Section 7 - Codes

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Adjudication Reason Codes

In adjudicating claim and TAR forms, it is sometimes necessary to clarify the criteria for dental services under Medi-Cal Dental. These processing policies are intended to supplement the criteria. The Adjudication Reason Code is entered during processing to explain unusual action taken (if any) for each claim service line. These codes will be found on Explanations of Benefits (EOBs) and Notices of Authorization (NOAs).

ARC #	Adjudication Reason Code Description
	DIAGNOSTIC/PREVENTIVE
001	Procedure is a benefit once per patient, per provider.
001A	An orthodontic evaluation is a benefit only once per patient, per provider.
002	Procedure is a benefit once in a six-month period for patients under age 21.
002A	Evaluation is not a benefit within six months of a previous evaluation to the same provider for members under age 21 or does not meet CRA criteria.
003	Procedure not payable in conjunction with other oral evaluation procedures for the same date of service.
004	Procedure D0120 is only a benefit when there is history of Procedure D0150 to the same provider.
004A	Procedure D1320 is only a benefit when billed on the same date of service as procedure D0150 or D0120 to the same provider.
006	Procedure is a benefit once per tooth.
008	Procedure was not adequately documented.
009	Procedure not a benefit when specific services other than radiographs or photographs are provided on the same day by the same provider.
010	Procedure 020 not a benefit in conjunction with Procedure 030.
011	Procedure 030 is payable only once for a visit to a single facility or other address per day regardless of the number of patients seen.
011A	Procedure 030 is payable only when other specific services are rendered same date of service.
012	Procedure 030, time of day, must be indicated for office visit.
012A	Procedure 030, time of day, must be indicated for office visit. Time indicated is not a benefit under Procedure 030
013	Procedure requires an operative report or anesthesia record with the actual time indicated.
013A	Procedure has been authorized. However, the actual fee allowance cannot be established until payment is requested with the hospital time documented in operating room report.
013B	Procedure D9410 is not payable when the treatment is performed in the provider's office or provider owned ambulatory surgical center.

ARC #	Adjudication Reason Code Description
013C	The anesthesia record must be signed by the rendering provider and the rendering provider's name and permit number must be printed and legible.
013D	The treating provider name on the anesthesia record does not coincide with the Rendering Provider Number (NPI) in field 33 on the claim.
013E	The treating provider performing the analgesia procedure must have a valid permit from the DBC and the permit number must be on file with Denti-Cal.
014	Procedure is not a benefit to an assistant surgeon.
015	The fee to an assistant surgeon is paid at 20 percent of the primary surgeon's allowable surgery fee.
016	Procedure 040 is payable only to dental providers recognized in any of the special areas of dental practice.
017	Procedure 040 requires copy of the specialist report and must accompany the payment request.
018	Procedure 040 is not a benefit when treatment is performed by the consulting specialist.
019	The procedure has been modified due to the age of the patient and/or previous history to allow the maximum benefit.
020A	Any combination of procedure 049, 050 (under 21), 061 and 062 are limited to once in a six-month period.
020B	Procedure 050 (age 21 and over) is limited to once in a twelve-month period.
020C	Prophy and fluoride procedures are allowable once in a six-month period.
020D	Prophy and fluoride procedures are allowable once in a 12-month period.
020E	Procedure will not be considered within 90 days of a previous prophylaxis and/or fluoride procedure.
020F	Prophy and a topical fluoride treatment performed on the same date of service are not payable separately.
020G	Topical application of fluoride is payable only for caries control.
020H	Prophy and fluoride procedures are allowable once in a 4-month period when the patient resides in an intermediate care facility (ICF) or a skilled nursing facility (SNF) that is licensed pursuant to health and safety code (H&S code) section 1250-1264.
020I	Patients under age 6, fluoride procedures are allowable once in a 4-month period and prophy procedures are allowable once in a 6-month period.
021	Procedure 080 is a benefit once per visit and only when the emergency procedure is documented with arch/tooth code and includes the specific treatment provided.
022	Full mouth or panographic X-rays are a benefit once in a three year period.
023	A benefit twice in a six-month period per provider.
024	A benefit once in a 12-month period per provider.

ARC #	Adjudication Reason Code Description
024A	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Cone cutting, creases, stains, distortion, poor density.
024B	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Apices, crowns, and/or surrounding bone not visible.
024C	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Interproximal spaces overlapping.
024D	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Bone structure distal to the last tooth not shown.
024E	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Complete arch not shown in films submitted.
024F	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Artifacts obscure teeth.
025	Procedure 125 is not a benefit as a substitute for the periapical radiographs in a complete series.
026	Panographic type films submitted as a diagnostic aid for periodontics, endodontics, operative dentistry or extractions in one quadrant only are paid as single periapical radiographs.
027	Procedure is not a benefit for edentulous areas.
028	A benefit once in a six-month period per provider.
028A	Procedure D0272 or D0274 is not a benefit within six months of Procedure D0210, D0272, or D0274, same provider.
028B	Procedure D0210 is not a benefit within six months of Procedure D0272 or D0274, same provider.
029	Payment/Authorization denied due to multiple unmounted radiographs.
029A	Payment/Authorization denied due to undated radiographs or photographs.
029B	Payment/Authorization denied. Final endodontic radiograph is dated prior to the completion date of the endodontic treatment.
029C	Payment/Authorization denied due to multiple, unspecified dates on the X-ray mount/envelope.
029D	Payment/Authorization denied. Date(s) on X-ray mount, envelope or photograph(s) are not legible or the format is not understandable/decipherable.
029E	Payment denied due to date of radiographs/photographs is after the date of service or appears to be post operative
029F	Payment/Authorization denied due to beneficiary name does not match or is not on the X-ray mount, envelope or photograph.
029G	Payment/Authorization disallowed due to radiographs/photographs dated in the future.
029H	Payment/Authorization denied due to more than four paper copies of radiographs/photographs submitted.

ARC #	Adjudication Reason Code Description
029I	Payment/Authorization denied. Radiographs/ photographs shall be of diagnostic quality, properly mounted, labeled with the date the radiograph/photograph was taken, the patient's name, and with the tooth/quadrant/area (as applicable). Submitted Radiographs/Photographs do not meet two or more of the above requirements.
030	An adjustment has been made for the maximum allowable radiographs.
030A	An adjustment has been made for the maximum allowable X-rays. Bitewings are of the same side.
030B	Combination of radiographs is equal to a complete series.
030C	An adjustment has been made for the maximum allowable X-rays. Submitted number of X-rays differ from the number billed.
030D	Periapicals are limited to 20 in any consecutive 12-month period.
031	Procedure is payable only when submitted.
031A	Photographs are a benefit only when appropriate and necessary to document associated treatment.
031B	Photographs are a benefit only when appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs.
031C	Photographs are not payable when taken for patient identification, multiple views of the same area, treatment in progress and postoperative views.
031D	Photographs are not payable when the date does not match the date of service on the claim.
032A	Endodontic treatment and postoperative radiographs are not a benefit.
032B	X-rays disallowed for the following reasons: Duplicate X-rays are not a benefit.
032C	X-rays disallowed for the following reasons: X-rays appear to be of another person.
032D	X-rays disallowed for the following reasons: X-rays not labeled right or left. Unable to evaluate treatment.
033	Procedure 150 not a benefit in conjunction with the extraction of a tooth, root, excision of any part or neoplasm in the same area or region on the same day.
033A	Procedure is payable only when a pathology report from a certified pathology laboratory accompanies the request for payment.
034	Emergency procedure cannot be prior authorized.
036	The dental sealant procedure code has been modified to correspond to the submitted tooth code.
037	Replacement/repair of a dental sealant is included in the fee to the original provider for 36 months.
038	Procedure is only a benefit when the tooth surfaces to be sealed are decay/restoration free

ARC #	Adjudication Reason Code Description
039	Dental sealants are only payable when the occlusal surface is included.
039A	Preventive resin restoration is only payable for the occlusal, buccal, and/or lingual surfaces.
	ORAL SURGERY
043	Resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
043A	This ortho case requires orthognathic surgery which is a benefit for patients 16 years or older. Submit a new authorization request following the completion of the surgical procedure(s).
044	First extraction only, payable as procedure 200. Additional extraction(s) in the same treatment series are paid as procedure 201 per dental criteria manual.
045	Due to the absence of a surgical, laboratory, or appropriate report, payment will be made according to the maximum fee allowance.
046	Routine post-operative visits within 30 days are included in the global fee for the surgical procedure.
046A	Postoperative visits are not payable after 30 days following the surgical procedure.
047	Postoperative care within 90 days by the same provider is not payable.
047A	Postoperative care within 30 days by the same provider is not payable.
047B	Postoperative care within 24 months by the same provider is not payable.
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.
049	Extractions are not payable for deciduous teeth near exfoliation.
050	Surgical extraction procedure has been modified to conform with radiographic appearance.
051	Procedure 201 is a benefit for the uncomplicated removal of any tooth beyond the first extraction, regardless of the level of difficulty of the first extraction, in a treatment series.
052	The removal of residual root tips is not a benefit to the same provider who performed the initial extraction.
053	The removal of exposed root tips is not a benefit to the same provider who performed the initial extraction.
054	Routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
054A	Procedure is not a benefit within six months of extractions in the same quadrant.
054B	Alveoloplasty is not a benefit in conjunction with 2 or more surgical extractions in the same quadrant.

