LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

Provider Reference Guide

Revision Date 1/31/24

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SECTION 1. LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

Welcome to LIBERTY Dental Plan's ("LIBERTY's") network of Participating Providers. We are proud to maintain a broad network of qualified dental providers who offer both general and specialized treatment, guaranteeing widespread access to our members.

The intent of this Provider Reference Guide is to aid each Participating Provider and their staff members in becoming familiar with the administration of LIBERTY plans. Please note that this Provider Reference Guide serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY and that additional terms and conditions of the Provider Agreement may apply. In the event of a conflict between a term of this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall supersede this Provider Reference Guide. You received a copy of the fully executed Provider Agreement at the time of your activation in LIBERTY's network or when you were oriented to LIBERTY; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to Provider@libertydentalplan.com.

In order to provide the most current information, updates to the Provider Reference Guide is available by logging in to the **Provider Portal**.

OUR MISSION

LIBERTY's mission is to be the industry leader in improving access to quality oral health care services for our members. LIBERTY seeks to increase annual member visits and improve the overall health of our population served through member outreach and education. Our continued expansion is an outgrowth of our commitment to exceptional service and expertise in our industry while providing a positive, rewarding, and enjoyable professional relationship with our network providers and members.

PROVIDER CONTACT AND INFORMATION GUIDE

LIBERY DENTAL PLAN PROVIDER CONTACT & INFORMATION GUIDE			
IMPORTANT PHONE NUMBERS AND GENERAL INFORMATION	**ELIGIBILITY AND BENEFITS VERIFICATION**	**CLAIMS SUBMISSIONS & PRIOR APPROVALS**	**PROVIDER WEB PORTAL**
TOLL FREE **888.352.7924** **Eligibility & Benefits:** Option 1 **Claims:** Option 2 **Prior Authorizations:** Option 3 **Referrals:** Option 4 **Request Materials:** Option 5	**Provider Portal** **888.352.7924** Option 1	**Provider Portal** **EDI** Payor ID #: CX083 **EMAIL** claims@libertydentalplan.com **TELEPHONE** **888.352.7924**	LIBERTY Dental Plan offers 24/7 real-time access to important information and tools through our secure online system • Electronic Claims Submission • Claims Inquiries • Real-time Eligibility Verification • Member Benefit Information

General Information: Option 6

HOURS
Live representatives are available

877.869.4299

Monday – Friday,
8 a.m. EST – 6 p.m. EST

PROVIDER RELATIONS DEPARTMENT

888.352.7924

Fax 949.313.0766

LIBERTY Dental Plan
Attn: Provider Relations
P.O. Box 26110
Santa Ana, CA 92799-6110

EMAIL
Provider@libertydentalplan.com

REFERRALS

Provider Portal

TELEPHONE
888.352.7924
Option 4

EMAIL
referrals@libertydentalplan.com

Regular Referrals by Mail

LIBERTY Dental Plan
Attn: Referral Department
P.O. Box 401086
Las Vegas, NV 89140

Urgent Referrals and Hotline
888.352.7924
Option 4

Fax: 888.334.6033

Hours
Monday- Friday
8 a.m. EST – 6 p.m. EST

General Information
Option 2

Fax: 888.401.1129

Paper Claims by Mail
or
Corrected Claims by Mail

LIBERTY Dental Plan
Attn: Claims Department
PO Box 15149
Tampa, FL 33684

- Prior Authorization Submission & Status

Please visit: **Provider Portal** to register as a new user and/or login.
Your **Office Number** and **Access Code** can be found on your LIBERTY Welcome Letter. If you cannot locate your office number and/or access code, or need help with the login process, please call **888.352.7924.**
For technical assistance, email portalsupport@libertydentalplan.com

GRIEVANCE AND APPEALS

Providers have the right to file a claim-related appeal regarding a medical necessity or experimental/investigational denial.

Grievance and Appeals must be in writing and mailed to:
LIBERTY Dental Plan
Attn: Grievance & Appeals Department
PO Box 26110
Santa Ana, CA 92799-6110

TOLL FREE NUMBER
888.352.7924

Fax: 833.250.1814

ONLINE
www.libertydentalplan.com

HOURS
Monday- Friday
8 a.m. EST –6 p.m. EST

Find a Dentist

SECTION 2. PROVIDER RELATIONS AND TRAINING

LIBERTY's team of Network Managers is responsible for recruiting, contracting, servicing and maintaining our network of Providers. We encourage our Providers to communicate directly with their designated Network Manager to assist with the following:

- Plan Contracting
- Escalated Claim Payment Issues
- Education on LIBERTY Policies and Member Benefits
- Provider Trainings and Orientations
- Directory Validation
- Changes in Office Demographics
- Opening, Changing, Selling or Closing a Location
- Adding or Terminating Associates
- Credentialing and Recredentialing of owner and associate dentist
- Change in Name or Ownership
- Taxpayer Identification Number (TIN) Change
- Changes in Office Hours

To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes 30 days in advance to Provider@libertydentalplan.com or in writing. Provider Relations will address your inquiry within three (3) business days of receipt.

	**LIBERTY Dental Plan** **ATTN: Provider Relations** P.O. Box 26110 Santa Ana, CA 92799-6110		**Provider Relations Team** M-F from 8 am – 6 pm (Eastern) 888.352.7924
	Email: Provider@libertydentalplan.com		

PROVIDER COMPLIANCE AND TRAINING

LIBERTY supplies required compliance training online for providers supporting government business. Participating providers are required to complete training annually and/or attest to completion of compliant training.

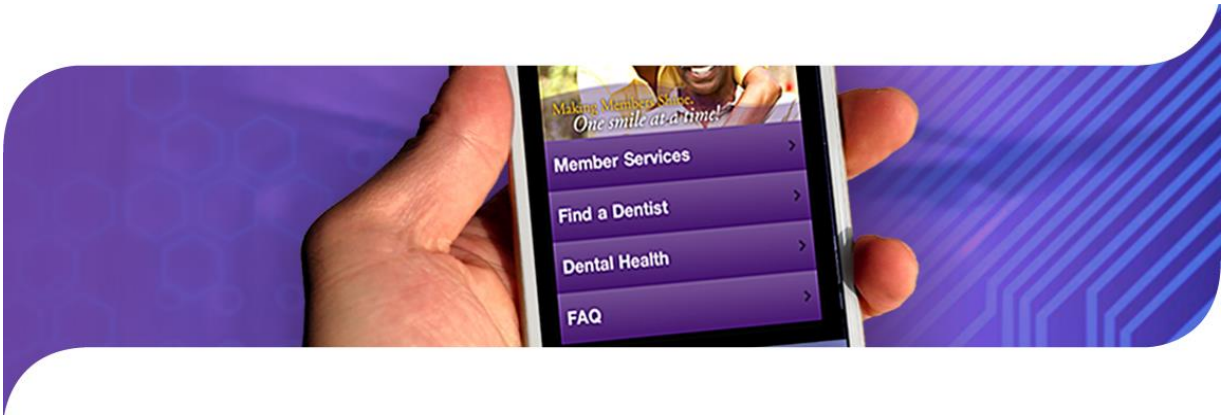
Provider Training can be accessed at **Provider Compliance Training.**
Trainings include, but are not limited to:

- LIBERTY Compliance Plan
- LIBERTY Code of Conduct
- LIBERTY and CMS General Compliance Training
- LIBERTY and CMS Fraud, Waste, and Abuse Training
- LIBERTY HIPAA Compliance Training
- LIBERTY Model of Care Training
- LIBERTY Cultural Competency Training

- LIBERTY Critical & Adverse Incident Awareness Training
- LIBERTY Affordable Care Act Section 1557 Training
- HHS Think Cultural Health Training

Providers must maintain supporting documentation for a period of ten (10) years after training for all office personnel supporting LIBERTY's government business and can furnish the documentation upon request.

SECTION 3. ONLINE SELF-SERVICE TOOLS



LIBERTY is dedicated to meeting the needs of our providers by utilizing leading technology to increase your office's efficiency. Online tools are available for billing, eligibility, claim inquiries, referrals and other transactions related to the operation of your dental practice.

We offer 24/7 real-time access to important information and tools free of charge through our secure online Provider Portal. Registered users will be able to:

- Submit Electronic Claims
- Requests for Prior Authorizations
- Verify Member Eligibility and Benefits
- View Office and Contact Information
- Submit Referrals and Check Status
- Access Benefit Plans
- Print Monthly Eligibility Rosters
- Perform a Provider Search

ON-LINE ACCOUNT ACCESS

You can register and obtain immediate access to your office's account by visiting the **Provider Portal.**

All contracted network dental offices are issued a unique **Office Number** and **Access Code**. These numbers can be found on your LIBERTY Welcome Letter and are required to register your office on LIBERTY's Online Provider Portal.

The designated Office Administrator should be the user to set up the account on behalf of all providers/staff. The Office Administrator will be responsible for adding, editing and terminating additional users within the office.

If you are unable to locate your **Office Number** and/or **Access Code**, please contact the Provider Relations Department at 888.352.7924 or email Provider@libertydentalplan.com for assistance. For technical assistance, email portalsupport@libertydentalplan.com.

Detailed instructions on how to utilize our online services can be found in the **Online Provider Portal User Guide.**

SYSTEM REQUIREMENTS

- Internet Connection compatible with Microsoft Edge, Google Chrome, and Mozilla Firefox
- Adobe Acrobat Reader

DIRECTORY INFORMATION VERIFICATION (DIV) ONLINE

LIBERTY actively works to verify and maintain the accuracy of our provider directories which are available to members and the general public. It is required that we maintain current office information in order to ensure the information provided to our members reflects both your current office demographic information and associate dentists that are available to LIBERTY members.

An easier way to update your office information is through our Provider Directory Information Verification (DIV) website at **ProviderDIV**.

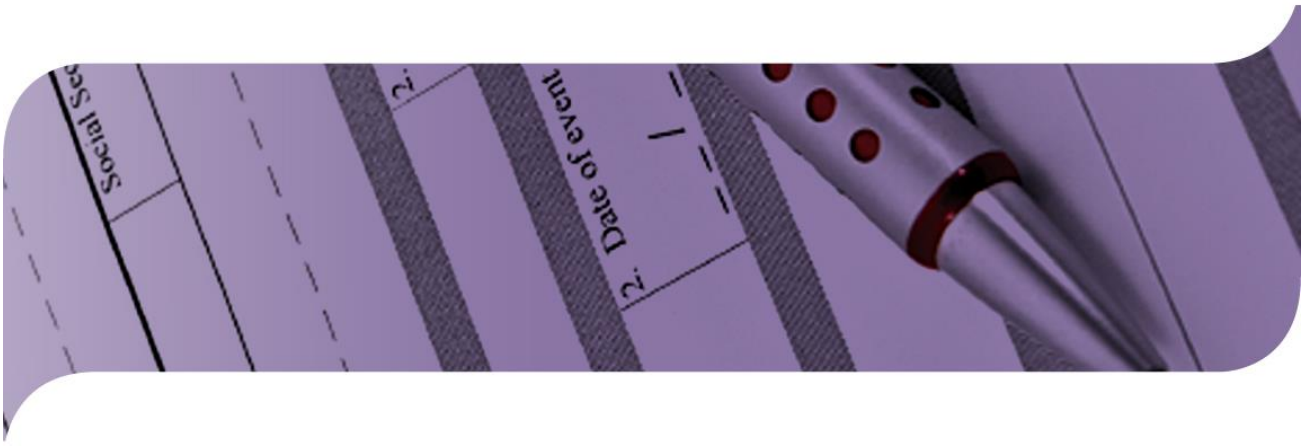
Anytime you have changes, including, but not limited to appointment times, office hours, address, phone number, fax number, associate dentists, etc., You'll be able to update or **attest** that no changes were made no less than **every 90 days** by going online. We also **highly recommend** that you set a calendar reminder in your system to go to the website every 85 days and validate the information.

Why do I need to update my provider information?

- Prevent and minimize costly claims payment delays
- Stop time consuming calls to validate your directory information
- Fix what's wrong with the click of a button
- No filling out paper forms and faxing or emailing
- Provide the most up-to-date information to existing and new members so they can make educational decisions about their provider office choices

You will need to have your office **Access Code** to use the online feature. This number can be found in your LIBERTY Welcome Letter. If you are unable to locate your **Access Code**, please email the Provider Relations Department at provider@libertydentalplan.com for assistance.

SECTION 4. ELIGIBILITY



PRIMARY CARE DENTAL HOME ASSIGNMENT

Dental home is the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate. Dental homes include general and pediatric dental offices also known as Primary Care Dentists (PCD).

Medicaid Members can choose a Primary Care Dentist (PCD) at any time. Upon initial enrollment, LIBERTY will assign members to their Primary Care Dentist based on such factors as proximity, language, cultural preference, previous history of the member or another family member. Members can change Primary Care Dentists at any time by either calling LIBERTY, going onto the LIBERTY website, or by being seen by an in-network Primary Care Dentist of their choice.

Providers are responsible for verifying member eligibility prior to providing dental services. In addition, your office should ensure the members are listed in the "My Members" section of the portal to ensure the member is assigned to your office. Checking eligibility will allow providers to complete medically necessary procedures and reduce the risk of denied claims.

HOW TO VERIFY ELIGIBILITY

- **Provider Portal**
  (We recommend using Member's Last Name, First Name and Date of Birth *for best results)*
- **Calling our Member Services Department at**: 888.869.4299 to speak with a live Representative from 8 a.m. to 6 p.m. EST

Eligibility Rosters

At the beginning of each month, LIBERTY will post a Medicaid member roster in the "My Resources" section of the Provider Portal. This list will provide your office with the following information:

- Member Name
- Member Telephone Number
- Member Address

- Member Identification Number
- Date of Birth
- Type of Coverage (Plan number/name)
- Effective Date of Coverage
- Indicator if Member had a visit within the Calendar Year

MEMBER IDENTIFICATION CARDS

Members should present their Health Plan ID card at each appointment. They do not have a separate LIBERTY ID card. Providers are encouraged to validate the identity of the person presenting an ID card by requesting some form of photo identification.

The presentation of an ID card does not guarantee eligibility and/or payment of benefits. In such cases, providers should check a photo ID and check against the online web portal for verification of eligibility. Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

RESTRICTED RECIPIENT PROGRAM

The Recipient Restriction Program (RRP) is a New York State Medicaid mechanism that identifies members who have a pattern of abusing Medicaid and restricts them to one or more health care providers where they can access their benefits. This can affect both primary and specialty care services.

SECTION 5. PROGRAM GUIDELINES

DEFINITION OF MEDICAL NECESSITY

We approve care that is "medically necessary" or "needed". This means:

- The treatment or supplies are needed to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition and that meet accepted standards of dentistry;
- Will prevent the onset of an illness, condition, or disability;
- Will prevent the deterioration of a condition;
- Will prevent or treat a condition that endangers life or causes suffering, pain or results in illness or infirmity;
- Will follow accepted medical practices;
- Services are member-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual;
- Services are provided in a safe, proper and cost-effective place, reflective of the services that can be safely provided consistent with the diagnosis;
- Services are not performed for convenience only; and
- Services are provided as needed when there is no better or less costly covered care, service or place available.

CARE FOR MEMBERS WITH SPECIAL NEEDS

LIBERTY offers care management services to members with special health care needs that include complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/substance abuse, and/or developmental disabilities, persons who are eligible for the MLTC program and require dental care.

Our care management programs are offered but not limited to members who:

- Have complex medical (such as asthma, diabetes, HIV/AIDS and high-risk pregnancy or behavioral health issues who have associated dental related comorbidities,
- with Individual Developmental Disabilities (IDD);
- with Traumatic Brain Injuries (TBI)
- with high dental services utilization;
- with intensive dental health care needs;
- who reside in a nursing facility;
- who consistently access services at the highest level of care;
- Are in Foster Care

- Are home-bound;
- Are homeless; and
- Are identified as needing assistance in accessing or using services.

Our care managers are trained to help providers, and members, to arrange services (including referrals to special care facilities for highly specialized care) that are needed to manage treatment. Our primary goal is to help members with special needs understand how to take care of themselves and maintain good oral health.

Our care management programs offer our members a care manager, care coordinator and other outreach workers. They'll work one-on-one to help coordinate oral health care needs. To do this, they:

- May ask questions to get more information about a member's medical and dental health condition(s);
- Will work with PCPs and PCDs to arrange services needed and to help members understand their illness; and
- Will provide information to help members understand how to care for themselves and how to access services, including local resources.

Offices are required to submit claims for all services rendered. It is recommended that claims be submitted each visit to ensure timely payment. For additional information regarding payment and eligibility, please contact the Member Services or visit the on-line **Provider Portal**.

ESSENTIAL SERVICES

The following general guidelines are used for the Medicaid dental benefit:

- Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration when determining medical necessity.

- Treatment is considered appropriate where the prognosis of the tooth is favorable. Treatment may be appropriate where the total number of teeth which require or are likely to require treatment is not considered excessive or when maintenance of the tooth is considered essential or appropriate in view of the overall dental status of the recipient.

- Treatment of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or other deciduous incisors in children five (5) years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

- Eight (8) posterior points of contact refers to four (4) maxillary and four (4) mandibular (molars/premolars) in natural or prosthetic functional contact with each other.

