PROVIDER REFERENCE GUIDE

NATIONAL

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

CHANGE CONTROL RECORD

Date	Effective Date	Section	Page(s)	Change Description
2/26/2021	3/1/2021	All	All	Amended/Restated Provider Reference Guide
9/1/2021	9/1/2021	All	All	Annual Review
5/3/2022	5/5/2022	Section 11	72-73	Clinical Criteria update to implant coverage

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WELCOME

Welcome to LIBERTY Dental Plan's ("LIBERTY's") network of Participating Providers. LIBERTY is a privately held dental benefits corporation established in 2001. LIBERTY's founder and CEO, Amir Neshat D.D.S., has assembled an Executive Management Team of dentists and health industry professionals with years of combined service and implementation experience. LIBERTY currently administers dental benefits to over 5 million members across the nation. LIBERTY also developed and maintains a national, proprietary contracted provider network, comprised of qualified general and specialty dentists as well as hospitals, dental schools, FQHCs and community-based clinics. Welcome to the LIBERTY team!

PURPOSE

The intent of this Provider Reference Guide is to aid each Participating Provider and their staff members in becoming familiar with the enrollment in, and administration of, LIBERTY's dental plans. Please note this Provider Reference Guide serves only as an addendum to the 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 apply. In the event of a conflict between this Provider Reference Guide and the Provider Agreement, the Provider Agreement shall prevail, unless the applicable statement in this Provider Reference Guide specifically indicates that it prevails over the Provider Agreement. You received a copy of the fully executed Provider Agreement at the time of your activation on LIBERTY's network or your LIBERTY orientation; however, you may also access your Provider Agreement at any time by logging into our **Provider Portal** or by submitting a request to Provider@libertydentalplan.com or by contacting the Provider Relations Department at 888.352.7924.

Updates to the Provider Reference Guide will be available by logging in to the **Provider Portal** and/or going to the Provider Resource Library on our website.

OUR MISSION

LIBERTY is committed to being the industry leader in providing quality, innovative and affordable dental benefits with the utmost focus on member satisfaction. Our 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 members 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, members, and LIBERTY staff members.

WHY JOIN LIBERTY?

- **Ease of Enrollment** – LIBERTY's online contracting and credentialing platform makes it easy to enroll as a LIBERTY provider and we make credentialing decisions within 3 weeks on average.
- **Dedicated Support** – We use a dedicated Medicare Advantage Provider Relations Team and pair each provider office with an experienced Network Manager to provide one-on-one support.
- **Access to Clinical Staff** - Our dedicated Medicare Advantage Dental Director and a team of staff dentists support dental offices in improving patient care. We offer peer to peer consultations within 72 hours of request and ensure we have dentists available to talk to dentists.
- **Resources and Training** – We are a trusted resource to our provider network on the latest industry trends and regulatory actions. We offer providers the opportunity to earn continuing education credits and access our library of online trainings, quarterly provider newsletters, and videos, among other resources.
- **LIBERTY's Concierge-Style Customer Service** – We answer the phone! Our call center provides "live," first call resolution using qualified staff with dental backgrounds. Our experienced team is trained in first-call resolution to address issues in real time. We took over 550,000 provider calls last year, answering 95% of them in under 20 seconds with a 91% first call resolution rate. That means less time on the phone and more time serving patients!
- **Provider-friendly Tools** – Our newly enhanced portal includes real-time eligibility, benefits, and improved history search for claims and prior authorizations.
- **Provider Recognition** – Our programs identify providers whose performance meets our quality of care expectations so we can recognize and reward these offices with reduced administrative requirements, among other benefits.
- **Data Exchange and Interoperability** – We provide real-time information with a seamless, coordinated healthcare experience to reduce administrative burden. This environment creates higher operational efficiency, thereby, increasing provider capacity and output.
- **Increased Opportunity** – The Medicare Advantage population is one of the fastest growing market segments in the country. Many of our Plans function similarly to PPO Plans with quarterly and annual maximums that allow more flexibility in the types of treatment you can render to your patients. Becoming a LIBERTY Medicare Advantage provider will open your office up to a new segment of the population with great dental benefits who are looking for a dental home.

PROVIDER ENROLLMENT ASSISTANCE

LIBERTY provides local and regional network managers to assist with the enrollment process and provide guidance on contracting and credentialing with LIBERTY. There are several ways to access a Network Manager in your service area.

PHONE	**Dial 888.352.7924** • Press Star ★ to speak to a Provider Service Representative about joining the LIBERTY network
EMAIL	**Provider@libertydentalplan.com** • Enter "Enrollment Assistance", the state abbreviation and the county for the location you want to contract in the Subject Line of the email o Example: "Enrollment Assistance_TX_Harris" • The appropriate Network Manager will respond within one to two (1-2) business days.

PROVIDER ENROLLMENT OVERVIEW

LIBERTY has a simple 5-step process for enrolling in our networks.

1. Contact your local/regional Network Manager for contracting information, fee schedules, and guidance on how to streamline the enrollment process to start your LIBERTY network participation off on the right foot.
2. Gather key documents needed for completion and submission of your contracting and credentialing package. Key Documents are listed below in the "Required Documents List" section.
3. Submit your Contract and Credentialing Application(s) along with all required documents (See Provider OnlineEnrollment Instructions below).
4. Stay in communication with your Network Manager to ensure all required documents are kept up to date until credentialing is complete.
5. Work with your dedicated Network Manager to schedule an orientation once you receive your Welcome Letter.

REQUIRED DOCUMENTS LIST

There are two categories of required documents when enrolling with LIBERTY.

1. **Contracting Documents** – One of each document below is required for each Location
   - Facility Application: Provides relevant location and payee data to set up an in-network location
   - Provider Agreement: An agreement to accept payment on behalf of LIBERTY Dental Plan'scontracted members.
   - Medicaid and/or Medicare Addenda: Contains the required regulatory language for the applicable government programs.
   - Fee Addendum: Represents the agreement to accept specific compensation arrangements (i.e. Feefor Service, Value Based, Capitation, etc.)
   - W-9: Required to generate a 1099 for tax purposes and must have the address registered

with the IRS listed as your corporate billing address for multiple locations with the same tax ID #.

- Provider Compliance Attestation: Indicates that your office and all relevant staff have completed the required annual compliance training to participate in our networks.
- Payment Options Form: Used to select from available options regarding how payments will be processed. Payment options vary depending on state and appropriate state forms should be included in the package that is sent by your Network Manager or viewable on the Provider Online Enrollment site.
- Authorized Signatory form: Optional form signed by the CEO/Owner delegating another employee (i.e. Office Manager, Management Company Contact, etc.) to sign enrollment documents on their behalf.
- State Required Documents: Some states have specific contracting requirements. Additional state requirements will be included on the checklist contained in your state's Contracting & Credentialing package.

2. **Credentialing Documents** – These are required for each Dentist/Hygienist/Denturist
   - Provider Credentialing Application: Allows each participating provider to provide the required credentialing information for third party verification. CAQH applications are allowed in most states, but may require additional information or completion of a state-mandated application.
   - Current Dental License: Successful Credentialing requires a non-expired dental license. If License expires prior to the completion of credentialing, an updated copy of your dental license will be required prior to credentialing approval.
   - Current Federal DEA Certificate or waiver: Waivers expire after 65 days from the signature date
   - Current Malpractice insurance certificate declaration page showing professional liability – Proves the dentist has the required liability insurance in place prior to enrollment. If certificate expires prior to the completion of credentialing, an updated copy of your declaration page will be required prior to credentialing approval. ***(Please note: Liability limits may vary per state and line of business)***
   - State Required Documents: Some states have specific credentialing requirements. Additional state requirements will be included on the checklist contained in your state's Contracting and Credentialing package.
   - Copy of Specialty Certificate or Board Certification (if applicable)
   - Copy of Internship/Residency/Fellowship Certificate (if applicable)
   - Work History and Educational – Gaps may require explanations (requirements vary by state)

PROVIDER ONLINE ENROLLMENT (POE)

LIBERTY's Provider Online Enrollment allows providers, or their delegates, to complete enrollment and re-enrollment, using an online application. The website is accessed from LIBERTY's website at **www.libertydentalplan.com** or click on this link to **Join Our Network**.

Prior to starting the application, download the **Provider Online Enrollment User Guide** and gather all pertinent information, including applicable ownership, agent and managing employee information for your provider type.

It's important to keep your enrollment information up to date. To avoid any delays in payment of your claims, be sure to report ***any*** change within thirty (30) days. Changes include, but are not limited to:

- a change in ownership

- an adverse legal action
- a change in practice location

If you have any questions about enrollment or need assistance, please contact your assigned Provider Relations Network Manager.

REQUIRED ANNUAL COMPLIANCE TRAINING

LIBERTY monitors and ensures all contracted offices and their staff operate in compliance withapplicable laws and regulations required by your contract. Contracted offices have the option to complete LIBERTY's required trainings listed below or other comparable trainings on the required topics within thirty (30) days of initial hiring, contracting, and annually thereafter.

Providers can access all compliance training modules at Provider Compliance Training and clicking on the individual links to view training materials. An option is available to print Certificate of Completion upon successful attestation.

1. Affordable Care Act Section 1557
2. Code of Conduct*
3. Compliance Plan*
4. Critical Incident
5. Cultural and Linguistic Competency
6. Fraud, Waste, and Abuse (CMS Medicare Part C &D)
7. Fraud, Waste, and Abuse (LIBERTY)
8. General Compliance (CMS Medicare Part C & D)
9. HIPAA (Privacy & Security)

LIBERTY is required to communicate, through dissemination of LIBERTY's Code of Conduct and Compliance Plan, its commitment to conducting business in an ethical manner, and consistent with governing law and program requirements. LIBERTY will also accept the dissemination of Provider's comparable Code of Conduct and Compliance Plan to fulfill this requirement.