ARC #	Adjudication Reason Code Description
055	Diagnostic X-rays fully depicting subject tooth (teeth) are required for intraoral surgical procedures.
056	A tuberosity reduction is not a benefit in the same quadrant in which extractions and/or an alveoloplasty or alveoloplasty with ridge extension unless justified by documentation.
057	Procedure is only payable to a certified oral pathologist and requires a pathology report.
058	Procedure is a benefit for anterior permanent teeth only.
059	Procedure allowed per Current Procedural Terminology (CPT) code description.
060	Procedure D9410 is payable only when associated with procedures that are a payable benefit.
	DRUGS
063	Only the most profound level of anesthesia is payable per date of service. This procedure is considered global and is included in the fee for the allowed anesthesia procedure.
064	A benefit only for oral, patch, intramuscular or subcutaneous routes of administration.
065	Procedure 300 is a benefit only for injectable therapeutic drugs, when properly documented.
066	The need for 301 must be justified and documented.
067	Procedure 301 requires prior authorization for beneficiaries 13 years of age or older and documentation of mental or physical handicap.
068	Procedure 400 is not a benefit except when the use of local anesthetic is contraindicated or cannot be used as the primary agent. The need for general anesthesia must be documented and justified.
069	Procedure is not a benefit when all additional services are denied or when there are no additional services submitted for the same date of service.
070	Anesthesia procedures are not payable when diagnostic procedures are the only services provided and the medical necessity is not justified.
071	Intravenous Sedation or General Anesthesia is not deemed medically necessary based on the treatment plan and/or documentation submitted. Please submit additional documentation to justify the medical necessity for IV Sedation/GA or attempt treatment under a less profound sedation modality.
071A	Behavior Modification (D9920) is not payable when sedation is used as a behavior modification modality.
071B	Behavior Modification (D9920) is only payable when the patient is a special needs patient that requires additional time for a dental visit.
071C	Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit.

ARC #	Adjudication Reason Code Description
071D	This procedure does not have a fee in the Schedule of Maximum Allowance and is not payable through a claim submission. Please see https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Dental_Case_Management_Program/ for further instructions.
	PERIODONTICS
072	Periodontal procedure requires documentation specifying the definitive periodontal diagnosis.
073	Periodontal chart not current.
073A	Periodontal chart not current. Older than 14 months.
073B	Periodontal chart not current. Periodontal treatment performed after charting date.
073C	Periodontal chart not current. Charting date missing or illegible.
073D	Periodontal chart not current. Charting date invalid or dated in the future.
073E	Periodontal chart not current. Older than 12 months
074A	Periodontal procedure disallowed due to inadequate charting of: Pocket depths.
074B	Periodontal procedure disallowed due to inadequate charting of: Mobility.
074C	Periodontal procedure disallowed due to inadequate charting of: Teeth to be extracted.
074D	Periodontal procedure disallowed due to inadequate charting of: Two or more of the above.
075	Procedure 451 must be documented as to the emergency condition and the definitive treatment provided.
076	A benefit twice in a 12-month period per provider.
077	Periodontal procedures 452, 472, 473, and 474 are not benefits for beneficiaries under 18 years of age except for cases of drug-induced hyperplasia.
077A	Periodontal procedures are not benefits for patients under 13 years of age except when unusual circumstances exist and the medical necessity is documented.
078	Procedure 452 is a full mouth treatment not authorized by arch or quadrant.
079	Multiples of Procedure 452 must be performed on different days.
080	A prophy or prophy and fluoride procedure is not payable on the same date of service as a surgical periodontal procedure.
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.
081A	Periodontal evaluation chart does not coincide with submitted radiographic evidence.
082	Procedure 453 is considered part of completed prosthodontics and/or multiple restorations involving occlusal surfaces.

ARC #	Adjudication Reason Code Description
083	Procedures 472 and 473 may be a benefit following procedure 452 and when the 6-9 month postoperative charting justifies need.
083A	Surgical periodontal procedure cannot be authorized within 30 days following periodontal scaling and root planing for the same quadrant.
084	Procedure 452, 472, 473, and 474 are not payable as emergency procedures.
085	Procedure 452 requires a minimum of a 3-month healing period prior to evaluation for another 452.
085A	Periodontal post-operative care is not a benefit when requested within 3 months by the same provider.
085B	Only one Scaling and Root Planing, or Perio Maintenance or Prophylaxis procedure is allowable within the same calendar quarter.
086	Periodontal scaling and root planing must be performed within 24 months prior to authorization of a surgical periodontal procedure for the same quadrant.
086A	Perio Maintenance is a benefit only when Scaling and Root Planing has been performed within 24 months.
086B	Full Mouth Debridement is not payable when rendered within 24 months of a scaling and root planning.
087	Unscheduled dressing change is payable only when the periodontal procedure has been allowed by the program.
087A	Unscheduled dressing change is not payable to the same provider who performed the surgical periodontal procedure.
087B	Unscheduled dressing change is not payable after 30 days from the date of the surgical periodontal procedure.
088	Procedure is a benefit once per quadrant every 24 months.
088A	Procedure is a benefit once per quadrant every 36 months.
089	Procedure is not a benefit for periodontal grafting.
	ENDODONTICS
090	Procedure 503 is not a benefit when permanent restorations are placed before a reasonable length of time following Procedure 503.
091	Procedure(s) require diagnostic radiographs depicting entire subject tooth.
091A	Procedure(s) require diagnostic radiographs depicting entire subject tooth. Procedure requires diagnostic X-rays depicting furcation.
092	Payment request for root canal treatment and apicoectomy must be accompanied by a final treatment radiograph and include necessary postoperative care within 90 days.
093A	Endodontic procedure is not payable when root canal filling underfilled.
093B	Endodontic procedure is not payable when root canal filling overfilled.
093C	Endodontic procedure is not payable when: Incomplete apical treatment due to inadequate retrograde fill and/or sealing of the apex.

ARC #	Adjudication Reason Code Description
093D	Endodontic procedure is not payable when: Root canal filling is undercondensed.
093E	Endodontic procedure is not payable when: Root canal has been filled with silver points. Silver points are not an acceptable filling material.
093F	Endodontic procedure is not payable when: Root canal therapy has resulted in the gross destruction of the root or crown.
094	Crowns on endodontically treated teeth may be considered for authorization following the satisfactory completion of root canal therapy. Submit a new request for authorization on a separate TAR with the final endodontic radiograph.
095	Procedure 530 submitted is not allowed. Procedure 511, 512 or 513 is authorized per X-ray appearance.
096	Procedure not a benefit in conjunction with a full denture or overdenture.
097	Need for root canal procedure not evident per radiograph appearance, or documentation submitted.
098	Procedures 530 and 531 include retrograde filling.
099	A benefit once per tooth in a six-month period per provider.
100	Procedure is not a benefit for an endodontically treated tooth.
101	This procedure requires a prerequisite procedure.
101A	Procedure D9999 documented for a live interaction associated with Teledentistry is only payable when procedure D0999 has been rendered.
	RESTORATIVE
109	Procedures D2161, D2335, D2390 and D2394 are the maximum allowances for all restorations of the same material placed in a single tooth for the same date of service.
110	Procedures 603, 614, 641 and 646 are the maximum allowance for all restorations placed in a single tooth for each episode of treatment.
111	Payment is made for an individual surface once for the same date of service regardless of the number or combinations of restorations or materials placed on that surface.
112	Separate restorations of the same material on the same tooth will be considered as connected for payment purposes.
113	Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
113A	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a restoration or pre-fabricated crown.
113B	Per radiographs, the tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
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.

