

**March 2021**

Dear Medi-Cal Dental Provider:

Enclosed is the most recent update of the Medi-Cal Dental Provider Handbook (Handbook). The pages reflect changes made to the Medi-Cal Dental Program during the month of March 2021. These changes are indicated with a vertical line next to the text.

The following list indicates the pages that have been updated for this month's Handbook release. The latest version of the Handbook can be found on the Medi-Cal Dental website [Provider Handbook page](#).

<b>Handbook Updates</b>
<b>Section 7 – Codes</b>
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<b>Section 12 – Bulletin Index</b>
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Thank you for your continual support of the Medi-Cal Dental Program. If you have any questions, please call (800) 423-0507.

Sincerely,

MEDI-CAL DENTAL  
CALIFORNIA MEDI-CAL DENTAL PROGRAM



**March 2021**

Dear Doctor:

We are pleased to provide you with the Medi-Cal Dental Provider Handbook (Handbook).

The purpose of this Handbook is to give dental care professionals and their staff a concise explanation of billing instructions and procedures under the California Medi-Cal Dental Program. It is designed to assist you in your continued participation in Medi-Cal Dental.

We trust you will find the Handbook useful and that it will be maintained as a working document. Please do not hesitate to visit the [Medi-Cal Dental website](#) for further assistance.

Sincerely,

Alani Jackson, MPA  
Division Chief  
Medi-Cal Dental Services Division  
Department of Health Care Services

Diane Silva, Executive Director  
Government Programs  
California Medi-Cal Dental Program  
Delta Dental of California

# How to Use This Handbook

This Handbook is your primary reference for information about Medi-Cal Dental, as well as submission and processing of all necessary documents. The Handbook contains detailed instructions for completing Medi-Cal dental claims, Treatment Authorization Requests, Resubmission Turnaround Documents, Claim Inquiry Forms, and other billing forms for dental services and should be consulted before seeking other sources of information.

The Handbook is organized into 13 major sections:

- Section 1 - Introduction
- Section 2 - Program Overview
- Section 3 - Enrollment Requirements
- Section 4 - Treating Members
- Section 5 - Manual of Criteria and Schedule of Maximum Allowances
- Section 6 - Forms
- Section 7 - Codes
- Section 8 - Fraud, Abuse, and Quality of Care
- Section 9 - Special Programs
- Section 10 - CDT 19 Tables
- Section 11 - Glossary
- Section 12 - Bulletin Index
- Section 13 - Index

The Table of Contents provides an overview of all major sections and subsections in the Handbook.

Bulletin information released from December 2020 through March 2021 has been incorporated into the Handbook. Please refer to the Bulletin Index for the page where the information may be found.

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# Section 7 - Codes

## 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
<b>DIAGNOSTIC/PREVENTIVE</b>	
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	An evaluation is not a benefit within six months of a previous evaluation, to the same provider, for patients under age 21; or does not meet DTI Domain 2 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.
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.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>016</b>	Procedure 040 is payable only to dental providers recognized in any of the special areas of dental practice.
<b>017</b>	Procedure 040 requires copy of the specialist report and must accompany the payment request.
<b>018</b>	Procedure 040 is not a benefit when treatment is performed by the consulting specialist.
<b>019</b>	The procedure has been modified due to the age of the patient and/or previous history to allow the maximum benefit.
<b>020A</b>	Any combination of procedure 049, 050 (under 21), 061 and 062 are limited to once in a six-month period.
<b>020B</b>	Procedure 050 (age 21 and over) is limited to once in a twelve-month period.
<b>020C</b>	Prophy and fluoride procedures are allowable once in a six month period.
<b>020D</b>	Prophy and fluoride procedures are allowable once in a 12 month period.
<b>020E</b>	Procedure will not be considered within 90 days of a previous prophylaxis and/or fluoride procedure.
<b>020F</b>	Prophy and a topical fluoride treatment performed on the same date of service are not payable separately.
<b>020G</b>	Topical application of fluoride is payable only for caries control.
<b>020I</b>	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.
<b>021</b>	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.
<b>022</b>	Full mouth or panoramic X-rays are a benefit once in a three year period.
<b>023</b>	A benefit twice in a six-month period per provider.
<b>024</b>	A benefit once in a 12-month period per provider.
<b>024A</b>	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Cone cutting, creases, stains, distortion, poor density.
<b>024B</b>	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Apices, crowns, and/or surrounding bone not visible.
<b>024C</b>	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Interproximal spaces overlapping.
<b>024D</b>	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.
<b>024E</b>	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Complete arch not shown in films submitted.
<b>024F</b>	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Artifacts obscure teeth.
<b>025</b>	Procedure 125 is not a benefit as a substitute for the periapical radiographs in a complete series.
<b>026</b>	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.
<b>027</b>	Procedure is not a benefit for edentulous areas.
<b>028</b>	A benefit once in a six-month period per provider.
<b>028A</b>	Procedure D0272 or D0274 is not a benefit within six months of Procedure D0210, D0272, or D0274, same provider.
<b>028B</b>	Procedure D0210 is not a benefit within six months of Procedure D0272 or D0274, same provider.
<b>029</b>	Payment/Authorization denied due to multiple unmounted radiographs.
<b>029A</b>	Payment/Authorization denied due to undated radiographs or photographs.
<b>029B</b>	Payment/Authorization denied. Final endodontic radiograph is dated prior to the completion date of the endodontic treatment.

