California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 24, NUMBER 5 **PO BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609** **FEBRUARY 2008**

Current Dental Terminology Version 4 (CDT-4) Implementation Update

CDT-4 Codes

Effective March 1, 2008, Denti-Cal will begin accepting Current Dental Terminology Version 4 (CDT-4) procedure codes. Prior to that date, CDT-4 codes will not be accepted by Denti-Cal. On or after March 1, 2008, only CDT-4 codes will be accepted. Any other versions of CDT will be denied.

Upcoming bulletins will provide additional information regarding CDT. This information will also be on the Denti-Cal Web site (www.denti-cal.ca.gov).

Denti-Cal Processing of Treatment Authorization Requests (TARs) Submitted Prior to March 1, 2008

The specific code set (either local or CDT-4) that Denti-Cal will utilize to process Treatment Authorization Requests (TARs) during the transition period surrounding March 1, 2008 will depend on the date of final processing. Some TARs received prior to March 1, 2008 will require additional information before final processing can occur. For example, Denti-Cal may send a Resubmission Turnaround Document (RTD) to request additional supporting documentation or radiographs, or it may be required that a patient attend a clinical screening appointment. When a TAR is initially reviewed prior to March 1, 2008 but final processing does not occur until after March 1, 2008, Denti-Cal will process the document utilizing CDT-4 codes and their new, associated criteria.

Medi-Cal Dental Program Provider Handbook (Handbook)

Denti-Cal is making available the Medi-Cal Dental Program Provider Handbook (Handbook)which will be a replacement of the current Denti-Cal Provider Manual. The Handbook will be available on the Denti-Cal Web site (www.denti-cal.ca.gov) in February 2008, and will be mailed to provider offices shortly thereafter.

New CDT-4 Adjudication Reason Codes

Attached to the end of this bulletin is a complete list of adjudication reason codes. Included in this document are new and updated codes that will not be applicable until March 1, 2008 with the implementation of the CDT-4 Codes.

CDT-4 Document Submission Requirements

Claims:

- Claims submitted with dates of service prior to March 1, 2008 must utilize Denti-Cal local codes. Do not submit CDT-4 codes for dates of service prior to March 1, 2008. They will be denied.
- Claims submitted with dates of service on or after March 1, 2008 must utilize CDT-4 codes.
- Do not submit claims with a mixture of local and CDT-4 codes. They should be submitted on separate claims, based on date of service and the appropriate code set in effect.

TARs:

- Effective March 1, 2008, TARs must be submitted with CDT-4 codes. Do not submit CDT-4 codes prior to March 1, 2008. They will be denied.
- Do not include dates of service on TARs. Dates of services should only be used on claims.
- TARs postmarked on or before February 29, 2008 will be accepted with local codes. For processing purposes only, these will be converted to CDT-4 codes. These documents will be subject to the new criteria and submission requirements for CDT-4 codes.

Notices of Authorization (NOAs):

- NOAs issued with local codes will be valid on or after the effective date of March 1, 2008 as long as the services are rendered during the authorization period.
- If there is a change in the authorized treatment plan or additional services are required, do not add these services to the NOA. They will be denied. Submit a new claim or TAR for any additional services.

CDT-4 Revised Forms

As a result of CDT-4, the Handicapping Labio-Lingual Deviation (HLD) Index Scoresheet (DC016) and Justification of Need for Prosthesis (DC 054) are changing. Effective March 1, 2008, the new CDT-4 compliant versions of the DC016 and DC 054 forms will be accepted. The updated DC016 and DC 054 forms may be ordered February 11, 2008.

Prior to March 1, 2008, the current versions of the DC016 and DC 054 must be submitted. The revised forms will not be accepted prior to March 1, 2008.

DC016:

- Submissions *before* the March 1, 2008 CDT-4 implementation date require the DC016 forms with the revision date of 8/98.
- Submissions *on or after* the March 1, 2008 CDT-4 implementation date require the DC016 forms with the revision date of 04/07.

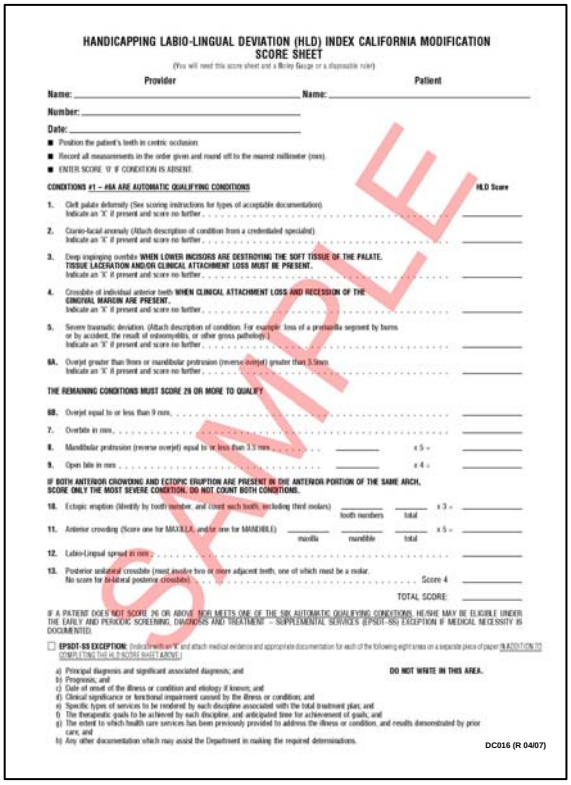
DC 054:

- Submissions *before* the March 1, 2008 CDT-4 implementation date require the DC 054 forms with the revision date of 11/00.
- Submissions *on or after* the March 1, 2008 CDT-4 implementation date require the DC 054 forms with the revision date of 10/05.

Additional form changes due to CDT-4 include the DC 563, DC 564A, and DC 564B. Please remember that the Periodontal Evaluation Form (DC 008) is no longer available but any standard periodontal charting form will be accepted if it includes the specific information required by periodontal procedure criteria (as stated in the Manual of Criteria).

Remember: CDT-4 codes will *not* be accepted before March 1, 2008!

The New DC016 Form



HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Provider Patient

Name: Name:

Number:

Date:

- Position the patient's teeth in centric occlusion
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF CONDITION IS ABSENT.

CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS — HLD Score

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation). Indicate an 'X' if present and score no further . . . .
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist). Indicate an 'X' if present and score no further . . . .
3. Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE, TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT. Indicate an 'X' if present and score no further . . . .
4. Crossbite of individual anterior teeth WHEN CLINICAL ATTACHMENT LOSS AND RECESSION OF THE GINGIVAL MARGIN ARE PRESENT. Indicate an 'X' if present and score no further . . . .
5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.) Indicate an 'X' if present and score no further . . . .
6A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm Indicate an 'X' if present and score no further . . . .

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

6B. Overjet equal to or less than 9 mm . . . .
7. Overbite in mm . . . .
8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm . . . . x 5 =
9. Open bite in mm . . . . x 4 =

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, including third molars) ____ (tooth numbers) ____ (total) x 3 =
11. Anterior crowding (Score one for MAXILLA and/or one for MANDIBLE) ____ (maxilla) ____ (mandible) ____ (total) x 5 =
12. Labio-Lingual spread in mm . . . .
13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bilateral posterior crossbite) . . . . Score 4

TOTAL SCORE:

IF A PATIENT DOES NOT SCORE 26 OR ABOVE NOR MEETS ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS, HE/SHE MAY BE ELIGIBLE UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SERVICES (EPSDT-SS) EXCEPTION IF MEDICAL NECESSITY IS DOCUMENTED.

