIRTH DOES NOT MATCH THE DATA RECEIVED FROM THE PLAN. PLEASE	0	0	1	0	0	2	0	0	0	4	0	1

UPDATE YOUR RECORDS TO AVOID FUTURE ISSUES WITH CLAIM SUBMISSIONS.												
294 - 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.	5	5	13	7	1	25	0	0	0	25	0	13
297 - THE QUANTITIES REPORTED ARE OVER THE MAXIMUM ALLOWABLE QUANTITIES FOR THIS PROCEDURE/SERVICE. RESUBMIT WITH THE CORRECT QUANTITIES.	0	0	2	0	0	0	0	0	0	0	0	0
298 - THE SERVICE THAT YOUR DENTIST REQUESTED FOR YOU IS NOT COVERED ON THE TOOTH FOR WHICH IT WAS REQUESTED.	0	0	21	7	0	4	0	0	0	2	0	0
305 - THE X-RAYS DO NOT SUPPORT THE PROPOSED TREATMENT PLAN. PLEASE SUBMIT DETAILED RATIONALE FOR TREATMENT.	0	0	0	0	0	0	0	0	0	1	0	0
311 - THE SERVICES WERE NOT RENDERED AT THIS FACILITY, THEREFORE THIS CLAIM IS DENIED.	0	0	0	0	0	0	0	0	0	4	0	1
321 - THE CLINICAL REVIEWER HAS DETERMINED THAT THE TREATMENT IS IN EXCESS OF THE MEMBER'S NEEDS.	1	1	9	0	0	0	0	0	0	0	0	105
329 - THIS REPRESENTS AN ADJUSTMENT TO THE ORIGINAL REQUEST.	0	0	3	0	0	0	0	0	0	0	0	0
34 - RESTORATIVE SERVICES AND/OR EXTRACTIONS ARE NOT COVERED ON PRIMARY TEETH IF LOSS IS EXPECTED WITHIN SIX MONTHS PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	1	0	0	0	0	0	27	0	0
341 - THE DENTAL OFFICE ADVISED MCNA THAT THIS REQUEST WAS SUBMITTED IN ERROR.	8	6	11	2	0	8	0	0	0	29	1	14
347 - THIS PROCEDURE IS NOT COVERED WHEN PERFORMED ON THE SAME DATE OF SERVICE AS A MORE DEFINITIVE TREATMENT	0	0	0	0	0	0	0	0	0	0	0	1

OR IN CONJUNCTION WITH THE REPORTED SERVICE(S).												
36 - PROCEDURE IS LIMITED TO ONCE IN A FIVE YEAR PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	0	0	3	0	0	0	0	0	0
360 - THIS CODE MUST BE BILLED WITH THE PRIMARY CODE. REFER TO YOUR CDT CODES TO DETERMINE THE PRIMARY CODE. THE CODE BILLED IS FOR AN ADDITIONAL SERVICE RELATED TO THE PRIMARY CODE.	0	0	0	0	0	0	0	0	0	0	0	5
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	0	0	0	0	0	0	0	0	0	0	84
368 - APPEALS MUST BE SUBMITTED ACCORDING TO THE PLAN GUIDELINES OUTLINED IN YOUR PROVIDER MANUAL. PLEASE REFER TO YOUR PROVIDER MANUAL FOR SUBMISSION GUIDELINES AND SUBMIT ACCORDINGLY.	0	0	0	0	0	0	0	0	0	0	0	1
37 - RESTORATIVE SERVICES PERFORMED ON TEETH WITH POOR OR QUESTIONABLE PROGNOSIS ARE NOT COVERED.	0	0	10	5	0	0	0	0	0	0	0	0
377 - THIS CODE REQUIRES PRE-OPERATIVE X-RAYS TO BE SUBMITTED WITH THE CLAIM FOR CONSIDERATION. THE PROCEDURE WILL BE EVALUATED FOR MEDICAL NECESSITY DURING THE CLAIM REVIEW.	2	0	19	9	0	0	0	0	0	6	0	2
389 - 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.	0	0	0	0	0	0	0	0	0	0	0	4