ARC #	Adjudication Reason Code Description
113E	Prefabricated crowns are not a benefit as abutments for any removable prosthesis with cast clasps or rests. Please reevaluate for a laboratory processed crown.
113F	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a pre-fabricated or laboratory processed crown and the need for the restoration is not justified.
114	Tooth and soft tissue preparation, crown lengthening, cement bases, build-ups, bonding agents, occlusal adjustments, local anesthesia and other associated procedures are included in the fee for a completed restorative service.
115	Amalgam or plastic build-ups are included in the allowance for the completed restorations.
116	Procedures 640/641 are only benefits when placed in anterior teeth or in the buccal (facial) of bicuspids.
117	Procedure not a benefit for a primary tooth near exfoliation.
118	Proximal restorations in anterior teeth are paid as single surface restorations.
119	Payment/Authorization cannot be made as caries not clinically verified by a Clinical Screening Consultant.
120	A panoramic film alone is considered non-diagnostic for authorization or payment of restorative, endodontic, periodontic, fixed and removable partial prosthodontic procedures.
121	Radiographs do not substantiate immediate need for restoration of surface(s) requested.
121A	Neither radiographs nor photographs substantiate immediate need for restoration of surface(s) requested.
122	Tooth does not meet the Manual of Criteria for a prefabricated crown.
123	Radiograph or photograph does not depict the entire crown or tooth to verify the requested surfaces or procedure.
124	Radiograph or photograph indicate additional surface(s) require treatment.
124A	Decay not evident on requested surface(s), but decay evident on other surface(s).
125	Replacement restorations are not a benefit within 12 months on primary teeth and within 24 months on permanent teeth.
125A	Replacement restorations are not a benefit within 12 months on primary teeth and within 36 months on permanent teeth.
125B	Replacement of otherwise satisfactory amalgam restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist).
126	Fillings, stainless steel crowns and/or therapeutic pulpotomies in deciduous lower incisors are not payable when the child is over five years of age.

ARC #	Adjudication Reason Code Description
127	Pin retention is not a benefit for a permanent tooth when a prefabricated or laboratory-processed crown is used to restore the tooth.
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.
129	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.
130	Payment for a crown or fixed partial denture is made only upon final cementation regardless of documentation.
131	Procedure is a benefit only in cases of extensive coronal destruction.
132	Procedure 640/641 has been allowed but priced at zero due to the reduced SMA effective July 1, 1995.
133	Procedure not allowed due to denial of a root canal filled with silver points.
134	This change reflects the maximum benefit for a filling, (Procedure 600-614) placed on a posterior tooth regardless of the material placed, i.e. amalgam, composite resin, glass ionomer cement, or resin ionomer cement.
135	Procedure not a benefit for third molars unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
136	Procedure not a benefit for prefabricated crowns.
	PROSTHODONTICS
137	Procedure has been performed previously in less than the 5-year policy period. The request has been allowed under special circumstances per documentation.
138	Partial payment for an undeliverable prosthesis requires the reason for non-delivery to be adequately documented and a laboratory invoice indicating the prosthesis was processed.
139	Payment adjustment reflects 80% of the SMA for an undeliverable prosthesis. The prosthesis must be kept in a deliverable condition for at least one year.
140	Payment adjustment reflects 20% of the SMA for delivery only of a previously undeliverable prosthesis.
141	Procedure 724 includes relines, additions to denture base to make appliance serviceable such as repairs, tooth replacement and/or resetting of teeth as necessary.
142	A prosthesis has been paid within the last 12 months. Please refer the patient to the original provider and/or Beneficiary Services at 1 (800) 322-6384.
143	Authorization not granted for a replacement prosthesis within a five-year period. Insufficient documentation substantiating need for prosthesis to prevent a significant disability or prosthesis loss/destruction beyond patient's control.

ARC #	Adjudication Reason Code Description
144	Procedure 720 is a benefit once per visit per day and when documented to describe the specific denture adjustment location.
145	Please submit a separate request for authorization of Procedure 722 when ready to reline denture.
146	A removable partial denture includes all necessary clasps, rests and teeth.
147	Cast framework partial denture is only a benefit when necessary to balance on opposing full denture.
148	Sufficient teeth are present for the balance of the opposing prosthesis.
149	Procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
149A	A resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
150	Procedure 722 disallowed; allowance for Procedure 721 is maximum benefit for reline of stayplate.
151	This procedure is not a benefit for a resin base partial denture.
152	Relines are a benefit 6 months following an immediate prosthesis (with extractions).
153	Relines are a benefit 12 months following a non-immediate prosthesis (without extractions).
154	Tissue conditioning is not a benefit when dated the same date of service as a non-immediate prosthetic appliance or reline.
155	Procedure requires a properly completed prosthetic DC054 form.
155A	Procedure requires a properly completed Prosthetic DC054 Form. Information submitted on the DC054 Form does not justify the need for prosthesis.
155B	Procedure requires a properly completed Prosthetic DC054 Form. The information submitted on the DC054 Form does not match the information on the TAR (Treatment Authorization Request).
155C	Procedure requires a properly completed Prosthetic DC054 Form. Teeth to be replaced and clasped are not indicated or are in conflict on the DC054 Form.
156	Evaluation of a removable prosthesis on a maintenance basis is not a benefit.
157	A laboratory invoice is required for payment.
160	Laboratory or chairside relines are a benefit once in a 12-month period per arch.
161	Procedure 722 is a benefit once in a 12-month period per arch.
161A	Procedure 724 is not a benefit within 12 months of procedure 722, same arch.
161B	Procedure 722 is not a benefit within 12 months of procedure 724, same arch.

ARC #	Adjudication Reason Code Description
162	Patient's existing prosthesis is adequate at this time.
163	Patient returning to original provider for correction and/or modifications of requested procedure(s).
164	Prosthesis serviceable by laboratory reline.
165	Existing prosthesis can be made serviceable by denture duplication (“jump”, “reconstruction”).
166	The procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
168A	Patient does not wish extractions or any other dental services at this time.
168B	Patient has selected different provider for treatment.
169	Procedure 723 is limited to two per appliance in a full 12-month period.
169A	Procedure is limited to two per prosthesis in a 36-month period.
170	A reline, tissue conditioning, repair, or an adjustment is not a benefit without an existing prosthesis.
171	The repair or adjustment of a removable prosthesis is a benefit twice in a 12-month period, per provider.
172	Payment for a prosthesis is made upon insertion of that prosthesis.
173	Prosthetic appliances (full dentures, partial dentures, reconstructions, and stayplates) are a benefit once in any five-year period.
174	Procedure 724 is a benefit only when the existing denture is at least two years old.
175	The fee allowed for any removable prosthetic appliance, reline, reconstruction or repair includes all adjustments and post-operative exams necessary for 12 months.
175A	The fee allowed for any removable prosthesis, reline, tissue conditioning, or repair includes all adjustments and post-operative exams necessary for 6 months.
176	Per radiographs, insufficient tooth space present for the requested procedure.
177	New prosthesis cannot be authorized. Patient’s dental history shows prosthesis made in recent years has been unsatisfactory for reasons that are not remediable.
178	The procedure submitted is no longer a benefit under the current criteria manual. The procedure allowed is the equivalent to that submitted under the current Schedule of Maximum Allowances and criteria manual.
179	Procedure requires prior authorization and cannot be considered as an emergency condition.
180	Patient cancelled his/her scheduled clinical screening. Please contact patient for further information.
SPACE MAINTAINERS	

ARC #	Adjudication Reason Code Description
191	Radiograph depicts insufficient space for eruption of the permanent tooth/teeth.
192	Procedure not a benefit when the permanent tooth/teeth are near eruption or congenitally missing.
193	Replacement of previously provided space maintainer is a benefit only when justified by documentation.
194	Tongue thrusting and thumb sucking appliances are not benefits for children with erupted permanent incisors.
195	A space maintainer is not a benefit for the upper or lower anterior region.
196	Procedure not a benefit for orthodontic services, including tooth guidance appliances.
197	Procedure requested is not a benefit when only one tooth space is involved or qualifies. Maximum benefit has been allowed.
197A	Procedure is only a benefit to maintain the space of a single primary molar.
	ORTHODONTIC SERVICES
198	Procedure is not a benefit when the active phase of treatment has not been completed.
199	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.
200	Adjustments of banding and/or appliances are allowable once per calendar month.
200A	Adjustments of banding and/or appliances are allowable once per quarter.
200B	Procedure D8670 is payable the next calendar month following the date of service for Procedure D8080.
200C	Procedure D8670 and D8680 are not payable for the same date of service.
201	Procedure 599 - Retainer replacements are allowed only on a one-time basis.
201A	Replacement retainer is a benefit only within 24 months of procedure D8680.
202	Procedure is a benefit only once per patient.
203	Procedure 560 is a benefit once for each dentition phase for cleft palate orthodontic services.
204	Procedures 552, 562, 570, 580, 591, 595 and 596 for banding and materials are payable only on a one-time basis unless an unusual situation is documented and justified.
205	Procedures 556 and 592 are allowable once in three months.
205A	Pre-orthodontic visits are payable for facial growth management cases once every three months prior to the beginning of the active phase of orthodontic treatment.
206	Anterior crossbite not causing clinical attachment loss and recession of the gingival margin.