ARC #	Adjudication Reason Code Description
<b>029C</b>	Payment/Authorization denied due to multiple, unspecified dates on the X-ray mount/envelope. Payment/Authorization denied. Date(s) on X-ray mount, envelope or photograph(s) are not legible or
<b>029E</b>	Payment denied due to date of radiographs/photographs is after the date of service or appears to be post operative Payment/Authorization denied due to beneficiary name does not match or is not on the X-ray mount,
<b>029G</b>	Payment/Authorization disallowed due to radiographs/photographs dated in the future.
<b>030</b>	An adjustment has been made for the maximum allowable radiographs. An adjustment has been made for the maximum allowable X-rays. Bitewings are of the same side.
<b>030B</b>	Combination of radiographs is equal to a complete series. An adjustment has been made for the maximum allowable X-rays. Submitted number of X-rays differ
<b>030D</b>	Periapicals are limited to 20 in any consecutive 12-month period.
<b>031A</b>	Photographs are a benefit only when appropriate and necessary to document associated treatment. Photographs are a benefit only when appropriate and necessary to demonstrate a clinical condition
<b>031C</b>	Photographs are not payable when taken for patient identification, multiple views of the same area, treatment in progress and postoperative views.
<b>032A</b>	Endodontic treatment and postoperative radiographs are not a benefit. X-rays disallowed for the following reasons: Duplicate X-rays are not a benefit.
<b>032C</b>	X-rays disallowed for the following reasons: X-rays appear to be of another person. X-rays disallowed for the following reasons: X-rays not labeled right or left. Unable to evaluate
<b>033</b>	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.
<b>033A</b>	Procedure is payable only when a pathology report from a certified pathology laboratory accompanies the request for payment.
<b>034</b>	Emergency procedure cannot be prior authorized.
<b>036</b>	The dental sealant procedure code has been modified to correspond to the submitted tooth code.
<b>037</b>	Replacement/repair of a dental sealant is included in the fee to the original provider for 36 months.
<b>038</b>	Procedure is only a benefit when the tooth surfaces to be sealed are decay/restoration free
<b>039</b>	Dental sealants are only payable when the occlusal surface is included.
<b>039A</b>	Preventive resin restoration is only payable for the occlusal, buccal, and/or lingual surfaces.
<b>ORAL SURGERY</b>	
<b>043</b>	Resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
<b>043A</b>	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).
<b>044</b>	First extraction only, payable as procedure 200. Additional extraction(s) in the same treatment series are paid as procedure 201 per dental criteria manual.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>045</b>	Due to the absence of a surgical, laboratory, or appropriate report, payment will be made according to the maximum fee allowance.
<b>046</b>	Routine post-operative visits within 30 days are included in the global fee for the surgical procedure.
<b>046A</b>	Post-operative visits are not payable after 30 days following the surgical procedure.
<b>047</b>	Post operative care within 90 days by the same provider is not payable.
<b>047A</b>	Post operative care within 30 days by the same provider is not payable.
<b>047B</b>	Post operative care within 24 months by the same provider is not payable.
<b>048</b>	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.
<b>049</b>	Extractions are not payable for deciduous teeth near exfoliation.
<b>050</b>	Surgical extraction procedure has been modified to conform with radiographic appearance.
<b>051</b>	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.
<b>052</b>	The removal of residual root tips is not a benefit to the same provider who performed the initial extraction.
<b>053</b>	The removal of exposed root tips is not a benefit to the same provider who performed the initial extraction.
<b>054</b>	Routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
<b>054A</b>	Procedure is not a benefit within six months of extractions in the same quadrant.
<b>054B</b>	Alveoloplasty is not a benefit in conjunction with 2 or more surgical extractions in the same quadrant.
<b>055</b>	Diagnostic X-rays fully depicting subject tooth (teeth) are required for intraoral surgical procedures.
<b>056</b>	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.
<b>057</b>	Procedure is only payable to a certified oral pathologist and requires a pathology report.
<b>058</b>	Procedure is a benefit for anterior permanent teeth only.
<b>059</b>	Procedure allowed per Current Procedural Terminology (CPT) code description.
<b>060</b>	Procedure D9410 is payable only when associated with procedures that are a payable benefit.
<b>DRUGS</b>	
<b>063</b>	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.
<b>064</b>	A benefit only for oral, patch, intramuscular or subcutaneous routes of administration.
<b>065</b>	Procedure 300 is a benefit only for injectable therapeutic drugs, when properly documented.
<b>066</b>	The need for 301 must be justified and documented.
<b>067</b>	Procedure 301 requires prior authorization for beneficiaries 13 years of age or older and documentation of mental or physical handicap.
<b>068</b>	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.
<b>069</b>	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.
<b>070</b>	Anesthesia procedures are not payable when diagnostic procedures are the only services provided and the medical necessity is not justified.
<b>071</b>	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.