☐ **EPSDT-SS EXCEPTION:** (Indicate with an 'X' and attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE.)

a) Principal diagnosis and significant associated diagnosis; and
b) Prognosis; and
c) Date of onset of the illness or condition and etiology if known; and
d) Clinical significance or functional impairment caused by the illness or condition; and
e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and
f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and
g) The extent to which health care services has been previously provided to address the illness or condition, and results demonstrated by prior care; and
h) Any other documentation which may assist the Department in making the required determinations.

DO NOT WRITE IN THIS AREA.

DC016 (R 04/07)

SAMPLE

The new DC 054 Form

JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures, Resin Base Partial Dentures, Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Both arches must be evaluated and addressed. Chart missing teeth and teeth to be extracted. Complete each section of the form. Attach this form to the submitted TAR.

PATIENT: DATE:

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE ITEM (TYPE OR PRINT CLEARLY)

MAXILLARY ARCH

Appliance Requested: ☐ PUD ☐ Cast Metal PUD ☐ Resin base PUD
Existing Appliance: ☐ PUD ☐ Cast Metal PUD ☐ Resin base PUD ☐ Never had a maxillary prosthetic appliance
Wears appliance? ☐ Yes ☐ No Age of Appliance:
Catastrophic Loss? ☐ Yes ☐ No **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.
If lost in facility or hospital, explain circumstances:

	Adequate	Inadequate	IF INADEQUATE, EXPLAIN:
Denture Base	☐	☐	
Framework	☐	☐	
Denture Teeth	☐	☐	
Retention	☐	☐	
Soft Tissue	☐	☐	
Hard Tissue	☐	☐	
Opposing Dentition	☐	☐	

Centric Occlusion ☐ ☐
Vertical Relation ☐ ☐ Open ___ mm. Closed ___ mm.

MANDIBULAR ARCH

Appliance Requested: ☐ PUD ☐ Cast Metal PUD ☐ Resin base PUD
Existing Appliance: ☐ PUD ☐ Cast Metal PUD ☐ Resin base PUD ☐ Never had a mandibular prosthetic appliance
Wears appliance? ☐ Yes ☐ No Age of Appliance:
Catastrophic Loss? ☐ Yes ☐ No **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report.
If lost in facility or hospital, explain circumstances:

	Adequate	Inadequate	IF INADEQUATE, EXPLAIN:
Denture Base	☐	☐	
Framework	☐	☐	
Denture Teeth	☐	☐	
Retention	☐	☐	
Soft Tissue	☐	☐	
Hard Tissue	☐	☐	
Opposing Dentition	☐	☐	

☐ Edentulous ☐ Maxillary ☐ Mandibular

1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

X Block out missing teeth ○ **Circle teeth to be extracted**

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH
Teeth Being Replaced:
Teeth Being Clasped:

MANDIBULAR ARCH
Teeth Being Replaced:
Teeth Being Clasped:

If treatment involves retaining teeth in the incident, indicate treatment plan for remaining teeth (Root canals, periodontal treatment, restorative, crowns, etc.):

Does the patient want requested services? ☐ No ☐ Yes

Does health condition of the patient limit dental adaptability? ☐ No ☐ Yes Explain:

ADDITIONAL COMMENTS:

CONVALESCENT CARE: Comments about patient's condition as stated by Charge Nurse / Social Services / Caregiver:

Provider Signature License #

DC 054 (R10/05)

SAMPLE

Denti-Cal CDT-4 Seminars

To prepare for implementation of CDT-4, Denti-Cal seminars have focused on CDT-4 training and will do so through the first quarter of 2008. As implementation of CDT-4 will change criteria, all providers should seriously consider these CDT-4 training seminars as must-attend events. Please refer to December 2007 Denti-Cal Bulletin Volume 23, Number 51 or to the Provider Seminars page on the Denti-Cal Web site (www.denti-cal.ca.gov) for a complete first quarter seminar schedule. Listings of seminars offered in the month of February are found below.

Denti-Cal Seminars Scheduled for February 2008

Basic Seminar/EDI/Delta Day/D149	San Diego	February 8, 2008
CDT Training/D150	Covina	February 14, 2008
CDT Training/D151	Santa Ana	February 15, 2008
CDT Training/D152	Novato	February 29, 2008

For questions on the above, or any other information, please contact the Denti-Cal Telephone Service Center at (800) 423-0507.

Denti-Cal Adjudication Reason Codes

Local: This code will be used only for 3-, 4-, and 5-digit Denti-Cal procedures, for dates of service prior to March 1, 2008.

CDT: This code will only be used with CDT procedures, for dates of service after March 1, 2008**.**

Both: This code will be used for both local and CDT procedures.

		Local	CDT	Both
DIAGNOSTIC/PREVENTIVE				
001	Procedure is a benefit once per patient, per provider.			X
001A	An orthodontic evaluation is a benefit only once per patient, per provider.			X
002	Procedure is a benefit once in a six-month period for patients under age 21.			X
002A	Evaluation is not a benefit within six months of a previous evaluation to the same provider for patients under age 21.			X
003	Procedure not payable in conjunction with other oral evaluation procedures for the same date of service.			X
004	Procedure D0120 is only a benefit when there is history of Procedure D0150 to the same provider.		X	
006	Procedure is a benefit once per tooth.		X	
008	Procedure was not adequately documented.	X		
009	Procedure not a benefit when specific services other than radiographs or photographs are provided on the same day by the same provider.			X
010	Procedure 020 not a benefit in conjunction with Procedure 030.	X		
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.	X		
011A	Procedure 030 is payable only when other specific services are rendered same date of service.	X		
012	Procedure 030, time of day, must be indicated for office visit.	X		
012A	Procedure 030, time of day, must be indicated for office visit. Time indicated is not a benefit under Procedure 030	X		
013	Procedure requires an operative report including the hospital time for payment.			X
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.			X
014	Procedure is not a benefit to an assistant surgeon.			X
015	The fee to an assistant surgeon is paid at 20 percent of the primary surgeon's allowable surgery fee.			X
016	Procedure 040 is payable only to dental providers recognized in any of the special areas of dental practice.	X		
017	Procedure 040 requires copy of the specialist report and must accompany the payment request.	X		
018	Procedure 040 is not a benefit when treatment is performed by the consulting specialist.	X		
019	The procedure has been modified due to the age of the patient and/or previous history to allow the maximum benefit.			X
020A	Any combination of procedure 049, 050 (under 21), 061 and 062 are limited to once in a six-month period.	X		
020B	Procedure 050 (age 21 and over) is limited to once in a twelve-month period.	X		

