

<i>Explanation Code</i>	<i>Description</i>
API	According to our records, the authorization submitted for this service did not support the payment of benefits.
B54	The contractual maximum for this service has been reached. The patient is responsible for the amount indicated as "Patient Pays."
CP1	The deadline for submitting this procedure/claim has expired.
D34	Benefits could not be determined because the submitted procedure number is not recognized. Upon receipt of a new claim with correct and complete itemized procedure information including the fee, we will process the submitted service(s) in accordance with our processing guidelines.
D35	Benefits could not be determined because the submitted procedure number is not recognized. Upon receipt of a new claim with correct and complete itemized procedure information including the fee, we will process the submitted service(s) in accordance with our processing guidelines.
D56	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D57	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D58	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D59	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D60	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D61	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D62	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D63	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
D65	Benefits could not be determined because this service requires x-rays. Upon receipt of a new claim with dated, diagnostic x-rays, we will process the submitted service(s) in accordance with our processing guidelines.
D67	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
FDP	This procedure was previously processed or is a duplicate of another procedure on this claim.
FED	This procedure was previously processed or is a duplicate of another procedure on this claim.
ME2	The patient was not eligible when this service was performed or submitted for predetermination. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
ME3	This service is not a covered benefit because it was performed prior to the patient's effective date of coverage. The patient is responsible for the amount indicated as "Patient Pays."
ME4	The patient was not eligible when this service was performed or submitted for predetermination. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
ME5	The patient was not eligible when this service was performed or submitted for predetermination. Therefore, the patient is responsible for the amount indicated as "Patient Pays."

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ME6	The patient was not eligible when this service was performed or submitted for predetermination. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
ME7	The patient's eligibility ended before this service was provided. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
MX3	The patient was not eligible when this service was performed or submitted for predetermination. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
PVW	The deadline for submitting this procedure/claim has expired.
108	We are unable to establish the patient's eligibility. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
111	We are unable to establish the patient's eligibility. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
117	Benefits could not be determined because the submitted procedure number is not recognized. Upon receipt of a new claim with correct and complete itemized procedure information including the fee, we will process the submitted service(s) in accordance with our processing guidelines.
119	Benefits could not be determined because the submitted procedure number is not recognized. Upon receipt of a new claim with correct and complete itemized procedure information including the fee, we will process the submitted service(s) in accordance with our processing guidelines.
161	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.
1P1	We have applied an alternate procedure number and allowance to ensure accurate processing.
1P4	This procedure requires prior authorization, and the date of service must be within the authorization period.
1V1	The combined fees for x-rays are equal to or more than the fee for a complete x-ray series. Therefore, according to our guidelines, the x-rays are considered to be equivalent to a complete series. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
202	The payment was calculated based on the coordination of benefits.
203	This is an orthodontic installment benefit payment.
206	According to the enrollee's program, this procedure is a covered benefit only after a contractual waiting period has ended. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
3X1	Our records show this provider is not enrolled and credentialed as a Delta Dental State Government Program provider. This service is only a covered benefit when the enrollee is treated by a provider enrolled in the Delta Dental State Government Program.
3X2	Benefits could not be determined because the provider/billing information is not current. Upon receipt of a new claim with the treating provider's identification and billing information including name, address, license # and/or Tax ID #, we will process the submitted service(s) in accordance with our processing guidelines.
3X3	The billing provider's Tax Identification Number (TIN) is missing or is different from the one that we have on file for this provider and office location. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure the billing provider's TIN is registered with the local Delta Dental member company before submitting additional claims.
3X4	The practice location submitted on the claim is missing or is different from the one that we have on file. We request that the provider verify that the information on the claim is accurate. If it is correct, please ensure this practice location is registered with the local Delta Dental member company before submitting additional claims.
401	This procedure was previously processed or is a duplicate of another procedure on this claim.
402	This procedure was previously processed or is a duplicate of another procedure on this claim.
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4U1	This procedure was previously processed or is a duplicate of another procedure on this claim.
501	Delta Dental's allowance is based on the dental consultant's evaluation of the treatment performed.
503	This service is not a covered benefit of the enrollee's program. We have applied an alternate procedure number and allowance to ensure accurate processing. The patient is responsible for the amount indicated as "Patient Pays."
504	The submitted documentation does not support the payment of benefits for the procedure. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
505	Delta Dental's allowance reflects a fee deduction for a related procedure that was previously processed. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
506	This procedure has been previously reviewed by our dental consultant, and the original benefit determination is unchanged.
507	Non-definitive (incomplete) treatment is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
508	Specialized techniques are not covered benefits of the enrollee's program. We have applied an alternate procedure number and allowance to ensure accurate processing. The patient is responsible for the amount indicated as "Patient Pays."
509	Specialized techniques are not covered benefits of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
510	The enrollee's program excludes services to replace/stabilize tooth structure that is lost as a result of any type of wear, including, but not limited to: attrition, erosion, abrasion and abfraction. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
511	The enrollee's program excludes procedures to correct congenital or developmental malformations. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
512	According to our guidelines, a consultation is not a benefit when other services are performed by the same provider during the same visit. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
515	This service is not a covered benefit of the enrollee's program because there is a less expensive, professionally acceptable alternative treatment available. We have applied an alternate procedure number and allowance to ensure accurate processing. The patient is responsible for the amount indicated as "Patient Pays."
530	Based on our dental consultant's professional review of the submitted documentation, this service is not a covered benefit because of questionable prognosis. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
531	Based on our dental consultant's professional review of the submitted documentation, this service is not a covered benefit because of questionable prognosis. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
532	Based on the dental consultant's professional review of the submitted documentation, this service is not a covered benefit of the enrollee's program because of the periodontal prognosis of the involved tooth or teeth. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
533	Based on the dental consultant's professional review of the submitted documentation, this service is not a covered benefit of the enrollee's program because of the endodontic prognosis of the involved tooth or teeth. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
564	Benefits could not be determined because of missing information. Upon receipt of a new claim with clinical treatment narrative, we will process the submitted service(s) in accordance with our processing guidelines.
565	Benefits could not be determined because of missing/conflicting information. Upon receipt of a new claim with arch, quadrant, tooth number, and/or surface code information, we will process the submitted service(s) in accordance with our processing guidelines.