- For more information, please see the **NYS Medicaid Dental Policy and Procedure Code Manual**.

INTERRUPTED TREATMENT POLICY

When an individual changes insurer during a course of treatment, the insurer at the time of the decisive appointment is responsible for the payment for the entire treatment. Claims must be submitted when the product or service is completed and delivered as the date of service.

For more information, please see the **NYS Medicaid Dental Policy and Procedure Code Manual.**

EXCLUDED SERVICES

The following dental services are excluded under the Medicaid and will not be reimbursed:

- Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;
- Immediate full or partial dentures;
- Crown lengthening except when associated with medically necessary crown or endodontic treatment;
- Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified;
- Dental work for cosmetic reasons or because of the personal preference of the recipient member or provider;
- Periodontal surgery, except when associated with implants or implant related services Gingivectomy or gingivoplasty, except for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;
- Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts;
- Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210). D0330 is not payable on the same date of services as D0210.
- Placement of sealants for members under 5 or over 15 years of age;
- Experimental procedures.

If you believe that your claim has been improperly denied, you may request a plan appeal. For more information, please see **Section 11**.

OTHER NON-REIMBURSABLE SERVICES

Services associated with a non-approved procedure will not be considered for reimbursement.

HOSPITAL IN-PATIENT; AMBULATORY SURGERY; EMERGENCY ROOM

The "professional component" for dental services can be reimbursed pursuant to your contract. Payment for those services requiring prior approval/prior authorization is dependent upon obtaining approval from LIBERTY. For more information, please refer to the prior authorization section of this manual.

D9420 procedure code must be billed with the appropriate place of service defined by CMS.

Place of Service Code(s)	Place of Service Name	Place of Service Description
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

OWNERSHIP AND CONTROL DISCLOSURE

Contracted Dental Offices must provide LIBERTY with complete and accurate information regarding ownership and control of the Dental Office on the Disclosure Form specified by LIBERTY. In addition, on or before the anniversary of the Effective Date of the Provider Agreement, Dental Office must provide to LIBERTY an updated Disclosure Form or written confirmation that there has been no change in the ownership and/or control of the Dental Office as disclosed on the Disclosure Form. Failure to provide ownership and control information annually may result in termination of the Provider Agreement pursuant to Section 4.2(c)(ii) of the Provider Agreement. Required Ownership Information Disclosure, a federal regulation (42 CFR 455.104) requires network providers to disclose, at application/credentialing and recredentialing, ownership and control information to managed care organizations that contract with the state Medicaid agency.

Providers may meet this requirement by providing LIBERTY with a copy or update of the standard Medicaid FFS enrollment form. Otherwise, the following information must be provided:

- Name (individual or corporation)

- Address (for corporate entities, this must include, as applicable, business address, every business location and P.O. Box address)
- DOB and SS# (individual)
- Tax ID # (corporation with ownership/control interest in disclosing entity and any subcontractor in which provider has a 5% or more interest)
- Familial relationships (spouse, parent, child or sibling) among persons with ownership or control interest in the provider
- Familial relationships (spouse, parent, child or sibling) between persons with ownership or control interest in the provider and persons with ownership or control interest in any subcontractor in which the provider has a 5% or more interest
- Name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the provider has an ownership or control interest in addition, within 35 days of a request made by the New York State Department of Health, Office of the Medicaid Inspector General, or Department of Health and Human Services, participating providers must provide the following to LIBERTY:
    - Ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12-month period prior to the request; and
    - Any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor, during the five-year period ending on the date of the request.

Please refer to 42 CFR 455.101 for definitions of key terms under 42 CFR 455.104.

CERTIFICATION REGARDING INDIVIDUALS WHO HAVE BEEN DEBARRED OR SUSPENDED BY FEDERAL OR STATE GOVERNMENT

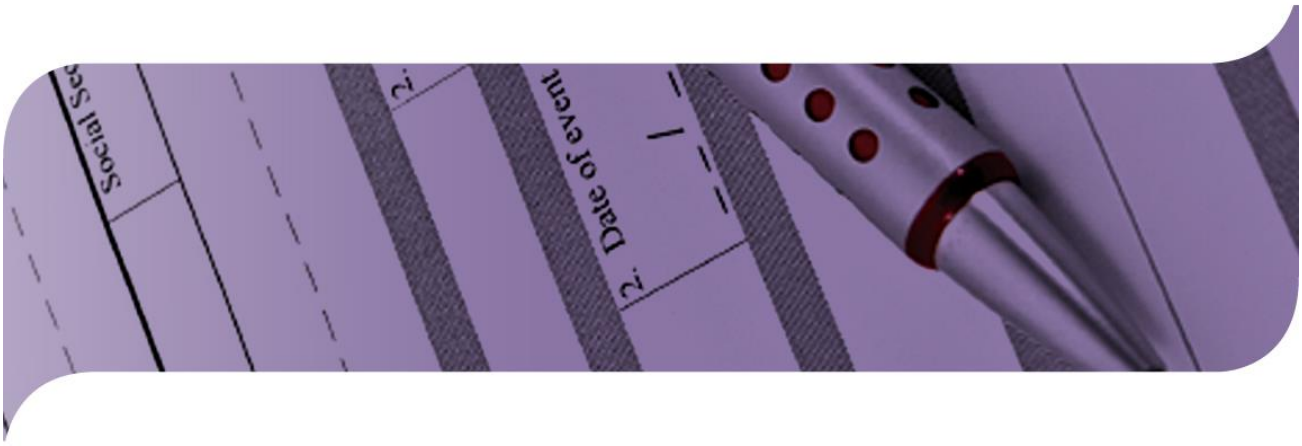
- Participating providers are required to have procedures in place to identify and determine the exclusion status of managing employees through routine checks of Federal databases. These include the Social Security Administration's Death Master file, The National Plan and Provider Enumeration System (NPPES), The Excluded Parties List System (EPLS), and either the List of Excluded Individuals and Entities or the Medicare Excluded Database (MED).
    - The LEIE (or the MED), the EPLS, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanction Lists and NYS OMIG Exclusion List must be checked no less frequently than monthly. Providers must report to LIBERTY when a match occurs.

COLLECTION AND DISCLOSURE OF CRIMINAL CONVICTION INFORMATION

- In accordance with LIBERTY's policies on credentialing and recredentialing, all practitioners must disclose any history of felony convictions.
    - LIBERTY will review disclosed criminal conviction information including, but not limited to:
        - Felony, conviction, guilty plea, plea of nolo contendere
        - Misdemeanor, in past ten years, conviction, guilty plea, plea of nolo contendere, found liable or responsible for: civil offense, reasonably related to qualifications, competence, functions, duties as a medical professional, fraud, act of violence, child abuse, sexual offense or sexual misconduct Note: Excludes minor traffic violations

- Court-martialed, for actions related to duties as a medical professional

SECTION 6. CLAIMS AND BILLING



All claims billed to LIBERTY must be submitted with the appropriate procedure code and correct date of service. The *False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733* is a federal law that prohibits a person or entity, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government. The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

Claims submitted to LIBERTY must reflect the date the actual treatment was rendered to a member. If the member was not seen, then no treatment was provided and therefore no claim should be submitted.

- The date of service indicated in Box 24 of the claim form must be the date that the service was actually completed and/or delivered.

At LIBERTY, we are committed to accurate and efficient claims processing. It is imperative that all information be accurate and submitted in the correct format. Network dentists are encouraged to submit clean claims within 90 calendar days of treatment completion. Payment will be denied for claims submitted more than 120 calendar days from the date of service. LIBERTY receives dental claims in four possible formats. These formats include the following:

1. HIPAA Compliant "837D" file
2. Electronic submissions via clearinghouse
3. Electronic submissions via LIBERTY's Provider Portal
4. Paper claims

HIPAA COMPLIANT 837D FILE

LIBERTY currently accepts HIPAA Compliant 837D files. If you would like to set up or inquire about this option, please contact our IT Department at 888.352.7924.

ELECTRONIC SUBMISSION – CLAIMS, PRIOR AUTHORZATIONS AND REFERRALS

LIBERTY strongly encourages the electronic submission of claims. This convenient feature assists in reducing

costs, streamlining administrative tasks and expediting claim payment turnaround time for providers. There are

two ways to submit electronically:

1. **PROVIDER PORTAL**
2. **THIRD PARTY CLEARINGHOUSE**

LIBERTY currently accepts electronic claims/encounters from providers through the clearinghouses listed below. If you do not have an existing relationship with a clearinghouse, please contact the clearinghouse of your choice to begin electronic claims submission. The EDI vendors accepted by LIBERTY are:

LIBERTY EDI VENDOR	PHONE NUMBER	WEBSITE	PAYER ID
DentalXchange	**800.576.6412**	www.dentalxchange.com	CX083
Emdeon	**877.469.3263**	www.emdeon.com	CX083
Tesia	**800.724.7240 x6**	https://www.tesia.com/	CX083

All electronic submissions should be submitted in compliance with state and federal laws, and LIBERTY's policies and procedures.

National Electronic Attachment, Inc. (NEA) is recommended for electronic attachment submission. For additional information regarding NEA and to register your office, please visit **www.nea-fast.com**, select *FASTATTACH™,* then select Providers.

PAPER CLAIMS

Paper claims must be submitted on an ADA approved claim forms. Please mail all paper claim/encounter forms to:

ATTN: CLAIMS DEPARTMENT	
LIBERTY DENTAL PLAN (Medicare) **PO Box 401086** **Las Vegas, NV 89140**	**LIBERY Dental Plan (Medicaid)** **PO Box 15149** **Tampa, FL 33684**

"CLEAN" CLAIMS

A "clean claim" is a claim submitted on ADA approved dental claim form and is one that can be processed without obtaining additional information from the provider of service or a third party. A "clean" claim includes all attachments and supplemental information or documentation which provides reasonably relevant information necessary to determine payer liability. The information for a clean claim may vary somewhat based on the type of provider service.

- Provider name and address;
- Member name, date of birth, and member ID number;

- Date(s) of service;
- CDT diagnoses code(s);
- Billed charges for each service or item provided;
- Provider Tax ID number and/or social security number, and;
- Name and state license number of dentist.

Emergency services or out-of-network urgently needed services do not require authorization, however, in order to be considered "complete," the claim must include:

- A Diagnoses which is immediately identifiable as emergent or out-of-network urgent, and;
- The dental records required to determine medical/necessity/urgency.

CLAIMS SUBMISSION PROTOCOLS AND STANDARDS

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by LIBERTY:

1. All claims must be submitted to LIBERTY for payment of services with the member ID number, first and last name and pre- or post-treatment documentation, if required.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.
3. All claims must include the name of the program under which the member is covered and all the information and documentation necessary to adjudicate the claim.

For emergency services, please submit a standard claim form which must include all the appropriate information, including pre-operative radiographs and a detailed explanation of the emergency circumstances.

DATE OF INSERTION

When submitting a dental claim for reimbursement of multi-step procedures (i.e., dentures), the date of service shall be the date of insertion.

CLAIMS STATUS INQUIRY

There are two options to check the status of a claim:

	**888.352.7924**, press option 2		**Provider Portal**

CLAIMS STATUS EXPLANATIONS

CLAIM STATUS	EXPLANATION
Completed	Claim is complete, and one or more items have been approved

Denied	Claim is complete, and all items have been denied
Pending	Claim is not complete. Claim is in the process of being reviewed and may not reflect the benefit determination

CLAIMS RESUBMISSION

Providers have 90 calendar days from the date of service to request a resubmission or reconsideration of a claim that was previously denied for:

- Missing documentation
- Incorrect coding
- Processing errors

CLAIMS OVERPAYMENT

The following paragraphs describe the process that will be followed if LIBERTY determines that it has overpaid a claim.

Notice of Overpayment of a Claim

If LIBERTY determines that it has overpaid a claim, LIBERTY will notify the provider in writing through a separate notice clearly identifying the claim; the name of the member, the date of service and a clear explanation of the basis upon which LIBERTY believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Recovery of Overpayments of a Claim

Consistent with the exception language in Section 3224 (b) of New York State Insurance Law, LIBERTY shall have and retain the right to audit participating providers' claims for a six-year period from the date the care, services or supplies were provided or billed, whichever is later, and to recoup any overpayments discovered as a result of the audit. This six-year limitation does not apply to situations in which fraud may be involved or in which the provider or an agent of the provider prevents or obstructs LIBERTY auditing.

Contested Notice

The provider may appeal LIBERTY's request for reimbursement of an overpayment within 30 calendar days, following the internal claims appeal process. LIBERTY shall conduct the appeal at no cost to the provider.

No Contest

If the provider does not contest LIBERTY's notice of overpayment of a claim, the provider must reimburse LIBERTY within 30 business days of the provider's receipt of the notice of overpayment of a claim. In the event that the provider fails to reimburse LIBERTY within 30 business days of the receipt of overpayment of the claim, LIBERTY is authorized to offset the uncontested notice of overpayment of a claim from the provider's current claim submissions.

Offset to Payments – Uncontested Notice of Overpayment

LIBERTY may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when: (1) the provider fails to reimburse LIBERTY within the timeframe set forth above, and (2) LIBERTY has the right to offset an uncontested notice of overpayment of a claim from the provider's current claims

submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, LIBERTY will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

PROMPT PAYMENT OF CLAIMS

LIBERTY's processing policies, payments, procedures and guidelines follow applicable State and Federal requirements.

ELECTRONIC FUNDS TRANSFER (EFT)

LIBERTY offers a payment solution through ECHO Health, Inc. (ECHO®). You can enroll in EFT/ACH by logging into: **ECHO Health Inc**.

EFT enrollment is verified after banking account information is provided to ECHO. **PLEASE NOTE: If you do not sign up for ECHO Health EFT/ACH, you will be enrolled in Virtual Card Services.** Virtual Cards allow your office to process payments as credit card transactions. Your office will receive fax notifications, each containing a virtual card number unique to that payment transaction. Once the number is received, you simply enter the code into your office's credit card terminal to process the payment as a regular card transaction. Normal transaction fees apply based on your merchant acquirer relationship.

- There are no fees to enroll and receive EFT payments **if you select the LIBERTY only option**: **ECHO Health Inc.**
- If your office opts to enroll in EFT payments through the above link, you will need to wait for the first payment to be issued as a virtual card and reference the draft number provided on the virtual card.

You may register at **www.ProviderPayments.com** to access a detailed explanation of payment for each transaction, to elect to receive email notifications of payments, and to access ERAs (835s) associated with your payments.

If you have any questions or need further information regarding this notification, please contact ECHO Health, Inc. at **(833) 629-9725** or email **EDI@ECHOHealthInc.com.**

PAPER CHECKS

If you prefer to receive paper checks, and paper explanation of payment you must elect to opt out of Virtual Card Services. To opt out, of virtual cards or EFT payments, please call (833) 629-9725.

PEER-TO-PEER COMMUNICATION

If you have questions or concerns about a referral, pre-authorization and/or claim determination and would like to speak to a licensed clinical reviewer, you may contact the number listed on the Explanation of Payment. Please leave a detailed message and your call will be returned by a licensed clinical reviewer.

SECTION 7. COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies when a Member has more than one source of dental coverage. The purpose of COB is to allow members to receive the highest level of benefits up to 100 percent of the cost of covered services. COB also ensures that no one collects more than the actual cost of the Member's dental expenses.

IDENTIFYING THE PRIMARY CARRIER

Members may be enrolled in a Managed Care Organization (MCO) or have benefits through the state Fee for Service Program. **MEDICAID is always the payor of last resort. If the member has any other plan, it will always be the primary coverage.**

- Primary Carrier – the program that takes precedence in the order of making payment
- Secondary Carrier – the program that is responsible for paying after the primary carrier

When determining the order of benefits (making payment) between two coordinating plans, the effective date refers to the first date the plan actively covers a member.

When there is a break in coverage, LIBERTY will be primary based on the LIBERTY effective date versus the new group effective date.

Scenarios of COBs:

1. **When LIBERTY is Primary Carrier**
   LIBERTY will only be considered the primary carrier for Medicaid when the member has no other dental coverage. Medicaid is always considered the payor of last resort.

2. **When LIBERTY is Secondary Carrier**
   A claim should always be sent to the primary carrier first. Following the primary carrier's payment, a copy of the primary carrier's Explanation of Benefits (EOBs) should be sent with the claim to LIBERTY. LIBERTY will take into consideration the dentist's participation status with the primary carrier and coordinate the claim with the EOB provided.

The Provider should submit Coordination of Benefits (COB) claims within 60 calendar days from the date of primary insurer's Explanation of Benefits (EOB) or 120 calendar days from the dates of service, whichever is later. LIBERTY will pay the difference up to the agreed upon or existing fee schedule.