		Local	CDT	Both
020C	The following procedures: D1120, D1201 or D1203 are allowable once in a six month period.		X	
020D	The following procedures: D1110, D1204 or D1205 are allowable once in a 12 month period.		X	
020E	Procedure will not be considered within 90 days of a previous prophylaxis and/or fluoride procedure.		X	
020F	Prophy and a topical fluoride treatment performed on the same date of service are not payable separately.		X	
020G	Topical application of fluoride is payable only for caries control.		X	
021	Procedure 080 is a benefit once per visit and only when the emergency procedure is documented with arch/tooth code and includes the specific treatment provided.	X		
022	Full mouth or panographic X-rays are a benefit once in a three year period.	X		
023	A benefit twice in a six-month period per provider.		X	
024	A benefit once in a 12-month period per provider.		X	
024A	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Cone cutting, creases, stains, distortion, poor density.	X		
024B	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Apices, crowns, and/or surrounding bone not visible.	X		
024C	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Interproximal spaces overlapping.	X		
024D	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Bone structure distal to the last tooth not shown.	X		
024E	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Complete arch not shown in films submitted.	X		
024F	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Artifacts obscure teeth.	X		
025	Procedure 125 is not a benefit as a substitute for the periapical radiographs in a complete series.	X		
026	Panographic type films submitted as a diagnostic aid for periodontics, endodontics, operative dentistry or extractions in one quadrant only are paid as single periapical radiographs.	X		
027	Procedure is not a benefit for edentulous areas.			X
028	A benefit once in a six-month period per provider.			X
028A	Procedure D0272 or D0274 is not benefit within six months of Procedure D0210, same provider.		X	
028B	Procedure D0210 is not a benefit within six months of Procedure D0272 or D0274, same provider.		X	
029	Payment/Authorization denied due to multiple unmounted radiographs.			X
029A	Payment/Authorization denied due to undated radiographs or photographs.			X
029B	Payment/Authorization denied. Final endodontic radiograph is dated prior to the completion date of the endodontic treatment.			X
029C	Payment/Authorization denied due to multiple, unspecified dates on the X-ray mount/envelope.			X
029D	Payment/Authorization denied. Date(s) on X-ray mount, envelope or photograph(s) are not legible or the format is not understandable/decipherable.			X
029E	Payment denied due to date of radiographs/photographs is after the date of service.			X
029F	Payment/Authorization denied due to beneficiary name does not match or is not on the X-ray mount, envelope or photograph.			X
029G	Payment/Authorization disallowed due to radiographs/photographs dated in the future.			X

		Local	CDT	Both
029H	Payment/Authorization denied due to more than four paper copies of radiographs/photographs submitted.			X
030	An adjustment has been made for the maximum allowable radiographs.			X
030A	An adjustment has been made for the maximum allowable X-rays. Bitewings are of the same side.	X		
030B	Combination of radiographs is equal to a complete series.			X
030C	An adjustment has been made for the maximum allowable X-rays. Submitted number of X-rays differ from the number billed.	X		
030D	Periapicals are limited to 20 in any consecutive 12-month period.			X
031	Procedure is payable only when submitted.			X
031A	Photographs are a benefit only when appropriate and necessary to document associated treatment.		X	
031B	Photographs are a benefit only when appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs.		X	
032A	Endodontic treatment and postoperative radiographs are not a benefit.			X
032B	X-rays disallowed for the following reasons: Duplicate X-rays are not a benefit	X		
032C	X-rays disallowed for the following reasons: X-rays appear to be of another person.	X		
032D	X-rays disallowed for the following reasons: X-rays not labeled right or left. Unable to evaluate treatment.	X		
033	Procedure 150 not a benefit in conjunction with the extraction of a tooth, root, excision of any part or neoplasm in the same area or region on the same day.	X		
033A	Procedure is payable only when a pathology report from a certified pathology laboratory accompanies the request for payment.		X	
034	Emergency procedure cannot be prior authorized.			X
036	The dental sealant procedure code has been modified to correspond to the submitted tooth code.	X		
037	Replacement/repair of a dental sealant is included in the fee to the original provider for 36 months.	X		
038	Dental sealant procedures are benefits only when the tooth surfaces to be sealed are decay/restoration free.			X
039	Dental sealants are only payable when the occlusal surface is included.		X	

ORAL SURGERY				
043	Resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.			X
043A	This ortho case requires orthognathic surgery which is a benefit for patients 16 years or older. Submit a new authorization request following the completion of the surgical procedures(s).			X
044	First extraction only, payable as procedure 200. Additional extraction(s) in the same treatment series are paid as procedure 201 per dental criteria manual.	X		
045	Due to the absence of a surgical, laboratory, or appropriate report, payment will be made according to the maximum fee allowance.	X		
046	Routine post-operative visits within 30 days are included in the global fee for the surgical procedure.			X
046A	Post-operative visits are not payable after 30 days following the surgical procedure.		X	
047	Post operative care within 90 days by the same provider is not payable.			X

		Local	CDT	Both
047A	Post operative care within 30 days by the same provider is not payable.		X	
047B	Post operative care within 24 months by the same provider is not payable.		X	
048	Extraction of asymptomatic teeth is not a benefit.			X
049	Extractions are not payable for deciduous teeth near exfoliation.	X		
050	Surgical extraction procedure has been modified to conform with radiograph appearance and/or documentation.			X
051	Procedure 201 is a benefit for the uncomplicated removal of any tooth beyond the first extraction, regardless of the level of difficulty of the first extraction, in a treatment series.	X		
052	The removal of residual root tips is not a benefit to the same provider who performed the initial extraction.			X
053	The removal of exposed root tips is not a benefit to the same provider who performed the initial extraction.			X
054	Routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.			X
054A	Procedure is not a benefit within six months of extractions in the same quadrant.			X
054B	Alveoloplasty is not a benefit in conjunction with 2 or more surgical extractions in the same quadrant.		X	
055	Diagnostic X-rays fully depicting subject tooth (teeth) are required for intraoral surgical procedures.	X		
056	A tuberosity reduction is not a benefit in the same quadrant in which extractions and/or an alveoloplasty or alveoloplasty with ridge extension unless justified by documentation.	X		
057	Procedure is only payable to a certified oral pathologist and requires a pathology report.		X	
058	Procedure is a benefit for anterior permanent teeth only.			X
059	Procedure allowed per Current Procedural Terminology (CPT) code description.			X
060	Procedure D9410 is payable only when associated with procedures that are a payable benefit.		X	

DRUGS				
064	A benefit only for oral, patch, intramuscular or subcutaneous routes of administration.		X	
065	Procedure 300 is a benefit only for injectable therapeutic drugs, when properly documented.	X		
066	The need for 301 must be justified and documented.	X		
067	Procedure 301 requires prior authorization for beneficiaries 13 years of age or older and documentation of mental or physical handicap.	X		
068	Procedure 400 is not a benefit except when the use of local anesthetic is contraindicated or cannot be used as the primary agent. The need for general anesthesia must be documented and justified.	X		
069	Procedure is not a benefit when all associated procedures are denied.			X
070	Procedure 301, analgesia, and procedure 400, anesthesia, are not payable when diagnostic procedures are only services provided.	X		
071	Procedure 400 is not a benefit when the surgical procedures are performed in a hospital or surgicenter.	X		