Record Retention. Provider(s)/Office(s) must maintain supporting documentation for a period of ten (10) years after training completion.

Attestations are required annually and may be submitted via one of the following means:

Mail	LIBERTY Dental Plan ATTN: Provider Relations P.O. Box 26110 Santa Ana, CA 92799-6110	**Fax**	800.268.0154
Email	**Florida:** FLinquiries@libertydentalplan.com **All Other States:** Provider@libertydentalplan.com	**Online**	**Provider Compliance Training**

CREDENTIALING/RECREDENTIALING

Prior to acceptance in the LIBERTY provider network, dentists must submit a copy of the following information for verification:

- State Mandated Credentialing Application, if applicable
- Current State dental license for each participating dentist
- Current DEA license and/or State Drug Cert (If no DEA or SDC must submit a DEA Waiver)
- Current evidence of malpractice insurance for at least one million ($1,000,000) per incident and three million ($3,000,000) annual aggregate for each participating dentist
- Current certificate of a recognized training internship and/or residency program with completion (for specialists)
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist (as applicable)
- Immediate notification of any professional liability claims, suits, or disciplinary actions
- Verification is made by referencing the State Dental Board and National Practitioner Data Bank
- All provider credentials are continually monitored and updated on an on-going basis. Providers will receive notification of license/credential expiration from LIBERTY's delegated Certified Verification Organization (CVO), sixty (60) days prior to expiration to allow time to submit current copies.

For all accepted providers, your assigned Network Manager will conduct an orientation within thirty (30) days of activation (upon receipt of your welcome letter). All Providers receive a copy of LIBERTY's Provider Reference Guide. The Provider Reference Guide requires all providers to abide by LIBERTY's QMI Program Policies and Procedures. The ReferenceGuide is considered an addendum to the Provider Agreement. To resolve any issues for the new provider, and following orientation, a representative will make a follow-up service call within sixty (60) days either in person or by telephone.

LIBERTY maintains two separate and distinct files for each provider. The first is the provider's quality improvement file, which is maintained with restricted access by the Quality Management Department. This file includes confidential credentialing information. The second file is the provider's facility file that is maintained by the Provider Relations Department, which also includes audit results. The latter contains copies of signed agreements, addenda, and related business correspondence.

ENROLLMENT FAQs

For answers to the most frequently asked questions, please visit our **Enrollment FAQs**.

SECTION 3. GETTING STARTED AS A LIBERTY CONTRACTED PROVIDER

Getting started on the right foot in a new network is critical to maintaining a solid relationship with any payer. This section is dedicated to ensuring you have all the tools and support you need to succeed in your relationship with LIBERTY.

LIBERTY is dedicated to meeting the needs of our providers by utilizing leading edge technology to increase your office'sefficiency. 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 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 Contract Information
- Submit Referrals and Check Status
- Access Benefit Plans
- Print Monthly Eligibility Rosters
- Perform a Provider Search
- Check the status of a claim

Mail	Phone	Fax	Email
	MAIN 888.352.7924 **Press * to JOIN NETWORK** **ELIGIBILITY & BENEFITS** Option 1		
CLAIMS LIBERTY Dental Plan Attn: Claims Department P.O. Box 401086 Las Vegas, NV 89140	**CLAIMS** Option 2	**CORRECTED CLAIMS** 888.401.1129	**CLAIMS & PRE-ESTIMATES** claims@libertydentalplan.com
PRE-ESTIMATES LIBERTY Dental Plan Attn: Claims Department P.O. Box 401086 Las Vegas, NV 89140	**PRE-ESTIMATES** Option 3	**PRE-ESTIMATES** 949.253.0096	**PRE-ESTIMATES** referralfax@libertydentalplan.com
REGULAR REFERRALS LIBERTY Dental Plan Attn: Referral Department P.O. Box 401086 Las Vegas, NV 89140	**REFERRALS & SPECIALTY PRE-AUTHORIZATIONS** Option 4 **PROVIDER RELATIONS – MATERIALS REQUEST** Option 5	**REFERRALS & SPECIALTY PRE-AUTHORIZATIONS** 888.334.6033	**REFERRALS** referralfax@libertydentalplan.com
PROVIDER RELATIONS LIBERTY Dental Plan Attn: Provider Relations P.O. Box 26110 Santa Ana, CA 92799-6110	**General Information** Option 6	**PROVIDER RELATIONS** 800.268.0154	**PROVIDER RELATIONS** Provider@libertydentalplan.com

OTHER INFORMATION

HOURS OF OPERATION
Live representatives available
Monday – Friday,
5 a.m. PST – 5 p.m. PST

SECTION 4. PROVIDER RELATIONS

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 for assistance with the following:

- Plan Contracting
- Escalated Claim Payment Issues
- Education on LIBERTY Policies and Members 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 inquiries
- Change in Name or Ownership
- Taxpayer Identification Number (TIN) Change
- Changes in office hours

You may contact a member of the Provider Relations Team in one of the following ways:

Mail	LIBERTY Dental Plan ATTN: Provider Relations P.O. Box 26110 Santa Ana, CA 92799-6110	**Phone**	Provider Relations Department Monday – Friday 8 am – 5 pm PST 888.352.7924, Option 5 or 6
Email	**Florida:** FLinquiries@libertydentalplan.com **All Other States:** Provider@libertydentalplan.com		

SECTION 5. ONLINE SELF-SERVICE TOOLS

ONLINE ACCOUNT ACCESS

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 Dental Plan Welcome Letter and are required to register your office on LIBERTY's Provider Portal.

A 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 dental 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.

Short tutorial videos are available in the Library on the Provider Portal. These detail how to use the portal, accomplish specific tasks, and provide best practices. Detailed instructions on how to utilize the **Provider Portal** 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 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.

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 **once per quarter** by going online. We also **highly recommend** you set a calendar reminder in your system togo to the website every three (3) months and validate the information.

To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes thirty (30) days in advance. The easiest way to update your office information is through our Provider Directory Information Verification (DIV) website at **ProviderDIV**. You may also contact Provider Relations for further instructions on updating your provider demographics and

The benefits of online DIV updates:

- 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 contact the Provider Relations Department at 888.352.7924 for assistance.

PROVIDER RESOURCE LIBRARY

Looking for training materials and up-to-date information regarding LIBERTY? We have state-specific educational and reference materials available for download on our website in the **Provider Resource Library**.

SECTION 6. ELIGIBILITY

PRIMARY CARE DENTAL HOME ASSIGNMENT (DHMO Programs Only)

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.

Members can choose a Primary Care Dentist (PCD) at any time. Upon initial enrollment, LIBERTY will assign members to the nearest Primary Care Dentist based on such factors as language, cultural preference, previous history of the member or another family member, within the specified distance of member's home. Members canchange 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.

All members must be assigned to their primary care dental home prior to treatment. Dental homes may include offices that offer the full scope of general dentistry services, also known as Primary Care Dentists (PCD).

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 **Provider 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

Providers are responsible for verifying member eligibility before each visit. The member ID card does not guarantee eligibility. Checking eligibility will allow you to complete the necessary prior authorizations and reduce the risk of denied claims.

There are several options available to verify eligibility:

- **Provider Portal** (We recommend using the Member's Last Name, First Name, and Date of Birth for best results)
- **Telephone:** Speak with a live Representative from 8 a.m. to 5 p.m. PST, Monday through Friday by contacting 888.352.7924, press option 1.

ELIGIBILITY ROSTERS (CAPITATION PROGRAMS ONLY)

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

- Member name
- Dependent(s) name(s) or number of dependents covered
- Member Identification Number
- Member date of birth
- Group name (if through employer group, name of employer)
- Type of coverage (Plan number/name)
- Effective date of coverage

Dependents include spouse and eligible children. In most cases, eligible children are those who are unmarried and financially dependent upon the member for full support. Dependents include natural children, stepchildren, and foster children under the age of nineteen (19). Children may continue to be eligible up to age of twenty-six (26) if they are full time students.

In the event a member does not appear on the monthly Roster, please contact LIBERTY's Member Services Department at 888.352.7924.

MEMBER IDENTIFICATION CARDS

Members should present their ID card at each appointment. Providers are encouraged to confirm 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 LIBERTY's payment of benefits. Not all LIBERTY plans provide printed ID Cards. In such cases, providers should check a photo ID and check against an eligibility list, contact the Member Services Department or the **Provider 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.

SECTION 7. BENEFIT PLANS AND FEE ADDENDA

BENEFIT PLANS

Benefit Plans allow providers to evaluate member coverage and are available by logging into the **Provider Portal** and navigating to "My Members" or by contacting the Provider Relations Department at 888.352.7924. Please refer to the **Online Provider Portal User Guide** for further instructions.

Benefit Schedules also include a listing of CDT code descriptions, exclusions, benefit limitations, prior authorization requirements as well as member applicable co-payment or co-insurance.

ACCESSING MY CONTRACTED FEES

You can access your current fee schedule(s) in one of the following ways:

1. Contact your assigned Provider Relations Network Manager
2. Requesting via email at Provider@libertydentalplan.com
3. Call Provider Services at 888.352.7924
4. LIBERTY's secure **Provider Portal** under "My Resources"

PLAN OFFERINGS

Preferred Provider Organization (PPO): A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Exclusive Provider Organization (EPO): A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).