399 - MCNA DOES NOT ISSUE RETROSPECTIVE AUTHORIZATIONS. REQUESTS FOR AUTHORIZATIONS AFTER WE HAVE PROCESSED THE CLAIM ARE NOT APPROVED.	0	1	1	1	0	0	0	0	0	1	0	1
40 - COVERAGE IS LIMITED TO THE MORE DEFINITIVE TREATMENT OR SERVICES PERFORMED.	0	1	0	0	0	0	0	0	0	1	0	0
405 - PLEASE SUBMIT A COLOR PHOTOGRAPH.	0	0	0	0	0	0	0	0	0	2	0	1
406 - RESUBMIT WITH THE APPROPRIATE NARRATIVE TO REVIEW THIS CHARGE.	2	0	1	3	1	1	0	0	0	2	0	70
408 - DOCUMENTATION INDICATES THE ROOT CANAL TREATMENT WAS NOT COMPLETED TO AN ACCEPTABLE STANDARD OF CARE.	0	0	0	85	0	0	0	0	0	0	0	0
41 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO PATIENTS WHO HAVE A SEVERE PHYSICAL OR MENTAL DISABILITY AND/OR ARE DIFFICULT TO MANAGE PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	0	0	0	0	0	0	0	0	2
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	3
420 - CONSIDERATION FOR THIS SERVICE REQUIRES COMPLETION OF THE CRITERIA FOR DENTAL THERAPY UNDER GENERAL ANESTHESIA FORM	0	0	0	0	0	0	0	0	0	0	0	2
45 - PAYMENT DENIED BECAUSE PRE-AUTHORIZATION OR REFERRAL WAS NOT OBTAINED PRIOR TO TREATMENT WITH THIS PROVIDER AND/OR FACILITY.	41	46	81	70	18	39	0	0	0	159	8	48
46 - SERVICES PERFORMED BY A NON-PARTICIPATING PROVIDER ARE NOT COVERED.	1	1	0	0	0	0	0	0	0	0	0	0
461 - BASED ON A MEDICAL NECESSITY REVIEW OF THE PRE AND POST X-RAYS SUBMITTED WITH THIS CLAIM, REIMBURSEMENT IS BEING DENIED BECAUSE TREATMENT WAS NOT COMPLETED TO AN	0	0	0	5	0	0	0	0	0	0	0	0

ACCEPTABLE STANDARD OF CARE UTILIZATION REVIEW GUIDELINES FOR ENDODONTIC THERAPY.												
463 - MCNA WILL REVIEW THIS PROCEDURE ONCE ENDODONTIC THERAPY IS COMPLETED TO AN ACCEPTABLE STANDARD OF CARE A PRE-PAYMENT REVIEW OF THE PRE- AND POST-OP X-RAYS.	0	0	467	57	0	0	0	0	0	0	0	1
48 - PLEASE SUBMIT X-RAY(S) AND NARRATIVE WITH THIS REQUEST.	0	4	19	36	0	0	0	0	0	460	0	0
500 - THE REQUESTED INFORMATION WAS NOT RECEIVED WITHIN THE REQUIRED TIME-FRAME IN ORDER FOR THE PLAN TO PROCESS ACCORDINGLY.	4	14	117	139	0	11	0	0	0	13	1	102
504 - PLEASE SUBMIT A CORRECT CDT CODE.	0	0	3	2	0	0	0	0	0	0	1	1
505 - PLEASE SUBMIT AN ADA CLAIM FORM OR AN MCNA PRE-AUTHORIZATION FORM.	0	0	0	0	0	0	0	0	0	0	0	3
511 - PLEASE SUBMIT THE CORRECT TOOTH NUMBER.	0	0	0	3	0	0	0	0	0	0	0	0
513 - PLEASE SUBMIT THE APPLICABLE QUADRANT.	0	2	0	0	0	0	0	0	0	0	0	0
514 - PLEASE SUBMIT THE ARCH LOCATION.	0	3	0	0	0	3	0	0	0	6	0	39
515 - PLEASE SUBMIT A PATHOLOGY REPORT.	0	0	0	0	0	0	0	0	0	13	0	0
517 - PLEASE SUBMIT A COMPLETED COPY OF THE ANESTHESIA TIME RECORD FOR REVIEW WITH YOUR CLAIM. THIS DOCUMENT MUST INCLUDE THE NAME OF THE RENDERING PROVIDER FOR THE ANESTHESIA. THE PROVIDER NAME MUST BE LEGIBLE.	1	0	1	1	0	0	0	0	0	1	0	833
518 - PLEASE SUBMIT A CRITERIA FOR DENTAL THERAPY UNDER GENERAL ANESTHESIA FORM.	0	0	0	0	0	0	0	0	0	0	0	4
520 - THROUGH THE APPEAL PROCESS AND AFTER FURTHER REVIEW, THE PREVIOUS DECISION REGARDING THIS SERVICE HAS BEEN UPHELD.	0	0	0	1	0	0	0	0	0	0	0	0