		Local	CDT	Both
PERIODONTICS				
072	Periodontal procedure requires documentation specifying the definitive periodontal diagnosis.		X	
073	Periodontal chart not current.		X	
073A	Periodontal chart not current. Older than 14 months.	X		
073B	Periodontal chart not current. Periodontal treatment performed after charting date.			X
073C	Periodontal chart not current. Charting date missing or illegible.			X
073D	Periodontal chart not current. Charting date invalid or dated in the future.		X	
073E	Periodontal chart not current. Older than 12 months		X	
074A	Periodontal procedure disallowed due to inadequate charting of: Pocket depths.			X
074B	Periodontal procedure disallowed due to inadequate charting of: Mobility.			X
074C	Periodontal procedure disallowed due to inadequate charting of: Teeth to be extracted.			X
074D	Periodontal procedure disallowed due to inadequate charting of: Two or more of the above.			X
075	Procedure 451 must be documented as to the emergency condition and the definitive treatment provided.	X		
076	A benefit twice in a 12-month period per provider.			X
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.	X		
077A	Periodontal procedures are not benefits for patients under 13 years of age except when unusual circumstances exist and the medical necessity is documented.		X	
078	Procedure 452 is a full mouth treatment not authorized by arch or quadrant.	X		
079	Multiples of Procedure 452 must be performed on different days.	X		
080	A prophy or prophy and fluoride procedure is not payable on the same date of service as a surgical periodontal procedure.			X
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 and/or charting.			X
081A	Periodontal evaluation chart does not coincide with submitted radiographic evidence.			X
082	Procedure 453 is considered part of completed prosthodontics and/or multiple restorations involving occlusal surfaces.	X		
083	Procedures 472 and 473 may be a benefit following procedure 452 and when the 6-9 month postoperative charting justifies need.	X		
083A	Surgical periodontal procedure cannot be authorized within 30 days following periodontal scaling and root planing for the same quadrant.		X	
084	Procedure 452, 472, 473, and 474 are not payable as emergency procedures.	X		
085	Procedure 452 requires a minimum of a 3-month healing period prior to evaluation for another 452.	X		
085A	Periodontal post-operative care is not a benefit when requested within 3 months by the same provider.		X	
086	Periodontal scaling and root planing must be performed within 24 months prior to authorization of a surgical periodontal procedure for the same quadrant.		X	
087	Unscheduled dressing change is payable only when the periodontal procedure has been allowed by the program.		X	

		Local	CDT	Both
087A	Unscheduled dressing change is not payable to the same provider who performed the surgical periodontal procedure.		X	
087B	Unscheduled dressing change is not payable after 30 days from the date of the surgical periodontal procedure.		X	
088	Procedure is a benefit once per quadrant every 24 months.		X	
088A	Procedure is a benefit once per quadrant every 36 months.		X	
089	Procedure is not a benefit for periodontal grafting.		X	

ENDODONTICS				
090	Procedure 503 is not a benefit when permanent restorations are placed before a reasonable length of time following Procedure 503.	X		
091	Procedure(s) require diagnostic radiographs depicting entire subject tooth.	X		
091A	Procedure(s) require diagnostic radiographs depicting entire subject tooth. Procedure requires diagnostic X-rays depicting furcation.	X		
092	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.	X		
093A	Endodontic procedure is not payable when root canal filling underfilled.			X
093B	Endodontic procedure is not payable when root canal filling overfilled.			X
093C	Endodontic procedure is not payable when: Incomplete apical treatment due to inadequate retrograde fill and/or sealing of the apex.			X
093D	Endodontic procedure is not payable when: Root canal filling is undercondensed.			X
093E	Endodontic procedure is not payable when: Root canal has been filled with silver points. Silver points are not an acceptable filling material.			X
093F	Endodontic procedure is not payable when: Root canal therapy has resulted in the gross destruction of the root or crown.			X
094	Crowns on endodontically treated teeth may be considered for authorization following the satisfactory completion of root canal therapy. Submit a new request for authorization on a separate TAR with the final endodontic radiograph.			X
095	Procedure 530 submitted is not allowed. Procedure 511, 512 or 513 is authorized per X-ray appearance.	X		
096	Procedure not a benefit in conjunction with a full denture or overdenture.			X
097	Need for root canal procedure not evident per radiograph appearance, or documentation submitted.	X		
098	Procedures 530 and 531 include retrograde filling.	X		
099	A benefit once per tooth in a six-month period per provider.			X
100	Procedure is not a benefit for an endodontically treated tooth.			X
101	This procedure requires a prerequisite procedure.		X	

RESTORATIVE				
109	Procedures D2161, D2335, D2390 and D2394 are the maximum allowances for all restorations of the same material placed in a single tooth for the same date of service.		X	
110	Procedures 603, 614, 641 and 646 are the maximum allowance for all restorations placed in a single tooth for each episode of treatment.	X		
111	Payment is made for an individual surface once for the same date of service regardless of the number or combinations of restorations or materials placed on that surface.			X
112	Separate restorations of the same material on the same tooth will be considered as connected for payment purposes.			X

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

		Local	CDT	Both
128	Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.			X
129	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.			X
130	Payment for a crown or fixed partial denture is made only upon final cementation regardless of documentation.			X
131	Procedure is a benefit only in cases of extensive coronal destruction.			X
132	Procedure 640/641 has been allowed but priced at zero due to the reduced SMA effective July 1, 1995.	X		
133	Procedure not allowed due to denial of a root canal filled with silver points.			X
134	This change reflects the maximum benefit for a filling, (Procedure 600-614) placed on a posterior tooth regardless of the material placed; i.e. amalgam, composite resin, glass ionomer cement, or resin ionomer cement.	X		
135	Procedure not a benefit for third molars unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.		X	
136	Procedure not a benefit for prefabricated crowns.		X	

PROSTHODONTICS				
138	Partial payment for an undeliverable prosthesis requires the reason for non-delivery to be adequately documented and a laboratory invoice indicating the prosthesis was processed.		X	
139	Payment adjustment reflects 80% of the SMA for an undeliverable prosthesis. The prosthesis must be kept in a deliverable condition for at least one year.			X
140	Payment adjustment reflects 20% of the SMA for delivery only of a previously undeliverable prosthesis.			X
141	Procedure 724 includes relines, additions to denture base to make appliance serviceable such as repairs, tooth replacement and/or resetting of teeth as necessary.	X		
142	A prosthesis has been paid within the last 12 months. Please refer the patient to the original provider and/or Beneficiary Services at 1 (800) 322-6384.			X
143	Authorization not granted for a replacement prosthesis within a five-year period. Insufficient documentation substantiating need for prosthesis to prevent a significant disability or prosthesis loss/destruction beyond patient's control.	X		
144	Procedure 720 is a benefit once per visit per day and when documented to describe the specific denture adjustment location.	X		
145	Please submit a separate request for authorization of Procedure 722 when ready to reline denture.	X		
146	A removable partial denture includes all necessary clasps, rests and teeth.			X
147	Cast framework partial denture is only a benefit when necessary to balance on opposing full denture.			X
148	Sufficient teeth are present for the balance of the opposing prosthesis.			X
149	Procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).	X		
149A	A resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.		X	
150	Procedure 722 disallowed; allowance for Procedure 721 is maximum benefit for reline of stayplate.	X		
151	This procedure is not a benefit for a resin base partial denture.			X