SECTION 8. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

PRIMARY CARE DENTIST PROVIDER RESPONSIBILITIES

- Provide and/or coordinate all dental care for member;
- Perform an oral evaluation;
- Provide a written treatment plan to members upon request that identifies covered services, non-covered services, and clearly identifies any costs associated of each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues;
- Provide supporting materials for dental services and procedures which document their medical necessity;
- Treatment plans and informed consent documents must be signed by the member or responsible party showing understanding of the treatment plan;
- A financial agreement for any non-covered services shall be documented separate from any treatment plan or informed consent;
- Work closely with specialty care provider to promote continuity of care;
- Maintain adherence to LIBERTY's Quality Management and Improvement Program;
- Identify dependent children with special health care needs and notify LIBERTY of these needs;
- Notify LIBERTY of a member death;
- Arrange coverage by another provider when away from dental facility;
- Request the reassignment of a member by contacting LIBERTY and informing the member that he/she must contact LIBERTY for assignment to a new office.
- Provide emergency dental treatment no later than twenty-four (24) hours, or earlier as the condition warrants and urgent care appointments within 24 hours of request;
- Maintain scheduled office hours;
- Maintain dental records in accordance with New York State Board of Dentistry regulations;
- Provide updated credentialing information upon renewal dates;
- Provide requested information upon receipt of member grievance/complaint within the timeframe specified by LIBERTY on the written request;
- Notify LIBERTY of any changes regarding practice, including location name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc. at least 30 calendar days in advance.

- Provide dental services in accordance with peer reviewed clinical principles, criteria, guidelines and any evidence-based parameters of care.
- Provider will not discriminate or retaliate against a member or attempt to disenroll a member for filing a grievance or appeal.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES

LIBERTY's specialty providers are Board eligible. Providers who wish to advertise an area of dental specialty must meet the NY Board requirements for that dental specialty and have a current "specialty permit".

- All the Responsibilities & Rights of the PCD listed above;
- Provide specialty care to members;
- Work closely with primary care dentists to ensure continuity of care;
- Bill LIBERTY Dental Plan for all dental services that were provided;
- Dentists with certification in the following specialties: Endodontics, Oral Surgery/OMFS, Periodontics, and Prosthodontics must have, or have confirmation of application submission, of valid DEA or waiver and CDS certificates.
- Provide credentialing information upon renewal dates.

MEMBER RIGHTS AND RESPONSIBILITIES

Members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to members in their Handbook and Evidence of Coverage.

As a member of LIBERTY, each individual is entitled to the following rights:

- To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical and dental information;
- To be provided with information about the plan and its services, including covered services;
- To request a printed copy of the Member Handbook at least once per year or more frequently as determined necessary;
- To be able to choose a Primary Care Dentist within the Contractor's network;
- Freedom to change their Primary Care Dentist upon request for any reason and as frequently as needed, except for a member who is a restricted recipient;
- Instruction on this procedure are provided and outlined in the Member Handbook;
- To participate in decision making regarding their own dental care including the member's preference about future treatment decisions, and the right to refuse treatment;
- To have access to the grievance and appeal system and file a grievance about the organization or the care received, excluding adverse benefit determinations; either verbally or in writing;
- To request an appeal of an adverse benefit determination to deny, defer or limit services or benefits- either verbally or in writing;
- To receive interpretation services in their preferred language;
- To have access to all medically necessary dental service provided in Federally Qualified Health Centers, Rural
- Health Clinics or Indian Health Service Facilities, and access to emergency dental services outside the Contractor's network pursuant to federal law;

- To have access to, and where legally appropriate, receive copies of, amend or correct their dental record;
- To be provided disenrollment requirements and limitations and to dis-enroll upon request;
- To receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested;
- To receive information in a way that does not disclose they are a member of Medicaid;
- To be provided information about the definitions of emergency care;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
- Freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State;
- Freedom from LIBERTY prohibiting a provider from advising on behalf of a Member;
- To have access to Contractor's health education programs and outreach services in order to improve dental health;
- To request a second opinion, including from a specialist at no cost;
- To formulate advance directives.

As a member of LIBERTY, each member has the responsibility to behave according to the following standards:

- Provide accurate and updated information to contracting dentists, dental office staff and LIBERTY administrative staff to provide care (to the extent possible);
- To not allow any other person to use their ID Card;
- To communicate changes in demographic of dependent information, or other changes that would affect eligibility;
- Notify LIBERTY of any other insurance coverage;
- Respect and follow the policies and guidelines given by LIBERTY's contracting dentists, dental office staff and LIBERTY administrative staff with respect and courtesy;
- Cooperate with LIBERTY's contracting dentist in following a prescribed course of treatment; including instructions and oral health care recommendations/guidelines provided;
- Actively participate in treatment decisions;
- Keep scheduled appointments or communicate with the dental office at least 24 hours in advance to cancel an appointment;
- To be responsible for being on-time to scheduled appointments;
- To communicate and provide feedback on their needs and expectations to their dental office and to LIBERTY;
- Report any suspected provider fraud/abuse;
- Be aware of and follow LIBERTY's guidelines in seeking dental care.

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must give LIBERTY at least 60 calendar days' advance notice of intent to terminate a contract and adhere including, but not limited to the following:

- Provider must continue to treat members when medically necessary until the last day of the fourth month following the date of termination;
- The Provider must continue to treat members for postoperative care when medically necessary until the last day of the sixth month following the date of termination;
- Affected members are given advance written notification informing them of their transitional rights;
- Certain contractual rights survive termination, such as the agreement to furnish records during a grievance or claims review;
- Consult your provider contract for your responsibilities beyond termination.

MOBILE DENTAL PRACTICES AND MOBILE DENTAL VANS

Mobile Dental Practice is a provider traveling to various locations who utilizes portable dental equipment to provide dental services to facilities, schools and residences. These providers are expected to provide on-site comprehensive dental care, necessary dental referrals to PCDs or specialists and emergency dental care in accordance with all State Board of Dentistry regulations and the NYS Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care. Duplicate member records must be maintained at the location when this is a LTCF or skilled nursing facility and are to be maintained in a central and secure area in accordance with State Board of Dentistry regulations.

Mobile Dental Van is a designated vehicle specifically equipped to provide dental services on site. A mobile dental van is not to be considered a dental practice. Member records are to be maintained in accordance with State Board of Dentistry regulations.

STANDARDS OF ACCESSIBILITY AND AVAILABILITY

LIBERTY is committed to our members receiving timely access to care. Providers are required to schedule appointments for eligible members in accordance with the standards listed below, when not otherwise specified by state-specific regulation or by client performance standards.

Type of Appointment	Appointment Waiting Time Standards
Routine Care	**Within 28 days**
Urgent Care	**Within 24 hours**
Emergency Care	**Immediately upon presentation or within 24 hours**
After-Hours / Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: • Answering service that will contact provider (or provider on call) on behalf of the member • Call forwarding system that automatically directs members to call the provider (or the provider on call) • Answering system with explicit instructions on how to reach the provider and emergency instructions with assurance of a reasonable call-back (within 1-3 hours) in most cases • Calls involving life-threatening conditions or imminent loss of limb or functions may be referred to the 9-1-1, emergency medical services, emergency room or urgent care facilities in the community as per regionally available resources

Type of Appointment	Appointment Waiting Time Standards
Scheduled Appointment In-Office Wait Time	**Not to exceed 60 minutes.** Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider
Office Hours	**Minimum of 3 days/30 hours per week**
"Appointment Waiting Time" means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.	

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider's after-hours response system must enable members to reach an on-call dentist 24 hours a day, seven days a week. In the event the primary care dentist is not available to evaluate an emergency member of record within 24 hours, it is his/her responsibility to make arrangements to ensure that emergency services are available.

A dental emergency is defined as an unforeseen dental condition recognizable by acute signs and symptoms, such as cellulitis, uncontrolled oral hemorrhage, infection, swelling or trauma of sufficient severity that a prudent layperson who possesses an average knowledge of dentistry could reasonably expect the absence of immediate dental attention to result in disability or harm to a member if not immediately diagnosed and treated.

A medical emergency is limited to procedures administered in a hospital, when the condition could cause:

- Bodily injury
- Damage to an organ or other body part
- Harm to a member's health (this includes a mom-to-be and her unborn baby)

A member must be scheduled to a time appropriate for the emergency or urgent condition, which could be within 24 hours, or the next business day in most cases. Only the emergency will be treated at an emergency or urgent care appointment. If the member is unable to access emergency care within our guidelines and must seek services outside of your facility, LIBERTY will be financially responsible for the payment of the covered emergency services.

FACILITY PHYSICAL ACCESS FOR THE DISABLED – AMERICANS WITH DISABILITIES ACT

In accordance with The Americans with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504), providers may not discriminate against individuals with disabilities and are required to make their services available in an accessible manner by:

- Offering full and equal access to their health care services and facilities; and
- Making reasonable modifications to policies, practices and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e. alter the essential nature of the services).

The Americans with Disabilities Act sets requirements for new construction of and alterations to buildings and facilities, including health care facilities. In addition, all buildings, including those built before the ADA went into effect, are subject to accessibility requirements for existing facilities. Detailed service and facility requirements for disabled individuals can be found by visiting **www.ada.gov**.

APPOINTMENT RESCHEDULING

When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice. Appointments for follow-up care are required to be scheduled according to the same standards as initial appointments. Medicaid members cannot be charged for no show or missed appointment.

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established members. Recall systems should incorporate follow up on missed appointments and referrals. Missed or cancelled appointments should be noted in the member's record. Please note that Medicaid beneficiaries cannot be charged for broken or missed appointments.

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY AND AVAILABILITY

LIBERTY monitors compliance to the standards set forth in this manual through dental facility site assessments, provider/member surveys and other Quality Management processes. LIBERTY may seek corrective action for providers that are not meeting accessibility standards.

Expect Medicaid Managed Care Secret Shopper Calls for LIBERTY participating providers in Medicaid. Please be aware that the state New York State imposes special requirements for access to care. The New York State Department of Health contacts provider offices to verify participation in the Medicaid program and to check your compliance with appointment timeframes.

TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate written treatment plan. If there is more than one treatment available, the treating dentist must also present those treatment plans, and any related costs for non-covered services.

Non-Covered Procedures and Treatment Plans: LIBERTY members cannot be denied their plan benefits if they do not choose "non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the member or his/her guardian and the treating dentist. Refer to the Members' benefit plans to determine covered and non-covered procedures.

Non-Covered Services: Non-covered services can be discussed with the member. **Important Notice:** Any non-covered services selected by a member must be clearly presented on a separate treatment plan clearly stating that the service is **not covered,** and that the member has been informed of covered services and elects the non-covered service and understands and accepts the financial responsibility. LIBERTY recommends that payment

agreements with members be recorded in writing and agreed to by the member before any treatment is rendered. The member is responsible 100% of the entire fee.

In instances where dental services are not covered by LIBERTY, a dentist may charge a member for non-covered services after following certain protocols:

1. LIBERTY must issue a denial of the prior-authorization request and the member must exhaust their appeal rights.
2. The provider must enter into a private-pay financial agreement with the member ***prior*** to rendering the service.
3. The agreement should be a mutual and voluntary decision and the member must consent in writing.
4. The consent should include the specific codes, description and dollar amount that the member is agreeing to pay the provider.
5. The provider must maintain a record of the member's signed consent (for example, in the member's medical record). You may access the Consent for Non-Treatment Services on our Provider Portal.

SECOND OPINIONS

Members may request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan. Dentist should refer these members to LIBERTY's Member Services Department, Monday through Friday, 8 a.m. to 6 p.m. EST. Second Opinions may be requested for non-covered services.

CONTINUITY AND COORDINATION OF CARE

LIBERTY ensures appropriate and timely continuity and coordination of care for all plan members.

A panel of network dentists shall be available in currently assigned counties from which members may select a provider to coordinate all their dental care.

Continuity of care between the Primary Care Dentist (PCD) and any specialty care dentist must be available and properly documented. Communication between the PCD and dental specialist shall occur when members are referred for specialty dental care. LIBERTY expects PCDs to follow up with the Member and with the Specialist to ensure that referrals are occurring as per the best interest of the Member. Specialist providers are encouraged to send treatment reports back to the referring PCD to ensure that continuity of care occurs as per generally accepted clinical criteria.

The PCD is responsible for evaluating the need for specialty care, the need for any follow-up care after specialty care services have been rendered and should schedule the member for any appropriate follow-up care. LIBERTY expects PCD to provide an array of services and reserve specialty referrals only for procedures beyond the scope or training of the PCD.

The contracted dentist should refer a member to his/her current physician for any condition that may require active medical attention. The referral should include any relevant evaluation noted by the treating dentist. Copies of communications should be provided to the member and filed in their dental record.

INFECTION CONTROL

All contracted dentists must comply with the Centers for Disease Control (CDC) guidelines as well as other related federal and state agencies for sterilization and infection control protocols in their offices. Offices are not allowed to pass an infection control fee onto LIBERTY members.

REPORTING COMMUNICABLE DISEASES, DEVELOPMENTAL DELAYS, AND ABUSE

Physicians play a critical role in the prompt reporting of communicable diseases, suspected cases of developmental delay or disability in children, and suspected incidents of child abuse.

Please be aware of the requirements of New York State Sanitary Code (10NYCRR 2.10) regarding the reporting of communicable diseases, including suspected cases and certain carriers, to local health departments. Learn more and download the necessary form at www.health.state.ny.us/professionals/diseases/reporting/communicable/.

Learn more about the New York State Early Intervention Program (EIP) at www.health.ny.gov/community/infants_children/early_intervention/.

For details about mandated reporting of physical abuse, please go to www.ocfs.state.ny.us/main/publications/Pub1159.pdf.

Reporting of suspected or confirmed communicable disease is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). *The primary responsibility for reporting rests with the physician* who is also required to report the diseases listed below.

Anaplasmosis
Amebiasis
Animal bites for which rabies prophylaxis is given
Anthrax
Arboviral infection
Babesiosis
Botulism
Brucellosis
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cholera
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli O157:H7 infection
Ehrlichiosis
Encephalitis
Foodborne Illness
Giardiasis
Glanders
Gonococcal infection
Haemophilus influenzae (invasive disease)
Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles
Melioidosis
Meningitis
Aseptic or viral
Haemophilus
Meningococcal
Other (specify type)
Meningococcemia
Monkeypox
Mumps
Pertussis
Plague
Poliomyelitis
Psittacosis
Q Fever
Rabies
Rocky Mountain spotted fever
Rubella (including congenital rubella syndrome)
Salmonellosis
Severe Acute Respiratory Syndrome (SARS)
Shigatoxin-producing E.coli (STEC)
Shigellosis
Smallpox
Staphylococcus aureus (due to strains showing reduced susceptibility or resistance to vancomycin)
Staphylococcal enterotoxin B poisoning
Streptococcal infection (invasive disease)
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
Syphilis, specify stage
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies (TSE)
Trichinosis
Tuberculosis current disease (specify site)
Tularemia
Typhoid
Vaccinia disease
Vibriosis
Viral hemorrhagic fever
Yersiniosis

THE MEMBER'S DENTAL RECORD

Dental Records – the complete, comprehensive records of dental services, to include chief complaint, treatment needed, and treatment planned to include charting of hard and soft tissue findings, diagnostic images to include radiographs and digital views and to be accessible on site of members participating dentist and in the records of a facility for members in a facility.

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive members must be accessible for at least 10 years State Board of Dentistry Regulations.

Dental records must be comprehensive, organized and legible. All entries should be in ink, signed and dated by the treating dentist or other licensed health care professional who performed services.

Contracted dentists must make available copies of all member records to LIBERTY upon request. Records may be requested for grievance resolutions, second opinions or for state/federal compliance. The dentist must make records available at no cost to LIBERTY or the member. Non-compliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

LIBERTY takes pride in the fact that we administer our dental plan in an effective and innovative manner while safeguarding our members' protected health information. We are committed to complying with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

LIBERTY requires all dental providers to comply with HIPAA laws, rules and regulations. LIBERTY reminds network providers, that by virtue of the signed Provider Agreement (Contract), providers agree to abide by all HIPAA requirements, Quality Management Program requirements and that member protected Personal Health Information (PHI) may be shared with LIBERTY as per the requirement in the HIPAA laws that enable the sharing of such information for treatment, payment and health care operations (TPO), as well as for peer review and quality management and improvement requirements of health plans. There is no need for special member authorizations when submitting member PHI for these purposes.

Federal HIPAA laws require practitioners to use current CDT codes to report dental procedures.

Our commitment is demonstrated through our actions

LIBERTY has appointed a Privacy Officer to develop, implement, maintain and provide oversight of our HIPAA Compliance Program, as well as assist with the education and training of our employees on the requirements and implications of HIPAA. As a health care provider and covered entity, you and your staff must follow HIPAA guidelines regarding Protected Health Information (PHI).

LIBERTY has created and implemented internal corporate-wide policies and procedures to comply with the provisions of HIPAA. LIBERTY has and will continue to conduct employee training and education in relation to HIPAA requirements. LIBERTY has disseminated its Notice of Privacy Practices to all required entities. Existing

members were mailed a copy of the Notice and all new members are provided with a copy of the Notice with their member materials.

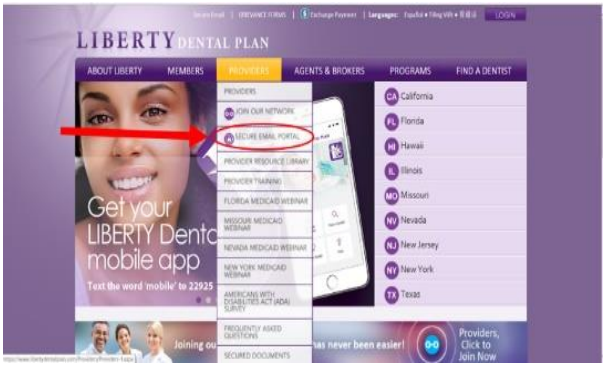
SAFEGUARDING PROTECTED HEALTH INFORMATION (PHI)

As a dental provider, your office is fully aware that the Health Insurance Portability Accountability Act (HIPAA) requires the protection and confidential handling of patient Protected Health Information (PHI). HIPAA requires health care providers to develop and implement safeguards that ensure the confidentiality and security of all forms of PHI (whether electronic, verbal, or tangible) when transmitted or stored.