522 - THE ADA CODE SUBMITTED IS NO LONGER A VALID CODE. PLEASE RE-SUBMIT WITH A VALID ADA CODE.	0	0	0	0	0	0	0	0	0	0	0	3
526 - THE TREATMENT RENDERED WAS NOT THE TREATMENT THAT WAS AUTHORIZED.	0	0	0	1	0	0	0	0	0	0	0	0
527 - THE TREATMENT RENDERED WAS NOT COMPLETED TO AN ACCEPTABLE STANDARD OF CARE.	0	0	17	4	0	0	0	0	0	0	0	0
53 - PLEASE SUBMIT THE PRIMARY CARRIER'S BENEFIT STATEMENT AND ANY PREVIOUS EXPLANATION OF BENEFITS.	13	6	47	24	5	31	0	0	0	149	0	53
534 - PERIAPICAL X-RAY NEEDS TO INCLUDE APEX OF THE SUBMITTED TOOTH FOR REVIEW.	0	0	8	197	0	0	0	0	0	0	0	0
535 - NO BENEFIT IS PROVIDED FOR THE EXTRACTION OF ASYMPTOMATIC TEETH WHICH SHOW NO SIGNS OF INFECTION; INCLUDING BUT NOT LIMITED TO THE REMOVAL OF THIRD MOLARS. THE MEMBER'S CONDITION DOES NOT MEET MCNA'S ORAL SURGERY GUIDELINES.	0	0	0	2	0	0	0	0	0	27	0	0
537 - BASED ON REVIEW OF THE INFORMATION PROVIDED, THE CLINICAL CRITERIA HAVE NOT BEEN MET FOR ANESTHESIA, ANALGESIA, PHYSICALLY, OR COGNITIVELY COMPROMISED, HAS A DOCUMENTED FAILURE OF, OR TOXICITY RELATED TO LOCAL ANESTHESIA.	0	0	0	0	0	0	0	0	0	0	0	1
540 - YOUR REQUEST FOR RECONSIDERATION HAS BEEN DENIED. THE REQUIRED SUPPORTING DOCUMENTATION, AS DESCRIBED IN THE MCNA PROVIDER MANUAL, WAS NOT SUBMITTED WITH YOUR REQUEST.	6	0	7	10	0	6	0	0	0	0	0	24
543 - AS OUTLINED IN YOUR PROVIDER MANUAL, PLEASE SUBMIT A LAB RECEIPT FOR REVIEW OF CDT D2790, CROWN - FULL CAST HIGH NOBLE METAL.	0	0	0	1	0	0	0	0	0	0	0	0
545 - THIS SERVICE IS NOT PAYABLE AS AN EMERGENCY. EMERGENCY SERVICES ARE	0	0	0	0	0	0	0	0	0	0	0	1

RESTRICTED TO PROCEDURES PERFORMED FOR ACUTE SYMPTOMS,OF TEETH, AND PALLIATIVE THERAPY FOR PERICORONITIS.												
548 - 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.	0	30	0	0	0	0	0	0	0	0	0	0
549 - PLEASE SUBMIT WITH THE PRE-OPERATIVE AND POST-OPERATIVE COLOR PHOTOGRAPHS	0	0	0	0	5	0	0	0	0	0	0	0
550 - CDT D4355 IS NOT PAYABLE IF PAYMENT HAS BEEN MADE FOR CDT D1110/D1120 IN THE LAST 12 MONTH PERIOD	0	0	0	0	15	0	0	0	0	0	0	0
553 - PLEASE RESUBMIT WITH THE LOCATION AND DESCRIPTION OF THE FRACTURE	0	0	0	0	0	5	0	0	0	0	0	0
558 - PLEASE SUBMIT THE MCNA BEHAVIOR MANAGEMENT REPORT FORM WITH THE CLAIM.	0	0	0	0	0	0	0	0	0	0	0	55
559 - AS OUTLINED IN YOUR PROVIDER MANUAL, 90 DAYS MUST ELAPSE BETWEEN INDIVIDUAL APEXIFICATION TREATMENTS AND ROOT CANAL TREATMENT.	0	0	0	4	0	0	0	0	0	0	0	0
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	5	2	0	0	0	0	0	0	0	1
561 - AS OUTLINED IN YOUR PROVIDER MANUAL, A REDUCTION OF THE APPROVED AMOUNT HAD TAKEN PLACE DUE TO OTHER RESTORATIVE PROCEDURES BEING PERFORMED IN THE PAST SIX (6) MONTHS	0	0	72	0	0	0	0	0	0	0	0	0
562 - COVERAGE FOR THIS PROCEDURE IS LIMITED TO ONCE IN A EIGHT YEAR PERIOD PER THE COVERED BENEFITS OUTLINED IN YOUR PROVIDER MANUAL.	31	0	0	0	0	16	0	0	0	0	0	0