		Local	CDT	Both
152	Relines are a benefit 6 months following an immediate prosthesis (with extractions).			X
153	Relines are a benefit 12 months following a non-immediate prosthesis (without extractions).			X
154	Tissue conditioning is not a benefit when dated the same date of service as a non-immediate prosthetic appliance or reline.			X
155	Procedure requires a properly completed prosthetic DC054 form.		X	
156	Evaluation of a removable prosthesis on a maintenance basis is not a benefit.		X	
157	A laboratory invoice is required for payment.		X	
160	Laboratory or chairside relines are a benefit once in a 12 month period per arch.			X
161	Procedure 722 is a benefit once in a 12-month period per arch.	X		
161A	Procedure 724 is not a benefit within 12 months of procedure 722, same arch.	X		
161B	Procedure 722 is not a benefit within 12 months of procedure 724, same arch.	X		
162	Patient's existing prosthesis is adequate at this time.			X
163	Patient returning to original provider for correction and/or modifications of requested procedure(s).			X
164	Prosthesis servicable by laboratory reline.	X		
165	Existing prosthesis can be made serviceable by denture duplication ("jump", "reconstruction").	X		
166	The procedure has been modified to reflect the allowable benefit and may be provided at your discretion.			X
168A	Patient does not wish extractions or any other dental services at this time.			X
168B	Patient has selected different provider for treatment.			X
169	Procedure 723 is limited to two per appliance in a full 12 month period.	X		
169A	Procedure is limited to two per prosthesis in a 36-month period.		X	
170	A reline, tissue conditioning, repair, or an adjustment is not a benefit without an existing prosthesis.			X
171	The repair or adjustment of a removable prosthesis is a benefit twice in a 12-month period, per provider.			X
172	Payment for a prosthesis is made upon insertion of that prosthesis.			X
173	Prosthetic appliances (full dentures, partial dentures, reconstructions, and stayplates) are a benefit once in any five year period.	X		
174	Procedure 724 is a benefit only when the existing denture is at least two years old.	X		
175	The fee allowed for any removable prosthetic appliance, reline, reconstruction or repair includes all adjustments and post-operative exams necessary for 12 months.	X		
175A	The fee allowed for any removable prosthesis, reline, tissue conditioning, or repair includes all adjustments and post-operative exams necessary for 6 months.		X	
176	Per radiographs, insufficient tooth space present for the requested procedure.			X
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.			X
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.			X

		Local	CDT	Both
179	Procedure requires prior authorization and cannot be considered as an emergency condition.			X
180	Patient cancelled his/her scheduled clinical screening. Please contact patient for further information.			X

SPACE MAINTAINERS				
190	Radiographs do not depict the erupting permanent tooth/teeth.			X
191	Radiograph depicts insufficient space for eruption of the permanent tooth/teeth.			X
192	Procedure not a benefit when the permanent tooth/teeth are near eruption or congenitally missing.			X
193	Replacement of previously provided space maintainer is a benefit only when justified by documentation.	X		
194	Tongue thrusting and thumb sucking appliances are not benefits for children with erupted permanent incisors.	X		
195	A space maintainer is not a benefit for the upper or lower anterior region.			X
196	Procedure not a benefit for orthodontic services, including tooth guidance appliances.			X
197	Procedure is not a benefit when only one tooth is involved or qualifies.			X

ORTHODONTIC SERVICES				
198	Procedure is not a benefit when the active phase of treatment (monthly visits) has not been completed.			X
199	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.			X
200	Adjustments of banding and/or appliances are allowable once per calendar month.			X
201	Procedure 599 - Retainer replacements are allowed only on a one-time basis.	X		
201A	Replacement retainer is a benefit only within 24 months of procedure D8680.		X	
202	Procedure is a benefit only once per patient.			X
203	Procedure 560 is a benefit once for each dentition phase for cleft palate orthodontic services.	X		
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.	X		
205	Procedures 556 and 592 are allowable once in three months.	X		
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.		X	
206	Anterior crossbite not causing clinical attachment loss and recession of the gingival margin.			X
207	Deep overbite not destroying the soft tissue of the palate.			X
208	Both anterior crowding and anterior ectopic eruption counted in HLD index.	X		
209	Posterior bilateral crossbite has no point value on HLD index.	X		

MAXILLOFACIAL SERVICES				
210	TMJ X-rays - Procedure 955 is limited to twice in 12 months.	X		
211	Procedures 950 and 952 allowed once per dentist per 12 month period.	X		

		Local	CDT	Both
212	In the management of temporomandibular joint dysfunction, symptomatic care over a period of three months must be provided prior to major definitive care.	X		
213	Procedure 952 is intended for cleft palate and maxillofacial prosthodontic cases.	X		
214	Procedure must be submitted and requires six views of condyles – open, closed, and rest on the right and left side.			X
215	Overjet is not greater than 9mm or the reverse overjet is not greater than 3.5mm.			X
216	Documentation submitted does not qualify for severe traumatic deviation, cleft palate or facial growth management.			X
217	Procedures 962, 964, 966 and 968 require complete history with documentation for individual case requirements. Documentation and case presentation is not complete.	X		
218	Procedures 962, 964, 966 and 968 include all follow-up and adjustments for 90 days.	X		
220	Procedures 970 and 971 include all follow-up and adjustments for 90 days.	X		
221	Procedure is a benefit only when orthodontic treatment has been allowed by the program.		X	
222	Inadequate description or documentation of appliance to justify requested prosthesis.			X
223	Procedure is a benefit only when the orthodontic treatment is authorized.			X
224	Photograph of appliance required upon payment request.	X		
225	Procedure 977 requires complete case work-up with accompanying photographs. Documentation inadequate.	X		
226	Procedure D8692 is a benefit only when procedure D8690 has been paid by the program.		X	
227	Splints and stents are part of the global fee for surgical procedure unless they are extremely complex. Supporting documentation missing.	X		
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.			X
229	Procedure 979 (radiation therapy fluoride carriers) is a benefit only when radiation therapy is documented.	X		
230	Procedure is not a benefit for acupuncture, acupressure, biofeedback, or hypnosis.		X	
233	Procedure 985 requires prior authorization.	X		
234	Allowance for grafting procedures includes harvesting at donor site.	X		
235	Degree of functional deficiency does not justify requested procedure.			X
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.	X		
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.	X		
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.	X		
241	Allowance for splints and/or stents includes all necessary adjustments.			X
242	Procedure 996 Request for payment requires submission of adequate narrative documentation.	X		
243	Procedure is a benefit six times in a three-month period.			X

		Local	CDT	Both
245	Authorization disallowed as diagnostic information insufficient to identify TMJ syndrome.	X		
246	Except in documented emergencies, all unlisted therapeutic services (Procedure 998) require prior authorization with sufficient diagnostic and supportive material to justify request.	X		
247	Osteotomies on patients under age 16 are not a benefit unless mitigating circumstances exist and are fully documented.			X
248	Procedure is not a benefit for the treatment of bruxism in the absence of TMJ dysfunction.			X
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.			X
250	Procedure 995 is a benefit once in 24 months.	X		
251	Documentation for Procedure 992 or 994 is inadequate.	X		
253	Combination of Procedures 970, 971 and Procedure 978 are limited to once in six months without sufficient documentation.	X		
254	Procedure disallowed due to absence of one of the following: "CCS approved" stamp, signature, and/or date.	X		
255	Procedure disallowed due to dentition phase not indicated.	X		
256	The orthodontic procedure requested has already received CCS authorization. Submit a claim to CCS when the procedure has been rendered.	X		
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.	X		