Failure to properly safeguard PHI can result in data breaches, enforcement actions and significant monetary penalties, and with LIBERTY members, is a violation of LIBERTY's provider agreement. If LIBERTY discovers that a provider has transmitted LIBERTY member PHI via a potentially non-secure method, or if we are otherwise notified that a provider may not be properly safeguarding such PHI, we will contact the provider to investigate the matter. Non-compliance will result in a Corrective Action Plan and continued, or egregious non-compliance will lead to contract termination.

Safeguards which Providers must adhere to include, but are not limited to:

1. **Electronic PHI**
   A. Ensure referrals, authorization requests, medical records and other e-PHI are transmitted via a HIPAA compliant method using secure fax, secure FTP, encrypted email (which requires member authentication to access email content), or LIBERTY's secure web portal* Note the following:
      - Use of PHI (including member name, ID, or other identifying information) in the subject lines of emails or to name e-files is **not** permitted.
      - Use of free email service providers, like Gmail, Hotmail, or Yahoo, is **not** a permitted method for transmitting LIBERTY Member PHI*
      - Transmission of PHI via text is **not** permitted*
      - LIBERTY providers may transmit e-phi to LIBERTY using LIBERTY's HIPAA compliant, secure web portal by following these simple steps:
        - Go to www.libertydentalplan.com
        - Go to Providers menu at top of the page
        - Select Secure Email Portal



   B. Use physical and technical safeguards to ensure that monitors cannot be viewed by unauthorized individuals, and that screens automatically lock on devices, after a reasonable period of inactivity.
   C. Maintain protocols to ensure faxes containing PHI are issued to the correct member, and that increased precautions are applied when faxing especially sensitive information (such as sensitive diagnoses).

**When transmitting a member's own PHI to the member, the member's written request to receive the PHI electronically through a method other than those listed above may be honored, provided that reasonable steps are taken to validate the member's identity, and the potentially unsecure nature of the transmission has been disclosed to the member in writing in advance of the transmission, and the member consents to such transmission in writing.*

D. Review and adhere to LIBERTY's *Secure Use & Transmission of e-PHI* policy, located at: **Provider Resource Library**.

2. Verbal PHI

A. Do not discuss members information in public areas (including waiting rooms, hallways and other common areas), even if you believe you are masking the member's identity. Ensure conversations within examination rooms or operatories cannot be overheard by those outside of the room. Use heightened discretion when discussing sensitive diagnoses or other sensitive matters, including when such discussions occur with the patient in an exam room or operatory. Best practices include:

- Implementing appropriate physical safeguards such as closed doors and insulated walls for exam rooms and operatories. Use ambient music or white noise to cover conversations in common areas.
- Arranging waiting areas to minimize one-member overhearing conversations with another.
- Posting a sign requesting that patients who are waiting to sign-in or be seen, do not congregate in reception area.
- Ensuring unauthorized persons cannot overhear phone calls and limiting what is communicated by phone and voicemail to the minimum necessary information to accomplish the required purpose. Also, please avoid use of speaker phones.

3. Tangible PHI

A. Do not display or store paper or other tangible PHI in common areas. Do not leave such PHI unattended on desks or in exam rooms or operatories. Never dispose of paper or other tangible PHI in the trash. Use secure methods to destroy and dispose of such PHI (for example, cross-cut shredder).

B. Lock away all PHI during close of business (for example, in a locked cabinet).

C. Close window blinds to prevent outside disclosure.

D. Do **not** overstuff mailing envelopes; and print mailing addresses accurately and clearly to minimize the possibility that mail is lost in transit.

E. Take precautions to ensure PHI is not lost while transporting from one location to another, and never leaving tangible PHI in vehicles unattended.

ANTI-DISCRIMINATION

Discrimination is against the law. LIBERTY complies with all applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex. LIBERTY provides free aids and services to people with disabilities, and free language services to people whose primary language is not English, such as:

- Qualified interpreters, including sign language interpreters
- Written information in other languages and formats, including large print, audio, accessible electronic formats, etc.

If you need these services, please contact us at 1-888-844-3344. If you believe LIBERTY has failed to provide these services or has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LIBERTY's Civil Rights Coordinator:

Phone: 888-704-9833

TTY: 800-735-2929

Fax: 714-389-3529

Email: compliancehotline@libertydentalplan.com

Online: https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx

If you need help filing a grievance, LIBERTY's Civil Rights Coordinator is available to help you. You can also file a civil rights grievance with the U.S. Department of Health and Human Services, Office for Civil Rights:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Online at: https://www.hhs.gov/civil-rights/filing-a-grievance/grievance-process/index.html
Grievance forms are available at http://www.hhs.gov/ocr/office/file/index.html

CULTURALLY COMPETENT CARE

In accordance with state and federal regulations, LIBERTY provides culturally competent care and services in a nondiscriminatory manner that ensures all members including those with Limited English Proficiency (LEP) and members with disabilities, receive effective and respectful care in a timely manner compatible with their culture, health beliefs, practices and preferred language. LIBERTY collaborates and participates with applicable state and regulatory agencies to promote the delivery of care in a culturally competent manner.

Cultural considerations for appropriate care include but are not limited to ethnicity, race, gender, age, preferred language, English proficiency, sexual orientation, immigration status, acculturation factors, spiritual beliefs and practices, physical abilities and limitations, family roles, community networks, literacy, employment, and socioeconomic factors.

LANGUAGE ASSISTANCE SERVICES

Language Assistance services are available to ensure Limited English Proficient (LEP) members have appropriate access to language assistance including special format for hearing and visually impaired members, while accessing dental care.

Interpretation services for Limited English Proficient members (when and where required by state law or group/client arrangement):

- Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting LIBERTY's Member Services Department at **888.869.4299**. When and where

required by law or client group requirement, LIBERTY offers free telephonic interpretation through our language service vendor. When required, this service is available to the member at no cost.

- To engage an interpreter once the member is ready to receive services, please call **888.869.4299**. You will need the member's LIBERTY Dental ID number, date of birth and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance.
- LIBERTY discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.
- Providers must also fully inform the member that he or she has the right not to use family, friends or minors as interpreters.
- If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.
- Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries, and only for those members entitled to receive such services by virtue of state requirement or client group requirement.
- Written Member Informing Materials in threshold languages and alternative formats (including Braille and large font) are available to members at no cost and can be requested by contacting LIBERTY's Member Services Department.
- Assistance in working effectively with members using in-person, telephonic interpreters, other media such as TTY/TDD and remote interpreting services can be obtained by contacting LIBERTY's Member Services Department.

IDENTIFYING AND REPORTING ABUSE, NEGLECT AND EXPLOITATION OF MEMBERS

Domestic Violence Community Resources Information found at https://opdv.ny.gov/.

Domestic violence (DV) is a public health issue which negatively impacts a patient's health outcome. Victims of DV are more at risk of a wide range of physical, mental, reproductive, and other health consequences over their lifetime than non-victims. Women and men of all races, ages, sexual orientations, and marital and socioeconomic statuses are at risk for domestic violence. However, some populations report higher rates of victimization. It is important to examine the impact of domestic violence on all patients, as well as high-risk populations such as pregnant women, children, women with sexually transmitted infections (STIs), immigrants, and limited English proficient (LEP) victims. As a healthcare provider, you have a crucial role in the successful treatment and safety of your patients. New York State Domestic Violence Hotlines Your local hotline can provide you with information on domestic violence resources in your community. For the hotline number of your local domestic violence program, call the New York State Domestic Violence Hotline at 1-800-942-6906, English & Español/Multi-language Accessibility: Deaf or Hard of Hearing: 711.

SECTION 9. REFERRAL AND PRIOR AUTHORIZATION GUIDELINES

NON-EMERGENCY SPECIALTY REFERRAL SUBMISSION AND INQUIRIES

PCDs must submit referral requests to LIBERTY for prior authorization. There are three options to submit a specialty care referral:

1. **Provider Portal**
2. **Fax**: 888.700.1727
3. **Mail:**

ATTN: REFERRAL DEPARTMENT
LIBERTY Dental Plan PO Box 401086 Las Vegas, NV 89140

If there is no contracted LIBERTY specialist available within a reasonable proximity to your office, our Member Services Representatives will assist in referring the member to a non-contracted Specialist.

If a referral is made by the members assigned PCD without prior authorization, the referring office may be held financially responsible. Failure to use the proper forms and submit accurate information may cause delays in processing or payment of claims.

The LIBERTY Specialty Care Referral Request Form must be completed and used when making a referral. The form may be photocopied and duplicated in your office as needed.

Radiographs and other supporting documentation will not be returned. Please do not submit original radiographs. Radiographic copies of diagnostic quality, including paper copies of digitalized images, are acceptable.

EMERGENCY REFERRAL

Emergency Referral Guidelines

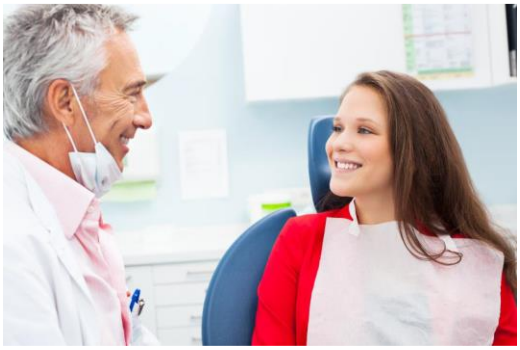
Emergency referrals must be obtained when a member is experiencing pain, swelling, bleeding or trauma. The fastest method for PCDs and oral surgeons to obtain an emergency referral is through our **Provider Portal.**

Additionally, emergency referrals can be requested in one of the following ways:

- **Referral Unit: 888.352.7924**, Option 4
- The Emergency Referral Unit is staffed with Dental Consultants who can review and approve immediate referral requests and any treatment plan modifications to existing referral requests during normal business hours Monday through Friday, 8am – 6pm EST.
- Emergency referrals are valid for thirty (30) days. Extensions can be requested by a member or provider.

Emergency Referral Guidelines for Oral Surgeons

If a member presents themselves to an oral surgeon's office for emergency services without an approved referral, you may treat the member for the emergency service. If a member is treated without a referral, you will need to submit a completed **Emergency Oral Surgery Specialty Care Attestation Form** along with the appropriate radiographs, narrative and dated claim to be considered for payment.



Any additional non-emergency treatment must be submitted for prior authorization to ensure payment.

In order for LIBERTY to approve an oral surgery referral, the Primary Care Dentist must complete a LIBERTY Specialty Care Referral Request Form and include the following information:

- Member's name, subscriber identification number and group name;
- Radiographs that clearly show all current conditions, and which allow for the proper evaluation and diagnosis of the member's condition and any other pertinent information that will assist in determining the necessity and appropriateness of the referral;
- LIBERTY will designate the specialist and issue the referral for the treatment that has been authorized;
- Specialty referral guidelines are available in the LIBERTY Provider Reference Guide.

You may access a copy of the Emergency Oral Surgery Specialty Care Attestation Form through the **Provider Resource Library**.

Criteria for General Anesthesia

LIBERTY will review and approve up to four (4) of units for general anesthesia on prior authorization requests. If subsequent units are utilized, a copy of the anesthesia record will be required with submission.

Referral Guidelines for the Primary Care Dentists - Confirm the need for a referral and that the Referral Criteria listed below are met. Complete a LIBERTY Specialty Care Referral Request Form and provide the following:

- Member's name, subscriber identification number, and group name;
- Name, address and telephone number of the contracted LIBERTY network Endodontist;
- Procedure code(s), tooth number(s) and member copayments for the covered endodontic treatment, which requires referral.
- Radiographs that clearly show all current conditions, and which allow for the proper evaluation and diagnosis of the entire dentition and any other pertinent information that will assist in determining the necessity and appropriateness of the referral.

Inform the member that:

- Only services approved by LIBERTY will be covered;
- The member will be financially responsible for non-covered and non-approved services provided by the Endodontist;
- Payment by LIBERTY is subject to eligibility at the time services are rendered.

For non-emergency referrals, submit referral to LIBERTY with appropriate documentation/radiographs through the Provider Portal (i-Transact), fax or via standard mail service. LIBERTY's Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Endodontist - Obtain the LIBERTY Specialty Care Authorization and pre-operative periapical radiograph(s) from LIBERTY Dental Plan, General Dentist or member.

For any services, other than those listed on the original authorization form from LIBERTY Dental Plan, you must submit a preauthorization request to the LIBERTY with a copy of pre-operative periapical radiograph(s) and the member's LIBERTY Specialty Care Authorization.

If an emergency endodontic service is needed but has not been listed on the original authorization form, the Endodontist should contact LIBERTY's Referral Unit at, Option 4 for an emergency authorization number.

After completion of treatment, submit your claim for payment with pre-operative and post-operative periapical radiographs. To avoid delays in claim payment, please always attach a copy of the member's Authorization Form. **Radiographs and other supporting documentation will not be returned. Please do not submit original radiographs. Radiographic copies of diagnostic quality or paper copies of digitized images are acceptable.**

<table>
<tr><th colspan="6">Endodontic Referral Guidelines</th></tr>
<tr><th colspan="2">Endodontic Referrals
Primary Care Dentist
Specialty Care Guidelines
(Subject to Plan Benefits)</th><th>Procedures Usually Approved fo Referral</th><th>Referral Criteria

(teeth must have a good prognosis & be restorable)</th><th>Emergency Referral Criteria</th><th>Qualifies for Emergency Referrals</th></tr>
<tr><td>D0220</td><td>Intraoral - periapical first film</td><td>No</td><td>N/A</td><td rowspan="3">Swelling, bleeding and/or pain and the PCD has attempted palliative treatment</td><td>If diagnostic PA radiographs are not available</td></tr>
<tr><td>D3310</td><td>Root canal - anterior (excluding final restoration)</td><td>No</td><td rowspan="2">When excessive root curvature or calcification evident on radiographs precludes PCD from treating</td><td>Considered on a case-by-case basis</td></tr>
<tr><td>D3320</td><td>Root canal - bicuspid (excluding final restoration)</td><td>No</td><td>Considered on a case-by-case basis</td></tr>
<tr><td>D3330</td><td>Root canal - molar (excluding final restoration)</td><td>Yes</td><td>Attending PCD documents procedure to be "outside the scope" o his or her skills</td><td rowspan="2">Swelling, bleeding and/or pain and the PCD has attempted palliative treatment</td><td>If no diagnostic PA radiographs available</td></tr>
<tr><td>D3346</td><td>Retreatment of previous root canal therapy - anterior</td><td>Yes</td><td>Case-by-Case</td><td>Yes</td></tr>
</table>

Endodontic Referral Guidelines					
Endodontic Referrals Primary Care Dentist Specialty Care Guidelines (Subject to Plan Benefits)		**Procedures Usually Approved fo Referral**	**Referral Criteria** (teeth must have a good prognosis & be restorable)	**Emergency Referral Criteria**	**Qualifies for Emergency Referrals**
D3347	Retreatment of previous root canal therapy - bicuspid	Yes			Yes
D3348	Retreatment of previous root canal therapy - molar	Yes			Yes
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Yes			Extraordinary circumstances considered on a case-by-case basis
D3352	Apexification/recalcification, interim medication replacement				
D3353	Apexification/recalcification, final visit				
D3410	Apicoectomy/periradicular surgery – anterior	Yes			
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	Yes			
D3425	Apicoectomy/periradicular surgery - molar (first root)	Yes			
D3426	Apicoectomy/periradicular surgery (each additional root)	Yes			
D3430	Retrograde filling - per root	Yes			
D9310	Consultation, other than requesting dentist	Yes			Yes

ORAL SURGERY

Referral Guidelines for the Primary Care Dentist - Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Referral Request Form and provide the:

- Member's name, subscriber identification number and group name;
- Name, address and telephone number of the contracted LIBERTY network Oral Surgeon;
- Procedure code(s) and, tooth number(s)/quadrant(s), which require referral.

Inform the member that:

- Only services approved by LIBERTY will be covered
- Payment by LIBERTY is subject to eligibility at the time services are rendered

For non-emergency referrals, submit referral to LIBERTY with appropriate documentation/radiographs through the Provider Portal or via standard mail service.

A LIBERTY Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Oral Surgeon - Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY, PCD or member.

Standard referrals will be reviewed and issued for approved services requested by the PCD. Code D9310 (consultation, other than the requesting dentist) is not payable on the same day as treatment. Any treatment plan modifications added to the referral by the oral surgeon are subject to claim submission review and must meet benefit guidelines.

If an emergency oral surgery service is needed but has not been listed by the PCD on the LIBERTY Specialty Care Authorization, the Oral Surgeon should contact LIBERTY's Referral Unit for an emergency authorization number.