Health Maintenance Organization Network (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Dental Health Maintenance Organization (DHMO)
A legal entity that accepts the responsibility of providing services at a fixed price. The enrollees in these plans must have dental care provided through designated doctors.

SECTION 8. 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 completed and/or delivered.

At LIBERTY, we are committed to efficient and accurate claims processing. It is imperative that all submitted information be accurate and in the correct format. As a rule, network dentists are encouraged to submit clean claims within forty-five (45) calendar days of treatment completion. Timely claim filing may vary based on Plan in accordance with your Provider Agreement and applicable laws, and as indicated on your Explanation of Payment (EOP).

LIBERTY may require prior authorization for certain dental benefit programs. When prior authorization is not required, you may still request prior authorization for extensive treatment plans to help clarify any member financial obligations before treatment is rendered.

LIBERTY receives dental claims in four possible formats:

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 AUTHORIZATIONS 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 options 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 x 6	www.tesia.com/	CX083

All electronic submissions must follow 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 ADA approved claim forms. Please mail all paper/encounter forms to:

Products	LIBERTY Dental Plan PO Box 26110 Santa Ana, CA 92799-6110	LIBERTY Dental Plan P.O. Box 15149 Tampa, FL 33684	LIBERTY Dental Plan PO Box 401086 Las Vegas, NV 89140
Commercial	All states except FL & NV	FL Only	NV Only
Medicare	All other Medicare Plans	Devoted and MMM Only	N/A
Exchange	All Exchange	N/A	N/A
Medicaid	CA Only	FL & OK Only	NV, NJ, NY, & TX Only

"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, 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 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 NPIs will be rejected. All health care providers, health plans and clearinghouses are required to use the NPI number 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. If applicable, the LIBERTY Specialty Care Referral Request Form should be completed and submitted with the Emergency box checked.

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 and is being reviewed for benefit determination

CLAIMS RESUBMISSION

Providers have three hundred sixty-five (365) calendar days from the original 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 a claim has been overpaid, 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 more than the amount due, including interest and penalties on the claim.

Contested Notice

If the provider contests LIBERTY's notice of a claim overpayment, the provider, within thirty (30) working days of the receipt of LIBERTY's notice of claim overpayment, must send written notice to LIBERTY stating the basis upon which the provider believes the claim was not overpaid. LIBERTY will follow the contracted provider dispute resolution process described in the Section 13 (Quality Management) titled "Provider Dispute Resolution Process."

No Contest

If the provider does not contest LIBERTY's notice of a claim overpayment, the provider must reimburse LIBERTY within thirty (30) working days of the provider's receipt of LIBERTY's notice of claim overpayment. If the provider does not contest the overpayment notice and fails to reimburse LIBERTY within thirty (30) working days of the receipt of LIBERTY's notice of claim overpayment, LIBERTY may offset the amount of the overpayment from any

amounts due the provider for current and/or future claim submissions as described below.

Offset to Payments – Uncontested Notice of Overpayment

LIBERTY may only offset an uncontested notice of claim overpayment against a provider's current and/or future 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. If 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's Electronic Funds Transform Form can be located on our website at https://www.libertydentalplan.com/Resources/Documents/ma_EFT_transfer_Form.pdf

PAPER CHECKS

If you do not elect EFT, we ask that your office deposit all issued paper checks within fourteen (14) business days.

PEER-TO-PEER COMMUNICATION

If you have questions or concerns about a referral, prior 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 9. 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% of the cost of covered services. COB also ensures that providers do not collect more than the actual cost of the member's dental expenses.

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

IDENTIFYING THE PRIMARY CARRIER

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

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

The table below is a guide to assist your office in determining the primary carrier:

MEMBER IS THE MEMBER	PRIMARY
Member has dental coverage through employer	Member coverage is always primary
Member has dental coverage as an active employee and through the spouse	Member coverage is primary
Member has two active insurance carriers; both provide dental coverage	The carrier with the earliest effective date is primary
Member has dental coverage through a group plan and COBRA coverage	Group plan is primary
Member has dental coverage through a group plan and individual or supplemental coverage through another carrier Note: Supplemental/Individual plans are purchased by the member for added coverage Examples: Student Accident Plans Supplemental Plans Prepaid Trust Plans	Group plan is primary

MEMBER IS THE MEMBER	PRIMARY
Individual Plan (AFLAC) Reimbursement Plans Discount/Reduced Fee Plan	
Member has dental coverage as an active employee of one plan and as retired employee of another plan	The active coverage is primary
Member has two retiree plans	The plan that covered the member longer is primary
Member has a retiree plan and spouse holds a group plan	Spouse's group plan is primary
Member has a government funded plan and individual or supplemental coverage through another carrier	Individual/Supplemental coverage is primary
Member has two government funded plans. One is Federal (Medicare) and the other is State (Medicaid, Medi-Cal or Value Add)	Federal coverage is primary
Member has dental coverage through a group plan and a government funded plan	Group plan is primary
Member has dental coverage through a retiree plan and a government funded plan	Government funded plan is primary
Member has two Medicare plans	The Plan with the earliest effective date is considered primary
Dependent Child and the Birthday Rule	• The plan of the parent whose birthday falls earlier in the calendar year (month and day only) holds the primary coverage for dependent children. • If both parents have the same birthday, the plan that has covered either of the parents the longest is the primary plan. However, if the other plan follows the "gender rule" with male coverage always primary, LIBERTY will follow the rules of that plan. • These rules may be superseded by a court order that establishes the responsible party for the child's coverage. When determining the primary carrier for dependents with dual coverage, verify that both parents are the biological parents before applying the birthday rule. • Coverage through the biological parent is primary.
If coverage is through a biological parent and a step-parent residing in the same household	The biological parent's plan is primary
If parents are divorced or separated and there are two dental plans	The parent with custody to be the primary
If coverage is through both biological parents and stepparent, in absence of a court order, if the biological parents are legally separated or divorced	• The plan covering the parent with custody or with whom the child resides is primary. • The plan covering the stepparent residing in the same household is secondary. • The plan covering the other biological parent's coverage is third (tertiary). • The plan covering the other stepparent's coverage is fourth.

MEMBER IS THE MEMBER	PRIMARY
If child has a government funded plan and group plan through child's parent Examples of Government Funded Plans: • Medicaid • Medicare • CHIP • TRICARE (see note below) Note: TRICARE is a self-funded government plan and does not follow the Active vs. Retiree guidelines. TRICARE follows the effective date regardless of the plan's active or retiree status. The plan with the earliest effective date is considered prime. If member has a group plan and TRICARE; the group plan will be primary	Group plan through parent is primary

Scenarios of COBS:

When Member has two Managed Care Plans (DHMO-CAP program)

When the member is eligible under two managed care programs and assigned to the same contracted dentists, the member would be responsible for the copayment of the plan with the lesser copayment for the covered benefit. The member can be charged for copayment under one program only. If the treatment is a benefit under one program only, the applicable copay for that program applies.

Examples:

CDT Code	Carrier	Copayment	Member's Portion	Determination
D7240	Plan #1 Plan #2	$150 $125	$125	The plan with the lesser copayment
D7240	Plan #1 Plan #2	$100 Not Covered	$100	The plan with the covered benefit

When LIBERTY is Primary Carrier

When LIBERTY is the primary carrier, payment is made for covered services without regard to what the other plan might pay. The secondary carrier, then, depending upon its provisions and limitations, may pay the amounts not covered by LIBERTY.

Because LIBERTY's participating dentists have agreed to accept LIBERTY's allowance as payment in full for covered services, they should bill the secondary carrier for the member's coinsurance, any amounts exceeding the annual or lifetime maximums and/or any amounts applied towards the member's deductible or non-covered services.

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.

When LIBERTY is secondary, payment is based on the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the member's total out-of-pocket cost payable under the

primary carrier for benefits covered under the secondary carrier (according to AB895). That means whatever amount remains on the member's bill that was not paid by the member's primary carrier is now the responsibility of the secondary carrier to pay with the following conditions:

The remaining amount is for procedures that are benefits of the secondary plan

- The secondary carrier is responsible for an amount only up to what is contracted to pay under its primary responsibility of coverage to the member; and only up to what the actual out-of-pocket responsibility of the member is with their primary carrier.
- When LIBERTY is secondary and does not cover a service, although the service is covered under the Primary Carrier, the member's responsibility for that procedure is deducted from the amount of the member's responsibility from the Primary Carrier's EOB.
- When LIBERTY is secondary and the service was performed at a specialist, the member will need an authorization from the primary carrier and from LIBERTY, only if the group requires prior authorization.

Example #1:

Standard Calculation (before COB)				
Who Pays	Submitted Fee	Allowed Fee	Member's Portion	Plan Pays Office
Primary Carrier	$325.00	$137.00	$67.40	$69.60 ($137 - $67.40)
LIBERTY	$325.00	$81.00	$55.00	$26.00 ($81 - $55.00)

After applying COB:

- Member's Portion is reduced = $ 41.40 ($67.40 - $26.00)
- LIBERTY pays office = $26.00

Example #2:

Standard Calculation (before COB)				
Who Pays	Submitted Fee	Allowed Fee	Member's Portion	Plan Pays Office
Primary Carrier	$325.00	$137.00	$67.40	$69.60 ($137 - $67.40)
LIBERTY	$325.00	$150.00	$55.00	$95.00 ($150 - $55.00)

After applying COB:

- Member's Portion is reduced = $0 (since member's primary liability is less than LIBERTY's portion - $67.40 < $95.00)
- LIBERTY pays office = $67.40 (LIBERTY pays the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage or the member's total out-of-pocket liability under the primary carrier)

SECTION 10. PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

PRIMARY CARE DENTIST (PCD) RESPONSIBILITIES

All dental services, including those proposed, recommended and/or performed, must be documented and /or provided consistent with professionally recognized standards of dental practice.