ARC #	Adjudication Reason Code Description
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.
071D	This procedure does not have a fee in the Schedule of Maximum Allowance and is not payable through a claim submission. Please see <a href="https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Dental_Case_Management_Program/">https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Dental_Case_Management_Program/</a> for further instructions.
<b>PERIODONTICS</b>	
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.
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.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>086</b>	Periodontal scaling and root planing must be performed within 24 months prior to authorization of a surgical periodontal procedure for the same quadrant.
<b>086A</b>	Perio Maintenance is a benefit only when Scaling and Root Planing has been performed within 24 months.
<b>086B</b>	Full Mouth Debridement is not payable when rendered within 24 months of a scaling and root planning.
<b>087</b>	Unscheduled dressing change is payable only when the periodontal procedure has been allowed by the program.
<b>087A</b>	Unscheduled dressing change is not payable to the same provider who performed the surgical periodontal procedure.
<b>087B</b>	Unscheduled dressing change is not payable after 30 days from the date of the surgical periodontal procedure.
<b>088A</b>	Procedure is a benefit once per quadrant every 36 months.
<b>ENDODONTICS</b>	
<b>090</b>	Procedure 503 is not a benefit when permanent restorations are placed before a reasonable length of time following Procedure 503.
<b>091</b>	Procedure(s) require diagnostic radiographs depicting entire subject tooth.
<b>091A</b>	Procedure(s) require diagnostic radiographs depicting entire subject tooth. Procedure requires diagnostic X-rays depicting furcation.
<b>092</b>	Payment request for root canal treatment and apicoectomy must be accompanied by a final treatment radiograph and include necessary post operative care within 90 days.
<b>093A</b>	Endodontic procedure is not payable when root canal filling underfilled.
<b>093B</b>	Endodontic procedure is not payable when root canal filling overfilled.
<b>093C</b>	Endodontic procedure is not payable when: Incomplete apical treatment due to inadequate retrograde fill and/or sealing of the apex.
<b>093D</b>	Endodontic procedure is not payable when: Root canal filling is undercondensed.
<b>093E</b>	Endodontic procedure is not payable when: Root canal has been filled with silver points. Silver points are not an acceptable filling material.
<b>093F</b>	Endodontic procedure is not payable when: Root canal therapy has resulted in the gross destruction of the root or crown.
<b>094</b>	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.
<b>095</b>	Procedure 530 submitted is not allowed. Procedure 511, 512 or 513 is authorized per X-ray appearance.
<b>096</b>	Procedure not a benefit in conjunction with a full denture or overdenture.
<b>097</b>	Need for root canal procedure not evident per radiograph appearance, or documentation submitted.
<b>098</b>	Procedures 530 and 531 include retrograde filling.
<b>099</b>	A benefit once per tooth in a six-month period per provider.
<b>100</b>	Procedure is not a benefit for an endodontically treated tooth.
<b>101</b>	This procedure requires a prerequisite procedure.
<b>101A</b>	Procedure D9999 documented for a live interaction associated with Teledentistry is only payable when procedure D0999 has been rendered.

ARC #	Adjudication Reason Code Description
<b>RESTORATIVE</b>	
<b>109</b>	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.
<b>110</b>	Procedures 603, 614, 641 and 646 are the maximum allowance for all restorations placed in a single tooth for each episode of treatment.
<b>111</b>	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.
<b>112</b>	Separate restorations of the same material on the same tooth will be considered as connected for payment purposes.
<b>113</b>	Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
<b>113A</b>	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a restoration or pre-fabricated crown.
<b>113B</b>	Per radiographs, the tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
<b>113C</b>	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.
<b>113E</b>	Prefabricated crowns are not a benefit as abutments for any removable prosthesis with cast clasps or rests. Please reevaluate for a laboratory processed crown.
<b>113F</b>	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.
<b>114</b>	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.
<b>115</b>	Amalgam or plastic build-ups are included in the allowance for the completed restorations.
<b>116</b>	Procedures 640/641 are only benefits when placed in anterior teeth or in the buccal (facial) of bicuspids.
<b>117</b>	Procedure not a benefit for a primary tooth near exfoliation.
<b>118</b>	Proximal restorations in anterior teeth are paid as single surface restorations.
<b>119</b>	Payment/Authorization cannot be made as caries not clinically verified by a Clinical Screening Consultant.
<b>120</b>	A panoramic film alone is considered non-diagnostic for authorization or payment of restorative, endodontic, periodontic, fixed and removable partial prosthodontic procedures.
<b>121</b>	Radiographs do not substantiate immediate need for restoration of surface(s) requested.
<b>121A</b>	Neither radiographs nor photographs substantiate immediate need for restoration of surface(s) requested.
<b>122</b>	Tooth does not meet the Manual of Criteria for a prefabricated crown.
<b>123</b>	Radiograph or photograph does not depict the entire crown or tooth to verify the requested surfaces or procedure.
<b>124</b>	Radiograph or photograph indicate additional surface(s) require treatment.
<b>124A</b>	Decay not evident on requested surface(s), but decay evident on other surface(s).
<b>125</b>	Replacement restorations are not a benefit within 12 months on primary teeth and within 24 months on permanent teeth.
<b>125A</b>	Replacement restorations are not a benefit within 12 months on primary teeth and within 36 months on permanent teeth.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>125B</b>	Replacement of otherwise satisfactory amalgam restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist).
<b>126</b>	Fillings, stainless steel crowns and/or therapeutic pulpotomies in deciduous lower incisors are not payable when the child is over five years of age.
<b>127</b>	Pin retention is not a benefit for a permanent tooth when a prefabricated or laboratory-processed crown is used to restore the tooth.
<b>128</b>	Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.
<b>129</b>	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.
<b>130</b>	Payment for a crown or fixed partial denture is made only upon final cementation regardless of documentation.
<b>131</b>	Procedure is a benefit only in cases of extensive coronal destruction.
<b>132</b>	Procedure 640/641 has been allowed but priced at zero due to the reduced SMA effective July 1, 1995.
<b>133</b>	Procedure not allowed due to denial of a root canal filled with silver points.
<b>134</b>	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.
<b>135</b>	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.
<b>136</b>	Procedure not a benefit for prefabricated crowns.
<b>PROSTHODONTICS</b>	
<b>138</b>	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.
<b>139</b>	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.
<b>140</b>	Payment adjustment reflects 20% of the SMA for delivery only of a previously undeliverable prosthesis.
<b>141</b>	Procedure 724 includes relines, additions to denture base to make appliance serviceable such as repairs, tooth replacement and/or resetting of teeth as necessary.
<b>142</b>	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.
<b>143</b>	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.
<b>144</b>	Procedure 720 is a benefit once per visit per day and when documented to describe the specific denture adjustment location.
<b>145</b>	Please submit a separate request for authorization of Procedure 722 when ready to reline denture.
<b>146</b>	A removable partial denture includes all necessary clasps, rests and teeth.
<b>147</b>	Cast framework partial denture is only a benefit when necessary to balance on opposing full denture.
<b>148</b>	Sufficient teeth are present for the balance of the opposing prosthesis.
<b>149</b>	Procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
<b>149A</b>	A resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
<b>150</b>	Procedure 722 disallowed; allowance for Procedure 721 is maximum benefit for reline of stayplate.
<b>151</b>	This procedure is not a benefit for a resin base partial denture.
<b>152</b>	Relines are a benefit 6 months following an immediate prosthesis (with extractions).