After completion of treatment, submit your claim for payment. To avoid delays in claim payment, please attach a copy of the member's LIBERTY Specialty Care Authorization or LIBERTY's authorization form. If emergency care was provided after obtaining a Plan emergency authorization number, print that number on the claim form and attach the radiograph(s). For a biopsy, also attach a copy of the laboratory's report. **Radiographs and other supporting documentation will not be returned. Please do not submit original radiographs. Radiographic copies of diagnostic quality or paper copies of digitized images are acceptable.**

Emergency Situations - Providers should not turn away members who are in pain without a referral. If a member presents to the oral surgeon's office for an emergency without a referral, the provider should treat the condition and submit all appropriate documentation for payment including the Emergency Oral Surgery Specialty Care Attestation Form. An emergency is described as the presence of pain, swelling, bleeding and/or infection. Providers should include a narrative to explain the emergency condition. All services provided will be subject to claim submission review.

It is recommended that any additional, non-emergency treatment be prior authorized to ensure payment. If services are not prior authorized, they will be subject to claim submission review.

Oral Surgery Referral Guidelines				
Oral Surgery Referrals (Subject to plan Benefits)		**Procedures Usually Approved for Referral**	**Referral Criteria**	**Qualified for Emergency Referral**
D0220	Intraoral - periapical first film	By Report	Non-diagnostic radiographs sent by referring PCD	By Report
D0330	Panoramic film	By Report		By Report

Oral Surgery Referral Guidelines				
Oral Surgery Referrals (Subject to plan Benefits)		**Procedures Usually Approved for Referral**	**Referral Criteria**	**Qualified for Emergency Referral**
D7111	Extraction, coronal remnants deciduous tooth	No	N/A	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	N/A	No
D7210	Extraction of erupted tooth requiring - removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap, if indicated	By Report	PCD's radiograph(s) supports the procedure to be "outside the scope" of his or her skills and/or four (4) or more teeth to be extracted.	By Report
D7220	Removal of impacted tooth - soft tissue	Yes	With documented active pathology	Yes
D7230	Removal of impacted tooth - partially bony	Yes		Yes
D7240	Removal of impacted tooth - completely bony	Yes		Yes
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Yes		Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	By Report	Radiograph must support the use of this code	Yes
D7280	Surgical access of an unerupted tooth	Yes	Radiograph must support the use of this code; Orthodontic approval on file if performed in conjunction with orthodontic treatment	Yes
D7283	Placement of device to facilitate eruption of impacted tooth	Yes		Yes
D7285	Biopsy of oral tissue - hard (bone, tooth)	Yes	Diagnostic radiograph, description, and location of lesion	Yes
D7286	Biopsy of oral tissue - soft	Yes	Description and location of lesion	Yes
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	By Report	Not reimbursable in addition to surgical extractions in the same quadrant	Yes

Oral Surgery Referral Guidelines				
Oral Surgery Referrals (Subject to plan Benefits)		**Procedures Usually Approved for Referral**	**Referral Criteria**	**Qualified for Emergency Referral**
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	By Report		Yes
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	By Report	By Report	Yes
D7321	Alveoloplasty not in conjunction with extractions - to 3 teeth or tooth spaces, per quadrant	By Report	By Report	Yes
D7471	Removal of lateral exostosis (maxilla or mandible)	Yes	By Report	
D7472	Removal of torus palatinus	Yes	By Report	
D7473	Removal of torus mandibularis	Yes	By Report	
D7510	Incision and drainage of abscess-intraoral soft tissue	Yes	By Report	Yes
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	Yes		
D7970	Excision of hyperplastic tissue - per arch	Yes	By Report	Yes
D7971	Excision of pericoronal gingiva	Yes	By Report	Yes
D9310	Consultation, other than requesting dentist	Yes		Yes

PERIODONTICS

Referral Guidelines for the Primary Care Dentist - Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Authorization and provide the:

- Member's name, subscriber identification number and group name;
- Name, address and telephone number of the contracted LIBERTY network Periodontist (optional);
- Procedure code(s), tooth number/quadrant(s) and member copayments for the covered periodontal treatment, which require referral.

Inform the member that:

- Only services approved by LIBERTY will be covered

- Payment by LIBERTY is subject to eligibility at the time services are rendered;

Submit the referral to LIBERTY with appropriate documentation to include current periodontal radiographs and charting showing six-point probing of each natural tooth through the Provider Portal or via standard mail service.

A LIBERTY Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Periodontist - Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY, PCD or member.

For any services, other than those listed on the referral from the member's assigned PCD, submit a prior authorization request to LIBERTY with copies of:

- Pre-operative full mouth radiographs;
- Complete periodontal charting showing six-point probing of each natural tooth and any furcation involvements, abnormal mobility or areas of recession. Submit radiographs that were enclosed with original authorization form (or copies);
- The member's LIBERTY Specialty Care Authorization.

After completion of treatment, submit your claim for payment with a copy of LIBERTY's authorization for treatment.

Periodontic Referral Guidelines				
Periodontal Referrals Primary Care Dentist Specialty Care Guidelines (Subject to Plan Benefits)		**Procedures Usually Approved for Referral**	**Referral Criteria**	**Documentation to be sent to LIBERTY and Specialist**
D0210	Intraoral - complete series (including bitewings)	No	No	Yes
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	By Report	Reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects.	Diagnostic full mouth radiographs periodontal charting must be submitted. Additional documentation may include narrative and/or photos demonstrating need for treatment.
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	By Report		
D4245	Apically positioned flap	By Report		
D4249	Clinical crown lengthening-hard tissue	By Report	Reimbursable when associated with a covered crown and/or root canal procedure.	All requests for coverage of a crown lengthening should include a complete treatment plan addressing all areas of pathology.
D4341	Periodontal scaling & root planing - 4 or more teeth per quadrant	No	For moderate to severe periodontitis, "may" be considered for referral. If approved, limited to no more than two quadrants on the same date of service. Diagnostic Full Mouth Radiographs, current full mouth periodontal charting	If approved, limited to no more than two quadrants on the same date of service. Diagnostic Full Mouth Radiographs, current full mouth periodontal charting
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	No		
D9310	Consultation, other than requesting dentist	Yes	Not payable when rendered on the same day of other treatment	By Report

PERIODONTIC REFERRAL COVERAGE BASED ON DIAGNOSIS

Slight Chronic/Aggressive Periodontitis (localized or generalized)

Referral to a Periodontist is covered only for a problem-focused examination on a case-by-case basis.

Moderate Chronic/Aggressive Periodontitis (localized or generalized)

- Pocket depths of 5-6 mm with the possibility of localized greater pocket depths with 3 - 4 mm of clinical attachment loss;

- Generalized bleeding upon probing;
- Possible Class 1 to Class 2 (1 – 2 mm) tooth mobility;
- Class I furcation involvement with the possibility of some early Class II (i.e., can probe between the roots); and
- Radiographic evidence of moderate (20%-40%) bone loss, which is usually horizontal in nature.

Referral to a Periodontist **may be** covered, **if indicated**, after scaling and root planing by the assigned PCD for a problem-focused examination. -

Severe Chronic/Aggressive Periodontitis (localized or generalized)

- Pocket depths are generally greater than 6 mm with 5 mm or greater clinical attachment loss;
- Generalized bleeding upon probing;
- Possible Class 1, Class 2 or Class 3 (>2 mm or depressibility) tooth mobility.
- Grades I and II furcation involvements with possibly Grade III involvement (i.e., "through and through" access between the roots); and
- Radiographic evidence of severe (over 40%) bone loss, which may be horizontal and vertical in nature.

Referral to a Periodontist is covered for a problem-focused examination, scaling and root planing.

Refractory Chronic/Aggressive Periodontitis

- Defined as a periodontal condition where treatment fails to arrest the progression of periodontitis – whatever the thoroughness or frequency – as well as members with recurrent disease at single or multiple sites
- Referral to a Periodontist covered to confirm the diagnosis of Refractory Chronic/Aggressive Periodontitis and to advise you on the member's management and care.

SECTION 10. CLINICAL DENTISTRY PRACTICE PARAMETERS

The following clinical dentistry criteria, processing guidelines and practice parameters represent the view of the Peer Review Committee of LIBERTY and represent LIBERTY's processing guidelines, benefit determination guidelines and the generally acceptable clinical parameters as agreed upon by consensus of the Peer Review Committee to be professionally recognized best practices. In some cases, guidance is given about procedure code services that may not be within the scope of benefits of all LIBERTY benefit plans.

Please consult the New York State Medicaid Program Dental Policy and Procedure Code Manual for covered services under the Medicaid Program. https://www.emedny.org/ProviderManuals/Dental/index.aspx

NEW MEMBER INFORMATION

Registration information should include:

1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number, language of preference;
2. Name and telephone number of person(s) to contact in an emergency;
3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above;
4. Pertinent information relative to the member's chief complaint and dental history, including any problems or complications with previous dental treatment;
5. Medical History - There should be a detailed medical history form comprised of questions which require "Yes" or "No" response, including:
    a. Member's current health status
    b. Name and telephone number of physician and date of last visit
    c. History of hospitalizations and/or surgeries
    d. Current medications, including dosages and indications
    e. History of drug and medication use (including Fen-Phen/Redux and bisphosfonates)

f. Allergies and sensitivity to medications or materials (including latex)

g. Adverse reaction to local anesthetics

h. History of diseases or conditions:

i. Cardio-vascular disease, including history of abnormal (high or low) blood pressure, heart attack, stroke, history of rheumatic fever or heart murmur, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.

ii. Pulmonary disorders including COPD, tuberculosis, asthma and emphysema

iii. Nervous disorders, including psychiatric treatment

iv. Diabetes, endocrine disorders, and thyroid abnormalities

v. Liver or kidney disease, including hepatitis and kidney dialysis

vi. Sexually transmitted diseases

vii. Disorders of the immune system, including HIV status/AIDS

viii. Other viral diseases

ix. Musculoskeletal system, including prosthetic joints and when they were placed

x. History of cancer, including radiation or chemotherapy

6. Pregnancy

a. Document the name of the member's obstetrician and estimated due date.

b. Follow current guidelines in the ADA publication, Women's Oral Health Issues.

7. The medical history form must be signed and dated by the member or member's parent or guardian.

8. Dentist's notes following up member comments, significant medical issues and/or consultation with a physician should be documented on the medical history form or in the progress notes.

9. Medical alerts for significant medical conditions must be uniform and conspicuously located on the monitor for paperless records or on a portion of the chart used and visible during treatment and should reflect current conditions.

10. The dentist must sign and date all baseline medical histories after review with the member. If electronic dental records are used, indication in the progress notes that the medical history was reviewed is acceptable.

11. The medical history should be updated at appropriate intervals, dictated by the member's history and risk factors, and must be documented at least annually and signed by the member and dentist.

CLINICAL ORAL EVALUATIONS

A. Periodic oral evaluations (Code D0120) of an established member may only be provided for a member of record who has had a prior comprehensive examination. Periodontal evaluations and oral cancer screenings

should be updated at appropriate intervals, dictated by the member's history and risk factors, and should be done at least annually.

B. A problem-focused limited evaluation (Code D0140) must document the issue substantiating the medical necessity of the evaluation.

C. An oral evaluation of a member (Code D0145) less than three years of age should include documentation of the oral and physical health history, evaluation of caries susceptibility and development of an oral health regimen.

D. A comprehensive oral evaluation for new or established members (Code D0150) who have been absent from active treatment for at least three years or have had a significant change in health conditions should include the following:

   1. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including dental caries, missing or impacted teeth, existing restorations, prior endodontic treatment, fixed and removable appliances.

   2. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented.

   3. Full mouth periodontal screening must be documented for all members; for those members with an indication of periodontal disease, probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.

   4. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented for all members, regardless of age.

E. A detailed and extensive problem focused evaluation (Code D0160) - entails extensive diagnostic and conceptual modalities to develop a treatment plan for a specific problem. The condition requiring this evaluation should be documented and described.

DIAGNOSTIC IMAGING

Based on the dentist's determination that there is generalized oral disease or a history of extensive dental treatment, an adequate number of images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines to minimize the member's exposure. Photographic images may also be needed to evaluate and/or document the existence of pathology.

A. An attempt should be made to obtain any recent radiographic images from the previous dentist.

B. An adequate number of initial radiographic images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines. This includes the ALARA Principle (As Low As Reasonably Achievable) to minimize the member's exposure. It is important to limit the number of radiographic images obtained to the minimum necessary to obtain essential diagnostic information.

C. The member should be evaluated by the dentist to determine the radiographic images necessary for the examination prior to any radiographic survey.

D. Intraoral – comprehensive series (Code D0210)

Note: D0210 is a radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, interproximal areas, periapical areas and alveolar bone including edentulous areas

1. Benefits for this procedure are determined within each plan design.
2. Any benefits for periapical and/or bitewing radiographs taken on the same date of service will be limited to a maximum reimbursement of the dental provider's fee for a complete series.
3. Any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, for benefit purposes only.
4. Decisions about the types of recall films should also be made by the dentist and based on current FDA/ADA radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the member's last radiographic examination.

E. Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.

F. Radiographs should exhibit good contrast.

G. Diagnostic digital radiographs should be submitted electronically when possible or should be printed on photographic quality paper and exhibit good clarity and brightness.

H. All radiographs must be mounted, labeled left/right and dated.

I. Intra or extra-oral photographic images should only be taken to diagnose a condition or demonstrate a need for treatment that is not adequately visualized radiographically.

J. Any member refusal of radiographs should be documented.

K. Radiograph duplication fees:

1. Radiographic image duplication fees are not allowed.
2. When a member is transferred from one contracted provider to another, diagnostic copies of all radiographic images less than two years old should be duplicated for the second dental provider.

L. 2D Oral/Facial Photographic Image obtained Intra-orally or Extra-orally (D0350) are only reimbursable when associated with the below procedures:

   a. Periodontics (Limited to limited to gingivectomy or gingivoplasty, procedure codes D4210, D4211 (as pretreatment documentation)
   b. Implants (as required documentation for covered procedures)
   c. Orthodontics (fee includes all intra-oral and extra-oral images taken on the same date of service

M. Diagnostic casts (Code D0470) are for the evaluation of orthodontic benefits only and are only payable upon approved orthodontic treatment.

TESTS, EXAMINATIONS AND REPORTS

A. Tests, examinations and reports may be required when medically necessary to determine a diagnosis or treatment plan for an existing or suspected oral condition or pathology.

B. Oral pathology laboratory procedure/report may be required when there is evidence of a possible oral pathology problem.

PREVENTIVE TREATMENT

A. Dental prophylaxis (Code D1110) may be medically necessary when documentation shows that there is evidence of plaque, calculus or stains on tooth structures.

B. Topical fluoride and fluoride varnish (Code D1206 and D1208) treatment may be medically necessary when documentation shows that there is evidence of the need for this preventive procedure.

C. Interim caries arresting medicament application (Code D1354) Silver Diamine Fluoride (SDF) is the topical application of a caries arresting medicament applied to an active, non-symptomatic carious lesion. This conservative treatment is performed primarily on young children with primary teeth without mechanical removal of sound tooth structure and should be submitted on a per tooth basis.

D. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the member's physician. Verify plan benefits prior to performing additional prophylaxis procedures in excess of plan limitations.

RESTORATIVE TREATMENT

Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the clinical crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered. Restorations placed solely for the treatment of abrasion, attrition, erosion or abfraction and which are not associated with the treatment of any other pathology will not be reimbursed.

A. Amalgam Restorations (Codes D2140-D2161)

1. . Numerous scientific studies conducted over the past several decades indicate dental amalgam is a safe, effective cavity-filling material for children and others. In its review of the scientific literature on amalgam safety, the American Dental Association (ADA) has agreed with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used restorative material:

    a. The procedure of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally an amalgam or composite restoration.

    b. Facial or buccal restorations are generally considered to be "one surface" restorations, not three surfaces such as MFD or MBD.

    c. The replacement of clinically acceptable amalgam restorations with an alternative material (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture of the existing restoration is present.

d. If a dentist chooses not to provide amalgam -restorations, alternative posterior -restorations must be made available for LIBERTY members. Any listed amalgam copayments would still apply.

e. An amalgam restoration includes tooth preparation and all adhesives, liners and bases.

f. An amalgam restoration may be medically necessary when a tooth has a fracture, defective restoration or decay penetrating into the dentin.

g. An amalgam restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.

B. Resin-based Composite Restorations (Codes D2330 – D2394)

1. The procedure of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is a composite restoration. Decay limited to the incisal edge only, may still be a candidate for a composite restoration if little to no other surfaces manifest caries or breakdown.

2. Facial or buccal restorations are generally considered to be "one surface" restorations, not three surfaces such as MFD or MBD.

3. The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture is present.

4. A resin-based composite restoration includes tooth preparation, acid etching, adhesives, liners, bases and curing.

5. A resin-based composite restoration may be medically necessary when a tooth has a fracture, defective filling, recurrent decay or decay penetrating into the dentin.

6. A composite restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.

7. If LIBERTY determines that there is a more appropriate procedure code to describe the restoration provided, either number of surfaces, or material used, an alternate procedure code may be approved.

C. Restorations for primary teeth

1. Covered only if the tooth is expected to be present for at least six months.

2. For posterior primary teeth that have had extensive loss of tooth structure or when it is necessary for preventive reasons, the appropriate treatment is generally a prefabricated stainless-steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.

