TOP REASONS FOR CLAIM DENIALS

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

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 a 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 340 – This procedure is a duplicate of a previously paid procedure. If you are requesting re-adjudication for a dated, allowed procedure, submit a Claim Inquiry Form (CIF). The denial of this procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim.

- Claim/NOA previously submitted and payment has been made.
- **Helpful Tip:** Submit CIF to request re-evaluation of a modified or denied claim or NOA for payment.
- **Helpful Tip:** Claim re-evaluations must be received within *6 months* of the date on the EOB. Providers should submit a copy of the disallowed or modified claim, or NOA, plus any additional radiograph(s) or documentation to support the procedure being requested.

ARC 004 – Procedure D0120 is only a benefit when there is history of procedure D0150 to the same provider.

- Provider must have been paid for D0150 (complete exam) before D0120 (periodic exam) is payable.

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 337 – The procedure is not a benefit for the age of the member.

- Depending on the procedure, age restrictions may apply. See Section 5 in the Provider Handbook for specific criteria.
- Commonly denied procedures:
    - D1110 Adult Prophy – benefit 21 and over
    - D1120 Child Prophy – benefit under 21
    - D1351 Sealant – benefit for under 21
    - D0210 Full Mouth X-rays (FMX) – benefit for 11 and older
    - D0274 Bitewings (4 BWX) – benefit for 10 and older

ARC 020C – Prophy and fluoride procedures are allowable once in a six-month period.

- A benefit once every *6 months per member*, not provider.
- This denial code is commonly associated with:
    - D1120 Child Prophy and/or
    - D1206/1208 Fluoride Treatment
        - Note: once in a *4 month* period for *patients up to 6.*
- **Helpful Tip:** Verify member eligibility to confirm *at least 6 months* have elapsed since last prophy and/or fluoride treatment. Patient may have recently visited another provider and treatment has already been billed.

ARC 266G – Payment and/or prior authorization disallowed. Unable to evaluate treatment. Photographs, digitized images, paper copies, or duplicate radiographs are not labeled adequately to determine right or left, or individual tooth numbers.

- Radiographs and/or photographs must be labeled with tooth/teeth number, surface(s), quadrant or arch as applicable for requested procedure.
- **Helpful Tip:** Be as specific as possible and indicate tooth/area (ex: #30 MOD/LR quadrant).
- **Did You Know?** Depending on your office software and electronic attachment vendor (i.e., NEA, EHG, etc.) there may be a default orientation setting (i.e., Right/Left) – be sure to verify your preferred settings.
- Commonly denied procedures:
    - D0350 Photos
    - D7210 Surgical Removal of Erupted Tooth

    - D2331 Two Surface Anterior Composite
    - D2332 Three Surface Anterior Composite
    - D2940 Protective Restoration

ARC 030 – An adjustment has been made for the maximum allowable radiographs.

- Number of radiographs are limited per provider within a time period and/or per DOS. See Section 5 in the Provider Handbook for specific criteria.
- Common procedures associated with this denial code:
  - D0220/D0230 Intraoral Periapical – a benefit to a maximum of ***20 periapicals in a 12- month period*** by the same provider, excludes periapicals taken as part of an FMX (D0210).
  - D0272/D0274 Bitewings – benefit once every ***6 months*** per provider.

ARC 341 – This procedure is a duplicate of a previously denied procedure. If you are requesting re-adjudication for a dated, denied procedure, submit a Claim Inquiry Form (CIF). This denied, duplicate procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim. (If you are requesting re-evaluation of an undated, denied procedure, submit the Notice of Authorization (NOA).)

- NOA/Claim previously submitted and denied
- **Helpful Hint:** Submit CIF to request re-evaluation of a modified or denied claim or NOA for payment.
    - **Did You Know?** Claim re-evaluations must be received within ***6 months*** of the date on the EOB. Providers should submit a copy of the disallowed or modified claim, or NOA, plus any additional radiograph(s) or documentation to support the procedure being requested.

ARC 259C – Procedure not a benefit within 36 months to the same provider.

- Commonly denied procedures:
    - D0210 – Intraoral – Complete Series of Radiographs
    - D0330 – Panoramic Radiograph Image
    - D1351 – Sealant
    - D1352 – Preventative Resin Restoration
        - Note: Above procedures are a ***benefit per provider***

ARC 002 – Procedure D0150 is payable once every 36 months from the last D0120 or D0150, per provider.

- D0120 (periodic exam) and D0150 (complete exam) is a ***benefit per provider***

ARC 031 – Procedure is payable only when submitted.

- Photo(s) not submitted for the requested procedure
- **Helpful Tip:** Check EDI report and confirm photos were successfully submitted (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 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 289 – Procedure requires prior authorization.

- Submit a TAR with radiographs (including arch films, if needed), photos and/or documentation to support requested procedure(s)
- **Helpful Tip:** See Section 2: Prior Authorization for list of Medi-Cal Dental procedures requiring prior authorization.
- **Did You Know?** Common procedures include crowns, post and core, adult RCTs, SRP, and partial dentures (Refer to Section 5 of the Provider Handbook for specific criteria).

ARC 031A – Photographs are a benefit only when appropriate and necessary to document associated treatment.

- Submitted photographs are payable only when it is needed to support the requested procedure and the clinical condition of the patient is not readily apparent on the radiographs.
- Payable photos include intra-oral photos showing pit and fissure decay or caries around crown margin.
- Photos are not payable when used for patient identification, post-operative, and/or for multiple photos showing the same area/surfaces.
- **Example:** #30 buccal, 1 surface restoration requested for payment; submitted 2 photos, occlusal and buccal view. Buccal photo shows decay, which is not evident on radiograph, occlusal photo not necessary – Only photo depicting buccal surface is payable, occlusal photo is not.
- **Helpful Tip:** Photo(s) must:
    - be dated and current
    - include member name

    - include orientation – indicate tooth number(s) or quadrant/area as needed
    - be of diagnostic quality
- **Did You Know?** Up to a maximum of 4 photos are payable per DOS – additional photos may be submitted as needed, but are not payable
    - Date on photo must match the DOS on the claim form, i.e., DOS is date photo was taken and may differ from DOS treatment was rendered.

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 a 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.)