TOP REASONS FOR TREATMENT AUTHORIZATION DENIALS

Top Denials (Refer to Section 7 of the Provider Handbook)

ARC 081 – Periodontal procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by the submitted radiographs.

- Radiographic *bone loss* and/or *root surface* calculus not seen on radiographs.
- **Helpful Tip:** Requires submission of *current periapicals and BWX* radiographs, FMX not required but helpful.
- **Helpful Tip:** Requires quadrant code – UR, UL, LR, LL.
- **Did You Know?** Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant.
    - A qualifying tooth shall have a significant amount of bone loss, be restorable and have arch integrity.
    - Teeth shall not be counted as qualifying when they are indicated to be extracted.
    - Third molars shall not be counted unless it occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
    - D4341 – *4 or more diseased teeth* per quadrant
    - D4342 – *1-3 diseased teeth* per quadrant

ARC 269C – Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.

- Procedure is denied because of the denial of a related procedure.
- Multiple requested procedures submitted on the same TAR will be reviewed in relation to other associated procedure(s) requested and may be denied for a consistent treatment plan.
- **Helpful Tip:** Request for removable prosthodontics procedures requires *upper and lower arch request on the same TAR/Claim.*
- **Helpful Tip:** Submit properly completed DC054 form with documentation of *comprehensive treatment plan (completed and proposed) for both upper and lower arches.*
- **Did You Know?** All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.
- This denial code is commonly associated with:
    - D2951 Pin Retention
    - D3426 Apicoectomy (each additional root)
    - D5000-D5899 Removable Prosthodontics Procedures

ARC 326 – Procedures being denied on this document due to invalid response to the RTD or,

if applicable, failure to provide radiographs/attachments for this EDI document.

- Submission of all applicable documents are required for requested procedure(s). Refer to Section 5 of the Provider Handbook for specific criteria.
- An incomplete or inaccurate TAR or Claim will delay processing and may result in the generation of RTD or denial (see Section 7 in the Provider Handbook for RTD codes and messages).
- **Helpful Tip:** RTDs may be requested to verify member information – enter the member's information on the TAR/Claim as it appears on their BIC (Benefits Identification Card) to avoid RTD.
- **Helpful Tip:** Be sure to submit radiograph(s), attachment and/or respond to RTDs promptly (by mail). Radiographs and/or responses not received after *45 days* will result in denial of Tar or Claim
- **Helpful Tip:** Review EDI reports to pinpoint any documents that may require follow-up (Refer to EDI How to Guide)
- **Did you know?** EDI reports are made available by the Medi-Cal Dental program (or if applicable, through provider's clearinghouse) to help providers track their electronically submitted documents.

ARC 128 – Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.

- Posts are allowable only for teeth with successful RCTs and crowns, either authorized or previously paid by the program.
- **Helpful Tip:** Submit post and crown request on the same TAR/NOA/Claim.
- **Did You Know?** If a crown is denied per Medi-Cal Dental criteria, the post will be denied as an unallowable adjunct procedure. See Section 5 of the Provider Handbook for specific criteria.
- This denial code is commonly associated with ARC 113 and 113C

ARC 300A – Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office.

- TAR previously submitted and allowed to a different provider.
- **Helpful Tip:** If authorized procedure(s) are not completed please submit NOA and request deletion of procedure(s).
- **Helpful Tip:** If the member wishes to go to another provider, submit a new TAR with an attached *statement from the member requesting a change in provider.*
    - Note: Statement must be signed and dated by member
- **Did You Know?** Prior authorization is not transferable from one provider to another. A provider cannot perform the service until a new treatment plan is authorized under his/her own provider number.

ARC 113 – Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.

- Laboratory processed crowns are benefit when a lesser service will not suffice because of extensive coronal destruction. The following criteria shall be met for prior authorization:
    - Anterior teeth (involves one of the following):
        - 4 or more surfaces and including 1 incisal angle or
            - Note: Facial or lingual surface are considered only when its involvement is at least to the midline
        - Loss of incisal angle with ½ width and ½ height of crown involved
        - Greater than 50% of crown involved
        - *Anterior teeth must meet above criteria, regardless of history of RCT*
    - Bicuspids – 3 surfaces and 1 cusp involved
    - Molars – 4 surfaces and 2 cusps involved
    - See Section 5 of the Provider Handbook for specific criteria
- **Did You Know?** Posterior crowns for patients over 21 are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests (D5213 and D5214) or for a fixed partial denture which meets current criteria.
- **Did You Know?** Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

ARC 300 – Procedure recently authorized to your office.