ARC #	Adjudication Reason Code Description
207	Deep overbite not destroying the soft tissue of the palate.
208	Both anterior crowding and anterior ectopic eruption counted in HLD index.
209	Posterior bilateral crossbite has no point value on HLD index.
	MAXILLOFACIAL SERVICES
210	TMJ X-rays - Procedure 955 is limited to twice in 12 months.
211	Procedures 950 and 952 allowed once per dentist per 12-month period.
212	In the management of temporomandibular joint dysfunction, symptomatic care over a period of three months must be provided prior to major definitive care.
213	Procedure 952 is intended for cleft palate and maxillofacial prosthodontic cases.
214	Procedure must be submitted and requires six views of condyles – open, closed, and rest on the right and left side.
215	Overjet is not greater than 9mm or the reverse overjet is not greater than 3.5mm.
216	Documentation submitted does not qualify for severe traumatic deviation, cleft palate or facial growth management.
217	Procedures 962, 964, 966 and 968 require complete history with documentation for individual case requirements. Documentation and case presentation is not complete.
218	Procedures 962, 964, 966 and 968 include all follow-up and adjustments for 90 days.
220	Procedures 970 and 971 include all follow-up and adjustments for 90 days.
221	Procedure is a benefit only when orthodontic treatment has been allowed by the program.
222	Inadequate description or documentation of appliance to justify requested prosthesis.
223	Procedure is a benefit only when the orthodontic treatment is authorized.
224	Photograph of appliance required upon payment request.
225	Procedure 977 requires complete case work-up with accompanying photographs. Documentation inadequate.
226	Procedure D8692 is a benefit only when procedure D8680 has been paid by the program.
227	Splints and stents are part of the global fee for surgical procedure unless they are extremely complex. Supporting documentation missing.
228	When requesting payment, submit documentation for exact amount of hydroxylapatite material (in grams) used on this patient unless your hospital has provided the material.
229	Procedure 979 (radiation therapy fluoride carriers) is a benefit only when radiation therapy is documented.

ARC #	Adjudication Reason Code Description
230	Procedure is not a benefit for acupuncture, acupressure, biofeedback, or hypnosis.
233	Procedure 985 requires prior authorization.
234	Allowance for grafting procedures includes harvesting at donor site.
235	Degree of functional deficiency does not justify requested procedure.
236	Genioplasty is a benefit only when required to complete restoration of functional deficiency. Requested procedure is cosmetic in nature and does not have a functional component.
237	A vestibuloplasty is a benefit only when X-rays and models demonstrate insufficient alveolar process to support a full upper denture or full lower denture. Diagnostic material submitted reveals adequate bony support for prosthesis.
238	Procedure 990 must be accompanied by a copy of occlusal analysis or study models identifying procedures to convert lateral to vertical forces, correct prematurities, and establish symmetrical contact.
241	Allowance for splints and/or stents includes all necessary adjustments.
242	Procedure 996 Request for payment requires submission of adequate narrative documentation.
243	Procedure is a benefit six times in a three-month period.
245	Authorization disallowed as diagnostic information insufficient to identify TMJ syndrome.
246	Except in documented emergencies, all unlisted therapeutic services (Procedure 998) require prior authorization with sufficient diagnostic and supportive material to justify request.
247	Osteotomies on patients under age 16 are not a benefit unless mitigating circumstances exist and are fully documented.
248	Procedure is not a benefit for the treatment of bruxism in the absence of TMJ dysfunction.
249	Payment for the assistant surgeon is not payable to the provider who performed the surgical procedures. Payment request must be submitted under the assistant surgeon’s provider number.
250	Procedure 995 is a benefit once in 24 months.
251	Documentation for Procedure 992 or 994 is inadequate.
253	Combination of Procedures 970, 971 and Procedure 978 are limited to once in six months without sufficient documentation.
254	Procedure disallowed due to absence of one of the following: “CCS approved” stamp, signature, and/or date.
255	Procedure disallowed due to dentition phase not indicated.
256	The orthodontic procedure requested has already received CCS authorization. Submit a claim to CCS when the procedure has been rendered.

ARC #	Adjudication Reason Code Description
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.
	MISCELLANEOUS
258	Functional limitations or health condition of the patient preclude(s) requested procedure.
259A	Procedure not a benefit within 6 months to the same provider.
259B	Procedure not a benefit within 12 months to the same provider.
259C	Procedure not a benefit within 36 months to the same provider.
259D	Procedure not a benefit within 24 months to the same provider.
259E	Procedure not a benefit within 12 months of the initial placement or a previous recementation to the same provider.
260	The requested tooth, surface, arch, or quadrant is not a benefit for this procedure.
261	Procedure is not a benefit of this program.
261A	Procedure code is missing or is not a valid code.
261B	CDT codes are not valid for this date of service.
261C	The billed procedure cannot be processed. Request for payment contains both local and CDT codes. Submit this procedure code on a new claim.
262	Procedure requested is not a benefit for children.
263	Procedure requested is not a benefit for adults.
264	Procedure requested is not a benefit for primary teeth.
265	Procedure requested is not a benefit for permanent teeth.
266A	Payment and/or prior authorization disallowed. Radiographs or photographs are not current.
266B	Payment and/or prior authorization disallowed. Lack of radiographs.
266C	Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic for the requested procedure.
266D	Payment and/or prior authorization disallowed. Procedure requires current radiographs of the remaining teeth for evaluation of the arches.
266E	Payment and/or prior authorization disallowed. Lack of postoperative radiographs.
266F	Payment and/or prior authorization disallowed. Procedure requires current periapicals of the involved areas for the requested quadrant and arch films.
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.
266H	Payment and/or prior authorization disallowed. Radiographs submitted to establish arch integrity are non-diagnostic.

ARC #	Adjudication Reason Code Description
266I	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to poor X-ray processing or duplication.
266J	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to elongation.
266K	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to foreshortening.
266L	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting.
266M	Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.
266N	Payment and/or prior authorization disallowed. Pre-operative radiographs are required.
266P	Payment and/or prior authorization disallowed. Photographs are required.
267	Documentation not submitted.
267A	Description of service, procedure code and/or documentation are in conflict with each other.
267B	Documentation insufficient/not submitted. Services disallowed. Required periodontal chart incomplete/not submitted.
267C	Documentation insufficient/not submitted. Services disallowed. Documentation is illegible.
267D	Documentation insufficient/not submitted. Study models not submitted.
267E	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment appears to be altered. Services disallowed.
267F	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment not submitted. Services disallowed.
267G	Denied by Prior Authorization/Special Claims Review Unit. Information on patient's record of treatment is not consistent with claim/NOA.
267H	All required documentation, radiographs and photographs must be submitted with the claim inquiry form.
267I	Documentation submitted is incomplete.
268	Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.
268A	Per radiographs, photographs, or study models, the need for the procedure is not medically necessary. The Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the criteria to qualify for orthodontic treatment.
268B	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit.
268C	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit. Please re-evaluate fo a FRADS that may be a covered benefit.

ARC #	Adjudication Reason Code Description
269A	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.
269B	Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.
269C	Procedure denied for the following reason: Associated with another denied procedure.
270	Procedure has been modified based on the description of service, procedure code, tooth number or surface(s), or documentation.
271A	Procedure is disallowed due to the following: Bone loss, mobility, periodontal pathology.
271B	Procedure is disallowed due to the following: Apical radiolucency.
271C	Procedure is disallowed due to the following: Arch lacks integrity.
271D	Procedure is disallowed due to the following: Evidence or history of recurrent or rampant caries.
271E	Procedure is disallowed due to the following: Tooth/teeth have poor prognosis.
271F	Procedure is disallowed due to the following: Gross destruction of crown or root.
271G	Procedure is disallowed due to the following: Tooth has no potential for occlusal function and/or is hyper-erupted.
271H	Procedure is disallowed due to the following: The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit.
271I	Procedure is disallowed due to the following: Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.
271J	Procedure is disallowed due to the following: Primary tooth has deep caries that appears to encroach the pulp. Radiograph inadequate to evaluate periapical or furcation area.
272	Tooth not present on radiograph.
272A	Per radiograph, tooth is unerupted.
272B	Radiographs and/or documentation reveals that tooth number may be incorrect.
273	Procedure denied as beneficiary is returning to original provider.
274	Comprehensive (full mouth) treatment plan is required for consideration of services requested.
274A	Incomplete treatment plan submitted. Opposing dentition lacks integrity. Consider full denture for opposing arch.
274B	Authorized treatment plan has been altered; therefore, payment is disallowed.
274C	Incomplete treatment plan submitted. Opposing prosthesis is inadequate.
274D	Incomplete treatment plan submitted. All orthodontic procedures for active treatment must be listed on the same TAR.

ARC #	Adjudication Reason Code Description
275	This procedure has been modified/disallowed to reflect the maximum benefit under this program.
276	Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion are not benefits.
277	Orthodontics for handicapping malocclusion submitted through the CCS program for Medi-Cal beneficiaries are not payable by Denti-Cal.
278	Preventive control programs are included in the global fee.
279	Procedure(s) beyond scope of program. If you wish, submit alternate treatment plan.
280	Not payable when condition is asymptomatic.
281	Services solely for esthetic purposes are not benefits.
282	By-report procedure documentation missing or insufficient for payment calculations.
283	Payment amount determined from documentation submitted for this by-report procedure.
284	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered.
284A	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Restorative treatment incomplete.
284B	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Crown treatment incomplete.
284C	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment is necessary.
284D	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
284E	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Two or more of the above pertain to your case.
285	Procedure does not show evidence of a reasonable period of longevity.
285A	Procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
286	Procedure previously rendered.
287	Allowance made for alternate procedure per documentation, radiographs, photographs and/or history.
287A	Allowance made for alternate procedure per documentation, radiographs and/or photos. Due to patient's age allowance made for permanent restoration on an over retained primary tooth.