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566	Benefits could not be determined because of missing information. Upon receipt of a new claim with the date for each service and time of the office visit, we will process the submitted service(s) in accordance with our processing guidelines.
567	Benefits could not be determined because of missing information. Upon receipt of a new claim with patient's treatment plan, we will process the submitted service(s) in accordance with our processing guidelines.
568	Benefits could not be determined because of missing information. Upon receipt of a new claim with an oral pathology and/or operative report, we will process the submitted service(s) in accordance with our processing guidelines.
569	Benefits could not be determined because of the nature of the x-rays submitted. Upon receipt of a new claim with dated, diagnostic x-rays, we will process the submitted service(s) in accordance with our processing guidelines.
570	Benefits could not be determined because of missing x-rays. Upon receipt of a new claim with current and dated pre-operative x-rays of diagnostic quality, we will process the submitted service(s) in accordance with our processing guidelines.
572	Benefits could not be determined because of missing x-rays. Upon receipt of a new claim with dated and mounted periapical x-rays of diagnostic quality, we will process the submitted service(s) in accordance with our processing guidelines.
573	Benefits could not be determined because of missing x-rays. Upon receipt of a new claim with full mouth x-rays of diagnostic quality, mounted and dated, we will process the submitted service(s) in accordance with our processing guidelines.
574	Benefits could not be determined because of missing periodontal information. Upon receipt of a new claim with a current and dated periodontal charting, we will process the submitted service(s) in accordance with our processing guidelines.
575	Benefits could not be determined for this procedure because of missing periodontal information. Upon receipt of a new claim from the dental office, we will process the submitted service(s) in accordance with our processing guidelines. The claim should include the following clinical information: millimeters of recession, frenum pull, mucogingival defect, sulcus depth, restorative considerations and/or clinical photographs for each tooth.
576	Benefits could not be determined without additional information. This benefit plan covers the submitted service(s) only if the patient has a history of prior periodontal therapy in two or more quadrants. Upon receipt of a new claim with documentation of prior periodontal therapy and the nature of the therapy, we will process the submitted service(s) in accordance with our processing guidelines.
577	Benefits could not be determined because of missing/conflicting orthodontic information. Upon receipt of a new claim with the date appliances were placed, total case fee, initial banding fee, monthly treatment fees, and estimated number of months of treatment, we will process the submitted service(s) in accordance with our processing guidelines.
586	Benefits for this procedure could not be determined due to missing information. Upon receipt of a new claim with current and dated post-operative periapical x-rays clearly depicting the root apex, we will process the submitted service(s) in accordance with our processing guidelines.
5S1	The submitted documentation was reviewed by a dental consultant. The consultant has applied an allowance for an alternate oral surgery procedure based on the anatomical position of the tooth. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
601	This service is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
609	Our records show this provider is not enrolled and credentialed as a Delta Dental State Government Program provider. This service is only a covered benefit when the enrollee is treated by a provider enrolled in the Delta Dental State Government Program.
6AA	This is reimbursement for emergency services.