- TAR previously submitted and allowed.
- **Helpful Tip:** If you are requesting re-evaluation of an undated, denied procedure, submit NOA with the "Re-evaluation is Requested" box marked.

ARC 088 – Procedure is a benefit once per quadrant every *24 months*.

- **Helpful Tip:** Verify member eligibility to confirm *at least 24 months* have elapsed since procedure(s) has been rendered. Patient may have recently visited another provider and procedure(s) have already been rendered and billed.
- This denial code is commonly associated with: D4341/D4342 Periodontal Scaling and Root Planing.

ARC 048 – Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.

- **Helpful Tip:** When radiographs do not accurately depict the degree of difficulty, submit written documentation and/or photographs to support requested procedure.
- **Did you know?** Extractions are not a benefit for prophylactic removal of asymptomatic teeth

ARC 113C – Laboratory processed crowns for adults are not a benefit for posterior teeth except as abutments for any fixed prosthesis or removable prosthesis with cast clasps or rests. Please reevaluate for alternate treatment.

- Laboratory processed crowns are not a benefit for members 21 and older unless it serves as an abutment for cast partials and also meets the Medi-Cal Dental criteria. Refer to Section 5 of the Provider Handbook for specific criteria.
- **Did You know?** Submission of radiograph and/or photo showing cast partial and abutment teeth are needed for evaluation of requested procedure(s).

ARC 269A – Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.

- Certain procedures cannot be billed separately as they are considered to be part of another procedure, these are termed *Global Procedures:* Treatment performed in conjunction with another procedure which is not payable separately.
- **Did you know?** Common procedures not payable separately include tooth and soft tissue preparation, crown lengthening, cement bases, build-ups, bonding agents, occlusal adjustments, local anesthesia and other associated procedures. These procedures are included in the fee for a completed restorative service. (Refer to Section 5 of the Provider Handbook for specific criteria).

ARC 268 – Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.

- Need for requested procedure cannot be determined based on submitted documents.
- **Helpful Tip:** When decay is not seen in radiographs and need cannot be determined, submit supporting documentation and intraoral photos for consideration.
- **Helpful Tip:** Radiographs and/or photographs must be labeled with tooth/teeth number, surface(s), quadrant or arch as applicable to be considered for requested procedure.
    - Note: Submission of radiographs and/or photos without labeled orientation cannot be used

ARC 266C – Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic for the requested procedure.

- Unable to evaluate requested procedure due to one or more of the following:
    - X-ray angulation – elongation, foreshortening, overlapping or cone cutting
    - Poor image contrast
    - Poor X-ray processing or duplication

ARC 275 – This procedure has been modified/disallowed to reflect the maximum benefit under this program.

- Certain procedures in the Medi-Cal dental program have frequency and time limitations. Paid amount for requested procedures will be adjusted accordingly. See Section 5 in the Provider Handbook for specific criteria.
- **Helpful Tip**: Limitations are specific to requested procedure and may be limited to:
    - Per provider or member

    - Per DOS, time period, or lifetime
    - Per tooth or area (quadrant/arch)
- **Did you know?** Common procedures with frequency and/or time limitations include: photos, space maintainer, protective restoration, pin(s), post and core, periodontal maintenance, denture adjustments or repair, and anesthesia (Refer to Section 5 of the Provider Handbook for specific criteria and maximum allowance).

ARC 271C – Procedure is disallowed due to the following: Arch lacks integrity.