- Provide and/or coordinate all dental care for member;
- Ensure LIBERTY members are seen by contracted LIBERTY providers;
- Perform an oral evaluation;
- Provider has the right to dismiss a member in writing to LIBERTY stating the reasons for dismissal. Dismissal may not include the following reasons:
    - Because the member's attempt to exercise his or her rights under the grievance system
    - Adverse change in the member's health status
    - Member's utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs
- Provide a written treatment plan to members that identifies covered services, non-covered services, and clearly identifies any costs associated with 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;
- Provide an informed consent discussion and supporting materials for all dental services and procedures for which the member has questions or concerns;
- Treatment plans and informed consent documents **must be signed by the member or responsible party** demonstrating an understanding of the treatment plan and an agreement with a treatment plan and the associated financial terms;
- A financial agreement for any non-covered service to be documented separately from any treatment plan or informed consent;
- Work closely with specialty care provider to promote continuity of care;
- Cooperate with, and adhere to LIBERTY 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 the dental facility;
- Ensure that emergency dental services and/or information are available and accessible for members of record 24 hours a day, 7 days a week;
- Maintain scheduled office hours;
- Maintain dental records for a period of ten (10) years;
- Post the availability of language assistance services signage in provider office;
- Coordinate and provide language assistance services, which includes telephonic and onsite interpretation services for members when necessary;
- Document member's preferred language and request/refusal of interpreting services in dental chart;
- Provide LIBERTY with updated credentialing information upon request;
- Provide requested information upon receipt of member grievance/complaint/appeal within three (3) business days of receiving the notice letter from LIBERTY;
- Provide claim or encounter data on standard ADA claim form within timely filing requirements;
    - Capitation plans require disclosure of services rendered
- Notify LIBERTY of any changes regarding his or her practice, including location name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc.;
- If a member chooses to transfer to another participating dental office; there will be no charge to the member for copies of records maintained in their chart. All copies of records must be provided to the member within fifteen (15) calendar days of the request;
- Provide dental services in accordance with peer reviewed clinical principles, criteria, guidelines and any evidence- based parameters of care;
- Providers may not close, or otherwise limit, their acceptable of members unless the same limitations apply to all commercially insured members;
- Providers understand and agree that assignment of delegation by Provider of services under its agreement with LIBERTY is null and void unless prior written approval is obtained from LIBERTY and, to the extent required, by LIBERTY from relevant Health Plan Partners.

SPECIALTY CARE DENTIST RESPONSIBILITIES

- All the Responsibilities of the PCD listed above
- Provide specialty care to members;
- Work closely with primary care dentists to ensure continuity of care;
- Submit claims to LIBERTY for all dental services that were authorized;
- 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

LIBERTY members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to each member in the member's Evidence of Coverage booklet and are outlined below.

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

- To be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his/her need for privacy.
- To a prompt and reasonable response to questions and requests
- To know who is providing dental services and who is responsible for his/her care
- To know what rules and regulations apply to his/her conduct
- To know what member support services are available, including whether an interpreter is available if he or she does not speak English
- To refuse any treatment, except as otherwise provide by law
- To be given, upon request, full information, and necessary counseling on the availability of known financial resources for his/her care.
- To receive, upon request prior to treatment, a reasonable estimate of charges for dental care.
- Medicare eligible members have the right to now, upon request and in advance of treatment, whether the health care provider or facility accepts the Medicare assignment rate.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To impartial access to treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Treatment for any emergency dental condition that will deteriorate from failure to provide treatment
- To know if treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such experimental research
- Know their treatment choices and participate in decisions about their health care
- Use Advance Directives (such as a living will or a durable health care power of attorney)
- To express grievances/complaints regarding any violation of his/her right, as state in applicable state law, through the grievance procedure of the heath care provider or facility which service his/her to the appropriate state licensing agency.
- To request an appeal of an adverse benefit determination to deny, defer, or limit services or benefits either verbally or in writing.
- To request a grievance about LIBERTY or the care provided and feel confident it will not affect the way they are treated
- Make recommendations about LIBERTY's policies regarding member rights and responsibilities; and

- Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved. Provider must provide the information to members in a way they understand

As a member of a LIBERTY affiliated Health Plan, everyone has the responsibility to behave according to the following standards:

- Become familiar with their coverage and the rules they must follow to get care as a member;
- Tell LIBERTY and dental providers if they have any additional health insurance coverage or prescription drug coverage;
- Tell their dentists and other health care providers that they are enrolled in LIBERTY Dental Plan; Give their dentist and other providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
- Provide their dentist or other health care providers, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health;
- Reporting to their dentist or other health care provider any unexcepted changes in his/her health conditions;
- Understand their dental health problems and help set treatment goals that they and their dentist agree to;
- Ask their dentist and other providers questions about treatment if they do not understand;
- Following the recommended treatment plan from their dentist or other health care provider;
- Tell their dentist that they understand the treatment plan, the course of treatment and what is expected from him/her;
- Make sure their doctors know all of the drugs they are taking, including over-the-counter drugs, vitamins, and supplements;
- Act in a way that supports the care given to other members and helps ensure the smooth running of their doctor's office, hospitals, and other offices;
- Pay their plan premiums and any co -payments or coinsurance they owe for the Covered Services they receive. Members must also meet their other financial responsibilities as described in the Evidence of Coverage booklet;
- Keeping scheduled appointments, and when he/she is unable to do so for any reason, notifying the dentist or other health care provider/facility at least 24 hours in advance;
- Inform LIBERTY Dental Plan if they move; and
- Inform LIBERTY Dental Plan of any questions, concerns, problems, or suggestions by calling the Member Services Department listed in their Evidence of Coverage booklet.

VOLUNTARY TERMINATION OF THE PROVIDER CONTRACT

Providers are required to provide to LIBERTY at least ninety (90) days advance written notice of their intent to terminate a provider contract. Providers must continue to treat members until the last day of the month following the date of termination. Impacted members are given advance written notification informing them of their transitional rights. Certain contractual rights survive termination, such as the agreement to furnish member records in response to a grievance or claims review. Please consult your provider contract for your responsibilities after the date of termination.

NATIONAL PROVIDER IDENTIFIER ("NPI")

In accordance with the Health Insurance Portability and Accountability Act ("HIPAA"), LIBERTY requires National Provider Identifiers ("NPI") for all HIPAA related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals, and claim status.

As outlined in Federal Regulations, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPIs with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

HOW TO APPLY FOR AN NPI

Providers can apply for an NPI in one of three ways:

1. Web based application: http://nppes.cms.hhs.gov
2. Dental providers can agree to have an Electronic File Interchange (EFI) Organization submit the application data on their behalf
3. Providers can obtain a copy of the paper NPI application/update form (CMS-10114) by visiting www.cms.gov and mail the completed, signed application to the NPI Enumerator

STANDARDS OF ACCESSIBILITY AND AVAILABILITY

LIBERTY is committed to ensuring our members receive timely access to care. Providers are required to schedule appointments for eligible members in compliance with standards of accessibility and availability as defined below.

Access Standards	
Non-urgent Appointments (exams, x-rays, restorative care)	Not to exceed thirty (30) business days
Emergency Appointments (acute pain/swelling/bleeding)	24 hours a day, 7 days a week
Preventive Care (prophys or periodontal care)	Not to exceed thirty (30) business days
Lobby Waiting Time (for scheduled appointments)	Not to exceed thirty (30) minutes

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider's after-hours response system must enable members to reach an on-call dentist twenty-four (24) hours a day, seven days a week. In the event the primary care provider is not available to see an emergency for a

member of record within twenty-four (24) hours, it is his/her responsibility to ensure that emergency services are available. Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider's "after hours" telephone service. Member must be scheduled within twenty-four (24) hours and should be informed that only the emergency treatment will be provided at that time. If the member is unable to access emergency care within these guidelines and must seek services outside of your facility, provider may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet LIBERTY guidelines, LIBERTY has the right to transfer some or all capitation programs enrollment to another provider or close your office to new enrollment.

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established members who fail to keep or who cancel scheduled appointments. Failed appointment charges may apply; copayments will vary based on the members' plan benefits. Refer to the members' benefits schedule or contact the Member Services Department for more information. Missed or cancelled appointments should be noted in the member's record.

Note: Medicaid members cannot be charged for no show or missed appointment.

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.

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 require corrective action from providers that are not meeting accessibility standards.

FACILITY PHYSICAL ACCESS FOR THE DIASBLED – 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**.

TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate, written treatment plan including an explanation of the benefits, alternatives, recommendations, and financial implications of the treatment recommended and/or proposed. If there are alternate treatments available, the treating dentist must also present those options and the related costs for both covered and/or non-covered services.

Alternate and/or Elective/Non-Covered Procedures and Treatment Plans: LIBERTY members cannot be denied appropriate plan benefits if they do not choose "alternative or elective/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, alternate, and elective 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 in the **Provider Resource Library**.
6. Treatment plans and informed consent documents **must be signed by the member or responsible party** demonstrating an understanding of the treatment plan and an agreement with a treatment plan and the associated financial terms.

Note: Most LIBERTY commercial (non-governmental) plans allow for an upgrade in materials to noble or high noble metal and for porcelain on molar teeth with a signed treatment plan and informed consent by the Member.

SECOND OPINIONS

Members may request a consultation with another network dentist for a second opinion to confirm a diagnosis

and/or treatment plan at no cost. Providers should refer these members to the Member Services Department at 888.352.7924, Monday through Friday, 8 a.m. to 5 p.m. PST.