ARC #	Adjudication Reason Code Description
288	Procedure cannot be considered an emergency.
289	Procedure requires prior authorization.
290	All services performed in a skilled nursing or intermediate care facility, except diagnostic and emergency services, require prior authorization.
291	Per date of service, procedure was completed prior to date of authorization.
292	Per documentation or radiographs, procedure requiring prior authorization has already been completed.
293	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan.
293A	Radiographs reveal open, underformed apices. Authorization for root canal therapy will be considered after radiographic evidence of apex closure following apexification.
293B	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Re-evaluate for apicoectomy.
293C	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Root canal should be retreated by conventional endodontics before apical surgery is considered.
293D	Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area.
294	Authorization disallowed as patient did not appear for a scheduled clinical screening.
294A	Authorization disallowed as patient failed to bring existing prosthesis to the clinical screening.
295	Payment cannot be made for services provided after the initial receipt date, because the patient failed the scheduled screening appointment.
296	Patient exhibits lack of motivation to maintain oral hygiene necessary to justify requested services.
297	Procedure 803 not covered as a separate item. Global fee where a benefit.
298	A fee for completion of forms is not a covered benefit.
299	Complete denture procedures have been rendered/authorized for the same arch.
299A	Extraction procedure has been rendered/authorized for the same tooth.
300	Procedure recently authorized to your office.
300A	Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office.
301	Procedure(s) billed or requested are a benefit once per patient, per provider, per year.
302	Procedure is not a benefit as coded. Use only one tooth number, one date of service and one procedure number per line.
303	Fixed Partial Dentures are only allowable under special circumstances as defined in the Manual of Dental Criteria.

ARC #	Adjudication Reason Code Description
303A	Fixed Partial Dentures are not a benefit when the number of missing teeth in the posterior quadrant(s) do not significantly impact the patient's masticatory ability.
304	Mixture of three-digit, four-digit and five-digit procedure codes is not allowed.
305	Procedure not a benefit for tooth/arch/quad indicated.
307	Payment for procedure disallowed per post-operative radiograph evaluation and/or clinical screening.
307A	Per post-operative radiograph(s), payment for procedure disallowed: Poor quality of treatment.
307B	Per post-operative radiograph(s), payment for procedure disallowed: Procedure not completed as billed.
308	Procedure disallowed due to a beneficiary identification conflict.
309	Procedures being denied on this claim/TAR due to full denture or extraction procedure(s) previously paid/authorized for the same tooth/arch.
310	Procedure cannot be authorized as it was granted to the patient under the Fair Hearing process. Please contact the patient.
311	Procedure cannot be evaluated at the present time because it is currently pending a Fair Hearing decision.
	PAYMENT POLICY
312	Certified orthodontist not associated to this service office.
313	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete.
313A	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No other coverage EOB/RA, fee schedule or proof of denial submitted.
313B	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No EOMB or proof of Medicare eligibility.
313C	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. Missing/invalid rendering provider ID.
313D	Study models submitted are non-diagnostic, untrimmed, or broken.
313E	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. PM 160 sent exceeded 36 months from date of issue.
314A	Per radiographs or documentation, please re-evaluate for: Complete upper denture.
314B	Per radiographs or documentation, please re-evaluate for: Complete lower denture.
314C	Per radiographs or documentation, please re-evaluate for: Resin base partial denture.

ARC #	Adjudication Reason Code Description
314D	Per radiographs or documentation, please re-evaluate for: Cast metal framework partial denture.
314E	Per radiographs or documentation, please re-evaluate for: Procedure 706
314F	Per radiographs or documentation, please re-evaluate for: Procedure 708
315	The correction(s) have been made based on the information submitted on the CIF. Payment cannot be made because the CIF was received over 6 months from the date of the EOB.
316	Payment disallowed. Request received over 12 months from end of month service was performed.
317	Request for re-evaluation is not granted. Resubmit undated services on a new Treatment Authorization Request (TAR).
317A	Orthodontic NOAs cannot be extended. Submit a new Treatment Authorization Request (TAR) to reauthorize the remaining orthodontic treatment.
317B	Request for reevaluation is not granted due to local and CDT codes on the same document. Resubmit undated service(s) on a new Treatment Authorization Request (TAR).
318	Recipient eligibility not established for dates of services.
318A	Recipient eligibility not established for dates of services. Share of cost unmet.
319	Rendering or billing provider NPI/ID not on file.
319A	The submitted rendering provider NPI is not registered with Denti-Cal. Prior to requesting re-adjudication for a dated, denied procedure on a Claim Inquiry Form (CIF), the rendering provider NPI must be registered with Denti-Cal.
320	Rendering or billing provider not enrolled for date of service.
320A	Rendering or billing provider is not enrolled as a certified orthodontist.
320B	The billing provider has discontinued practicing at this office location for these Dates of Service.
320C	Rendering provider has not submitted a proper attestation package.
321	Recipient benefits do not include dental services.
322	Out-of-state services require authorization or an emergency certification statement; payment cannot be made.
323	Authorization period for this procedure as indicated on the top portion of the Notice of Authorization form has expired.
324	Payment cannot be made as prior authorization made to another dentist. Authorization for services is not transferable.
325	Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.

ARC #	Adjudication Reason Code Description
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.
326A	Procedures being denied on this claim/TAR due to invalid or missing provider signature on the RTD. Rubber stamp or other facsimile of signature cannot be accepted.
327	Payment cannot be made; our records indicate patient deceased.
328	Request for partial payment is not granted. Delete undated services and submit them on a new TAR form.
329	Extension of time is granted once after the original TAR authorization without justification of need for extension.
330	Recipient is enrolled in a managed care program (MCP, PHP, GMC, HMO, or DMC) which includes dental benefits.
330A	Beneficiary is not eligible for Medi-Cal dental benefits. Verify beneficiary's enrollment in Healthy Families which may include dental benefits.
331	Authorized services are not a benefit if patient becomes ineligible during authorized period and services are performed after the patient has reached age 18 without continuing eligibility.
332	Share of cost patient must pay for these services.
333	Payment cannot be made for procedures with dates of service after receipt date.
333A	Payment disallowed. Date of service is after receipt date of first NOA page(s).
334	Out-of-country services require an emergency certification statement, and are a benefit only for approved inpatient services.
335	Billing provider name does not match our files; payment/ authorization cannot be made.
336	Beneficiary is not eligible for dental benefits.
337	The procedure is not a benefit for the age of the beneficiary.
337A	The number of authorized visits has been adjusted to coincide with beneficiary's 19th/21st birthday.
338	This service will be processed under the former contract separately.
339	The POE label on the claim appears to be altered. Please contact the recipient's county welfare office to validate eligibility. Resubmit the claim with a valid label.
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.

ARC #	Adjudication Reason Code Description
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).)
342	Rendering provider required for procedure, none submitted.
343	Billing provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
344	Rendering provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
345	Payment cannot be made for procedures with invalid dates of service.
345A	The PM 160 form sent was not current. Send claim inquiry form with current PM 160 form or document reason for delay in treatment.
346	Billing provider is not a group provider and cannot submit claims for other rendering providers.
347	Authorization previously denied, payment cannot be made.
348	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service already performed on the same day by the same DDS.
348A	The billed procedure cannot be paid because there is an apparent discrepancy between it and procedure D0220 already performed on the same day. If you are requesting re-adjudication for this procedure, submit a Claim Inquiry Form (CIF).
349	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service previously processed, performed by the same dentist on the same day in the same arch.
350	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided for this patient.
351	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided by your office for this patient.
352	The billed service is disallowed because of an apparent discrepancy with a related procedure billed by your office for the same tooth on the same day.
352a	The billed procedure is not payable because our records indicate a related procedure was provided on the same day.
353	The billed service on this tooth is disallowed because of an apparent discrepancy with a related procedure already provided.
354	The line item is a duplicate of a previous line item on the same claim.
355A	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.