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
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.
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.
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.
<b>SPACE MAINTAINERS</b>	
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.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
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.
<b>ORTHODONTIC SERVICES</b>	
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.
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.
<b>MAXILLOFACIAL SERVICES</b>	
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.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
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.
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.
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.

ARC #	Adjudication Reason Code Description
<b>MISCELLANEOUS</b>	
<b>258</b>	Functional limitations or health condition of the patient preclude(s) requested procedure.
<b>259A</b>	Procedure not a benefit within 6 months to the same provider.
<b>259B</b>	Procedure not a benefit within 12 months to the same provider.
<b>259C</b>	Procedure not a benefit within 36 months to the same provider.
<b>259D</b>	Procedure not a benefit within 24 months to the same provider.
<b>259E</b>	Procedure not a benefit within 12 months of the initial placement or a previous recementation to the same provider.
<b>260</b>	The requested tooth, surface, arch, or quadrant is not a benefit for this procedure.
<b>261</b>	Procedure is not a benefit of this program.
<b>261A</b>	Procedure code is missing or is not a valid code.
<b>261B</b>	CDT codes are not valid for this date of service.
<b>261C</b>	The billed procedure cannot be processed. Request for payment contains both local and CDT codes. Submit this procedure code on a new claim.
<b>262</b>	Procedure requested is not a benefit for children.
<b>263</b>	Procedure requested is not a benefit for adults.
<b>264</b>	Procedure requested is not a benefit for primary teeth.
<b>265</b>	Procedure requested is not a benefit for permanent teeth.
<b>266A</b>	Payment and/or prior authorization disallowed. Radiographs or photographs are not current.
<b>266B</b>	Payment and/or prior authorization disallowed. Lack of radiographs.
<b>266C</b>	Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic for the requested procedure.
<b>266D</b>	Payment and/or prior authorization disallowed. Procedure requires current radiographs of the remaining teeth for evaluation of the arches.
<b>266E</b>	Payment and/or prior authorization disallowed. Lack of postoperative radiographs.
<b>266F</b>	Payment and/or prior authorization disallowed. Procedure requires current periapicals of the involved areas for the requested quadrant and arch films.
<b>266G</b>	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.
<b>266H</b>	Payment and/or prior authorization disallowed. Radiographs submitted to establish arch integrity are non-diagnostic.
<b>266I</b>	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to poor X-ray processing or duplication.
<b>266J</b>	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to elongation.
<b>266K</b>	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to foreshortening.
<b>266L</b>	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting.
<b>266M</b>	Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.
<b>266N</b>	Payment and/or prior authorization disallowed. Pre-operative radiographs are required.
<b>267</b>	Documentation not submitted.
<b>267A</b>	Description of service, procedure code and/or documentation are in conflict with each other.
<b>267B</b>	Documentation insufficient/not submitted. Services disallowed. Required periodontal chart incomplete/not submitted.