CONTINUITY AND COORDINATION OF CARE

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

All care rendered to LIBERTY members must be properly documented in the member's dental charts according to established documentation standards. Communication between the primary care dentists (and dental specialists shall occur when members are referred for specialty dental care. LIBERTY expects General Dentistry providers to follow-up with the Member and with the Specialist to ensure that referrals are occurring consistent with the best interests of the Member. Specialist providers are encouraged to send treatment reports back to the referring General Dentist providers to ensure that continuity of care occurs consistent with generally accepted standards of practice.

LIBERTY enforces Quality Management and Improvement (QMI) Program policies and procedures that will ensure:

- An enrollment packet contains a list of Providers that shall be given to all members upon enrollment
- A current list of Providers is maintained on LIBERTY's web site at **Fina a Dentist**
- Members who do not select a Provider shall be assigned one, based on the member's geographic location **(for capitation plans)**
- Dental chart audits will verify compliance to documentation standards
- Guidelines for adequate communications between the referring and receiving providers when members are referred for specialty dental care are included in this provider guide
- During facility on-site audits, LIBERTY monitors compliance with continuity and coordination of care standards
- When a referral to a Specialist is authorized, the General Dentist provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and schedule the member for any appropriate follow-up care
- When a specialty care referral is denied, the General Dentist provider is responsible for the evaluation of the need to perform the services directly, and schedule the member for appropriate treatment
- The results of site audits shall be reported to the Peer Review and QMI Committees, and corrective action shall be ordered when deficiencies are identified.

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.

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 ten (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. Electronic dental records must capture the dentist's identification (signature, initials, or other indication showing that the dentist has approved the chart entry in the electronic dental record.

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.

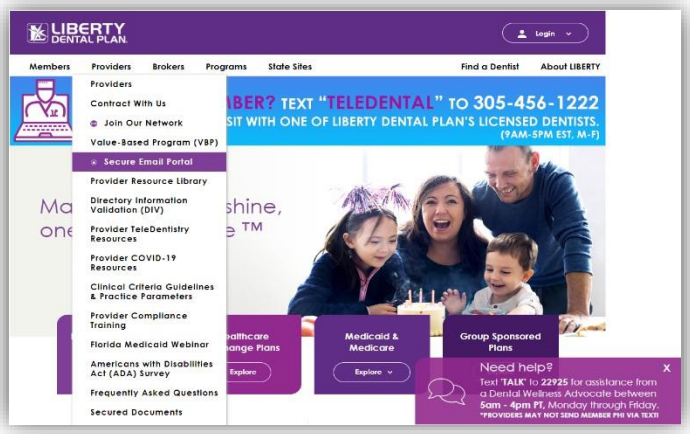
Failure to properly safeguard PHI can result in data breaches, enforcement actions and significant monetary penalties, and with LIBERTY members, is a violation of LIBERTY's provider agreement. If LIBERTY discovers that a provider has transmitted LIBERTY member PHI via a potentially non-secure method, 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 online at **Provider Resource Library**.

2. Verbal PHI

A. Do not discuss patient information in public areas (including waiting rooms, hallways and other common areas), even if you believe you are masking the patient'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 patient 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.

B. 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

Providers are responsible for verifying member eligibility before each visit. The member's ID card does not guarantee eligibility. Checking eligibility will allow providers to complete necessary authorization procedures and reduce the risk of denied claims.

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 888.352.7924. 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 LIBERTY's Member Services Department. 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.

SECTION 11. CLINICAL DENTISTRY PRACTICE PARAMETERS

LIBERTY expects contracted dentists to adhere to common record-keeping as per generally accepted clinical guidelines and requirements. All dental services, including those proposed, recommended and/or performed, must be documented and/or consistent with professionally recognized standards of dental practice.

DISCLAIMER: Please note that specific Plan/Program guidelines supersede the information contained in these Clinical Dentistry Practice Parameters. The practice parameters are the default set of practice parameters when plan documentation is silent on a particular topic.

NEW MEMBER INFORMATION

Registration information should minimally include:

- Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number, other contact information such as social media addresses
- Name and telephone number of person(s) to contact in an emergency
- For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above
- Pertinent information relative to the member's chief complaint and dental history, including problems or complications with previous dental treatment, previous dentist/dental clinic, and date of last dental examination

Medical History:

There should be a detailed medical history form comprised of questions which require a "yes" or "no" responses, minimally including:

- Member's current health status
- Name and telephone number of physician and date of last visit
- History of hospitalizations and/or surgeries
- History of abnormal (high or low) blood pressure
- Current medications, including dosages and indications
- History of drug and medication use (including Fen-Phen/Redux and bisphosphonates)

- Allergies and sensitivity to medications or materials (including latex)
- Adverse reaction to local anesthetics
- History of diseases:
  - Cardio-vascular disease, including history of abnormal (high or low) blood pressure, heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.
  - Pulmonary disorders including tuberculosis, asthma, and emphysema
  - Nervous disorders
  - Diabetes, endocrine disorders, and thyroid abnormalities
  - Liver or kidney disease, including hepatitis and kidney dialysis
  - Sexually transmitted diseases
  - Disorders of the immune system, including HIV status/AIDS
  - Other viral diseases
- Musculoskeletal conditions, including the location and date of placement of any prosthetic joints
- Pregnancy
  - Document the name of the member's obstetrician and estimated due date.
  - Follow current guidelines in the ADA publication, Women's Oral Health Issues.
- History of cancer, including radiation or chemotherapy
- The medical history form must be signed and dated by the member or member's parent or guardian.
- 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.
- Medial alerts for significant medical conditions must be in uniform and conspicuously located on a portion of the chart used and visible during treatment and should reflect current conditions.
- Medical alerts should be readily visible by the dentist and staff prior to and during treatment, but not to others who have no need to know.
- 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.
- The medical history should be updated at appropriate intervals, dictated by the member's history and risk factors, and must be done at least annually (or after a significant time away from treatment, when conditions might have changed) and signed by the member and dentist.

<u>Dental History:</u>

- Reason for seeking current dental care (Main Complaint)
- History of previous oral surgery, orthodontics, periodontics, etc.
- Problems with previous dental treatment
- Complications from local anesthesia

- Previous Risk Assessments
- Member's dental goals

BASELINE CLINICAL EVALUATION AND DIAGNOSTIC DOCUMENTATION

- Observations of the initial evaluation are to be recorded in writing for a written clinical record, and electronically for an electronic dental record. Observations should be charted graphically where appropriate, including missing or impacted teeth, existing restorations, and prior endodontic treatment, fixed and removable appliances.
- Assessment of TMJ status (necessary for adults) and/or classification of occlusion (especially necessary for minors) should be documented.
- Periodontal screening is required for all members. Full mouth periodontal probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, amount of attached gingiva, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements for all members where periodontal services is being prescribed.
- A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx, and floor of the mouth must be documented.
- Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the member's history and risk factors, and must be done at least annually (or after a significant time away from treatment, when conditions might have changed).
- Risk Assessment for caries is recommended. Risk Assessment forms are available from the American Dental Association and the American Academy of Pediatric Dentistry at www.ada.org and www.aapd.org. Risk assessments are also available and highly recommended for periodontal disease and oral cancer.
- Diagnostic casts (D0470) are benefited only as an aid for treatment planning specific oral conditions. See specific plan documentation for details. Routine diagnostic casts are not a benefit of most LIBERTY plans.
- Tests, examinations, and reports may be required when necessary to determine a diagnosis or treatment plan for an existing or suspected oral condition or pathology.
- Oral pathology laboratory procedure/reports may be required when there is evidence of a possible oral pathology.

DIAGNOSTIC IMAGING (RADIOGRAPHS AND PHOTOGRAPHS)

- An attempt should be made to obtain any recent radiographs from the previous dentist.
- An adequate number of initial radiographs should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines.
- Intraoral photographs may assist in the diagnostic process. Some plans provide a benefit for intraoral photographs, as per the Evidence of Coverage or governing plan documents. However, photos may help to justify need for restorative services not evident in the radiograph and are encouraged for this reason.

- D0210 Intraoral – complete series (including bitewings)

Note: As per the ADA's CDT, a radiographic survey of the whole mouth, usually consisting of 14-22 intraoral periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

Clinical/Coverage Guideline:

[X1]: LIBERTY covers D0210 complete series of radiographs only when the number of images meets the ADA definition, or some other combination of panoramic images with additional images taken on the same day. Despite the fact that a provider may itemize radiographs, LIBERTY may group radiographic images taken on the same day (or nearby in dates) as a complete series benefit and apply pertinent limitations or exclusions to this group of radiographic images.

- Benefits for this procedure are determined within each plan design.
- Any combination of covered radiographs that meets or exceeds a provider's fee for a complete series will be adjudicated as a complete series, for benefit purposes only.

Clinical/Coverage Guideline:

[X2]: Any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, for benefit purposes only.

- 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.
- A panoramic radiograph is a screening film and is not a substitute for periapical and/or bite wing radiographs when a dentist is performing a comprehensive evaluation.
- Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
- Radiographs should exhibit good contrast
- Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.
- Recent radiographs must be mounted, labeled left/right, and dated
- Any member refusal of radiographs should be documented
- When a member is transferred from one provider to another, diagnostic copies of all Radiographs less than two years old should be duplicated for the second provider.
- If the transfer is initiated by the provider, the member may not be charged any radiograph duplication fees.
- If the transfer is initiated by the member, many plans allow the provider to charge for the actual cost of copying the radiographs. Generally, a fee of $25 or the actual cost of duplication is allowable.