ARC #	Adjudication Reason Code Description
355B	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355C	Procedure does not require prior authorization, however, it was reviewed as part of the total treatment plan.
356	EOMB for different recipient, procedure(s) denied.
357	Procedure deleted/disallowed per provider request.
358	Payment for procedure disallowed per claims review.
359	Payment for procedure disallowed per clinical post-payment review.
360	Sign Notice of Authorization for payment of dated lines.
361	CSL has not been paid; NOA never returned for payment.
362	Procedure cannot be paid without explanation of benefits, fee schedule or letter of denial.
363	Procedure on EOMB is not a benefit of the program.
364	Unable to reconcile EOMB procedure code(s). Please reconcile with Medicare prior to billing.
365	The maximum allowance for this service/procedure has been paid by Medicare.
366	Dental benefits cannot be paid without proof of payment/denial from Medicare.
367	Medicare payment/denial notice does not have recipient name and/or date of service.
368	CMSP Aid Code recipient not eligible under Denti-Cal prior to 01/01/90. Forward request for payment to County Medical Services Program.
369	Emergency certification statement is insufficient /not submitted for recipient aid code.
369A	Provider must sign the emergency certification statement.
370	Procedure not a benefit for recipient aid code.
370A	Per box “D” marked in dental assessment column of PM 160, recipient is not eligible for any dental services.
371	Procedure(s) cannot be prior authorized for recipient aid code.
372	Recipient is eligible for Delta commercial coverage. Payment is disallowed.
373	Procedure not payable. CTP benefits terminate at age 19.
374	Recipient is not a resident of a CTP/CMSP contract county. Contact recipient county health department for billing procedures.
375	Re-evaluation denied. Insufficient documentation and/or radiographs not submitted. Please sign for payment of dated services and submit a new TAR.
376	Payment reflects a rate adjustment to the current Schedule of Maximum Allowances and may include an adjustment to the billed amount.

ARC #	Adjudication Reason Code Description
377	This procedure is not a benefit for an RDHAP/RDHEF/RDH.
377A	Procedure requested is only payable when the patient resides in an Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF) that is licensed pursuant to Health And Safety Code (H&S Code) Section 1250-1264.
378	CTP recipient. Payment cannot be made for procedures with dates of service after the 120 day authorization period.
379	Procedure(s) cannot be approved when the new issue date and new BIC ID are not valid or provided in the appropriate fields.
380	Fee adjustment, since Other Coverage exists for this claim.
381	Fee adjustment, since Third Party Liability exists for this claim.
382	Fee adjustment, since share of cost exists for this claim.
383	Fee adjustment, since services billed were not provided.
384	Fee adjustment, due to findings of professional peer review.
385	Aid code 80 recipients are eligible only for Medicare-approved procedures.
386	Payment/Authorization disallowed. CMSP dental services for dates of service after September 30, 2005, are the responsibility of Doral Dental Services of California (1-800-341-8478).
386A	Payment/authorization disallowed. CTP dental benefits are not payable for dates of service after March 31, 2009 or when received after May 31, 2009.
387	Payment disallowed. The request for CMSP dental services was not received before April 1, 2006. Contact Doral Dental Services of California (1-800-341-8478).
387A	Payment Disallowed. The request for a re-evaluation of denied CTP dental service(s) was not received before December 31, 2009.
389	Pregnancy aid codes require a periodontal chart to perform surgical periodontal procedures. Subgingival curettage and root planing must be in history, or documentation must be submitted stating why a prior subgingival curettage and root planing was not performed.
390	The procedure requested is not on the SAR for this CCS/GHPP beneficiary. Contact CCS/GHPP to obtain a SAR prior to submitting for re-evaluation or payment.
391	Final diagnostic casts are not payable within 6 months of initial diagnostic casts for CCS patients.
392	Beneficiary is not eligible for CCS/GHPP benefits.
393	TAR cannot be processed as part of the university project. Resubmit new TAR using your G billing provider number.
394	A credentialed specialist must submit documentation of cleft palate or the craniofacial anomaly.

ARC #	Adjudication Reason Code Description
395	Payment/authorization denied. Please contact the local governmental financing division at DHCS via general email box: DHCSIMCU@DHCS.CA.GOV for the responsible county for this service.
400	EPSDT services are not a benefit for patients 21 years and older.
401	The EPSDT service requested is primarily cosmetic in nature and not medically necessary per EPSDT criteria.
402	An alternative service is more cost effective than the requested EPSDT service and is a benefit of the Medi-Cal dental program. Please re-evaluate.
403	The EPSDT service requested is not medically necessary.
403A	Procedure has been allowed under EPSDT criteria.
403B	Procedure code was allowed under EPSDT criteria. In addition, procedure code also qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook Section 4 - Treating Members.
403C	The requested procedure could be considered with EPSDT documentation; however, none was submitted.
404	Procedure is disallowed due to presumptive eligibility card not submitted.
405	Procedure disallowed due to date of service is not within eligibility date(s) on presumptive eligibility card.
437	CRA procedure code must be performed in a DTI domain 2 county.
437A	CRA procedure code must have the same dates of service and be billed on the same claim.
438A	CRA procedure code is allowable once every 6 months for low risk patients.
438B	Procedure D1354 is allowable once every 6 months when CRA includes high risk procedure D0603.
438C	CRA procedure code is allowable once every 4 months for moderate risk patients.
438D	CRA procedure code is allowable once every 3 months for high-risk patients.
438E	Additional services are allowable in conjunction with CRA procedure codes.
439	Data submitted after DTI claims submission due date.
440	Procedure Code D1354 is allowable two visits per year, and lifetime maximum of four times per tooth.
500	Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.
501	Per documentation, service does not qualify as an emergency. Paid amount is applied towards the beneficiary services dental cap. Payment for this service reflects the maximum allowable amount as beneficiary services dental cap may have been met.

ARC #	Adjudication Reason Code Description
502	Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.
503A	Optional Adult Dental procedure is not a benefit
503B	Optional Adult Dental procedure is not a benefit
505	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook: Section 4 - Treating Members.
505A	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook: Section 4 – Treating Members. Additional services are allowable in conjunction with CRA procedure codes.
506	Procedure Code qualifies for CalAIM Preventive Services Performance Payment. For more details on CalAIM and the list of procedures, please refer to Provider Handbook: Section 4 – Treating Members.
507	Procedure Code qualifies for CalAIM Continuity of Care Performance Payment. For more details on CalAIM and the list of procedures, please refer to Provider Handbook: Section 4 – Treating Members.
555A	Authorization of this line no longer valid. Patient is/was being treated elsewhere.
555B	Authorization of this line is no longer valid: Treatment was performed as an emergency.
555C	Authorization of this line is no longer valid: A new claim/TAR is being processed.
555D	The requested procedure has been authorized. However, the procedure has also recently been authorized to a different provider. Contact member to determine treating provider office.
777	A special exception has been made for this procedure based on the documentation submitted.
888	Line allowed but unpaid due to date of service
900	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code for Medicare Crossover.
901	Primary aid code has unmet Share of Cost, and secondary aid code requires an emergency certification statement that is insufficient/not submitted.
902	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code.
	CLINICAL SCREENING CODES
603	Per clinical examination, procedure requested is only allowable under special circumstances.

ARC #	Adjudication Reason Code Description
607A	Per clinical screening, payment for procedure disallowed. Poor quality of treatment.
607B	Per clinical screening, payment for procedure disallowed. Procedure not completed as billed.
613	Per clinical screening, tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
613A	Per clinical screening, it has been determined that this tooth has been recently restored with a restoration or prefabricated crown.
613B	Per clinical screening, tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
614A	Per clinical screening, please re-evaluate for: Complete upper denture
614B	Per clinical screening, please re-evaluate for: Complete lower denture
614C	Per clinical screening, please re-evaluate for: Resin base partial denture
614D	Per clinical screening, please re-evaluate for: Cast metal framework partial denture
614E	Per clinical examination, please re-evaluate for: Procedure 706.
614F	Per clinical examination, please re-evaluate for: Procedure 708.
619	Per clinical screening, caries not clinically verified.
622	Per clinical screening, tooth does not meet the Manual of Criteria for a prefabricated crown.
624	Per clinical screening, radiographs and/or photographs, additional surface(s) require treatment.
628	Per clinical screening, cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid.
629	Per clinical screening, existing prosthesis was lost/destroyed through carelessness or neglect.
643	Per clinical screening, resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
644	Per clinical screening, sufficient teeth are present for the balance of the opposing prosthesis.
645	Per clinical screening, TMJ Syndrome is not identified as per the program criteria.
646	Per clinical screening, cast framework partial denture is only a benefit when necessary to balance an opposing full denture.
647	Per clinical screening, bruxism is not associated with diagnosed TMJ dysfunction.
648	Per clinical screening, 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.