- Poor oral condition such that remaining teeth will not support a partial denture, full denture should be considered.
- **Did You Know?** Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, with a supportable *5 year prognosis* shall be considered for requested procedure(s)

ABBREVIATIONS:
ARC – Adjudication Reason Code **TAR** – Treatment Authorization Request
NOA – Notice of Authorization **CIF** – Claim Inquiry Form **RTD** – Return Submission Turnaround
EOB – Explanation of Benefits **DOS** – Date of Service **EDI** – Electronic Data Interchange

Clinical Reasons for Denial

- **Radiographs**
    - Non-diagnostic radiographs
    - Missing or incomplete submission of radiographs
    - Radiographs/photographs fail to demonstrate medical necessity for restorative procedures
    - Radiographs not current and/or arch films not submitted:
        - Current Radiographs are 8 months for primary teeth, 14 months for permanent teeth and 36 months for Arch Integrity within date of submission
        - Arch Integrity: Anterior periapical radiographs and bitewings are enough to establish arch integrity of the upper/lower arches.
- **Poor prognosis for treatment:**
    - Tooth/teeth/arch show severe bone loss
    - Gross destruction rendering the tooth/teeth/arch unrestorable
- **Global procedures** are not separately payable from the associated procedure. "Global procedures" are those procedures that are performed in conjunction with, and as part of, another associated procedure. (Refer to Section 5 of the Provider Handbook for specific criteria).

Clerical Reasons for Denial

- Other coverage claims for payment must have an EOB/RA attached showing action taken from prime carrier. **Medi-Cal Dental is always the secondary carrier**.
- Failure to submit treating provider/NPI numbers.
- All Medi-Cal Dental forms i.e. claims/TARs/NOAs/RTDs/CIFs require a live signature from the provider or authorized staff member. Rubber stamps or "signature on file" cannot be accepted. (See Section 6 of the Provider Handbook for proper use and completion of forms.)
- RTDs may be requested to verify member information – enter the member's information on the TAR/Claim as it appears on their BIC (Benefits Identification Card) to avoid RTD
- **Radiograph(s) and/or response to RTD not received after *45 days* will result in denial** of Tar or Claim Be sure to submit radiograph(s), attachment and/or respond to RTDs promptly (by mail).

Helpful Hints to Avoid Denials

Medi-Cal Dental would like to offer the following to help offices avoid delays in payment and the denial of Claims and Treatment Authorization Requests (TARs).

- Do not use x-ray envelopes for periodontal charts or any other type of documentation. X-ray envelopes are to be used for radiographs and photographs only. Staple all attachments to the back of the Claim/TAR form. Do not reuse X-ray envelopes that have been returned to you by Medi-Cal Dental.
- **EDI reports** are made available by the Medi-Cal Dental program (or if applicable, through provider's clearinghouse) to help providers track their electronically submitted documents.
    - Review reports daily to (Refer to EDI How to Guide):
        - confirm the Medi-Cal Dental Program's receipt of the EDI documents
        - receive NOAs and RTDs
        - pinpoint any documents that may require follow-up
- See Section 6 of the Provider Handbook for proper use and completion of forms.
    - Submit *Claim* when requesting payment for *completed* treatment
    - Submit *TAR* when requesting authorizations for *proposed* treatment
    - Submit *CIF* if requesting re-evaluation of *claim*
    - Submit *NOA* (*unsigned*) if requesting *re-evaluation of previously requested procedures* – be sure to mark "Re-evaluation Requested" and include additional documentation and/or radiographs to support request.
    - Submit *NOA for payment* after all procedures have been completed

- **Authorized procedures on a Notice of Authorization (NOA)** for members 21 years and older:
    - Medi-Cal Dental authorized treatment on a NOA may be allowed even though the member's 21st birthday occurs before the expiration date on the NOA. Procedures requiring prior authorization will be payable as long as the member is eligible at the time services are rendered.
    - Orthodontic coverage is a benefit to age 21 for qualifying members. Authorized Ortho treatment may be rendered on an eligible member through the month of their 21st birthday.

Helpful Sites:

- Bulletin Updates – latest changes to program and submission requirements, check 1-2 times a month to stay current and/or sign up to be notified of bulletin updates via provider email list sign-up
- EDI How to Guide – provides information about EDI and answers questions providers may have about submitting claims electronically
- Provider Training Seminars – Medi-Cal Dental offers an extensive training program that has been designed to meet the needs of both new and experienced providers and their staff.
- Provider Handbook – contains information about the Medi-Cal Dental program and provides detailed information concerning policies, procedures and instructions for completing the necessary forms and other related documents.
- Verify beneficiary eligibility on the Medi-Cal Dental website or via Touch Tone Telephone (A.E.V.S.)