Clinical/Coverage Guideline:

[X3]: Narratives that are contradictory to radiographic or photographic presentation are ambiguous. In such cases, the radiographic presentation will be the determining factor in the determination of coverage.

PREVENTIVE

Preventive dentistry may include risk assessments for caries, periodontal disease and oral cancer, clinical tests, dental health education and other appropriate procedures to prevent caries, periodontal disease, oral cancer or injury to the mouth, teeth, and related oral structures.

Caries prevention may include the following procedures where appropriate:

- Member education in oral hygiene and dietary instruction
- Periodic evaluations and prophylaxis procedures
- Topical or systemic fluoride treatment
- Sealants

Periodontal disease prevention may include a comprehensive program of plaque removal and control in addition to the following procedures:

- Oral and systemic health information
- Oral hygiene and dietary instructions
- Prophylaxis procedures on a regular basis
- Occlusal evaluation
- Correction of malocclusion and malposed teeth
- Restoration and/or replacement of broken down, missing or deformed teeth D1110 and D1120 – prophylaxis procedures
- Plan policy - Procedure D1110 applies to members who are 14 years old and older.
- Plan Policy - Procedure D1120 applies to members who are 13 years old and younger.
- D1110 and D1120 are benefited when documentation shows there is evidence of plaque, calculus, or stains on tooth structures.

D1206 and D1208 Topical Fluoride Treatment (Office Procedure)

- Plan Policy Procedure D1206 topical fluoride varnish
- Plan Policy Procedure D1208 topical application of fluoride applies to members up to their 18th birthday
- D1206 and D1208 are benefited when documentation shows evidence of need for this procedure (i.e., risk assessment, history of caries.

Other areas of prevention may include:

- smoking cessation programs
- discontinuing the use of smokeless tobacco

- good dietary and nutritional habits for general health
- elimination of mechanical and/or chemical factors that cause irritation
- space maintenance in children, where indicated for prematurely lost posterior teeth to facilitate the future eruption of a succedaneous permanent tooth
- recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the member's physician

TREATMENT PLANNING

- Treatment plans should be comprehensive and documented in ink for written clinical records) and should be easily accessible in the electronic dental record.
- Treatment plans should be consistent with the clinical evaluation findings and diagnosis.
- Treatment plans should be consistent with the level of risk assessed. Large invasive restorative treatment plans may not be appropriate for a member with high risk for caries and periodontal disease. Conversely, conservative treatment such as fluoride and monitoring may be appropriate for incipient non-cavitated caries in low-risk members.
- Treatment plans should be signed by the member demonstrating an understanding and accepting the proposed treatment. Treatment plans must be clear and concise and must be understandable by a prudent layperson with a normal public knowledge of the procedures involved.

Clinical/Coverage Guideline:

[TP1]: The resolution of a grievance in which the member has not signed a treatment plan (and appropriate financial consent) that is clear concise and understandable will be ruled in favor of the member. Exceptions may be made for routine diagnostic, preventive and routine non-complex restorative treatment, or when other documented evidence is present showing a reasonable clinical and financial presentation was made to the Member.

[TP2]: Treatment proposed or rendered that is not consistent with the written or apparent diagnosis will not be benefited.

Sequencing: Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing generally include relief of pain, discomfort and/or infection; treatment of extensive caries and pulpal inflammation including endodontic procedures; periodontal procedures; restorative procedures, replacement of missing teeth; prophylaxis and preventive care; and establishing an appropriate recall schedule. Treatment sequencing may vary to accomplish functional goals of the member.

- Upgrades: Some upgraded procedures (i.e. metals and porcelain on molars) may not be covered.
- If the dentist recommends two covered procedures as "needed" services, either of the chosen procedure would be covered. Example: if an extraction is agreed to instead of an endodontic procedure, the extraction would be covered.

- Right to Extraction over Treatment: A Member always has the right to an extraction over any simple, routine, or complex restorative, endodontic or periodontal procedures. Providers may not inform Members of complex procedures and then present the extraction as "optional." If Provider feels that an extraction is not appropriate, it should not be offered, or the Member should be redirected to Member Services for re-assignment to another office.
- Member Indication of Choice of Treatment Option: Alternative treatment plans and options should be documented with a clear and concise indication of the treatment the member has chosen. In such cases, the Alternate Treatment Plan Formula should be presented and documented. Members should sign the treatment plan, informed consent and/or financial consent indicating they have chosen the presented course of treatment. Presentation should be understandable so that a prudent layperson would understand the treatment and choices made.
- Provider Disagreement of Member Request: Should a dentist not agree with a procedure requested by a member, the dentist may decline to provide the procedure and request that the member be transferred. In such cases, the dentist is responsible for completion of treatment-in-progress and emergencies until the transfer request is effective.
- Consultations, second opinions, referrals and their results must be documented in the clinical record.

[TP3]: Treatment proposed or rendered that appears to be inconsistent with generally accepted professional standards of treatment sequencing (based on radiographs, photographs, narrative or other information provided) may not be benefited.

INFORMED CONSENT PROCESS

- Dentists must document that all recommended treatment options have been reviewed with the member and that the member understood the risks, benefits, alternatives, expectancy of success, and the total financial responsibilities for all proposed procedures.
- In addition, the member should be advised of the likely results of not doing the treatment or of doing no treatment whatsoever.
- Appropriate informed consent documentation must be signed and dated by the member and dentist for the specific treatment plan that was accepted.
- Best practices provide a copy of the signed treatment plan to the member/patient at the time of member approval.

- If a member refuses recommended procedures, the member must sign a specific "refusal of care" document.

[TX4]: Treatment rendered without a signed consent form is inconsistent with generally accepted professional standards of practice. The resolution of a grievance that involves treatment rendered in which the member has not signed an informed consent (signed treatment plan, financial arrangement and/or clinical consent) will be ruled against the rendering provider. Exceptions may be made for routine diagnostic, preventive, and routine non-complex restorative treatment, or when other documented evidence is present showing a reasonable clinical presentation was made to the Member.

POOR PROGNOSIS

- When providers recommend endodontic, periodontal or restorative procedures (including crown lengthening), they should consider and document the anticipated prognosis, restorability and/or maintainability of the tooth or teeth involved.

Clinical/Coverage Guideline:

[TP5]: Procedures recommended for teeth with a guarded or poor prognosis (endodontic, periodontal, or restorative) are not covered. Poor prognosis is deemed to be an expected longevity of less than three (3) years in full function based on clinical presentation and experience of treating clinician and/or reviewing clinician.

[TP6]: Endodontic treatment should not be benefited for teeth that will require crown lengthening surgery UNLESS the crown lengthening will improve the prognosis of the tooth and is expected to have a successful outcome. The member must be informed of the need for the crown lengthening procedure, and any financial responsibilities related to the crown lengthening procedure. In many cases it will not be covered, and the member would be financially responsible for the crown lengthening. A commitment for payment for the crown lengthening should be obtained in advance of the related endodontic treatment.

[TP7]: Endodontic treatment should not be benefited on teeth with severe bone loss of 50% or more of the bone support. To do so would not be consistent with professionally recognized standards of practice.

- LIBERTY's licensed dental consultants adjudicate prognosis determinations for the above procedures on a case- by-case basis.
- LIBERTY will reconsider poor prognosis determinations for the above procedures upon receipt of a new claim with appropriate documentation and new diagnostic radiograph(s) taken a minimum of six (6) months after the original date of service.

PROGRESS NOTES

- Progress notes constitute a legal record and must be detailed, legible and in ink.
- All entries must be signed or initialed and dated by the person licensed to provide treatment.
- Entries may be corrected, modified, or lined out, but require the name of the person making any such changes and the date.
- The names and amounts of all local anesthetics must be documented, including the amount of any

vasoconstrictor present. If no local anesthetic is used for a procedure that normally requires it (i.e. scaling and root planing), the related rationale should be documented.

- All prescriptions must be documented in the progress notes or copies kept in the chart, including the medication, strength, amount, directions, and number of refills.
- Copies of all lab prescriptions should be kept in the chart.
- For paperless dental records, computer entries cannot be modified without identification of the person making the modification and the date of the change.

Clinical/Coverage Guideline:

[PN1]: Federal HIPAA laws require practitioners to use current CDT codes to report dental procedures. LIBERTY may reject/deny coverage for procedures not reported using current CDT codes. Clinical Dental Consultant reviewers may correct, alter or re-code the procedure that is apparently being submitted to the proper code at their discretion.

ENDODONTICS

Note: For benefit purposes providers should document endodontic dates of service as the dates when procedures have been entirely completed, subject to review.

Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:

- Pain and the stimuli that induce or relieve it by the following tests:
  - Thermal
  - Electric
  - Percussion
  - Palpation
  - Mobility
- Non-symptomatic radiographic lesions

Treatment planning for endodontic procedures may include consideration of the following:

- Strategic importance of the tooth or teeth
- Prognosis – endodontic procedures for teeth with a guarded or poor (less than 3-year prognosis (endodontic, periodontal, or restorative) are not generally covered
- Presence and severity of periodontal disease
- Restorability and tooth fractures – Teeth that require crown-lengthening procedures due to caries at or below the osseous crest are not generally benefited
- Excessively curved or calcified canals
- Following an appropriate informed consent process, if a member elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign

appropriate informed consent documents and financial agreements. See documentation requirements for non-covered services to avoid grievances or refunds.

- Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration and removed from occlusion pending the final restoration. Most posterior teeth should be restored with a full coverage restoration, unless access opening is small.
- Occlusion – endodontic treatment of teeth that are not in occlusion is not generally benefited

Clinical Performance Considerations:

- Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.
- 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.
- Gutta percha is the endodontic filling material of choice and should be densely packed and sealed. All canals should be obturated.
- Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.
- In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals to document success or presence of post-treatment complications.
- Endodontic referral necessity

Note: If the need for endodontic treatment is not clear, LIBERTY expects the general dentist to proceed with the decay removal and possible temporization prior to any referral to an Endodontist.

Endodontic irrigation

Providers are contractually obligated to perform the root canal treatments with the materials they choose as adequate and appropriate. Providers may not charge for the materials used in the procedure such as BioPure (MTAD), diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal. Filling materials such as Therma-Fil, or other brand name files or filling materials and posts may not be charged. The compensation for the root canal treatment includes all materials involved.

Providers may not unbundle dental procedures to charge members for intraoperative materials. The provider agreement and plan addenda determine what members are to be charged for covered dental procedures. Charging for BioPure as an alternative to diluted bleach is not allowed on LIBERTY's dental plans.

Clinical/Coverage Guideline:

[E1]: LIBERTY's policy does not allow charging for the use of irrigants or materials as part of root canal treatment, whether, or not a choice is presented to the Member.

Note regarding inappropriate unbundling/coding for endodontic irrigation:

D9630 – Providers should not use this procedure code when reporting endodontic irrigation (BioPure).

- This procedure code is primarily used to report material dispensed for home use, not to report drugs or medicaments used in the dental office.

Treatment of root canal obstruction; non-surgical access (D3331)

- LIBERTY acknowledges that procedure D3331 is a separate, accepted procedure code. This procedure should not be submitted with endodontic retreatment procedures D3346, D3347 or D3348.
- LIBERTY will not approve a benefit for this procedure when submitted as part of a pre-determination request, prior to actual treatment.

Note: It is not generally known that a canal obstruction is present until the time of the root canal treatment.

Clinical Guideline:

[E2]: As per the ADA CDT, at least 50% of the canal must be obstructed to be eligible for the code.

LIBERTY's licensed dental consultants will evaluate all available documentation on a case-by-case basis when this procedure is submitted for payment. Providers should submit brief narratives or copies of the member's progress notes, to document that this additional treatment was needed and performed.

Pulpotomy/Pulpal Therapy

- A pulpotomy may be indicated in a primary or permanent tooth when pulpal pathology is limited to the coronal pulp and the tooth has a reasonable period of retention and function
- Pulpal Therapy may be indicated when pulpal pathology affects the primary teeth.

Apexification

- Apexification may be indicated in a permanent tooth when there is evidence of a vital and normal pulp with an incompletely developed root or roots to allow maturation and completion of the root apex. Endodontic treatment should be completed when the root is fully formed.

Pulp Cap

- This procedure is not to be used for bases and liners.
- Direct pulp capping is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be indicated in the presence of a small, exposed vital or normal pulp.

Indirect pulp capping (re-mineralization) is indicated to attempt to minimize the possibility of pulp exposure in very deep caries in vital teeth.

Apical Surgery

Endodontic apical surgical treatment should be considered only in special circumstances, including:

- The root canal system cannot be instrumented and treated non-surgically
- There is active root resorption
- Access to the canal is obstructed
- There is gross over-extension of the root canal filling
- Periapical or lateral pathosis persists and cannot be treated non-surgically
- Root fracture is present or strongly suspected
- Restorative considerations make conventional endodontic treatment difficult or impossible Endodontic procedures may not be covered when a tooth or teeth have a poor prognosis dueto:
- Untreated or advanced periodontal disease
- Gross destruction of the clinical crown and/or root decay at or below the alveolar bone
- A poor crown/root ratio
- Caries at or below the osseous crest

Clinical/Coverage Guideline:

[E3]: Endodontic treatment will only be benefited for teeth that have decay at or below the alveolar bone crest if caries can be successfully restored and tooth prognosis improved by crown lengthening. Crown lengthening must be presented to the member prior to endodontic treatment with notification of any financial responsibility for this procedure. Otherwise, without member acceptance of financial responsibility of the crown lengthening, the endodontic treatment will be denied, and tooth is recommended for extraction.

Clinical/Coverage Guideline:

[E4]: Endodontic treatment will not be benefited on teeth with a crown/root ratio of less than 50%.

ORAL SURGERY

Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment choice of the dentist and the member.

General dentists are expected to provide routine oral surgery, including:

- Uncomplicated extractions
- Routine surgical extractions
- Incision and drainage of intra-oral abscesses
- Minor surgical procedures and postoperative services

Clinical/Coverage Guideline:

[OS1]: LIBERTY expects contracting general dentists to provide all services within their scope of practice, experience and clinical comfort including routine and surgical extractions. LIBERTY does not benefit referral of routine exactions to a specialist except when documented as complex or outside of the experience or scope of the primary care general dentist.

- Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist which provide compelling justification to eliminate existing or potential sources of oral infection.
- When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth (or teeth) is not removed, member notification must be documented.
- Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.
- Minor contouring of bone and soft tissues, and routine closure of the socket during a single tooth extraction (D7140) and surgical extraction (D7210) are a part of and included in the extraction process.
- Bone grafting (D7953) for ridge preservation may be indicated in preparation for implant placement or where alveolar contour is critical to planned prosthetic reconstruction.
- Documentation of a surgical procedure should include: recording the tooth number, tissue removed and a description of the surgical method used; a record of unanticipated complications such as: failure to remove planned tissue/root tips; displacement of tissue to abnormal sites; unusual blood loss; presence of lacerations and other surgical or non-surgical defects.

Clinical/Coverage Guideline:

[OS2]: LIBERTY will not benefit a procedure code unless the documentation justifies it and the diagnostic information demonstrates the appropriateness of a particular procedure.

Third molar extractions and benefit determinations

LIBERTY's licensed dental consultants adjudicate benefits on a case-by-case basis.

It is appropriate to report procedure D7220, D7230, D7240 or D7241 for the removal of an impacted tooth, with active pathology or symptomatology.

Note: Impacted tooth is defined in the ADA CDT as: "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely."

Clinical/Coverage Guideline:

[OS3]: The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology or current symptomatology is not covered on most LIBERTY dental benefit plans.

Clinical/Coverage Guideline:

[OS4]: The removal of third molars, or any other tooth, where pathology such as infection, non-restorable carious lesions, cysts, tumors, and damage to adjacent teeth is evident may be covered.

Clinical/Coverage Guideline:

[OS5]: The removal of asymptomatic, unerupted, third molars in the absence of active pathology may not be covered.

Note: Pericoronitis is considered to be pathology. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.

Clinical/Coverage Guideline:

[OS6]: Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic presentation will be the determining factor in the determination of coverage.

- All suspicious lesions should be biopsied and examined microscopically.
- Deep sedation/general anesthesia (D9220/D9221)

When D9220/21 is listed as covered procedures, benefits may be approved in conjunction with the following approved impaction extractions: D7230, D7240 and D7241.

Licensed dental consultants adjudicate D9220/D92221 benefits for other, simpler extractions on a case-by-case basis, with consideration for:

- Medical conditions affecting the ability of the member to tolerate an extraction such as special needs members (autism, developmental disability, complex medical conditions, etc.)
- The extent and/or number of infected teeth
- Alveoloplasty and/or procedures involving the excision of bone or extensive, invasive or surgical procedures requiring a sufficient length of time so that performing such procedures without alteration of consciousness would be difficult or impossible.
- Bone replacement graft for ridge preservation – per site (D7953)

Clinical/Coverage Guideline:

[OS7]: Osseous auto graft, allograft or non-osseous graft may be placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction) as a covered service.

Clinical/Coverage Guideline:

[OS8]: Grafting may be reported under a variety of codes. Reviewing Dental Consultants may alter or correct the code for grafting when the identified use of the code submitted appears to not be consistent with the definition or the apparent clinical application of the code.

Note: Code D7953 should be reported when the bone graft "is placed in an extraction site at the time of the extraction . . ." to preserve ridge integrity. It should not be confused with D4263, bone replacement graft – first site in quadrant, a periodontal code.

Bone replacement graft – first site in quadrant (D4263)

- "This procedure involves the use of osseous auto grafts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone..."
- Code D4263 is primarily used to report a bone graft performed to stimulate periodontal regeneration when the disease process has led to deformity of the bone around an existing tooth. This code should not be used in conjunction with extractions and/or ridge preservation.

Note: Benefits for bone graft procedures are based on individual plan designs, including limitations and exclusions.

PERIODONTICS

Periodontal Screening and Examination

- All children, adolescents and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 3 mm and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the member's periodontal status as being "within normal limits" (WNL).
- In many cases, a periodontal screening activity such as visual inspection, PSR® (Periodontal Screening and Recording) evaluation and rating of each sextant or other mechanism may provide sufficient information to make a diagnosis or treatment plan.
- Comprehensive oral evaluations should include the quality and quantity of gingival tissues. Additional components of the evaluation would include documenting: six-point periodontal probing for each tooth, the location of bleeding, exudate, plaque and calculus, significant areas of recession, mucogingival problems, level and amount of attached gingiva, mobility, open or improper contacts, furcation involvement, and occlusal contacts or interferences. Following the completion of a comprehensive evaluation, a diagnosis and treatment plan should be completed.
- Sequential charting over time to show changes in periodontal architecture is considerably valuable in determining suggested treatment needed or to evaluate the outcome of previous treatment.

Periodontal Treatment Sequencing

D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis D4355 is defined by the ADA's CDT as: *"The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures."*

In most cases, this procedure would be followed by the completion of a comprehensive evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage prior to performing full mouth periodontal probing.