<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>267C</b>	Documentation insufficient/not submitted. Services disallowed. Documentation is illegible.
<b>267D</b>	Documentation insufficient/not submitted. Study models not submitted.
<b>267E</b>	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment appears to be altered. Services disallowed.
<b>267F</b>	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment not submitted. Services disallowed.
<b>267G</b>	Denied by Prior Authorization/Special Claims Review Unit. Information on patient's record of treatment is not consistent with claim/NOA.
<b>267H</b>	All required documentation, radiographs and photographs must be submitted with the claim inquiry form.
<b>267I</b>	Documentation submitted is incomplete.
<b>268</b>	Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.
<b>268A</b>	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.
<b>268B</b>	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit.
<b>268C</b>	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit. Please re-evaluate for a FRADS that may be a covered benefit.
<b>269A</b>	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.
<b>269B</b>	Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.
<b>269C</b>	Procedure denied for the following reason: Associated with another denied procedure.
<b>270</b>	Procedure has been modified based on the description of service, procedure code, tooth number or surface(s), or documentation.
<b>271A</b>	Procedure is disallowed due to the following: Bone loss, mobility, periodontal pathology.
<b>271B</b>	Procedure is disallowed due to the following: Apical radiolucency.
<b>271C</b>	Procedure is disallowed due to the following: Arch lacks integrity.
<b>271D</b>	Procedure is disallowed due to the following: Evidence or history of recurrent or rampant caries.
<b>271E</b>	Procedure is disallowed due to the following: Tooth/teeth have poor prognosis.
<b>271F</b>	Procedure is disallowed due to the following: Gross destruction of crown or root.
<b>271G</b>	Procedure is disallowed due to the following: Tooth has no potential for occlusal function and/or is hyper-erupted.
<b>271H</b>	Procedure is disallowed due to the following: The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit.
<b>271I</b>	Procedure is disallowed due to the following: Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.
<b>271J</b>	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.
<b>272</b>	Tooth not present on radiograph.
<b>272A</b>	Per radiograph, tooth is unerupted.
<b>272B</b>	Radiographs and/or documentation reveals that tooth number may be incorrect.
<b>273</b>	Procedure denied as beneficiary is returning to original provider.
<b>274</b>	Comprehensive (full mouth) treatment plan is required for consideration of services requested.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>274A</b>	Incomplete treatment plan submitted. Opposing dentition lacks integrity. Consider full denture for opposing arch.
<b>274B</b>	Authorized treatment plan has been altered; therefore, payment is disallowed.
<b>274C</b>	Incomplete treatment plan submitted. Opposing prosthesis is inadequate.
<b>274D</b>	Incomplete treatment plan submitted. All orthodontic procedures for active treatment must be listed on the same TAR.
<b>275</b>	This procedure has been modified/disallowed to reflect the maximum benefit under this program.
<b>276</b>	Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion are not benefits.
<b>277</b>	Orthodontics for handicapping malocclusion submitted through the CCS program for Medi-Cal beneficiaries are not payable by Denti-Cal.
<b>278</b>	Preventive control programs are included in the global fee.
<b>279</b>	Procedure(s) beyond scope of program. If you wish, submit alternate treatment plan.
<b>280</b>	Not payable when condition is asymptomatic.
<b>281</b>	Services solely for esthetic purposes are not benefits.
<b>282</b>	By-report procedure documentation missing or insufficient for payment calculations.
<b>283</b>	Payment amount determined from documentation submitted for this by-report procedure.
<b>284</b>	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered.
<b>284A</b>	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Restorative treatment incomplete.
<b>284B</b>	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Crown treatment incomplete.
<b>284C</b>	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment is necessary.
<b>284D</b>	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
<b>284E</b>	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.
<b>285</b>	Procedure does not show evidence of a reasonable period of longevity.
<b>285A</b>	Procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
<b>286</b>	Procedure previously rendered.
<b>287</b>	Allowance made for alternate procedure per documentation, radiographs, photographs and/or history.
<b>287A</b>	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.
<b>288</b>	Procedure cannot be considered an emergency.
<b>289</b>	Procedure requires prior authorization.
<b>290</b>	All services performed in a skilled nursing or intermediate care facility, except diagnostic and emergency services, require prior authorization.
<b>291</b>	Per date of service, procedure was completed prior to date of authorization.
<b>292</b>	Per documentation or radiographs, procedure requiring prior authorization has already been completed.
<b>293</b>	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan.

ARC #	Adjudication Reason Code Description
	Radiographs reveal open, underformed apices. Authorization for root canal therapy will be considered
293B	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Re-evaluate for apicoectomy.
	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
293D	Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area. 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.
	the scheduled screening appointment.
296	Patient exhibits lack of motivation to maintain oral hygiene necessary to justify requested services.
298	A fee for completion of forms is not a covered benefit.
299A	Extraction procedure has been rendered/authorized for the same tooth.
300A	Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office.
302	Procedure is not a benefit as coded. Use only one tooth number, one date of service and one procedure number per line.
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.
<b>PAYMENT POLICY</b>	
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.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>313B</b>	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No EOMB or proof of Medicare eligibility.
<b>313C</b>	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. Missing/invalid rendering provider ID.
<b>313D</b>	Study models submitted are non-diagnostic, untrimmed, or broken.
<b>313E</b>	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.
<b>314A</b>	Per radiographs or documentation, please re-evaluate for: Complete upper denture.
<b>314B</b>	Per radiographs or documentation, please re-evaluate for: Complete lower denture.
<b>314C</b>	Per radiographs or documentation, please re-evaluate for: Resin base partial denture.
<b>314D</b>	Per radiographs or documentation, please re-evaluate for: Cast metal framework partial denture.
<b>314E</b>	Per radiographs or documentation, please re-evaluate for: Procedure 706
<b>314F</b>	Per radiographs or documentation, please re-evaluate for: Procedure 708
<b>315</b>	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.
<b>316</b>	Payment disallowed. Request received over 12 months from end of month service was performed.
<b>317</b>	Request for re-evaluation is not granted. Resubmit undated services on a new Treatment Authorization Request (TAR).
<b>317A</b>	Orthodontic NOAs cannot be extended. Submit a new Treatment Authorization Request (TAR) to reauthorize the remaining orthodontic treatment.
<b>317B</b>	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).
<b>318</b>	Recipient eligibility not established for dates of services.
<b>318A</b>	Recipient eligibility not established for dates of services. Share of cost unmet.
<b>319</b>	Rendering or billing provider NPI/ID not on file.
<b>319A</b>	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.
<b>320</b>	Rendering or billing provider not enrolled for date of service.
<b>320A</b>	Rendering or billing provider is not enrolled as a certified orthodontist.
<b>320B</b>	The billing provider has discontinued practicing at this office location for these Dates of Service.
<b>320C</b>	Rendering provider must be CRA certified and opt-in.
<b>321</b>	Recipient benefits do not include dental services.
<b>322</b>	Out-of-state services require authorization or an emergency certification statement; payment cannot be made.
<b>323</b>	Authorization period for this procedure as indicated on the top portion of the Notice of Authorization form has expired.
<b>324</b>	Payment cannot be made as prior authorization made to another dentist. Authorization for services is not transferable.
<b>325</b>	Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.
<b>326</b>	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.
<b>326A</b>	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.
<b>327</b>	Payment cannot be made; our records indicate patient deceased.