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

		Local	CDT	Both
266E	Payment and/or prior authorization disallowed. Lack of postoperative radiographs.			X
266F	Payment and/or prior authorization disallowed. Procedure requires current periapicals of the involved areas for the requested quadrant and arch films.			X
266G	Payment and/or prior authorization disallowed. Unable to evaluate treatment. Photographs, digitized images, paper copies, or duplicate radiographs are not labeled adequately to determine right or left, or individual tooth numbers.			X
266H	Payment and/or prior authorization disallowed. Radiographs submitted to establish arch integrity are non-diagnostic.			X
266I	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to poor X-ray processing or duplication.			X
266J	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to elongation.			X
266K	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to foreshortening.			X
266L	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting.			X
266M	Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.			X
266N	Payment and/or prior authorization disallowed. Pre-operative radiographs are required.			X
267	Documentation not submitted.			X
267A	Description of service, procedure code and/or documentation are in conflict with each other.			X
267B	Documentation insufficient/not submitted. Services disallowed. Required periodontal chart incomplete/not submitted.	X		
267C	Documentation insufficient/not submitted. Services disallowed. Documentation is illegible.			X
267D	Documentation insufficient/not submitted. Study models not submitted.	X		
267E	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment appears to be altered. Services disallowed.			X
267F	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment not submitted. Services disallowed.			X
267G	Denied by Prior Authorization/Special Claims Review Unit. Information on patient's record of treatment is not consistent with claim/NOA.			X
267H	All required documentation, radiographs and photographs must be submitted with the claim inquiry form.			X
267I	Documentation submitted is incomplete.			X
268	Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.			X
268A	Per radiographs, photographs, or study models, the need for the procedure is not medically necessary. The Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the criteria to qualify for orthodontic treatment.			X
269A	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.			X
269B	Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.			X
269C	Procedure denied for the following reason: Associated with another denied procedure.			X
270	Procedure has been modified based on the description of service, procedure code, tooth number or surface(s), or documentation.			X

		Local	CDT	Both
271A	Procedure is disallowed due to the following: Bone loss, mobility, periodontal pathology.			X
271B	Procedure is disallowed due to the following: Apical radiolucency.			X
271C	Procedure is disallowed due to the following: Arch lacks integrity.			X
271D	Procedure is disallowed due to the following: Evidence or history of recurrent or rampant caries.	X		
271E	Procedure is disallowed due to the following: Tooth/teeth have poor prognosis.			X
271F	Procedure is disallowed due to the following: Gross destruction of crown or root.			X
271G	Procedure is disallowed due to the following: Tooth has no potential for occlusal function and/or is hyper-erupted.			X
271H	Procedure is disallowed due to the following: The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit.			X
271I	Procedure is disallowed due to the following: Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.			X
271J	Procedure is disallowed due to the following: Primary tooth has deep caries that appears to encroach the pulp. Radiograph inadequate to evaluate periapical or furcation area.			X
272	Tooth not present on radiograph.			X
272A	Per radiograph, tooth is unerupted.			X
272B	Radiographs and/or documentation reveals that tooth number may be incorrect.			X
273	Procedure denied as beneficiary is returning to original provider.			X
274	Comprehensive (full mouth) treatment plan is required for consideration of services requested.			X
274A	Incomplete treatment plan submitted. Opposing dentition lacks integrity. Consider full denture for opposing arch.			X
274B	Authorized treatment plan has been altered; therefore, payment is disallowed.			X
274C	Incomplete treatment plan submitted. Opposing prosthesis is inadequate.		X	
274D	Incomplete treatment plan submitted. All orthodontic procedures for active treatment must be listed on the same TAR.		X	
275	This procedure has been modified/disallowed to reflect the maximum benefit under this program.			X
276	Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion are not benefits.			X
277	Orthodontics for handicapping malocclusion submitted through the CCS program for Medi-Cal beneficiaries are not payable by Denti-Cal.	X		
278	Preventive control programs are included in the global fee.	X		
279	Procedure(s) beyond scope of program. If you wish, submit alternate treatment plan.			X
280	Not payable when condition is asymptomatic.	X		
281	Services solely for esthetic purposes are not benefits.			X
282	By-report procedure documentation missing or insufficient for payment calculations.	X		
283	Payment amount determined from documentation submitted for this by-report procedure.			X
284	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered.			X

		Local	CDT	Both
284A	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Restorative treatment incomplete.			X
284B	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Crown treatment incomplete.			X
284C	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment is necessary.			X
284D	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.			X
284E	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Two or more of the above pertain to your case.	X		
285	Procedure does not show evidence of a reasonable period of longevity.			X
285A	Procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.			X
286	Procedure previously rendered.			X
287	Allowance made for alternate procedure per documentation, radiographs, photographs and/or history.			X
287A	Allowance made for alternate procedure per documentation, radiographs and/or photos. Due to patient's age allowance made for permanent restoration on an over retained primary tooth.	X		
288	Procedure cannot be considered an emergency.			X
289	Procedure requires prior authorization.			X
290	All services performed in a skilled nursing or intermediate care facility, except diagnostic and emergency services, require prior authorization.			X
291	Per date of service, procedure was completed prior to date of authorization.			X
292	Per documentation or radiographs, procedure requiring prior authorization has already been completed.			X
293	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan.			X
293A	Radiographs reveal open, underformed apices. Authorization for root canal therapy will be considered after radiographic evidence of apex closure following apexification.			X
293B	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Re-evaluate for apicoectomy.			X
293C	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Root canal should be retreated by conventional endodontics before apical surgery is considered.			X
293D	Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area.			X
294	Authorization disallowed as patient did not appear for a scheduled clinical screening.			X
294A	Authorization disallowed as patient failed to bring existing prosthesis to the clinical screening.			X
295	Payment cannot be made for services provided after the initial receipt date, because the patient failed the scheduled screening appointment.			X
296	Patient exhibits lack of motivation to maintain oral hygiene necessary to justify requested services.			X
297	Procedure 803 not covered as a separate item. Global fee where a benefit.	X		
298	A fee for completion of forms is not a covered benefit.			X

		Local	CDT	Both
299	Complete denture procedures have been rendered/authorized for the same arch.			X
299A	Extraction procedure has been rendered/authorized for the same tooth.			X
300	Procedure recently authorized to your office.			X
300A	Procedure recently authorized to a different provider.			X
301	Procedure(s) billed or requested are a benefit once per patient, per provider, per year.	X		
302	Procedure is not a benefit as coded. Use only one tooth number, one date of service and one procedure number per line.			X
303	Fixed Partial Dentures are only allowable under special circumstances as defined in the Manual of Dental Criteria.			X
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.			X
304	Mixture of three-digit, four-digit and five-digit procedure codes is not allowed.			X
305	Procedure not a benefit for tooth/arch/quad indicated.			X
307	Payment for procedure disallowed per post-operative radiograph evaluation and/or clinical screening.			X
307A	Per post-operative radiograph(s), payment for procedure disallowed: Poor quality of treatment.			X
307B	Per post-operative radiograph(s), payment for procedure disallowed: Procedure not completed as billed.			X
308	Procedure disallowed due to a beneficiary identification conflict.			X
309	Procedures being denied on this claim/TAR due to full denture or extraction procedure(s) previously paid/authorized for the same tooth/arch.			X
310	Procedure cannot be authorized as it was granted to the patient under the Fair Hearing process. Please contact the patient.			X
311	Procedure cannot be evaluated at the present time because it is currently pending a Fair Hearing decision.			X