565 - CDT D0150 MUST BE SUBMITTED WITH CDT D0210, D0330 OR D0240; AS OUTLINED IN YOUR PROVIDER MANUAL.	48	0	0	0	0	0	0	0	0	0	0	0
567 - AS OUTLINED IN YOUR PROVIDER MANUAL, THE INITIAL PAYMENT FOR THE DENTURE INCLUDES ALL RELINES FOR THE FIRST 12 MONTHS AFTER DENTURE SEATING.	0	0	0	0	0	1	0	0	0	0	0	0
568 - A COMBINATION OF RELINES OR RELINES AND COMPLETE/PARTIAL DENTURES IS ALLOWED ONCE IN A EIGHT YEAR PERIOD, AS OUTLINED IN YOUR PROVIDER MANUAL.	0	0	0	0	0	13	0	0	0	0	0	0
570 - ALVEOPLASTY IS ONLY COVERED WHEN PERFORMED IN CONJUNCTION WITH THREE OR MORE ADJACENT EXTRACTIONS IN A SINGLE QUADRANT.	0	0	0	0	0	0	0	0	0	0	1	0
571 - COVERAGE IS LIMITED TO THE PLAN GUIDELINES AS SPECIFIED IN YOUR PROVIDER MANUAL.	604	0	57	56	5	18	0	0	0	4	3	76
575 - YOUR RECONSIDERATION REQUEST HAS BEEN REVIEWED AND THE INITIAL DETERMINATION HAS BEEN UPHELD.	34	4	63	33	1	28	0	0	0	32	1	38
576 - THE CLAIM FORM SUBMITTED WAS INCOMPLETE. PLEASE COMPLETE ALL ADA REQUIRED FIELDS OF THE CLAIM FORM AND RESUBMIT.	1	0	2	1	0	0	0	0	0	3	0	0
577 - THIS PROCEDURE HAS BEEN REPORTED AS BEING RENDERED BY ANOTHER PROVIDER AND/OR FACILITY.	3	2	13	8	4	10	0	0	0	19	0	7
580 - THIS SERVICE IS DENIED BECAUSE THERE IS NO APPROVED AUTHORIZATION ON FILE FOR THE DENTURE(S).	20	0	0	0	0	0	0	0	0	0	0	0
581 - AFTER FURTHER REVIEW, THE ORIGINAL DETERMINATION FOR THIS SERVICE HAS BEEN OVERTURNED. REIMBURSEMENT FOR THIS SERVICE IS SUBJECT TO PLAN GUIDELINES AND LIMITATIONS.	2	3	7	5	0	3	0	0	0	1	0	2