ARC #	Adjudication Reason Code Description
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.
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).

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>349</b>	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.
<b>350</b>	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.
<b>351</b>	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.
<b>352</b>	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.
<b>352a</b>	The billed procedure is not payable because our records indicate a related procedure was provided on the same day.
<b>353</b>	The billed service on this tooth is disallowed because of an apparent discrepancy with a related procedure already provided.
<b>354</b>	The line item is a duplicate of a previous line item on the same claim.
<b>355A</b>	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.
<b>355B</b>	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.
<b>355C</b>	Procedure does not require prior authorization, however, it was reviewed as part of the total treatment plan.
<b>356</b>	EOMB for different recipient, procedure(s) denied.
<b>357</b>	Procedure deleted/disallowed per provider request.
<b>358</b>	Payment for procedure disallowed per claims review.
<b>359</b>	Payment for procedure disallowed per clinical post-payment review.
<b>360</b>	Sign Notice of Authorization for payment of dated lines.
<b>361</b>	CSL has not been paid; NOA never returned for payment.
<b>362</b>	Procedure cannot be paid without explanation of benefits, fee schedule or letter of denial.
<b>363</b>	Procedure on EOMB is not a benefit of the program.
<b>364</b>	Unable to reconcile EOMB procedure code(s). Please reconcile with Medicare prior to billing.
<b>365</b>	The maximum allowance for this service/procedure has been paid by Medicare.
<b>366</b>	Dental benefits cannot be paid without proof of payment/denial from Medicare.
<b>367</b>	Medicare payment/denial notice does not have recipient name and/or date of service.
<b>368</b>	CMSP Aid Code recipient not eligible under Denti-Cal prior to 01/01/90. Forward request for payment to County Medical Services Program.
<b>369</b>	Emergency certification statement is insufficient /not submitted for recipient aid code.
<b>369A</b>	Provider must sign the emergency certification statement.
<b>370</b>	Procedure not a benefit for recipient aid code.
<b>370A</b>	Per box "D" marked in dental assessment column of PM 160, recipient is not eligible for any dental services.
<b>371</b>	Procedure(s) cannot be prior authorized for recipient aid code.
<b>372</b>	Recipient is eligible for Delta commercial coverage. Payment is disallowed.
<b>373</b>	Procedure not payable. CTP benefits terminate at age 19.
<b>374</b>	Recipient is not a resident of a CTP/CMSP contract county. Contact recipient county health department for billing procedures.
<b>375</b>	Re-evaluation denied. Insufficient documentation and/or radiographs not submitted. Please sign for payment of dated services and submit a new TAR.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>376</b>	Payment reflects a rate adjustment to the current Schedule of Maximum Allowances and may include an adjustment to the billed amount.
<b>377</b>	This procedure is not a benefit for an RDHAP/RDHEF/RDH.
<b>377A</b>	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.
<b>378</b>	CTP recipient. Payment cannot be made for procedures with dates of service after the 120 day authorization period.
<b>379</b>	Procedure(s) cannot be approved when the new issue date and new BIC ID are not valid or provided in the appropriate fields.
<b>380</b>	Fee adjustment, since Other Coverage exists for this claim.
<b>381</b>	Fee adjustment, since Third Party Liability exists for this claim.
<b>382</b>	Fee adjustment, since share of cost exists for this claim.
<b>383</b>	Fee adjustment, since services billed were not provided.
<b>384</b>	Fee adjustment, due to findings of professional peer review.
<b>385</b>	Aid code 80 recipients are eligible only for Medicare-approved procedures.
<b>386</b>	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).
<b>386A</b>	Payment/authorization disallowed. CTP dental benefits are not payable for dates of service after March 31, 2009 or when received after May 31, 2009.
<b>387</b>	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).
<b>387A</b>	Payment Disallowed. The request for a re-evaluation of denied CTP dental service(s) was not received before December 31, 2009.
<b>389</b>	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.
<b>390</b>	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.
<b>391</b>	Final diagnostic casts are not payable within 6 months of initial diagnostic casts for CCS patients.
<b>392</b>	Beneficiary is not eligible for CCS/GHPP benefits.
<b>393</b>	TAR cannot be processed as part of the university project. Resubmit new TAR using your G billing provider number.
<b>394</b>	A credentialed specialist must submit documentation of cleft palate or the craniofacial anomaly.
<b>400</b>	EPSDT services are not a benefit for patients 21 years and older.
<b>401</b>	The EPSDT service requested is primarily cosmetic in nature and not medically necessary per EPSDT criteria.
<b>402</b>	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.
<b>403</b>	The EPSDT service requested is not medically necessary.
<b>403A</b>	Procedure has been allowed under EPSDT criteria.
<b>403B</b>	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 dates of service 07/01/2017-12/31/2021. For more details on Proposition 56 and the list of procedures, please refer to Provider Handbook Section 4-Treating Beneficiaries.
<b>404</b>	Procedure is disallowed due to presumptive eligibility card not submitted.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
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	Payment denied due to lack of DTI domain 2 Funding.
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.
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 dates of service 07/01/2017 - 12/31/2021. For more details on Proposition 56 and the list of procedures, please refer to Provider Handbook: Section 4-Treating Beneficiaries.* *Effective December 26, 2018.
505A	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA for dates of service 07/01/2017 - 12/31/2021. For more details on Proposition 56 and the list of procedures, please refer to Provider Handbook: Section 4-Treating Beneficiaries. Additional services are allowable in conjunction with CRA procedure codes.* *Effective December 26, 2018.
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.
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.
<b>CLINICAL SCREENING CODES</b>	
603	Per clinical examination, procedure requested is only allowable under special circumstances.
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.