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712	The enrollee's program excludes orthodontic benefits for the enrollee and spouse. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
717	Benefits are paid according to the enrollee's program.
718	According to our guidelines, this procedure is considered to be part of, and included in the fee for a completed service. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
719	This procedure requires prior authorization, and the date of service must be within the authorization period.
7A1	The enrollee's program excludes prescription drugs. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
7A2	According to our guidelines, emergency palliative treatment of dental pain includes all related services with the exception of required x-rays, and it is not a separate benefit if other services are performed on the same visit. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
7C2	Submitted procedure is not payable in conjunction with a related service that is in our records for this patient. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
7F1	The enrollee's program limits this service to a specific frequency, which has been exceeded. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
7A3	According to our guidelines, routine post-operative visits are considered part of, and included in the fee for, the total surgical procedure. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
7E1	According to our guidelines, therapeutic pulpotomy is a benefit only on primary teeth. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
743	The contractual maximum for this service has been reached. The patient is responsible for the amount indicated as "Patient Pays."
746	No additional benefits are available because the maximum benefit for this service has already been provided. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
7BB	This service is not a covered benefit of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
7O1	Orthodontic services are not covered benefits of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
7Q1	Based on the dental consultant's professional review of the submitted documentation, this service is not a covered benefit of the enrollee's program because of the periodontal prognosis of the involved tooth or teeth. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
7I1	According to our guidelines, the allowance for this procedure was included in the fee for the original service. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
7F2	The enrollee's program limits this service to a specific frequency, which has been exceeded. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
7A4	According to our guidelines, occlusal adjustments of recently completed appliances or restorations are considered to be part of, and included in the fee for, the completed service. Contracting dentists agree to charge the patient only the amount indicated as "Patient Pays."
7F3	This service has exceeded the program's frequency limitation of once in 90 days. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
7F4	This service has exceeded the program's frequency limitation of once in 30 days. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
745	The patient's lifetime benefit for this treatment has been reached. The patient is responsible for the amount indicated as "Patient Pays."
747	The patient's deductible and/or annual maximum has been applied.

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775	This service has exceeded the program's frequency limitation of once in a six-month period. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
776	This service has exceeded the program's frequency limitation within any twelve-month period. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
777	This service has exceeded the program's frequency limitation within a calendar year. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
778	This service has exceeded the program's frequency limitation within a twelve-month contract period. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
779	The enrollee's program has a limitation of once in a three-year period for this service. Because it was previously paid, the patient is responsible for the amount indicated as "Patient Pays."
780	The enrollee's program limits this service to once only. Because the service was previously paid, the patient is responsible for the amount indicated as "Patient Pays."
781	The enrollee's program has a limitation of once in a five-year period for this service. Because it was previously paid, the patient is responsible for the amount indicated as "Patient Pays."
786	The treatment of temporomandibular joint (TMJ) dysfunction and related services are not covered benefits of the enrollee's program. Therefore, the patient is responsible for the amount indicated as "Patient Pays."
788	Our records show that this tooth was extracted previously. Therefore, we cannot make a benefit allowance for the requested procedure.
799	Benefits could not be determined because the submitted procedure number is not recognized. Upon receipt of a new claim with correct and complete itemized procedure information including the fee, we will process the submitted service(s) in accordance with our processing guidelines.
989	Based on additional information received, we have recalculated a previous claim.
990	The original calculation of benefits contained an error. Therefore, we have recalculated the previous claim and adjusted the payment.
992	Based on the consultant review of the submitted documentation, an additional allowance for this procedure has been made.
995	Benefits could not be determined because of missing primary coverage information. Upon receipt of a new claim with a copy of the denial and/or payment notification from the primary carrier, we will process the submitted service(s) in accordance with our processing guidelines.
9C1	Based on the consultant review of the submitted documentation, an additional allowance for this procedure has been made.
9J2	Based on additional information received, we have recalculated a previous claim.
9J3	This service has been voided and the payment has been adjusted accordingly.
9M1	The amount indicated as "Delta Dental Pays" includes the interest due on this claim in accordance with state regulations as they relate to timely processing of insurance claims.
9M3	The original payment has been voided. The claim has been reprocessed and a new payment has been issued.
9M9	The original payment has been voided. The claim has been reprocessed and a new payment has been issued.
9N1	The original payment has been voided. The claim has been reprocessed and a new payment has been issued.
9Z1	The original information such as the date of service, procedure or tooth number has been updated for consistency. This is for informational purposes only.