PAYMENT POLICY				
312	Certified orthodontist not associated to this service office.			X
313	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete.			X
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.			X
313B	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No EOMB or proof of Medicare eligibility.			X
313C	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. Missing/invalid rendering provider ID.			X
313D	Study models submitted are non-diagnostic, untrimmed, or broken.			X
313E	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. PM 160 sent exceeded 36 months from date of issue.			X
314A	Per radiographs or documentation, please re-evaluate for: Complete upper denture.			X
314B	Per radiographs or documentation, please re-evaluate for: Complete lower denture.			X
314C	Per radiographs or documentation, please re-evaluate for: Resin base partial denture.			X

		Local	CDT	Both
314D	Per radiographs or documentation, please re-evaluate for: Cast metal framework partial denture.			X
314E	Per radiographs or documentation, please re-evaluate for: Procedure 706	X		
314F	Per radiographs or documentation, please re-evaluate for: Procedure 708	X		
315	The correction(s) have been made based on the information submitted on the CIF. Payment cannot be made because the CIF was received over 6 months from the date of the EOB.			X
316	Payment disallowed. Request received over 12 months from end of month service was performed.			X
317	Request for re-evaluation is not granted. Resubmit undated services on a new Treatment Authorization Request (TAR).			X
317A	Orthodontic NOAs cannot be extended. Submit a new Treatment Authorization Request (TAR) to reauthorize the remaining orthodontic treatment.			X
317B	Request for reevaluation is not granted due to local and CDT codes on the same document. Resubmit undated service(s) on a new Treatment Authorization Request (TAR).			X
318	Recipient eligibility not established for dates of services.			X
318A	Recipient eligibility not established for dates of services. Share of cost unmet.			X
319	Rendering or billing provider NPI/ID not on file.			X
319A	The submitted rendering provider NPI is not registered with Denti-Cal. Prior to requesting re-adjudication for a dated, denied procedure on a Claim Inquiry Form (CIF), the rendering provider NPI must be registered with Denti-Cal.			X
320	Rendering or billing provider not enrolled for date of service.			X
320A	Rendering or billing provider is not enrolled as a certified orthodontist.			X
320B	The billing provider has discontinued practicing at this office location for these Dates of Service.			X
321	Recipient benefits do not include dental services.			X
322	Out-of-state services require authorization or an emergency certification statement; payment cannot be made.			X
323	Authorization period for this procedure as indicated on the top portion of the Notice of Authorization form has expired.			X
324	Payment cannot be made as prior authorization made to another dentist. Authorization for services is not transferable.			X
325	Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.			X
326	Procedures being denied on this document due to invalid response to the RTD or, if applicable, failure to provide radiographs/attachments for this EDI document.			X
326A	Procedures being denied on this claim/TAR due to invalid or missing provider signature on the RTD. Rubber stamp or other facsimile of signature cannot be accepted.			X
327	Payment cannot be made; our records indicate patient deceased.			X
328	Request for partial payment is not granted. Delete undated services and submit them on a new TAR form.			X
329	Extension of time is granted once after the original TAR authorization without justification of need for extension.			X
330	Recipient is enrolled in a managed care program (MCP, PHP, GMC, HMO, or DMC) which includes dental benefits.			X
330A	Recipient is enrolled in Healthy Families which includes dental benefits.			X

		Local	CDT	Both
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.			X
332	Share of cost patient must pay for these services.			X
333	Payment cannot be made for procedures with dates of service after receipt date.			X
333A	Payment disallowed. Date of service is after receipt date of first NOA page(s).			X
334	Out-of-country services require an emergency certification statement, and are a benefit only for approved inpatient services.			X
335	Billing provider name does not match our files; payment/ authorization cannot be made.			X
336	Beneficiary is not eligible for dental benefits.			X
337	The procedure is not a benefit for the age of the beneficiary.			X
337A	The number of authorized visits has been adjusted to coincide with beneficiary's 19th/21st birthday.			X
338	This service will be processed under the former contract separately.			X
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.			X
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.			X
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).)			X
342	Rendering provider required for procedure, none submitted.			X
343	Billing provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.			X
344	Rendering provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.			X
345	Payment cannot be made for procedures with invalid dates of service.			X
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.			X
346	Billing provider is not a group provider and cannot submit claims for other rendering providers.			X
347	Authorization previously denied, payment cannot be made.			X
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.			X
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).		X	
349	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service previously processed, performed by the same dentist on the same day in the same arch.			X

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

		Local	CDT	Both
375	Re-evaluation denied. Insufficient documentation and/or radiographs not submitted. Please sign for payment of dated services and submit a new TAR.			X
376	Payment reflects a rate adjustment to the current Schedule of Maximum Allowances and may include an adjustment to the billed amount.			X
377	This procedure is not a benefit for an RDHAP.			X
378	CTP recipient. Payment cannot be made for procedures with dates of service after the 120 day authorization period.			X
379	Procedure(s) cannot be approved when the new issue date and new BIC ID are not valid or provided in the appropriate fields.			X
380	Fee adjustment, since Other Coverage exists for this claim.			X
381	Fee adjustment, since Third Party Liability exists for this claim.			X
382	Fee adjustment, since share of cost exists for this claim.			X
383	Fee adjustment, since services billed were not provided.			X
384	Fee adjustment, due to findings of professional peer review.			X
385	Aid code 80 recipients are eligible only for Medicare-approved procedures.			X
386	Payment/Authorization disallowed. CMSP dental services for dates of service after September 30, 2005, are the responsibility of Doral Dental Services of California (1-800-341-8478).			x
387	Payment disallowed. The request for CMSP dental services was not received before April 1, 2006. Contact Doral Dental Services of California (1-800-341-8478).			X
389	Pregnancy aid codes require a periodontal chart to perform surgical periodontal procedures. Subgingival curettage and root planing must be in history, or documentation must be submitted stating why a prior subgingival curettage and root planing was not performed.			X
390	The procedure requested is not on the SAR for this CCS/GHPP beneficiary. Contact CCS/GHPP to obtain a SAR prior to submitting for re-evaluation or payment.			X
391	Final diagnostic casts are not payable within 6 months of initial diagnostic casts for CCS patients.		X	
392	Beneficiary is not eligible for CCS/GHPP benefits.			X
393	TAR cannot be processed as part of the university project. Resubmit new TAR using your G billing provider number.			X
394	A credentialed specialist must submit documentation of cleft palate or the craniofacial anomaly.	X		
400	EPSDT-supplemental services are not a benefit for patients 21 years and older.			X
401	The EPSDT supplemental service(s) requested is primarily cosmetic in nature.			X
402	An alternative service(s) is more cost effective than the requested EPSDT supplemental service(s) and is a benefit of the Medi-Cal dental program.			X
403	The EPSDT supplemental service(s) requested is not medically necessary.			X
404	Procedure is disallowed due to presumptive eligibility card not submitted.			X
405	Procedure disallowed due to date of service is not within eligibility date(s) on presumptive eligibility card.			X
500	Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.			X
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.			X