582 - YOUR REQUEST FOR RECONSIDERATION WAS NOT RECEIVED IN THE TIME-FRAME OUTLINED IN YOUR PROVIDER MANUAL. THEREFORE, YOUR REQUEST HAS BEEN DENIED.	6	1	23	25	0	6	0	0	0	16	0	10
59 - INVALID OR NO INFORMATION RELATING TO THE TOOTH NUMBER/LETTER, QUADRANT, SURFACE(S)NUMBER/LETTER, QUADRANT, SURFACE(S), OR ARCH. RESUBMIT WITH THE CORRECT INFORMATION.	8	0	5	0	0	8	0	0	0	53	4	1
60 - PLEASE SUBMIT THE PROVIDER/SPECIALIST NAME OR ADDRESS.	6	0	10	2	1	2	0	0	0	7	0	3
62 - PROCEDURE DOES NOT MEET AGE REQUIREMENTS OF THE PLAN.	2	13	8	1	4	0	0	0	0	0	2	5
620 - THE INFORMATION CONTAINED IN THE CHART NOTES PROVIDED DOES NOT MATCH THE INFORMATION REPORTED ON THE CLAIM. WE ARE UNABLE TO DETERMINE OUR LIABILITY FOR THIS CLAIM AT THIS TIME.	2	0	0	1	0	4	0	0	0	0	0	0
626 - AFTER REVIEWING THE PRIMARY INSURANCE CARRIER'S EXPLANATION OF BENEFITS; MCNA IS UNABLE TO DETERMINE OUR LIABILITY DUE TO A DISCREPANCY. REPORTED TO THE PRIMARY CARRIER DIFFERS OR THE DATE OF SERVICE DIFFERS.	0	0	0	0	0	0	0	0	0	1	0	2
630 - DETAILED CHART NOTES MUST BE PROVIDED WITH THE CLAIM, INCLUDING THE DELIVERY DATE OF THE DENTURE.	2	0	0	0	0	30	0	0	0	0	0	0
644 - THE TAXONOMY CODE REPORTED ON THE CLAIM MUST MATCH THE TAXONOMY CODE REPORTED FOR THE NPI ON THE PROVIDER REGISTRY RECORD	0	0	0	0	0	1	0	0	0	0	0	0
65 - SERVICES PERFORMED BY A NON-PARTICIPATING FACILITY ARE NOT COVERED.	3	3	32	7	8	4	0	0	0	11	0	7
67 - SERVICE(S) DENIED AS FACILITY NOT SPECIFIED.	4	1	27	7	0	4	0	0	0	7	0	7

68 - SERVICE(S) DENIED AS PROVIDER NOT SPECIFIED.	0	0	0	0	0	2	0	0	0	0	0	0
72 - CLAIM/PREAUTHORIZATION DENIED AS IT IS MISSING THE PROVIDER'S SIGNATURE IN BOX 53 OF THE ADA CLAIM FORM.	0	0	1	1	0	0	0	0	0	1	0	0
75 - SEALANTS ARE NOT COVERED ON TEETH THAT HAVE PRIOR OCCLUSAL RESTORATIONS.	0	2	0	0	0	0	0	0	0	0	0	0
76 - RESUBMIT CLAIM WITH PRE AND POST OPERATIVE X-RAYS.	0	0	18	957	0	0	0	0	0	3	0	0
8 - SERVICES INCURRED PRIOR TO COVERAGE.	0	0	1	0	0	4	0	0	0	0	0	0
80 - ERUPTION OF THE PERMANENT TOOTH WILL OCCUR WITHIN 6 MONTHS WHICH WILL NATURALLY MAINTAIN THE SPACE.	0	3	0	0	0	0	0	0	0	0	0	0
81 - POST & CORE IS INCLUSIVE OF ALL CORE BUILD-UP AND PIN RETENTION CHARGES AND ONLY COVERED ON PERMANENT TEETH.	0	0	1	0	0	0	0	0	0	0	0	0
83 - PROCEDURE DENIED AS PRE-AUTHORIZATION HAS EXPIRED.	3	5	20	3	0	18	0	0	0	18	1	1
86 - CLAIM DENIED AS DATE OF SERVICE IS AFTER THE DATE THE CLAIM WAS RECEIVED.	0	1	1	0	0	0	0	0	0	0	0	0
88 - OUR RECORDS SHOW THAT THE MEMBER'S TOOTH/TEETH HAS ALREADY BEEN PULLED.	0	0	2	1	0	0	0	0	0	34	0	0
9 - SERVICES INCURRED AFTER COVERAGE TERMINATED.	6	0	15	7	6	35	0	0	0	121	0	50
94 - CLAIMS MUST BE FILED WITHIN SIX MONTHS OF THE DATE OF SERVICE PER THE CLAIMS AND PAYMENT SECTION OF YOUR PROVIDER MANUAL.	38	4	60	40	13	25	0	0	0	91	1	43
95 - NO SERVICES OR CHARGES WERE SPECIFIED ON THE CLAIM SUBMITTED.	9	1	31	30	2	10	0	0	0	15	10	20