<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>613B</b>	Per clinical screening, tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
<b>614A</b>	Per clinical screening, please re-evaluate for: Complete upper denture
<b>614B</b>	Per clinical screening, please re-evaluate for: Complete lower denture
<b>614C</b>	Per clinical screening, please re-evaluate for: Resin base partial denture
<b>614D</b>	Per clinical screening, please re-evaluate for: Cast metal framework partial denture
<b>614E</b>	Per clinical examination, please re-evaluate for: Procedure 706.
<b>614F</b>	Per clinical examination, please re-evaluate for: Procedure 708.
<b>619</b>	Per clinical screening, caries not clinically verified.
<b>622</b>	Per clinical screening, tooth does not meet the Manual of Criteria for a prefabricated crown.
<b>624</b>	Per clinical screening, radiographs and/or photographs, additional surface(s) require treatment.
<b>628</b>	Per clinical screening, cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid.
<b>629</b>	Per clinical screening, existing prosthesis was lost/destroyed through carelessness or neglect.
<b>643</b>	Per clinical screening, resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
<b>644</b>	Per clinical screening, sufficient teeth are present for the balance of the opposing prosthesis.
<b>645</b>	Per clinical screening, TMJ Syndrome is not identified as per the program criteria.
<b>646</b>	Per clinical screening, cast framework partial denture is only a benefit when necessary to balance an opposing full denture.
<b>647</b>	Per clinical screening, bruxism is not associated with diagnosed TMJ dysfunction.
<b>648</b>	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.
<b>649</b>	Per clinical screening, procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
<b>649A</b>	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.
<b>650</b>	Per clinical screening, surgical extraction procedure has been modified to conform with radiograph appearance.
<b>654</b>	Per clinical screening, routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
<b>662</b>	Per clinical screening, existing prosthesis is adequate at this time.
<b>662A</b>	Per clinical screening, recently constructed prosthesis exhibits deficiencies inherent in all prostheses and cannot be significantly improved by a reline.
<b>663</b>	Per clinical screening, the surgical or traumatic loss of oral-facial anatomic structure is not significant enough to justify a new prosthesis.
<b>664</b>	Per clinical screening, existing prosthetic prosthesis can be made serviceable by laboratory reline.
<b>665</b>	Per clinical screening, existing prosthesis can be made serviceable by reconstruction.
<b>666</b>	Per clinical screening, the procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
<b>666A</b>	Per clinical screening, the patient's medical condition does not preclude the taking of radiographs.
<b>667</b>	Per clinical screening, functional limitations or health condition of the patient precludes the requested procedure.
<b>667A</b>	Per clinical screening, patient has expressed a lack of motivation necessary to care for his/her prosthesis.

<b>ARC #</b>	<b>Adjudication Reason Code Description</b>
<b>668</b>	Per clinical screening, the need for procedure is not medically necessary.
<b>668A</b>	Per clinical screening, patient does not wish extractions or any other dental services at this time.
<b>668B</b>	Per clinical screening, patient has selected/wishes to select a different provider.
<b>669A</b>	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.
<b>669B</b>	Per clinical screening, procedure is disallowed due to the following: This procedure is not allowable in conjunction with another procedure.
<b>669C</b>	Per clinical screening, procedure is disallowed due to the following: This procedure is associated with another denied procedure.
<b>670</b>	Per clinical screening, a reline, tissue conditioning, repair or an adjustment is not a benefit in conjunction with extractions or without an existing prosthesis.
<b>671A</b>	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Bone loss, mobility, periodontal pathology.
<b>671B</b>	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Apical radiolucency.
<b>671C</b>	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Arch lacks integrity.
<b>671D</b>	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Evidence or history of recurrent or rampant caries.
<b>671E</b>	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.
<b>671F</b>	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Gross destruction of crown or root.
<b>671G</b>	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.
<b>671H</b>	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: The replacement of tooth structure lost by attrition or abrasion.
<b>671I</b>	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.
<b>672</b>	Per clinical screening, tooth not present.
<b>672B</b>	Per clinical screening and/or radiographs, tooth number may be incorrect.
<b>673A</b>	Per clinical screening, the patient is not currently using the prosthesis provided by the program within the past five years.
<b>674</b>	Per clinical screening, incomplete treatment plan submitted.
<b>674A</b>	Per clinical screening, opposing dentition lacks integrity. Consider full denture for opposing arch.
<b>674C</b>	Per clinical screening, incomplete treatment plan submitted. Opposing prosthesis is inadequate.
<b>676</b>	Per clinical screening, insufficient tooth space present for procedure(s) requested.
<b>677</b>	Per clinical screening, prosthesis made in recent years have been unsatisfactory for reasons that are remediable.
<b>680</b>	Per clinical screening, services solely for esthetic purposes are not benefits.
<b>681</b>	Per clinical screening, periodontal procedure cannot be justified on the basis of pocket depths, bone loss and/or degree of deposits.
<b>684</b>	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered.
<b>684A</b>	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Restorative treatment incomplete.

ARC #	Adjudication Reason Code Description
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.

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

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

#### Receivable Codes

<u>Code</u>	<u>Description</u>
<b>1</b>	S/UR Adjustment
<b>2</b>	Negative Claim Adjustment
<b>3</b>	Interim Payment Adjustment
<b>4</b>	Penalty Adjustment (Inactivated)
<b>5</b>	Overpayment Adjustment
<b>6</b>	Internal Adjustment
<b>9</b>	S/UR Interest

## Readjudication Codes

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

### Claim Correction Codes

<b>Code</b>	<b>Reason</b>
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
73	Overpayment

<b>Code</b>	<b>Reason</b>
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

<b>Code</b>	<b>Reason</b>
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

<b>Code</b>	<b>Reason</b>
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

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

<b>Code</b>	<b>Reason</b>
41	Submit x-rays/documentation
43	Send PA of present tooth condition

#### Clerical RTD Codes

<b>Code</b>	<b>Reason</b>
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

<b>Code</b>	<b>Reason</b>
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.