3. A resin infiltration of an incipient smooth surface lesion (decalcification) is appropriate for smooth surface lesions with some or minor enameloplasty.

D. Crowns - Single Restorations Only (Codes D2710 – D2794)

Crowns for members 21 years of age and under will be covered when medically necessary. In determining whether a requested crown is medically necessary, the following factors may be considered:

- The periodontal status, member compliance, and overall status and prognosis of the tooth is favorable;
- The tooth is not routinely restorable with a filling.

Crowns for members 21 years of age and over will be covered when medically necessary. In determining whether a requested crown is medically necessary, the following factors may be considered:

- There is a documented medical condition which precludes an extraction
- The tooth is a critical abutment for an existing or proposed prosthesis
- If the tooth is a posterior tooth, the following additional factors may be considered:
    - The periodontal status, member compliance, and overall status and prognosis of the tooth are favorable
    - The tooth is not routinely restorable with a filling
    - There are eight (8) or more natural or prosthetic posterior points of contact present
    - If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition
    - Consideration for a third (3rd) molar will be given if the third (3rd) molar occupies the first (1st) or second (2nd) molar position
    - Note: Requests for treatment on unopposed molars MUST include a narrative documenting medical necessity.
- If the tooth is an anterior tooth, the following additional factors may be considered:
    - The periodontal status
    - Member compliance
    - overall status and prognosis of the tooth are favorable
    - The tooth is not routinely restorable with a filling

1. Administrative Issues
    a. Providers must complete any irreversible procedure started regardless of payment or coverage and only bill for indirect restorations when the service is completed (permanently cemented).
    b. Crown services must be documented using valid procedure codes in the American Dental Association's Current Dental Terminology (CDT).
2. A crown may be medically necessary when the tooth is present and:
    a. There is evidence of decay, fracture, failing restoration, etc. undermining more than 50% of the tooth or a significant fracture is identified, and the tooth has a good prognosis, and is not required due to wear from attrition, abrasion and/or erosion.

b. There is a significantly defective crown (defective margins or marginal decay) or there is recurrent decay.

c. The tooth is in functional occlusion.

d. The tooth has a good endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50% and is expected to be maintained for at least five years.

3. Enamel "craze" lines or "imminent" or "possible" fractures: Anterior or posterior teeth that show a discolored line in the enamel indicating a non-decayed defect in the surface enamel and are not a through-and through fracture should be monitored for future changes. Crowns may be a benefit only when there is evidence of true decay undermining more than 50% of the remaining enamel surface, or when there is a through-and-through fracture identified radiographically or photographically, or when a portion of the tooth has actually fractured off and is missing. Otherwise, there is no benefit provided for crown coverage of a tooth due to a "suspected future or possible" fracture.

4. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontal procedures and such teeth should exhibit a minimum crown/root ratio of 50%.

   a. Margins, contours, contacts and occlusion must be clinically acceptable

   b. Tooth preparation should provide adequate retention and not infringe on the dental pulp.

   c. Crowns should be designed with a minimum life expectancy or service life of five years.

5. Post and core (Code D2952 and D2954) procedures for endodontically treated teeth include buildups. By CDT definitions, each of these procedures includes a "core." Therefore, a core buildup, cannot be billed with either Codes D2952 or D2954 for the same tooth, during the same course of treatment.

   a. The tooth is functional, has had a successful root canal treatment and requires additional structure to support and retain a crown.

   b. Code D2954 is built around a prefabricated post. This procedure includes the core material.

6. Pin retention (Code D2951) or restorative foundation may be medically necessary when a tooth requires a foundation for a restoration.

7. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure.

ENDODONTICS

Root canal therapy for members under the age of 21 will be covered when medically necessary. In determining whether a requested root canal is medically necessary, the following factors may be considered:

- The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
- The tooth is not routinely restorable with a filling.

Root canal therapy for members 21 years of age and over will be covered when medically necessary. In determining whether requested endodontic treatment is medically necessary, the following factors may be considered:

- There is a documented medical condition which precludes the extraction;
- The tooth is a critical abutment for an existing or proposed prosthesis;
- If the tooth is a posterior tooth, the following additional factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable;
    - There are eight or more natural or prosthetic posterior points of contact present;
    - If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patients dentition;
    - Consideration for a third molar will be given if the third molar occupies the first or second molar position.
    - Note: Requests for treatment on unopposed molars must include a narrative documenting medical necessity.
- If the tooth is an anterior tooth, the following additional factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.

ASSESSMENT

1. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:
    a. Pain and the stimuli that produce or relieve it by the following tests:
        i. Thermal
        ii. Electric
        iii. Percussion
        iv. Palpation
        v. Mobility
    b. Non-symptomatic radiographic lesions

A. Treatment planning for endodontic procedures may include consideration of the following:
    1. Strategic importance of the tooth or teeth
    2. Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered
        a. Excessively curved or calcified canals
        b. Presence and severity of periodontal disease
        c. Restorability and tooth fractures
    3. Occlusion

4. Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.

B. Clinical Guidelines

1. Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.

2. A rubber dam should be used and documented (via radiograph or in the progress notes) for most endodontic procedures. Documentation is required for any inability to use a rubber dam.

3. The endodontic filling material should show evidence of adequate density and length with respect to the apex of the tooth. All canals should be completely obturated.

4. Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.
5. In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals.
6. For therapeutic pulpotomy (D3220) on deciduous teeth, documentation is required that shows a good prognosis with a reasonable period of retention and function.

7. For pulpal therapy (Code D3230, D3240), documentation is required that shows pulpal pathology with a good prognosis and that the tooth has a reasonable period of retention and function.
8. For endodontic treatment (Codes D3310 – D3330), documentation is required that shows the treatment is medically necessary (i.e., tooth is broken, decayed or previously restored, functional with an unhealthy nerve and more than 50% of the tooth structure is sound) and the tooth has a good endodontic, periodontal and/or restorative prognosis.

Note: LIBERTY may determine that a different, more appropriate procedure code better describes the endodontic treatment performed and may make our determination based on the alternate code.

9. For endodontic retreatment (Codes D3346 – D3348), documentation is required that shows a tooth with previous endodontic treatment that is symptomatic or shows evidence of periapical pathology.
10. For apexification/recalcification (Code D3351), documentation is required that shows the apex of the tooth root(s) is/are incompletely developed.
11. For apical surgery (Codes D3410 – D3426), documentation is required that shows apical or lateral pathosis that cannot be treated non-surgically and that the tooth has a good periodontal and restorative prognosis. Endodontic apical surgical treatment should be considered only in specific circumstances, including:
    a. The root canal system cannot be instrumented and treated non-surgically.
    b. There is active root resorption.
    c. Access to the canal is obstructed.
    d. There is gross over-extension of the root canal filling.
    e. Periapical or lateral pathosis persists and cannot be treated non-surgically.
    f. Root fracture is present or strongly suspected.

g. Restorative considerations make conventional endodontic treatment difficult or impossible.

Note: LIBERTY may determine that the apical surgery requested could have a better/equivalent outcome with a different endodontic procedure code

12. For a retrograde filling (Code D3430), documentation is required that shows evidence of medical necessity for a retrograde filling during periradicular surgery.

PERIODONTICS

A. Clinical Crown Lengthening – Hard Tissue (Code D4249)

- Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio.
- The periodontal status, member compliance, and overall status and prognosis of the tooth may be taken into consideration when determining medical necessity.
- Reimbursable solely when associated with a medically necessary crown or root canal procedure.
- All requests for coverage of a crown lengthening should include a complete treatment plan addressing all areas of pathology.
- Treatment records must include detailed documentation describing the need for crown lengthening including pretreatment photographs depicting the condition of the tissues.
- Coverage of a crown lengthening should be requested at the same time as a request for coverage of a crown and/or a root canal. If the need for crown lengthening is discovered during a procedure, a new prior authorization request should be submitted with supporting documentation.

REMOVABLE PROSTHETICS

Note: Providers may document the date of service for these procedures to be the date when prosthetic appliances are completed.

A. Complete Dentures (Codes D5110 and D5120)

1. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Members should be fully informed of their significant limitations. A complete denture may not be covered if some teeth are still present in the arch and extraction of the remaining teeth is not necessary.
2. Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture. Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.
3. A conventional complete or removable partial denture includes routine post-delivery care and adjustments and soft liners for six months.
4. Proper member education and orientation to the use of removable complete dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage member expectation.

B. Partial Dentures (Codes D5211 – D5226)

1. Removable partial dentures may be covered when there is at least one missing maxillary anterior tooth, two missing mandibular anterior teeth or less than eight posterior natural or prosthetic teeth (molars

and/or bicuspids) in occlusion (four maxillary and four mandibular teeth in functional contact with each other).

2. Remaining teeth must have a good endodontic, periodontal and restorative prognosis.
3. Endodontic, periodontal and restorative treatment should be completed prior to fabrication of a removable partial denture.
4. Removable partial dentures should be designed so that they do not harm the remaining teeth and/or periodontal tissues, and to facilitate oral hygiene.
5. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.
6. Flexible partial dentures (Codes D5225, D5226) may be processed using different brands. There is no differentiation between different brands of flexible material; only the specific CDT code applies. A flexible partial denture may be needed to replace an existing partial denture that is not serviceable, and the remaining teeth have a good prognosis.
7. Partial dentures with acrylic clasps (also known as "Combo Partials") are considered under the coverage for Codes D5213 and D5214.

C. Proper member education and orientation to the use of partial dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage member expectation.

D. Replacement of an existing complete or partial denture:
   1. Removable complete or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by reline or repair.
   2. Complete or partial dentures are not covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a member demands replacement due to their own perceived functional and/or cosmetic concerns.
   3. Complete or partial dentures will not be covered for replacement for a minimum of 8 years (whether stolen, lost, broken or unserviceable) except when determined medically necessary with supporting documentation.
   4. Prior approval requests for replacement dentures prior to eight (8) years must include a completed Justification of Need for Replacement Prosthesis Form signed by the patient's dentist, explaining the specific circumstances that necessitate replacement of the denture. If replacement dentures are requested within the eight (8) year period after they have already been replaced once, then the dentist's supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

E. Complete or partial denture adjustments (Codes D5410 – 5422):
   1. A complete or removable partial denture includes routine post-delivery care, adjustments and soft liners for six months.
   2. A prospective or retrospective request for a complete or partial denture adjustment must include documentation that the appliance is ill-fitting.

F. Repairs to complete and partial removable dentures (Codes D5511–D5660) must include documentation that demonstrates the appliance is broken or in need of repair.

G. Rebases and relines for complete and partial removable dentures (Codes D5710 – D5761):
   1. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance.
   2. A rebase or reline of a partial or complete denture would be covered (subject to plan limitations) if documentation demonstrates that the appliance is ill-fitting and may be corrected by rebasing or relining, resulting in a serviceable appliance.

H. Requests for partial dentures will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.

I. Tissue conditioning (Codes D5850 and D5851) may be required when documentation shows that the tissue under a removable appliance is unhealthy or must be treated prior to fabricating a new appliance or rebasing or relining an existing appliance.

IMPLANTS

Please consult New York State Medicaid Program Dental Policy and Procedure Code Manual for covered services under the Medicaid program or other plan materials to determine plan-by-plan variations. https://www.emedny.org/ProviderManuals/Dental/index.aspx

Dental implants, including single implants, and implant related services, will be covered by Medicaid when medically necessary. Prior authorization requests for implants must have supporting documentation from the member's dentist. The member's dentist must submit a completed Evaluation of the Dental Implant Patient Form documenting, among other things, the member's medical history, current medical conditions being treated, list of all medications currently being taken by the patient, explaining why implants are medically necessary and why other covered functional alternatives for prosthetic replacement will not correct the member's dental condition and certifying that the patient is an appropriate candidate for implant placement. If the member's dentist indicates that the member is currently being treated for a serious medical condition, further documentation from the member's treating physician may be requested.

General Guidelines:

The dentist's explanation as to why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.

1. A complete treatment plan addressing all phases of care is required and should include the following:
   a. Accurate pretreatment charting;
   b. Complete treatment plan addressing all areas of pathology;
   c. Interarch distance;
   d. Number, type and location of implants to be placed;

e. Design and type of planned restoration(s)/prosthetics;
f. Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition.

2. If bone graft augmentation is needed, there must be a 4 to 6-month healing period before a dental implant can be placed.
3. Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.
4. Treatment on an existing implant/implant prosthetic will be evaluated on a case-by-case basis.
5. Implant and implant related codes not listed will be considered on a case-by-case basis and should be billed as a By Report using code D6199.
6. Documentation must include a list of all medications currently being taken and all conditions currently being treated.
7. All cases will be considered based upon supporting documentation and current accepted practices.

A. Pre-Surgical Services (Code D6190)
   1. A thorough history and clinical examination leading to the evaluation of the member's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.
   2. There should be adequate bone support and sufficient space for a replacement tooth.
   3. Bilateral implants in the same arch may be covered to support a full denture.
   4. A conservative treatment plan should be considered prior to providing a member with one or more implants. Dental implants may be contraindicated for the following reasons:
      a. Adverse systemic factors such as diabetes and history of recent smoking habit
      b. Poor oral hygiene and tissue management by the member
      c. Inadequate osseo-integration of the dental implant(s) (mobility)
      d. Excessive para-function or occlusal loading
      e. Poor positioning of the dental implant(s)
      f. Excessive loss of bone around the implant prior to its restoration
      g. Mobility of the implant(s) prior to placement of the prosthesis
      h. Need to restore the appearance of gingival tissues in high esthetic areas
      i. When the member is under 16 years of age, unless unusual conditions prevail
   5. Documentation must support the medical necessity of Pre-Surgical and Surgical Services.

B. For Surgical Services (Codes D6010 – D6104), documentation of medical necessity must be established prior to surgical treatment to place, remove or treat an implant.

C. Restoration
   1. The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.
   2. Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.

3. Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
4. Jaw relationship and intra arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.
5. Documentation of medical necessity is required for an implant supporting structure.

D. Outcomes
1. Second stage implant surgery (D6011) reimbursement for surgical access to an implant body for placement of the healing cap or to enable placement of an abutment after a sufficient period of osseo-integration is inclusive in the placement of the implant body (Code D6010).
2. Flap procedure (Code D4245) during placement of implant body (Code D6010) is inclusive.

FIXED PROSTHODONTICS

A. Fixed Bridges (Codes D6200 – D6794)
1. Fixed bridges are generally considered beyond the scope of the program and will only be considered for the anterior portion of the mouth in exceptional cases. Documentation of a physical or neurological disorder that would preclude placement of a removable denture or necessity for cleft palate stabilization is necessary for approval.
2. For cases other than cleft palate stabilization, tooth replacement is generally limited to one maxillary anterior tooth or two adjacent mandibular anterior teeth with no initial restorations placed during the past year, no unrestored carious lesions and no significant periodontal bone loss or posterior tooth loss with replaceable space in the same arch.

ORAL SURGERY

A. Extractions (Codes D7111 – D7251)
1. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the member.
2. For extraction of a deciduous tooth (Codes D7111 and D7140) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon or a member complaint of acute pain.
3. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amenable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.
    a. Extractions of erupted teeth
        i. An uncomplicated extraction (Code D7140) of an erupted or exposed root includes removal of all tooth structure, minor smoothing of socket bone and closure, as necessary. Extraction of an erupted tooth may be needed when the tooth has significant decay and/or bone loss, is causing irreversible pain and/or infection, or is impeding the eruption of another tooth. Preoperative radiographs are required with submission of dated claims or prior authorization request for

premolar teeth only. Extractions of asymptomatic premolar teeth for orthodontic purposes are only payable if the orthodontic case has been approved.

ii. A surgical extraction of an erupted tooth (Code D7210) requires removal of bone and/or sectioning the tooth, including elevation of a mucoperiosteal flap if indicated.

iii. Surgical extraction of an erupted tooth (D7210) is covered when:

- Complete breakdown of clinical crown
- There is insufficient remaining clinical crown to allow a non-surgical extraction
- The fracture of a tooth or roots during a non-surgical extraction procedure
- Erupted teeth with unusual root morphology (dilacerations, cementosis)
- Erupted teeth with developmental abnormalities that would make non-surgical extraction unsafe or cause harm
- When fused to an adjacent tooth
- When severe crowding or ectopic position of the tooth is present
- Endodontically treated teeth with crown fracture

b. Pre-operative radiographs are required with submission of dated claims or with prior authorization request. Surgical extractions require prior authorization if requesting four (4) or more surgical extractions.

c. An impacted tooth is "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." (CDT)

i. Extraction of a soft tissue impaction (Code D7220) is a tooth with the occlusal surface covered by soft tissue, and extraction requires elevation of a mucoperiosteal flap.

ii. Extraction of a partial bony impaction (Code D7230) is a tooth with part of the crown covered by bone and requires elevation of a mucoperiosteal flap and bone removal.

iii. Extraction of a completely bony impaction (Code D7240) is a tooth with most or all of the crown covered -by bone and requires elevation of a mucoperiosteal flap and bone removal.

iv. Extraction of Impacted Teeth (D7220, D7230, D7240)

The following is a list of covered reasons for extraction of impacted teeth

- Moderate to severe or acute pain, or recurrent episodes that do not respond to conservative treatment (i.e., pain medication or antibiotics)
- Teeth in the line of a jaw fracture or complicating fracture management
- As part of comprehensive treatment in orthognathic surgery
- Acute/chronic infection (abscess, cellulitis, pericoronitis)
- Resorption of adjacent tooth
- Tumor resection
- Ectopic position
- Pathology associated with tooth follicle or other related pathology (dentigerous cyst, tumors, other cysts)

v. Surgical extraction of Impacted Teeth is not indicated for the following:

- For prophylactic reasons other than an underlying medical condition

- When a more conservative procedure can be performed
- For pain or discomfort related to normal tooth eruption

vi. Extraction of a complicated completely bony extraction (Code D7241) requires documentation of unusual surgical complications.

vii. Removal of residual tooth roots (Code D7250) requires cutting of soft tissue and bone and includes closure. Surgical removal of residual tooth roots is covered when:

- Tooth roots or fragments of tooth roots remain in the bone following a previous incomplete tooth extraction
- Extreme tooth decay resulting in the destruction of the dentition to the extent that only root tips remain

B. The prophylactic removal of an impacted or unerupted tooth or teeth that appear(s) to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered. During our clinical review of requests for extraction of impacted and/or erupted teeth, LIBERTY may determine that treatment better fits the description of a different, more appropriate procedure code. In that situation, LIBERTY may approve the extraction under a different code.

