

R.C.	REMARK CODE DESCRIPTION
003	This procedure is only payable when the primary code has been submitted and performed on the same date of service
004	Services are not covered when D0170 has been performed on the same date of service.
01	responsible for payment.(Use OFFSET-ONCP)
02	The maximum dollar limit has been reached. (Used for the Benefit Strategy) <b>There may not be Patient Responsibility at the Benefit Strategy level.</b>
02PA	The maximum dollar limit has been reached. <b>This Remark Code is for UPMC's review for Radiograph Max per Provider. (\$69 xray max)</b>
03	This procedure is incidental to the primary procedure submitted on the same date of service.
04	Services performed on previously extracted teeth are not covered.
05/05D	The patient doesn't meet the age requirement for the this benefit.
09	Member responsibility reflects 25% discount.
119/119D	Benefit maximum for this time period or occurrence has been reached.
11N	This procedure is not covered for this tooth number. (USE OTN TO OFFSET to pay line)
125	Payment adjusted due to processing error(s).
203	Non-Covered Benefit. The member can not be billed for amounts exceeding the contracted rates for In-Network only.
204	The patient cannot be balance billed for any remaining balance.
209	This procedure code has been denied and reprocessed as D0272 on claim as per plan benefits.
210	This procedure code has been denied and reprocessed as D0274 on claim as per plan benefits.
211	D8660 is reimbursed only when an orthodontic case request has been denied.
224	The procedure code submitted has been changed to reflect the correct procedure code, identifying all surfaces for the same tooth number, on the same date of service.
226	Clinical information does not meet criteria for authorization of these services.
227	The procedure code submitted has been changed to reflect the correct procedure code, identifying all surfaces for the same tooth number, on the same date of service.
228	Denture adjustments are not covered when complete/immediate dentures have been performed within a six month period.
229	Denture adjustments are not covered when full or partial dentures have not been performed.
231	Claim denied. Member information on radiograph received doesn't match the member information on submitted claim.
232D	Conflicting service(s) filed on Same Day/Same Claim. (USE OBWX TO OFFSET THIS REMARK CODE TO PAY)
29	Receive Date is over timely filing limit.
34D	Lifetime benefit maximum for this tooth number has been reached.
35/35D	Lifetime benefit maximum has been reached.

52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
96/96D	Non-covered charge(s).
A12/A12D	Prior Authorization or Pre-Estimate Required.
A001	Provider not found
A002	Cannot determine location
A17	D0140 is not covered when billed with other oral exams and preventative services on the same date of service
A34	Receive Date is over timely filing limit.
A39	Post review with x-rays and reports required. (OA39 IS USED BY Claim Processors TO OFFSET AND PAY LINE)
A54	This service is only payable when other services have been performed and paid on the same day.(Use offset code OADJ to make line pay)
A56	This claim requires further review. Please provide pre and post treatment x-rays, clearly labeled with the date and patient name along with chart notes.
A58	Benefit not covered by same provider/provider group that placed the space maintainer.
A59	Review Member Reimbursement Claims for Accuracy.
A62	Periodic Orthodontic Treatment Visit is payable six months after a Comprehensive Orthodontic Treatment of the Adolescent Dentition has been performed.
A63	Cephalometric Film is not payable when orthodontic treatment has been performed prior to service.
A64	Alveoplasty for procedure code D7310 payable in conjunction with extractions. Alveoplasty for procedure code D7320 payable when not in conjunction with extractions.
A65	This service requires a narrative report for pre-transplant cases for patients over the age of 21.
A72	Lifetime benefit maximum for this procedure has been reached with this Provider/Dental Group.
A73	Post and Core needs post review when a crown has been previously performed on same tooth number. Provider must send post operative x-rays for claim consideration.
A74	Clinical documentation needed when services for fillings have been performed more than once on the same tooth, within a 12 month period.
A75	Review required for bundling when fillings have been performed on the same tooth number, on the same date of service.
ADJC	Previously paid/denied service has been reprocessed.
ADJP	Remark code for Claim correction for proper vendor.
AZ12	Prior Authorization is needed when more than two extractions have been performed on the same date of service. (For AZ BWY Extractions for 21+)
B13	Fees will be reduced upon claim receipt and adjudication based on services previously reimbursed on another claim.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
BLU	Review <a href="#">Blue Cross Blue Shield</a> , Out of Network claim submitted with In-Network fees.
CP1	Member's responsibility reflects copay amount.
CP2	Member's responsibility reflects coinsurance amount.