ARC #	Adjudication Reason Code Description
649	Per clinical screening, procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
649A	Per clinical screening, a resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
650	Per clinical screening, surgical extraction procedure has been modified to conform with radiograph appearance.
654	Per clinical screening, routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
662	Per clinical screening, existing prosthesis is adequate at this time.
662A	Per clinical screening, recently constructed prosthesis exhibits deficiencies inherent in all prostheses and cannot be significantly improved by a reline.
663	Per clinical screening, the surgical or traumatic loss of oral-facial anatomic structure is not significant enough to justify a new prosthesis.
664	Per clinical screening, existing prosthetic prosthesis can be made serviceable by laboratory reline.
665	Per clinical screening, existing prosthesis can be made serviceable by reconstruction.
666	Per clinical screening, the procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
666A	Per clinical screening, the patient's medical condition does not preclude the taking of radiographs.
667	Per clinical screening, functional limitations or health condition of the patient precludes the requested procedure.
667A	Per clinical screening, patient has expressed a lack of motivation necessary to care for his/her prosthesis.
668	Per clinical screening, the need for procedure is not medically necessary.
668A	Per clinical screening, patient does not wish extractions or any other dental services at this time.
668B	Per clinical screening, patient has selected/wishes to select a different provider.
669A	Per clinical screening, procedure is disallowed due to the following: This procedure is included in the fee for another procedure and is not payable separately.
669B	Per clinical screening, procedure is disallowed due to the following: This procedure is not allowable in conjunction with another procedure.
669C	Per clinical screening, procedure is disallowed due to the following: This procedure is associated with another denied procedure.
670	Per clinical screening, a reline, tissue conditioning, repair or an adjustment is not a benefit in conjunction with extractions or without an existing prosthesis.

ARC #	Adjudication Reason Code Description
671A	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Bone loss, mobility, periodontal pathology.
671B	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Apical radiolucency.
671C	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Arch lacks integrity.
671D	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Evidence or history of recurrent or rampant caries.
671E	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth/Teeth are in state of poor repair or have poor longevity prognosis.
671F	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Gross destruction of crown or root.
671G	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth has no potential for occlusal function and/or is hypererupted.
671H	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: The replacement of tooth structure lost by attrition or abrasion.
671I	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Deep caries appears to encroach upon pulp. Periapical radiograph is required.
672	Per clinical screening, tooth not present.
672B	Per clinical screening and/or radiographs, tooth number may be incorrect.
673A	Per clinical screening, the patient is not currently using the prosthesis provided by the program within the past five years.
674	Per clinical screening, incomplete treatment plan submitted.
674A	Per clinical screening, opposing dentition lacks integrity. Consider full denture for opposing arch.
674C	Per clinical screening, incomplete treatment plan submitted. Opposing prosthesis is inadequate.
676	Per clinical screening, insufficient tooth space present for procedure(s) requested.
677	Per clinical screening, prosthesis made in recent years have been unsatisfactory for reasons that are remediable.
680	Per clinical screening, services solely for esthetic purposes are not benefits.
681	Per clinical screening, periodontal procedure cannot be justified on the basis of pocket depths, bone loss and/or degree of deposits.
684	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered.

ARC #	Adjudication Reason Code Description
684A	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Restorative treatment incomplete.
684B	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Crown treatment incomplete.
684C	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment incomplete.
684D	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
684E	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Two or more of the above pertain to your case.
685	Per clinical screening, procedure does not show evidence of a reasonable period of longevity.
685A	Per clinical screening, procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
687	Per clinical screening, allowance made for alternate procedure.
692	Per clinical screening, documentation or radiographs, procedure already completed.
693	Per clinical screening, procedure requested is inadequate to correct problem.
693A	Per clinical screening, procedure requested is inadequate to correct problem. Tooth has open, underformed apices. Authorization for root canal will be considered after radiographic evidence of apex closure following apexification.
693B	Per clinical screening, procedure requested is inadequate to correct problem. Re-evaluate for apicoectomy.
693C	Per clinical screening, procedure requested is inadequate to correct problem. Root canal should be retreated by conventional endodontics before apical surgery is considered.
694	Authorization disallowed as the patient did not appear for a scheduled clinical screening.
694A	Authorization disallowed as the patient failed to bring most recent prosthesis to the clinical screening.
695	Authorization disallowed as the patient is no longer at the facility.
696	Per clinical screening, patient exhibits lack of motivation to maintain oral hygiene necessary to justify the requested services.
697	Need for root canal procedure not evident per clinical screening radiographic evidence or documentation submitted.

Claim In Process Reason Codes

The following codes indicate why a claim or TAR is in process in the automated Medi-Cal Dental processing system.

Code	Reason
DV	**DATA VALIDATION** – Document is awaiting review of keyed data against document information.
IR	**INFORMATION REQUIRED** – Document requires more data from the billing provider. An RTD has been sent to the billing provider.
RV	**RECIPIENT VERIFICATION** – Document is awaiting validation of recipient information.
PV	**PROVIDER VERIFICATION** – Document is awaiting validation of provider information.
PR	**PROFESSIONAL REVIEW** – Document is scheduled for professional review.
CS	**CLINICAL SCREENING** – Document is scheduled for a clinical screening review.
SR	**STATE REVIEW** – Document is scheduled for review by Department of Health Care Services.

Accounts Payable/Accounts Receivable Codes

These codes identify the reason for a receivable or payable item shown on an EOB.

Payable Codes

Code	Description
1	Replace Lost Check
2	Penalty Payment (Inactivated)
3	Interim Payment
4	S/URS Adjustment
5	Overpayment of Cash Receipt
9	Prior Underpayment

Receivable Codes

Code	Description
1	S/UR Adjustment
2	Negative Claim Adjustment
3	Interim Payment Adjustment

4 Penalty Adjustment (Inactivated)
5 Overpayment Adjustment
6 Internal Adjustment
9 S/UR Interest

Readjudication Codes

The following codes represent reasons why a claim is being processed for readjudication.

Claim Correction Codes

Code	Reason
01	Paid wrong provider number
02	Rendering provider license number missing
20	Corrected tooth number or arch code
21	Retroactive eligibility granted
22	Quantity of service provided or corrected
23	Corrected procedure code/fee
25	Corrected date of service
26	Corrected Medicare crossover amount
27	Share-of-Cost/Other coverage amount provided or corrected
29	Corrected place of service
30	New or additional documentation submitted
39	Denial upheld - See related adjudication/policy code
50	Fair hearing decision
51	Readjudication based on medical appeal
52	Readjudication based on mental appeal
53	Readjudication based on employment appeal
60	Readjudication based upon CDA peer review decision
61	Per post-payment screening, service below standard
62	Per post-payment screening or quality review, service not performed
63	Readjudication based upon professional re-evaluation
64	Readjudication of original underpayment based on Delta Quality Control (QC) review
65	Readjudication of original overpayment based on Delta Quality Control (QC) review
66	Original payment incorrect due to processing error - Erroneous Payment Correction (EPC) system
70	CRT input error
71	Provider claim preparation error
72	Claim not received within six months from last date of service

Code	Reason
73	Overpayment
74	CIF not submitted for reconsideration within 60 days of the EOB date
75	First level appeal not submitted within 90 days of the EOB date
90	Death transaction reversal
95	Original payment of claim adjusted per S/UR
96	Readjudication of orig payment based on Delta review
99	Special message

Resubmission Turnaround Document (RTD) Codes and Messages

The following codes represent missing or incorrect information originally submitted on TAR/Claim forms.

Member RTD Codes

Code	Reason
01	Submit x-rays with EDI label
02	Submit beneficiary's CIN/BIC ID
03	Verify birth date: month/day/year
04	EOMB or proof of denial/ineligibility
05	Verify recipient sex
06	Submit documentation with EDI label
07	Verify beneficiary's CIN/BIC ID
08	CIN belongs to someone else, send copy of BIC card
09	Verify patient name
10	Send photo ID by DMV/credible ID
11	Submit beneficiary facility name/address/phone#.

Provider RTD Codes

Code	Reason
13	Ortho - continuation signature reqd
16	Submit rendering provider number
18	Verify provider name and number
19	Verify billing agent name/number

X-Ray RTD Codes

Code	Reason
30	Submit current x-rays/photos for all restorative tx
31	Submit current x-rays/photos
32	Send x-ray showing apices of tooth

Code	Reason
33	Send PAs of all involved areas
34	Send x-rays of remaining teeth
35	Send final root canal x-rays
36	Procedure and description mismatch
37	Procedure tooth/surface mismatch
38	Submit opposing arch treatment plan
39	Submit x-rays of opposing arch
40	Submit BWs and periapical films
41	Submit x-rays/documentation
43	Send PA of present tooth condition

Clerical RTD Codes

Code	Reason
42	Submit completed HLD Index form
46	Indicate date of service
47	Indicate procedure code
48	Indicate tooth surface
49	Indicate upper/lower arch
50	Submit type of partial, i.e., procedure number
51	Procedure requires tooth code
52	Signature missing or invalid. Sign RTD.
54	Submit date of enrollment in HF
55	Indicate quadrant/area for treatment
56	Need other cov EOB/RA or denial
57	Submit other coverage fee schedule.
58	DOS cannot be after receipt date
59	Submit missing fees
60	POS code missing or invalid
61	Order date after NOA receipt date
62	Tooth number missing or invalid
63	Send copy of surgeon's claim/TAR
64	Submit your usual and customary fee
66	Submit 3 digit procedure code
67	Incomplete DC054 form was submitted
68	List teeth to be replaced & clasped
69	Submit all NOA pages/dates of service