1. The removal of asymptomatic, unerupted, third molars in the absence of active pathology will not be covered.
2. Pericoronitis is considered to be pathology. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.
3. Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic or photographic presentation will be the determining factor in the determination of coverage.

C. Other Surgical Procedures

1. Removal of residual tooth roots (Code D7250) may be needed when the residual tooth root is pathological or is interfering with another procedure.
2. Sinus perforation or oroantral fistula closure (Code D7260) requires documentation that there is a pathological opening into the sinus.
3. Tooth re-implantation and/or stabilization of an accidentally evulsed or displaced tooth (Code D7270) requires documentation that a tooth or teeth have been accidentally evulsed or displaced.
4. A tooth transplantation (Code D7272) requires documentation that it is medically necessary to remove a developing tooth and transplant it to an accessible place.
5. Exposure of an unerupted tooth (D7280) requires documentation that reflection of tissue and removal of bone is necessary to expose the crown of an impacted tooth not intended to be extracted. If performed in conjunction with orthodontic treatment, orthodontic case must be approved. Placement of device to facilitate eruption of impacted tooth (D7283) requires documentation of necessity for exposure of the crown of an impacted tooth; orthodontic case must be approved.
6. A biopsy of oral tissue (Codes D7285 and D7286) requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the harvesting of oral tissue.

D. Alveoloplasty-Preparation of Ridge (Codes D7310 – D7321) requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus. Alveoloplasty is not reimbursable in addition to surgical extractions in the same quadrant.

E. Vestibuloplasty (Codes D7340 and D7350) (a surgical procedure to increase relative alveolar ridge height) requires documentation that demonstrates the medical necessity of enhancing the alveolar ridge to facilitate successful prosthetic restoration.

F. Excision of soft tissue or intra-osseous lesions (Codes D7410 – D7461) requires documentation of the presence of an intra-oral lesion and the medical necessity to remove it.

G. Excision of bone tissue (Codes D7471 – D7473) (an exostosis) requires documentation that a bony growth interferes with the ability to function or wear a prosthesis.

H. Reduction of an osseous tuberosity (Code D7485) requires documentation that shows a large tuberosity that interferes with the ability to wear a prosthesis.

I. Incision and drainage of an abscess (Codes D7510 - D7521) requires documentation that shows an oral infection that requires drainage and is inclusive of both the insertion and the removal of the drain.

J. Removal of a foreign body (Code D7530 - D7560), non-vital bone or a tooth fragment requires documentation that it is medically necessary to remove it.

K. Open/closed reduction of a fracture (Codes D7610 – D7640) requires documentation that demonstrates evidence of a broken jaw.

L. Reduction of dislocation (Codes D7810 and D7820) and management of other temporomandibular joint dysfunctions require documentation showing a dislocation or other pathological condition of the temporomandibular joint.

M. Repair of traumatic wounds (Code D7910) and other repair procedures requires documentation showing that it is medically necessary to suture a traumatic wound and/or other repair procedures.

N. An osseous, osteoperiosteal, or cartilage graft (Code D7950) requires documentation that demonstrates the need for ridge preservation for planned implants or prosthetic reconstruction.

O. A frenulectomy (Code D7960) requires documentation that demonstrates evidence that a muscle attachment is associated with a pathological condition or is interfering with proper oral development or treatment.

P. Excision of hyperplastic tissue (Code D7970) or reduction of a fibrous tuberosity (Code D7972) requires documentation that demonstrates the medical necessity of removing redundant soft tissue to facilitate a removable prosthesis.

Q. Excision of pericoronal gingiva (Code D7971) requires documentation that demonstrates the medical necessity of removing inflammatory or hypertrophied tissues surrounding partially erupted or impacted teeth.

ADJUNCTIVE SERVICES

A. Unclassified Treatment

1. Palliative Treatment (Code D9110)
    a. Typically reported on a "per visit" basis for emergency treatment of dental pain.
    b. The submitted documentation must show the presenting issue and/or the emergency treatment provided that was medically necessary for the procedure.
2. Fixed Partial Denture Sectioning (Code D9120)
    a. This procedure involves separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment and includes all recontouring and polishing of retained portions.
    b. The submitted documentation must show that it is medically necessary to section and remove part of a fixed partial denture and that the remaining tooth or teeth have a good prognosis.

B. Anesthesia
1. Deep Sedation/General Anesthesia or Intravenous moderate sedation/analgesia (Codes D9222, D9223, D9239 and D9243)
    a. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the member. Anesthesia services are considered completed when the member may be safely left under observation of trained personnel and the doctor may leave the room to attend to other members or duties.
    b. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effect upon the central nervous system and not dependent on the route of administration. It is expected that dentists performing anesthesia on members be properly licensed by their state's regulatory body and comply with all monitoring requirements dictated by the licensing body.
    c. LIBERTY provides benefits for covered General Anesthesia ("GA") or Intravenous ("IV") Sedation in a dental office setting only when medical necessity is demonstrated by the following requirements, conditions and guidelines:
        i. A medical condition that requires monitoring (e.g., cardiac, severe hypertension);
        ii. An underlying medical condition exists which would render the member non-compliant without the GA or IV Sedation (e.g., cerebral palsy, epilepsy, developmental/intellectual disability, Down's syndrome);
        iii. Documentation of failed conscious sedation (if available);
        iv. A condition where severe infection would render local anesthesia ineffective.

2. Requirements for Documentation:
    a. The medical necessity for treatment with GA or IV Sedation in a dental office setting must be clearly documented in the member's dental record and submitted by the treating dentist;
    b. Pre-authorization and submission requirements:
        i. Prior to providing GA or IV Sedation in a dental office setting, all necessary medical and dental documentation, including the dental treatment plan, must be reviewed and approved by LIBERTY.

ii. Submit the member's dental record, health history, charting of the teeth and existing oral conditions, diagnostic radiographs (except where not available due to conditions listed above) and intra-oral photographs.

iii. Submit a written narrative documenting the medical necessity for general anesthesia or IV Sedation;

iv. Treatment rendered as an emergency, when pre-authorization was not possible, requires submission of a complete dental treatment plan and a written narrative documenting the medical necessity for the GA or IV Sedation.

v. The dental office has established, implemented and provided LIBERTY with approved sedation and general anesthesia policies and procedures that comply with the American Dental Association Guidelines for the Use of Sedation and General Anesthesia by Dentists.

3. The following oral surgical procedures may qualify for GA or IV Sedation:
   a. Removal of impacted teeth;
   b. Surgical root recovery from maxillary antrum (sinus);
   c. Surgical exposure of impacted or unerupted cuspids (for orthodontic cases, the orthodontic treatment must have been approved in advance);
   d. Radical excision of lesions in excess of 1.25 cm.

C. Professional Consultation (Code D9310)
   1. This is a member encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; it may be requested by another practitioner or appropriate source and it includes an oral evaluation.
   2. The consulted practitioner may initiate diagnostic and/or therapeutic services.
   3. The submitted documentation must demonstrate the medical necessity of assistance in determining the treatment required for a specific condition.

D. Professional Visits (Codes D9410 – D9440)
   1. Hospital, house, extended care or ambulatory surgical center call (D9410, D9420)
      a. Includes nursing homes, long term care facilities, hospice sites, institutions, hospitals or ambulatory surgical centers.
      b. Services delivered to the member on the date of service are documented separately using the applicable procedure codes.
      c. The submitted documentation must demonstrate the medical necessity of treatment outside of the dental office.
   2. Office visit for observation or case presentation during or after regularly scheduled hours (D9130, D9440)
      a. This is for an established member and is not performed on the same day as evaluation.
      b. The submitted documentation must demonstrate the medical necessity of an office visit or case presentation during or after regularly scheduled office hours.

E. Drugs (Code D9610)

1. Administration of a single parenteral drug requires documentation demonstrating the medical necessity of the drug or medicament for treating a specific condition.

F. Miscellaneous Services

a. Dental Case Management, patients with special health care needs (Code D9997) - Special treatment considerations for patients/individuals with physical, medical, developmental, or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized comprehensive oral health care services.

a. Limited to those who receive ongoing services from a community program operated by the New York State Office of People with Developmental Disabilities (OPWDD) with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OPWDD/Managed Care Exemption").
b. This is a per visit incentive to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population.
c. This fee will be paid in addition to the normal fees for specific dental procedures.
d. Not billable in conjunction with D9430 or procedures performed under deep sedation/general anesthesia.
e. Not billable as a "stand-alone" procedure; another clinical service must be provided on the same date.

Occlusal Guards (Code D9944 -D9946)

a. This is a removable dental appliance designed to minimize the effects of bruxism and other occlusal factors.
b. This must be supported by documentation demonstrating the medical necessity fabricating, adjusting or repairing/relining an occlusal guard to minimize the effects of bruxism or other occlusal factors.

RETROSPECTIVE REVIEW

Prospective and retrospective review will require documentation that demonstrates medical necessity. This documentation can include diagnostic radiographic or photographic images, the results of tests or examinations, descriptions of conditions in progress notes and/or a written narrative providing additional information. In cases where objective information (such as diagnostic images) conflicts with subjective information (such as written descriptions), objective information will be given preference in making a determination.

Retrospective review of services that had been previously pre-authorized will require documentation confirming that the procedure(s) was (were) completed as authorized and within the standard of care as defined by the New York State Medicaid Program Dental Policy and Procedure Code Manual.

Please consult New York State Medicaid Program Dental Policy and Procedure Code Manual for covered services under the Medicaid or other plan materials to determine plan-by-plan variations. https://www.emedny.org/ProviderManuals/Dental/index.aspx

SECTION 11. QUALITY MANAGEMENT

LIBERTY's Quality Management Program is compliant with all New York state, and Federal laws and regulations, and applicable contract requirements.

QUALITY MANAGMENT AND IMPROVEMENT PROGRAM DESCRIPTION

Program Description

LIBERTY's Quality Management and Improvement (QMI) Program is designed to ensure that licensed dentists are reviewing the quality of dental care provided, that quality of care problems are identified and corrected, and follow-up is planned when indicated. The QMI Program continuously and objectively assesses dental member care services and systems for all members, including members with special healthcare needs. Ongoing monitoring of compliance with prescribed standards ensures a constant process of quality improvement that encompasses clinical and non-clinical functions.

LIBERTY's QMI Program provides a structured and comprehensive review of the quality and appropriateness of care delivered by the entire network of dental providers. LIBERTY documents all quality improvement initiatives, processes and procedures in a formal QMI Plan. The Dental Director, or his/her designee, oversees the QMI Program and ensures that day-to-day quality assurance functions are carried out in compliance with dental program contracts and applicable requirements.

QMI Program Goals and Objectives

The goal of the QMI Program is to comprehensively identify and address the quality of dental care and service to our members. The QMI Program provides a review of the entire range of care to establish, support, maintain and document improvement in dental care. These goals are achieved through the ongoing, objective assessment of services, systems, issues, concerns, and problems that directly and indirectly influence the member's dental health care.

LIBERTY is committed to continuous improvement in the service delivery and quality of clinical dental care provided with the primary goal of improving members' dental health. LIBERTY also implements measures to prevent any further decline in condition or deterioration of dental health status when a member's condition is not amenable to improvement. LIBERTY has established quality-of-care guidelines that include recommendations developed by organizations and specialty groups such as the American Academy of Pediatric Dentistry, the

American Academy of Endodontists, the American Academy of Periodontists, the American Association of Oral Surgeons and the American Dental Association. LIBERTY applies these guidelines equally to Primary Dental Providers and specialists and uses them to evaluate care provided to members.

PROGRAM SCOPE

LIBERTY's QMI Program includes the following components: dental management, credentialing, standards of care, dental records, utilization review, peer review, environmental health and safety/infection control, member rights and responsibility, and member and provider grievances and appeals. The QMI document describes the programs and processes and activities that make up this integrated effort.

- Providing immediate and responsive feedback to members, providers, and the public as appropriate
- Policy and procedure development
- Annual QMI evaluation and report
- Annual QMI Work Plan development
- Identification of quality issues and trends
- Monitoring of quality measurements
- Quality-of-care focus studies
- Monitoring of the provider network
- Review of acceptable standards of dental care
- Continuing provider education
- Member health education

The QMI Program's activities focus on the following components of quality, which are included in established definitions of high-quality dental care services:

- **Accessibility of Care**: the ease and timeliness with which members can obtain the care they need when they need it by network providers.
- **Appropriateness of Care**: the degree to which the correct care is provided, given the current community standards.
- **Continuity of Care**: the degree to which the care members need is coordinated among practitioners and is provided without unnecessary delay.
- **Effectiveness of Care**: the degree to which the dental care provided achieves the expected improvement in dental health consistent with the current community standard.
- **Safety of the Care Environment**: the degree to which the environment is free from hazard and danger to the member.

QUALITY MANAGEMENT PROGRAM CONTENT AND COMMITTEES

Oversight of the QMI Program is provided through a committee structure, which allows for the flow of information to and from the Board of Directors. The QMI Program employs six major Committees and additional sub-committees to ensure that dental care delivery decisions are made independent of financial and administrative decisions.

- **Quality Management and Improvement Committee:** The Committee reviews, formulates, and approves all aspects of dental care provided by LIBERTY's Network Providers, including the structure under which care is delivered, the process and outcome of care, utilization and access to care, availability, referrals to specialists, continuity of care, safety, appropriateness, and any problem resolution in the dental delivery system identified by the Peer Review, Utilization Management.
- **Focus Reviews**: The Dental Director or designee may determine the need for focus reviews triggered by various findings such as Potential Quality Issues (PQIs), grievances, utilization outlier status, potential fraud, waste or abuse or other administrative reasons.

Upon identification of a PQI, LIBERTY's Dental Director, or designee, may apply corrective action plans necessary to ensure offices are in compliance with the QM Guidelines and Standards. The offices are monitored to ensure providers attain a sufficient level of compliance and follow up activities are undertaken at least quarterly or more frequently if warranted. If deficiencies and issues remain, LIBERTY's QMI Committee will determine additional corrective actions and Peer Review for recommendations for the office be terminated from the network.

- **Access and Availability**: LIBERTY's AA Committee has established standards for geographic access and for timeliness of preventive care appointments, routine appointments, urgent appointments, emergency care, after hours care access, wait time in the provider office, and elements of telephone service. Opportunities for improvement are identified, decisions are made, and specific interventions are implemented to improve performance where needed. Compliance with access and availability standards is monitored and CAPs are developed if deficiencies occur. Activities are reviewed by the QMI Committee quarterly, or more frequently, if necessary.
- **Credentialing:** Our Credentialing Program includes initial credentialing and re-credentialing at 36-month intervals of all primary and specialty care dentists listed in the Provider Directories. Pertinent findings are reviewed quarterly or more frequently if deemed necessary during Credentialing Committee meetings. Quality-of-care issues are then referred to the Peer Review Committee for recommendations and further action.
- **Cultural and Linguistic Competency (CLC):** LIBERTY establishes processes and procedures for providing support, maintaining compliance and creating cultural awareness for all members, providers and associates. As part of the CLC Program, information about language (spoken and written), race and ethnicity information are gathered and analyzed. LIBERTY monitors and assures that its delegated entities provide all services, conform to regulations, and develop all reports and assessments as specified by applicable regulations and agencies.
- **Health Education and Promotion/Outreach:** LIBERTY's Health Education Department communicates with and educates its participating dental providers about available health education and improvement services and programs. On a regular basis, the Health Education Department communicates a summary of health education and promotion activities to the QMI Committee.
- **Peer Review Committee (PRC):** The Peer Review Committee is responsible for identification and resolution of quality of care issues. PQIs are identified through various means, including but not limited to the review of

grievance and appeal patterns, onsite audit scores, as well as provider utilization data. The PRC is focused improving care to members and minimizing potential risk cases, identifying trends of questionable care and developing corrective action plans to ensure resolutions. The PRC identifies opportunities for improvement, with the goal of examining complex cases and options for treatment across the spectrum of care. LIBERTY's Peer Review activities routinely include the participation of providers and specialists when appropriate.