		Local	CDT	Both
502	Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.			X
555A	Authorization of this line no longer valid. Patient is/was being treated elsewhere.			X
555B	Authorization of this line is no longer valid: Treatment was performed as an emergency.			X
555C	Authorization of this line is no longer valid: A new claim/TAR is being processed.			X
777	A special exception has been made for this procedure based on the documentation submitted.			X
888	Line allowed but unpaid due to date of service			X
900	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code for Medicare Crossover.			X
901	Primary aid code has unmet Share of Cost, and secondary aid code requires an emergency certification statement that is insufficient/not submitted.			X
902	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code.			X

CLINICAL SCREENING CODES				
603	Per clinical examination, procedure requested is only allowable under special circumstances.	X		
607A	Per clinical screening, payment for procedure disallowed. Poor quality of treatment.			X
607B	Per clinical screening, payment for procedure disallowed. Procedure not completed as billed.			X
613	Per clinical screening, tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.			X
613A	Per clinical screening, it has been determined that this tooth has been recently restored with a restoration or prefabricated crown.			X
613B	Per clinical screening, tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.			X
614A	Per clinical screening, please re-evaluate for: Complete upper denture			X
614B	Per clinical screening, please re-evaluate for: Complete lower denture			X
614C	Per clinical screening, please re-evaluate for: Cast metal framework partial denture			X
614D	Per clinical screening, please re-evaluate for: Resin base partial denture			X
614E	Per clinical examination, please re-evaluate for: Procedure 706.	X		
614F	Per clinical examination, please re-evaluate for: Procedure 708.	X		
619	Per clinical screening, caries not clinically verified.			X
622	Per clinical screening, tooth does not meet the Manual of Criteria for a prefabricated crown.			X
624	Per clinical screening, radiographs and/or photographs, additional surface(s) require treatment.			X
628	Per clinical screening, cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid.			X
629	Per clinical screening, existing prosthesis was lost/destroyed through carelessness or neglect.		X	
643	Per clinical screening, resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.			X
644	Per clinical screening, sufficient teeth are present for the balance of the opposing prosthesis.			X

		Local	CDT	Both
645	Per clinical screening, TMJ Syndrome is not identified as per the program criteria.	X		
646	Per clinical screening, cast framework partial denture is only a benefit when necessary to balance an opposing full denture.			X
647	Per clinical screening, bruxism is not associated with diagnosed TMJ dysfunction.			X
648	Per clinical screening, extraction of asymptomatic teeth is not a benefit.	X		
649	Per clinical screening, procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).	X		
649A	Per clinical screening, a resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.		X	
650	Per clinical screening, surgical extraction procedure has been modified to conform with radiograph appearance and/or documentation.			X
654	Per clinical screening, routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.			X
662	Per clinical screening, existing prosthesis is adequate at this time.			X
662A	Per clinical screening, recently constructed prosthesis exhibits deficiencies inherent in all prostheses and cannot be significantly improved by a reline.		X	
663	Per clinical screening, the surgical or traumatic loss of oral-facial anatomic structure is not significant enough to justify a new prosthesis.		X	
664	Per clinical screening, existing prosthetic prosthesis can be made serviceable by laboratory reline.			X
665	Per clinical screening, existing prosthesis can be made serviceable by reconstruction.	X		
666	Per clinical screening, the procedure has been modified to reflect the allowable benefit and may be provided at your discretion.			X
667	Per clinical screening, functional limitations or health condition of the patient precludes the requested procedure.			X
667A	Per clinical screening, patient has expressed a lack of motivation necessary to care for his/her prosthesis.		X	
668	Per clinical screening, the need for procedure is not medically necessary.			X
668A	Per clinical screening, patient does not wish extractions or any other dental services at this time.			X
668B	Per clinical screening, patient has selected/wishes to select a different provider.			X
669A	Per clinical screening, procedure is disallowed due to the following: This procedure is included in the fee for another procedure and is not payable separately.			X
669B	Per clinical screening, procedure is disallowed due to the following: This procedure is not allowable in conjunction with another procedure.			X
669C	Per clinical screening, procedure is disallowed due to the following: This procedure is associated with another denied procedure.			X
670	Per clinical screening, a reline, tissue conditioning, repair or an adjustment is not a benefit in conjunction with extractions or without an existing prosthesis.			X
671A	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Bone loss, mobility, periodontal pathology.			X
671B	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Apical radiolucency.			X
671C	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Arch lacks integrity.			X

		Local	CDT	Both
671D	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Evidence or history of recurrent or rampant caries.	X		
671E	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth/Teeth are in state of poor repair or have poor longevity prognosis.			X
671F	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Gross destruction of crown or root.			X
671G	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth has no potential for occlusal function and/or is hypererupted.			X
671H	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: The replacement of tooth structure lost by attrition or abrasion.			X
671I	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Deep caries appears to encroach upon pulp. Periapical radiograph is required.			X
672	Per clinical screening, tooth not present.			X
672B	Per clinical screening and/or radiographs, tooth number may be incorrect.			X
673A	Per clinical screening, the patient is not currently using the prosthesis provided by the program within the past five years.			X
674	Per clinical screening, incomplete treatment plan submitted.			X
674A	Per clinical screening, opposing dentition lacks integrity. Consider full denture for opposing arch.			X
674C	Per clinical screening, incomplete treatment plan submitted. Opposing prosthesis is inadequate.		X	
676	Per clinical screening, insufficient tooth space present for procedure(s) requested.			X
677	Per clinical screening, prosthesis made in recent years have been unsatisfactory for reasons that are remediable.		X	
680	Per clinical screening, services solely for esthetic purposes are not benefits.			X
681	Per clinical screening, periodontal procedure cannot be justified on the basis of pocket depths, bone loss and/or degree of deposits.			X
684	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered.			X
684A	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Restorative treatment incomplete.			X
684B	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Crown treatment incomplete.			X
684C	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment incomplete.			X
684D	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.			X
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.			X
685	Per clinical screening, procedure does not show evidence of a reasonable period of longevity.			X
685A	Per clinical screening, procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.			X

		Local	CDT	
687	Per clinical screening, allowance made for alternate procedure.			X
692	Per clinical screening, documentation or radiographs, procedure already completed.			X
693	Per clinical screening, procedure requested is inadequate to correct problem.			X
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.			X
693B	Per clinical screening, procedure requested is inadequate to correct problem. Re-evaluate for apicoectomy.			X
693C	Per clinical screening, procedure requested is inadequate to correct problem. Root canal should be retreated by conventional endodontics before apical surgery is considered.			X
694	Authorization disallowed as the patient did not appear for a scheduled clinical screening.			X
694A	Authorization disallowed as the patient failed to bring most recent prosthesis to the clinical screening.			X
695	Authorization disallowed as the patient is no longer at the facility.			X
696	Per clinical screening, patient exhibits lack of motivation to maintain oral hygiene necessary to justify the requested services.			X
697	Need for root canal procedure not evident per clinical screening radiographic evidence or documentation submitted.	X		