Code	Reason
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.

<b>Code</b>	<b>Reason</b>
35	Payment of inpatient services contingent on submission of an O.R. rpt.
36	Auth disallowed, patient did not appear for a clinical screening.
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.

<b>Code</b>	<b>Reason</b>
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:

- |  |  |
|--|--|
| <p><b>1A</b> Provider indicated wrong DCN on CIF</p> <p><b>1B</b> Previous history needs to be updated</p> <p><b>1C</b> Provider indicated multiple DCNs on one CIF</p> <p><b>1D</b> Check problems needed CIF to correct</p> <p><b>1E</b> Delta Input Prep error</p> <p><b>1F</b> Other miscellaneous errors</p> <p><b>5A</b> Forwarded to on-site queue</p> <p><b>5B</b> Secondary review</p> <p><b>5C</b> Waiting for State directive</p> <p><b>5D</b> Incomplete application – letter sent</p> <p><b>5E</b> Request for additional information – 35 day letter sent</p> <p><b>5F</b> Denied applications</p> <p><b>5G</b> Returned call</p> <p><b>6A</b> Use of beneficiary's SSN is no longer acceptable</p> <p><b>01</b> Claim never received; please submit new claim</p> <p><b>02</b> Claim in process; awaiting final adjudication</p> <p><b>03</b> RTD has been sent, please respond on original RTD</p> <p><b>04</b> Claim under professional review</p> <p><b>05</b> Claim processed EOB _____ DT _____ \$ _____</p> <p><b>08</b> Insufficient documentation; procedure disallowed</p> <p><b>09</b> Requires prior authorization</p> <p><b>11</b> Claim not recvd within 6 mos from last mo of service</p> <p><b>12</b> Claim has been readjudicated for payment</p> <p><b>13</b> Submit original NOA for re-evaluation</p> <p><b>14</b> TAR never received; please submit new TAR</p> <p><b>15</b> TAR in process; awaiting adjudication</p> <p><b>18</b> Notice of Authorization (NOA) has been processed</p> <p><b>19</b> NOA expired submit new TAR</p> <p><b>20</b> Procedure not a benefit of program</p> <p><b>21</b> Procedure previously paid to same or other office</p> | <p><b>22</b> Procedure is adjunctive to another procedure</p> <p><b>23</b> NOA has been readjudicated</p> <p><b>24</b> Procedures not performed within 120-day time limitation</p> <p><b>26</b> Lack of beneficiary eligibility, claim disallowed</p> <p><b>27</b> Other coverage payment exceeds SMA</p> <p><b>28</b> Denial upheld</p> <p><b>29</b> Denial – recipient benefits do not include dental</p> <p><b>30</b> Procedures not allowed based on professional review</p> <p><b>31</b> Incomplete treatment plan submitted; denial upheld</p> <p><b>32</b> Exceeded 6 month time limitation; denial upheld</p> <p><b>33</b> Per documentation; claim in process</p> <p><b>34</b> Per our records, X-rays returned at time of processing</p> <p><b>35</b> Signature missing, adjustment/ correction cannot be made</p> <p><b>36</b> Open – no description</p> <p><b>37</b> Acknowledged electronic funds transfer complaint</p> <p><b>38</b> Please complete Claim Inquiry Form for each claim</p> <p><b>86</b> Payment adjusted per Surveillance and Utilization Review (S/UR).</p> <p><b>93</b> Original claim overpayment adjusted due to Quality Control (QC) review.</p> <p><b>94</b> Original claim underpayment adjusted due to Quality Control (QC) review.</p> <p><b>95</b> Original payment incorrect - adjusted by Erroneous Payment Correction (EPC) system.</p> |
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## **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:

<b>Code</b>	<b>Plan Name</b>
<b>403</b>	Care 1st Health Plan
<b>405</b>	Health Net of California, Inc.
<b>406</b>	Safe Guard Health Plan (Los Angeles)
<b>409</b>	Access Dental Plan (Los Angeles)
<b>410</b>	American Health Group (Los Angeles)
<b>413</b>	Western Dental Services (Los Angeles)
<b>414</b>	Western Dental (Riverside)
<b>415</b>	Western Dental (San Bernardino)
<b>416</b>	Liberty Dental Plan of Calif, Inc. (Los Angeles)
<b>417</b>	Community Dental Services, Inc. (Los Angeles)
<b>421</b>	Access Dental (Sacramento)
<b>424</b>	Western Dental (Sacramento)
<b>425</b>	Liberty Dental Plan of California, Inc. (Sacramento)
<b>426</b>	Community Dental Services (Sacramento)

## Section 12 - Bulletin Index

The following pages index the bulletins released December 2020 through March 2021, including the volume and number of the bulletin. This index indicates on which page(s) of the Provider Handbook the bulletin information has been incorporated.

Consider retaining in this section any bulletins which will help you more effectively provide services to members while remaining in compliance with the regulations set forth by the California Medi-Cal Dental Program.

Previously released bulletins can be found on the Medi-Cal Dental website [Provider Bulletins page](#).

# Medi-Cal Dental Bulletin Index

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<a href="#">Vol. 37, #4</a>	New COVID-19 Related Policy Code	7-29