  - **Potential Quality Issues (PQIs):** As part of the QMI Program, LIBERTY has policies and procedures in place that allow us to investigate PQIs from a variety of sources, and then routinely collate quality information about providers. LIBERTY commonly investigates PQIs from grievances ruled against the dental provider, utilization patterns, significant departure from expected contractual behavior or compliance, external vendor and business partner identification, and others. The Dental Director or designee reviews each case to assess the quality of care/service provided and provides a determination for corrective action based on the severity of an individual case. Follow-up actions, including provider counseling and/or CAPs are required of all involved providers for whom a quality-of-care or service issue is confirmed.

- **Grievances and Appeals:** The grievance unit investigates and resolves issues for the services or operations that are the subject of concern and ensures that issues presented by LIBERTY members are resolved in a fair and timely manner. LIBERTY's grievance and appeal program, policies and procedures are consistent with applicable program, state and/or federal requirements.

UTILIZATION MANAGEMENT

LIBERTY's Utilization Management (UM) Program is designed to meet contractual requirements and New York and federal regulations, while providing members access to high-quality, cost-effective medically necessary care. Monitor over – and under-utilization of services, identify treatment patterns for analysis and ensures that utilization decision is made in a timely manner which accommodate the urgency of the situation and minimizes any disruption in the provision of care.

The focus of the UM program is on:

- Evaluating requests for dental care services by determining whether the service or good is Medical Necessary consistent with the member's diagnosis and level of care required
- Providing access to medically appropriate, cost-effective dental care services in a culturally sensitive manner and facilitating timely communication of clinical information among Providers
- Reducing overall expenditures by developing and implementing programs that encourage preventive oral health care behaviors and member partnership
- Facilitating communication and partnerships among members, families, Dental Providers, Medicaid health plans, other Medicaid dental plans and LIBERTY in an effort to enhance cooperation and appropriate utilization of dental care services
- Reviewing, revising and developing dental services coverage policies to ensure members have appropriate access to new and emerging care and technology
- Enhancing the coordination and minimizing barriers in the delivery of dental care services

LIBERTY a has long-established and effective Utilization Management (UM) Program designed to ensure that dental services are delivered at the appropriate level of care and in a timely, cost-effective manner. The UM

Program focus is on improving the quality of care and enhancing the evaluation of practice patterns of oral health care delivery. Our UM program analyzes provider utilization data in the context of grievances and appeals, access and availability, and member satisfaction data for different categories of service and member demographics.

LIBERTY does not delegate any UM responsibility to a third party. We conduct all reviews in-house by our state dental directors and our appropriately licensed, experienced Staff Dentists and Dental Consultants, none of which are compensated or incentivized on clinical review decision making.

LIBERTY determines which dental services require prior authorization based on:

- Clinical Standards of practice: LIBERTY's Clinical Criteria Guidelines (CCG) are key components to the medical necessity decision-making process and ensure that decisions are based on sound clinical evidence. The CCG's are developed, updated, and reviewed by clinicians through our Peer Review Committee, which consists of both LIBERTY and network dentists, and reports directly to the LIBERTY Quality Management and Improvement Committee. The QMI has direct oversight by the Dental Director, who also chairs the Peer Review Committee.
- The Clinical Criteria Guidelines are updated annually for formal adaption and adhere to all state and federal regulations and guidelines. The CCG's are developed with guidance from the American Dental Association, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatric Dentistry, American Association of Endodontics, American Association of Orthodontics, and the American College of Prosthodontists. In addition, our Peer Review Committee utilizes contemporary research, practice trends, and literature reviews to help inform any updates or necessary edits, changes, or additions.
- Utilization Review: We include ongoing results of our Utilization management and review processes to determine which services should be reconsidered for prior authorization. In situations where particular services might seem to be excessive or abused without prior authorization occurring, we will consider changing the requirements for that procedure for the following plan year. When doing so, provider notification would occur prior to the effective date of the new plan year. We re-evaluate this annually upon the release of the Code on Dental Procedures and Nomenclature (CDT) code updates. In reviewing utilization patterns, LIBERTY also adjusts our claim system to identify and control Potential Fraud Waste and Abuse (PFW&A) billing patterns. The claims system is flexible and PFW&A controls are able to customize at the provider, office, group, plan, and code levels. These types of system rules include but are not limited to considering members claim history especially for procedures that do not have frequency limitations.

  LIBERTY Grievances and Appeals staff is prepared to accept and respond to any feedback and/or complaints from providers related to our prior authorization and UR process. LIBERTY will review and resolve each concern in a timely manner according to all state and plan guidelines, and will consult with the Authorization and Claims staff as well as the State Dental Director, the LIBERTY National Grievances and Appeals Dental Director, and the appropriate Staff Dentist(s) in the process.

MEDICAL NECESSITY DETERMINATION

LIBERTY identifies which procedures require medical necessity determination. LIBERTY's definition of medical necessity aligns with all federal and state requirements, and nationally accepted clinical criteria and practices. We approve care that is "medically necessary" and "appropriate," meaning:

- The treatment or supplies are needed to evaluate, diagnose, correct, alleviate, ameliorate/prevent the worsening of, or cure a physical condition and that meet accepted standards for dentistry;
- Will prevent the onset of an illness, condition, or disability;
- Will prevent the deterioration of a condition;
- Will prevent or treat a condition that endangers life or causes suffering, pain, or results in illness or infirmity;
- Will follow accepted medical practices;
- Services are member-centered and take into account the individual's needs, clinical and environmental factors, and personal values. The criteria do not replace clinical judgment and every treatment decision must allow for the consideration of the unique situation of the individual;
- Services are provided in a safe, proper, and cost-effective place, reflective of the services that can be safely provided consistent with the diagnosis;
- Services are not performed for convenience only;
- Services are provided as needed when there is no better or less costly covered care, service or place available; and
- Services are provided in a manner that is no more restrictive than that used/indicated in State statutes and regulations.

In making decisions of medical necessity, LIBERTY Staff Dentists and Dental Consultants actively work with the treating provider to ensure a clear understanding of the member's unique needs, review our written guidelines, and review criteria to ensure members obtain appropriate and necessary dental services:

- In a manner that considers the timeliness of care that meets their dental needs;
- That are within professionally recognized standards of dental care; and
- At a location appropriate for their condition.

PROCESSES TO ENSURE CONSISTENT APPLICATION OF REVIEW CRITERIA

State and or/plan specific requirements are built into our UM system to ensure all applicable procedure receive review and that procedures that should bypass this process are not subject to review. Procedures that require clinical review are systematically routed to the appropriate state-licensed staff dentist for review. All authorization requests received are scanned and included in LIBERTY's electronic prior authorization process within our MIS. The Staff Dentist reviews each procedure for evidence of need and prognosis electronically through our HSP system.

We ensure consistent application of our review criteria for authorization through a variety of strategies including:

- Documentation: Written policies and procedures and Provider and Member Handbooks clearly identify the procedures subject to prior authorization and how to process initial and continuing authorizations of services.
- Staff Dentist/ Dental Consultant Training: Receive ongoing and continuous training on state and plan specific medical necessity and prior authorization requirements, including our written policies and procedures. All Staff Dentists and Dental Consultants have extensive experience in both clinical practice and Utilization Review

and receive continuing education and calibration to ensure that LIBERTY is current on all new and emerging trends in clinical dentistry.

- Monthly Quality Assurance reviews completed by the State Dental Director to ensure all UM decisions align with LIBERTY Clinical Criteria Guidelines and the New York State Medicaid Manual.
- Quarterly Inter-Rater Reliability calibration exercises reviewing real claims and/or prior authorizations. Internal goals/requirements require 90% agreement by all clinicians. Any clinician who performs UM review and fails to meet this goal is required undergo one on one training with the LIBERTY National Director of Clinical Oversight and the State Dental Director until competency is achieved.

MEMBER GRIEVANCES AND APPEALS

The LIBERTY member grievance and appeals process ensures that all members have the opportunity to exercise their right to a fair and timely review and resolution of any grievance or appeal. Providers are **contractually obligated** to provide LIBERTY with copies of all member records requested as a result of a member grievance or appeal. All providers are required to respond to LIBERTY with a written response to the member's concerns, including any supporting documentation, i.e. progress notes, treatment plans, financial ledgers, x-ray(s), etc. Failure to cooperate/comply with LIBERTY's request for records with the grievance or appeal may lead to disciplinary actions, including but not limited to, claims or capitation deductions, referral to the PQI Unit or termination from the LIBERTY network.

LIBERTY's grievance and appeals process encompasses the investigation, review and resolution of member issues, including cultural and linguistic needs, as well as the needs of members with disabilities. The process is designed to ensure that all LIBERTY members have access to and can fully participate in the grievance and appeals process. LIBERTY makes available translation services for members whose primary language is not English. We currently provide translation services in 150 languages. Members may obtain a grievance form from LIBERTY's website, a contracted Provider office or by calling the Member Services Department. All contracted provider offices are required to provide members with a copy of the LIBERTY grievance form, upon request.

LIBERTY accepts member grievances and appeals in all manners of communication. LIBERTY processes all member grievances and appeals in accordance with state and federal regulation. Please reference the outlined member grievance and appeals turnaround times.

PROVIDER GRIEVANCES AND APPEALS

Contracted and non-contracted providers may submit any concern, including but not limited to, Plan quality of service, policy and procedure issues and any other concern not associated with a claim dispute to LIBERTY's Quality Management Department. Providers may also submit claim disputes/appeals of a claim that has been denied, adjusted or contested or of a request for reimbursement of an overpayment of a claim. Providers may not file a Grievance or an Appeal on behalf of a Member without written consent from the Member as the Member's representative.

Informal provider complaints may be resolved informally via phone by calling LIBERTY Member Services at **888.869.4299**.

Pre-service appeals submitted on behalf of Members will be processed in accordance with the member appeal process and requires receipt of a provider designation form. Providers may submit requests for expedited pre-service appeals on behalf of a Member, with written consent, in the event there is an imminent and serious threat to the member's health, including, but not limited to, severe pain, potential loss of life or when taking the time for a standard resolution could seriously jeopardize the member's ability to attain, maintain or regain maximum function. Qualifying cases will be resolved within the member expedited appeal timeframes referenced above.

- All provider grievances and appeals must be submitted in writing and contain, at minimum, the following information.
- Provider's name and license number
- Provider's contact information, i.e. telephone number
- A clear identification of the issue that is subject of the grievance or appeal, i.e. date of service, procedure, etc.
- A clear explanation/summary of the provider's position on the issue
- Copies of all documentation relative to the subject in support of the provider's position

Providers may submit an appeal on their own behalf if a claim denied as not medically necessary or experimental/investigational.

SECTION 12. FRAUD WASTE AND ABUSE

LIBERTY's Fraud, Waste and Abuse Program is compliant with all New York state, and Federal laws and regulations, and applicable contract requirements.

FRAUD, WASTE, AND ABUSE PROGRAM DESCRIPTION

LIBERTY is committed to conducting its business in an honest and ethical manner and to operate in strict compliance with all regulatory requirements that relate to and regulate our business and dealings with our employees, members, providers, business associates, suppliers, competitors and government agencies. LIBERTY takes provider fraud, waste and abuse seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. LIBERTY has made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law.

LIBERTY promotes provider practices that are compliant with all federal and state laws on fraud, waste, abuse and overpayment. Our expectation is that providers will submit accurate claims, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding which services to order for their members.

Our policies in this area reflect that both LIBERTY and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs, federally funded contracts and private insurance. LIBERTY complies with all applicable laws, including Federal False Claims Act, state false claims laws and makes a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval.

As a provider, you are responsible to:

- Comply with all federal and state laws and LIBERTY requirements regarding fraud waste and abuse and overpayment;
- Ensure that the claims that you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse, and do not violate any federal or state law relating to fraud, waste or abuse.
- Ensure that you provide and bill only for services to members that are medically necessary for services that were rendered, and consistent with all applicable requirements, regulations, policies and procedures.
- Ensure that all claims submissions are accurate;

- Notify LIBERTY immediately of any suspension, revocation, condition, limitation, qualification or other restriction on your license, or upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services;

LIBERTY has developed a Fraud, Waste and Abuse ("FWA") Compliance Policy to identify or detect incidents involving suspected fraudulent activity through timely detection, investigation, and resolution of incidents involving suspected fraudulent activity.

"Fraud" includes, but is not limited to, "knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit." Fraud also includes fraud or misrepresentation by a subscriber or member with respect to coverage of individuals and fraud or deception in the use of the services or facilities of LIBERTY or knowingly permitting such fraud or deception by another.

Examples of fraud may include:

- Billing for services not furnished;
- Misrepresenting the services performed (e.g., upcoding to increase reimbursement)
- Soliciting, offering or receiving a kickback, bribe or rebate.

"Waste" means the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls. Waste does not normally lead to an allegation of "fraud", but it could.

Examples of waste may include:

- Over-utilization of services; and,
- Misuse of resources.

"Abuse" means the excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use so to abuse one's position or authority. "Abuse" does not necessarily lead to an allegation of "fraud," but it could.

Examples of abuse **may** include:

- Misusing codes on a claim;
- Charging excessively for services or supplies; and,
- Billing for services that were not medically necessary.

"Overpayment" means any funds that a person receives or retains under Medicaid and Medicare and other government funded healthcare programs to which the person, after applicable reconciliation, is not entitled under such healthcare program. Overpayment includes any amount that is not authorized to be paid by the healthcare program whether paid as a result of inaccurate or improper cost reporting, improper claiming practices, fraud, abuse or mistake.

REPORTING SUSPECTED FRAUD, WASTE, AND ABUSE OR OVERPAYMENT

LIBERTY expects providers and their staff and agents to report any suspected cases of fraud, waste, abuse or overpayments. LIBERTY will not retaliate against you if you inform us, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

To ensure ongoing compliance with federal law, if you determine that you have received an overpayment from LIBERTY, you are contractually obligated to report the overpayment and to return the overpayment to LIBERTY within thirty (30) calendar days after the date on which the overpayment was identified. You must also notify LIBERTY in writing of the reason for and claims associated with the overpayment.

All suspected cases of fraud, waste or abuse related to LIBERTY, including Medicare and Medicaid, should be reported to LIBERTY's Special Investigation Unit. The caller will have the option of remaining anonymous. **Reports may be made to LIBERTY via one of the following methods:**

- **Corporate Compliance Hotline**: 888.704.9833
- **Compliance Unit email**: compliancehotline@libertydentalplan.com
- **Special Investigations Unit Hotline**: 888.704.9833
- **Special Investigations Unit email**: SIU@libertydentalplan.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

ATTN: SPECIAL INVESTIGATIONS UNIT

LIBERTY Dental Plan
PO Box 26110
Santa Ana, CA 92799-6110

NON-RETALIATION POLICY

LIBERTY will not retaliate against you or any of our employees, agents and contractors for reporting suspected cases of fraud, waste, overpayments or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits LIBERTY from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action. LIBERTY also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.

FRAUD, WASTE, AND ABUSE TRAINING AND EDUCATION

LIBERTY encourages providers in our Medicare and Medicaid provider network to actively pursue information on their role in treating Medicare and Medicaid members. CMS, Medicaid and Medicare information can be accessed directly at **www.cms.gov**.

As a provider in our Medicaid and/or Medicare network, and in order to treat Medicare and/or Medicaid members, you agree to:

- Comply with any CMS, LIBERTY or Medicaid/Medicare Advantage health plan training requirements including, but not limited to, annual completion of Medicaid/Medicare Fraud, Waste and Abuse training, review and distribution of LIBERTY's Code of Conduct;
- It is the owning providers responsibility to ensure that all staff and providers complete /Medicare Fraud, Waste and Abuse training, and review LIBERTY's Code of Conduct within thirty (30) days of hire;
- LIBERTY provides, free of charge, Fraud, Waste and Abuse Prevention Training for all contracted providers and any other downstream entity that you contract with to provide health, and/or administrative services on behalf of LIBERTY.

This training is available on-line at **Provider Compliance Training**.

Organizations must retain a copy of all documentation related to this training for a period of no less than 10 years – including methods of training, dates, materials, sign-in sheets, etc.

SECTION 13. FORMS AND RESOURCES

Electronic forms are available for download from LIBERTY's website: **Provider Resource Library**

- Select "New York" from the drop-down menu

Accessible forms include, but are not limited to:

- ADA Dental Claim Form
- Consent for Non-Covered Treatment
- ECHO Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Form
- Emergency Oral Surgery Specialty Care Attestation Form
- New York Specialty Care Referral Form
- Provider Compliance Attestation Form
- NYS Medicaid – Evaluation For Dental Implants Form
- NYS Medicaid – Justification of Need for Replacement Prosthesis Form

SECTION 14. BENEFITS SCHEDULE

PROGRAM PLAN BENEFITS

The Member schedule include diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, other adjunctive general services, coverage, limitations and prior authorization requirements.

- The schedules are a complete list of the dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered.
- This Plan does not allow alternate benefits.
- Enrollees must visit a contracted provider to utilize covered benefits. Unless otherwise noted in the specialty care referral section of the Provider Reference Guide, documentation/radiographs required refers to Primary Care Dentists "PCD."
- Specialty Providers should refer to their Specialty Referral guidelines in the Provider Reference Guide.
- Benefits Schedules are available with the Provider Portal or upon request by contacting LIBERTY's Member Services.