D012	Avesis is not the dental carrier for this group. Please submit to the current dental carrier.
D03	X-rays denied when billed with a Full Mouth Series on the same date of service.
D04	Hospital Call denied when billed with a Comprehensive Exam or Palliative Treatment on the same date of service.
D06	Periodontal Maintenance is payable when Gingivectomy/Gingivoplasty or Periodonatal Scaling and Root Planning have been performed previously.
D07	Procedure code covered for Oral Surgeons only.
D22	This procedure is not covered with any other service on the same date.
HCKY	CoventryCares Kentucky Medicaid Dental - Group Hold
HP12	Prior Authorization or Pre-Estimate Required for HealthPartners/KidzPartners
I4	Avesis is no longer the Carrier
I55	A detailed office receipt is required displaying charges and any amounts paid. Please resubmit claim with documentation.
KY02	The radiograph maximum has been reached for this provider/dental group.
KY03	Procedure is incidental to another procedure submitted/performed prior to code submitted.
KY04	Services performed on previously extracted teeth are not covered.
KY05	The patient doesn't meet the age requirement for this benefit.
KY06	Procedure payable only when primary procedure has been performed on same day of service.
KY07	Emergency exams inclusive when billed with other services on the same date of service.
KY08	Procedure code incidental to restorations when an occlusal surface has been performed on a restoration for the same tooth number.
KY12	Prior Authorization or Pre-Estimate Required for Coventry Care of KY
KY12	Authorization Required.
KY19	Ok to pay Frequency Limitation for EPSDT claims.
KY39	Review for Post Review.
KYCC	Claim is payable under Continuation of Care for Kentucky.
KYEP	Ok to pay procedure.
KYFS	Review \$0 fee amount for procedure code(s) to manually pay for amount approved.
KYNC	Non Contracted Dental Provider - KY Medicaid
KYPW	Review for Post Review. This procedure is covered for pregnant women only.
MM12	Prior Authorization or Pre-Estimate Required for Molina
N37	Missing/incomplete/invalid tooth number/letter.
N39	Procedure code is not compatible with tooth number/letter.
N40	Missing X-Ray
N48	Claim information does not agree with information received from other insurance carrier.

<b>N75</b>	<b>Missing/incomplete/invalid tooth surface information.</b>
<b>NCDP</b>	<b>Non Contracted Dental Provider</b>
<b>PD16</b>	<b>Clinical information does not meet criteria for authorization of these services. (USED BY UM IN GA ONLY)</b>
<b>PD27/MM27</b>	<b>Provider must include a signed Patient Responsibility form with all PTE requests. (USED BY UM DEPT.) For Molina \$1000 Plan, if the provider bills for more than \$500 per day.</b>
<b>PVR/D108</b>	<b>Services billed in error. This service is being denied at the request of the provider</b>
<b>PW12</b>	<b>Prior Authorization required. This procedure is covered for pregnant women only.</b>
<b>SSCR</b>	<b>SSC Review for AZ-BWY (2 per General Dentist) and (4 per PEDO)</b>
<b>S001</b>	<b>Price Stragety not found - varies reasons for this code to appear on claim but normally it means procecedure code is not covered.</b>
<b>DD02</b>	<b>Duplicate claim - Please re-evaluate (The EOB to the provider reads:</b>