Consultant RTD Codes

Code	Reason

70	Submit completed DC054 form
71	Procedure requires documentation
72	Must document lost/damaged dentures
73	Indicate quadrants for surgery
74	Note repair; send lab bill, if applicable
75	Submit Periodontal Evaluation Form
76	Submit copy of Operative Report
77	DOS needed for completed treatment
78	O.R. report required
79	Submit EOB from primary surgeon

Maxillofacial Program RTD Codes

Code	Reason
81	Submit history/diagnosis/symptom
82	Submit narrative report
83	Cleft lip/palate or facial anomaly?
84	Submit anesthesiologist report
85	Submit diagnostic study models
86	Submit pre-treatment panorex X-ray
87	Submit in-treatment panorex X-ray
88	Submit post-treatment panorex
89	Submit cephalometric X-ray
90	Submit intraoral photograph/slide
91	Send post-ortho diagnostic material
92	Submit TMJ X-ray
93	Submit copy of occlusal analysis
94	Send model/photo/film; note need
95	Submit documentation
96	Use MFO/cleft palate codes in SMA
97	Submit invoice for H.A. or appliance
98	Submit copy of CCS approval
99	Other (unspecified above)

TAR/Claim Policy Codes and Messages

These codes represent reasons that an entire document is being denied. The use of these codes causes all lines of the document to be denied.

Code	Reason
01	Duplicate claims/TARs from same/ different providers cannot be processed.
02	Payment disallowed – exceeds six-month billing limit.
03	NOA cannot be paid; TAR has expired.
04	Cannot process total claim; eligibility not established.
05	Payment disallowed – exceeds 12-month billing limit.
06	Cannot adjust claim received 13 mos or more after adjudication date.
07	Primary carrier paid more than this program allows.
08	POE label is invalid for dental program; contact county office.
09	Pt in Managed Care Program (MCP/PHP/GMC/HMO/DMC) which includes dental benefits.
10	TAR/Claim cannot be processed; no services were entered.
11	TAR/Clm/NOA cannot be processed without valid provider signature.
12	Unknown procedure codes, document unprocessable.
13	Recipient benefits do not include dental services.
15	Authorized services cannot be transferred between providers; claim denied.
16	Beneficiary not eligible for Medi-Cal; may have benefits through Healthy Families.
17	Procedure service data not submitted; please resubmit.
18	Recipient data not submitted; cannot process TAR/Claim.
19	Authd serv cannot be transferred between recipients; claim denied.
20	Second reeval or reevaluation of expired TAR not granted. Submit new TAR.
21	RTD was unsigned and cannot be used to correct claim errors.
22	Billing provider ID not on file; must be enrolled.
23	Out-of-state providers need prior authorization for non-emerg serv.
24	Out-of-country serv cov only for emerg hospit auth by field office.
25	Recipient eligibility not established for the dates of service.
26	Patient information on TAR/claim does not match State eligibility file.
27	Provider requested document be deleted.
28	Prov name does not match Delta file; no payment/authorization.
29	Recipient not on State eligibility file; payment denied.
30	Billing provider and recipient not on file, TAR/claim denied.
31	Recipient data insufficient to process claim or TAR after RTD.
32	Billing provider not enrolled for dates of svc, TAR/claim denied.
33	Mixture of 3-, 4- & 5-digit procedure codes not allowed.
34	X-rays appear to be of another person – payment disallowed.
35	Payment of inpatient services contingent on submission of an O.R. rpt.
36	Auth disallowed, patient did not appear for a clinical screening.

Code	Reason
37	Claims/TARs must be submitted in the English language.
38	Payment disallowed. Procedure(s) are non-benefit for RDHAP/RDHEF/RDH
39	CMSP Code not eligible under Denti-Cal prior 01/01/90. Send to County.
40	Procedures not a benefit for recipient aid code.
41	Pregnancy or emergency documentation is insufficient/not submitted for aid code.
42	Prior authorization not allowed for emergency services or pregnancy aid code.
43	Payment for claim disallowed per S/UR.
44	No EOB/RA, fee schedule, usual & customary fee, or proof of denial submitted.
45	CTP benefits terminate at age 19.
46	Provider not enrolled as certified Orthodontist.
47	Certified Orthodontist not associated to this service office.
48	Procedures allowable under special circumstances only
49	Payment cannot be made; our records indicate the patient is deceased.
50	Denied due to invalid response to RTD.
51	Document denied due to expired PM 160.
52	Share of cost unmet; not eligible.
53	Patient cancelled scheduled clinical evaluation. Please contact patient.
54	Service(s) granted by Fair Hearing process; please contact patient.
55	Pymt cannot be approved when new Issue Date/BIC ID are not provided or valid.
56	TARs not allowed for univ project; send new TAR with G prov billing number.
57	Authorization disallowed as the patient is no longer at the facility.
58	Emergency services documentation is insufficient. Bene cap applied.
59	Bene cap not applied. Documentation of services qualifies as an emergency.
60	Bill prov has discontinued practicing at this office location for these DOS.
61	Use of beneficiary's SSN is no longer acceptable.
69	Payment calculation based on date of service.
70	For CMSP dental services after 09/30/05 contact Doral Dental (1-800-341-8478).
71	Payment denied. Time limitation for submitting CMSP claims has expired.
72	Unable to screen due to pandemic, disturbance, or disaster.

Claim Inquiry Response (CIR) Status Codes and Messages/Claim Inquiry Form (CIF) Action Codes and Messages

The CIR form is a computer-generated response to a provider's CIF. In addition to provider and patient information, the response will appear as a status code and explanation to the CIF, as follows:

1A Provider indicated wrong DCN on CIF
1B Previous history needs to be updated
1C Provider indicated multiple DCNs on one CIF
1D Check problems needed CIF to correct
1E Delta Input Prep error
1F Other miscellaneous errors
5A Forwarded to on-site queue
5B Secondary review
5C Waiting for State directive
5D Incomplete application – letter sent
5E Request for additional information – 35-day letter sent
5F Denied applications
5G Returned call
6A Use of beneficiary's SSN is no longer acceptable
01 Claim never received; please submit new claim
02 Claim in process, awaiting final adjudication
03 RTD has been sent, please respond on original RTD
04 Claim under professional review
05 Claim processed EOB_____ DT_____ $_____
08 Insufficient documentation, procedure disallowed
09 Requires prior authorization
11 Claim not recvd within 6 mos. from last mo. of service
12 Claim has been readjudicated for payment
13 Submit original NOA for re-evaluation
14 TAR never received; please submit new TAR
15 TAR in process; awaiting adjudication
18 Notice of Authorization (NOA) has been processed
19 NOA expired submit new TAR
20 Procedure not a benefit of program
21 Procedure previously paid to same or other office
22 Procedure is adjunctive to another procedure
23 NOA has been readjudicated
24 Procedures not performed within 120-day time limitation
26 Lack of beneficiary eligibility, claim disallowed
27 Other coverage payment exceeds SMA
28 Denial upheld

29 Denial – recipient benefits do not include dental
30 Procedures not allowed based on professional review
31 Incomplete treatment plan submitted; denial upheld
32 Exceeded 6-month time limitation; denial upheld
33 Per documentation, claim in process
34 Per our records, X-rays returned at time of processing
35 Signature missing, adjustment/ correction cannot be made
36 Open – no description
37 Acknowledged electronic funds transfer complaint
38 Please complete Claim Inquiry Form for each claim
86 Payment adjusted per Surveillance and Utilization Review (S/UR).
93 Original claim overpayment adjusted due to Quality Control (QC) review.
94 Original claim underpayment adjusted due to Quality Control (QC) review.
95 Original payment incorrect - adjusted by Erroneous Payment Correction (EPC) system.

Prepaid Health Plans (PHP) and Codes

Medi-Cal dental members who are enrolled in prepaid health plans may be eligible for either comprehensive or non-comprehensive benefits. A member enrolled in a comprehensive prepaid health plan is entitled to both medical and dental benefits as defined by the plan. Services must be performed by a provider enrolled in the prepaid health plan. Emergency services only may be billed to the prepaid health plan. With a non-comprehensive plan, the member has medical benefits only and is eligible for dental benefits through Medi-Cal Dental.

Following is a list of current prepaid health plan codes:

Code	Plan Name
403	Care 1st Health Plan
405	Health Net of California, Inc.
406	Safe Guard Health Plan (Los Angeles)
409	Access Dental Plan (Los Angeles)
410	American Health Group (Los Angeles)
413	Western Dental Services (Los Angeles)
414	Western Dental (Riverside)
415	Western Dental (San Bernardino)
416	Liberty Dental Plan of Calif, Inc. (Los Angeles)
417	Community Dental Services, Inc. (Los Angeles)
421	Access Dental (Sacramento)
424	Western Dental (Sacramento)
425	Liberty Dental Plan of California, Inc. (Sacramento)

426 Community Dental Services (Sacramento)