Note, this procedure:

- must be supported by radiographic evidence of heavy calculus
- is not a replacement code for procedure D1110
- Is not appropriate on the same day as procedure D0120, D0150 or D0180

Non-Surgical Periodontal Therapy

D4341/D4342 - Scaling and root planing (also known as "SRP")

- Treatment follows a periodontal evaluation usually conducted at the examination appointment. The Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, biofilm and stains from these surfaces. The absence of calculus should be evident on post treatment radiographs. These procedures are:
- Considered to be within the scope of a general dentist or a dental hygienist
- Supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. It is common for radiographs to reveal evidence of bone loss of attachment and/or the presence of interproximal calculus.

- Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for 2 years following initial completion of these services. In the interim, any localized scaling and root planning would be included within periodontal maintenance procedure D4910.

Clinical/Coverage Guideline:

[PR1]: Perform no more than 2 quadrants of SRP at the same visit (or, in most cases, on the same date of service) unless a medical or other condition is present that would justify such AND there is demonstration of sufficient clinical treatment time to adequately perform judicious scaling and root planing of the submitted quadrants. Per clinical review, in the absence of such information, LIBERTY may limit the approval to no more than 2 quadrants on any given date of service.

Clinical/Coverage Guideline:

[PR2]: Scaling and Root Planing (SRP) should not be reported for an enhanced prophylaxis. Rather, it is the judicious removal of deposits on the root surface in the presence of periodontal disease. In most cases some form of local anesthesia would be indicated to properly render the SRP procedure.

Definitive or Pre-Surgical Scaling and Root Planing

- For early stages of periodontal disease, this procedure is used as definitive non-surgical treatment and the member may not need to be referred to a periodontist based upon tissue response and the member's oral hygiene.

- For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the member may need to be referred to a periodontist, again based on tissue response and the member's oral hygiene.

Note: LIBERTY requires that definitive and pre-surgical scaling and root planing to be provided at a primary facility before considering referral requests to a periodontal specialist.

Two quadrants per appointment

- Periodontal scaling and root planing is arduous and time consuming, involving judicious instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces.

Clinical/Coverage Guideline:

[PR3]: LIBERTY benefits only two quadrants per appointment. If a clinician recommends and/or completes more than two quadrants per appointment, documentation supporting the extraordinary need to perform additional quadrant(s) must be included in the member's records and/or progress notes.

- Local anesthesia is commonly used. If it is not used, the reason(s) should be documented. The use of topical anesthetics is considered to be a part of and included in the procedure.
- Home care oral hygiene techniques should be introduced and demonstrated.
- A re-evaluation following scaling and root planing should be performed. This re-evaluation should be performed at approximately 4-6 weeks later and include: a description of tissue response; pocket depth changes; sites with bleeding or exudate; evaluation of the member's homecare effectiveness.

D1110 and D4341

- It is usually not appropriate to perform D1110 and D4341 on the same date of service. LIBERTY's licensed dental consultants may review documented and submitted rationale for any such situations on a case-by-case basis.
- Periodontal maintenance at regular intervals should be instituted following scaling and root planing if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically to document tissue response and changes over time.
- The member's homecare compliance and instructions should be documented.

D4921 Gingival Irrigation – per quadrant

- If a member elects not to have elective irrigation with other procedures (i.e. D1110, D4355, D4341, D4342 or D4910), contracted dentists may not limit the member's access to other benefited procedures.
- is not covered when completed in conjunction with periodontal services (D1110/20, D4341/42, D4346, D4355, D4910) as it is considered inclusive of the procedure.
- A member's refusal of irrigation does not constitute grounds for requesting a member transfer.

Note: the use of CDT D9630 – Medicaments, by report: The American Dental Association implies that providers should not use this procedure code when reporting irrigation. LIBERTY may have included language in previous EOCs indicating the acceptability of D9630 for irrigation techniques. Plan documentation supersedes the code

definition for these Members. The EOC is the governing document for any plan.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report

- Benefits are not available when D4381 is performed with D4341 or D4342 in the same quadrant on the same date of service.

Clinical/Coverage Guideline:

[PR4]: Locally-delivered antimicrobials are defined by ADA as adjunctive to periodontal therapy and were intended for use in refractory or non-responsive periodontal pockets. It would not be considered within the standard application of D4381 to provide this service until after a clinical area was determined to be refractory or non-responsive to standard surgical or non-surgical pocket reduction techniques. Therefore, LIBERTY will not benefit this procedure on the same day as D4341 or D4342 or as surgical periodontal therapy. The determination of need for D4381 would occur at a subsequent visit after a healing period following the D4341 or D4342.

- Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis members as an adjunct to procedures D4341/D4342 (scaling and root planing) AFTER the following steps[1]:
  - A clinician has completed D4341/D4342 and allowed a minimum 4-week healing period. Then, the member's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing.
  - For example, re-evaluation confirms that several teeth were non-responsive to scaling and root planing, with localized residual pocket depths of 5 mm's or deeper plus inflammation.

Clinical/Coverage Guideline:

[PR5]: LIBERTY dental consultants may approve D4381 benefits for non-responsive cases following scaling and root planing on a 'by report' basis:

- In such cases, benefits may be approved for two teeth per quadrant in any twelve-month period
- Other procedures, such as systemic antibiotics[2] or surgery, should be considered when multiple teeth with 5 mm pockets or deeper exist in the same quadrant persist after scaling and root planing initial therapy.

Treatment alternatives such as systemic antibiotics[2] or periodontal surgery instead of procedure D4381 should be considered when:

- Multiple teeth with pocket depths of 5 mm's or deeper exist in the same quadrant
- Procedure D4381 was completed at least 4-weeks after D4341 but a re-evaluation of the member's clinical response confirms that D4381 failed to control periodontitis (i.e. a reduction of localized pocket depths)
- Anatomical defects are present (i.e. infrabony defects)
- Periodontal Surgical Procedures (D4240/D4241, D4260/D4261 and related surgical procedures)

[1] American Academy of Periodontology Statement on Local Delivery of Sustained or Controlled Release Antimicrobials as Adjunctive Therapy in the Treatment of Periodontitis. May, 2006

[2] American Academy of Periodontology Position Paper, Systemic Antibiotics in Periodontics. November, 2004 WARNINGS/PRECAUTIONS: This procedure may be contra-indicated during pregnancy.

"May cause fetal harm during pregnancy." ADA/PDR Guide to DENTAL THERAPEUTICS, Fourth Edition

Periodontal Surgical Procedures

Periodontal surgical procedures (especially osseous surgery procedures) are covered when the following factors are present:

- The member should exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures. (History, narrative and/or progress notes may help to indicate this).
- Case history should be documented (history and disease. Narrative and/or progress notes may help to indicate this.
- Member motivation should be documented in a narrative by the attending dentist and/or by a copy of member's progress notes documenting member follow through on recommended regimens.
- In most cases, there should be evidence of scrupulous oral hygiene for at least three months prior to the prior authorization for periodontal surgery.
- Consideration for a direct referral to a Periodontist would be considered on a 'by report' basis for complex treatment planning purposes. However, the performance of SRP, OHI and other pre- and non- surgical procedures should be performed at the general dentist (before or after the periodontal consultation).
- Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bone support to withstand the forces to which they are, or will be, subjected.
- Periodontal pocket reduction surgical procedures may be covered in cases where the residual pocket depths are 5 mm's or deeper, following soft tissue responses to scaling and root planing.
- Consideration for further periodontal treatment should be given for long-standing pockets of 5 mm following previous surgical intervention, which may or may not require further surgical intervention.
- Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
- Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
- Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.

Periodontal surgery (especially osseous surgery) procedures may not be covered if:

- Pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)

- Members are smokers or diabetics who's disease is not being adequately managed

D4249 clinical crown lengthening – hard tissue

Note: "This procedure is employed to allow a successful restorative procedure or crown with a service life of at least three (3) years, when there is little or no tooth structure remaining after caries or fracture. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area."

Clinical/Coverage Guideline:

[PR6]: LIBERTY will not benefit a periodontal surgical procedure on the same tooth on the same date of service as a final impression for a fixed or removable prosthesis, as healing has not occurred, which could change the architecture substantially affecting the outcome of the prosthesis.

Clinical/Coverage Guideline:

[PR7]: LIBERTY considers the management or alteration of soft tissues performed during a restorative procedure or crown preparation with final impressions to be a part of and included in the fee for the related procedure. Providers may not charge LIBERTY or the member a separate fee for D4249 if it is performed on the same tooth on the same day as preparation and final impressions for a crown.

D4910 - Periodontal maintenance and supportive therapy intervals should be individualized, although three-month recalls are common for many members.

Clinical/Coverage Guideline:

[PR8]: Periodontal Maintenance D4910 is allowable for 3 years (or even longer) when there is a history of periodontal therapy evident in the member's treatment record (by report, by LIBERTY record, or by narrative).

RESTORATIVE

Diagnosis and Treatment Planning

It is appropriate to restore teeth with radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or for post-endodontic purposes.

Restorative treatment must be identified using valid procedure codes as found in the current edition of the American Dental Association's Current Dental Terminology (CDT). This source includes nomenclature and descriptors for each procedure code.

Sequencing of treatment must be appropriate to the needs of the member.

Clinical/Coverage Guideline:

[R1]: Treatment results, including margins, contours, and contacts, should be clinically acceptable. The long-term prognosis should be good.

- Restorative dentistry includes the restoration of hard tooth structure lost as a result of caries, fracture, erosion, attrition, or trauma.

- Restorative procedures in operative dentistry include silver amalgam; resin-based composites; direct or indirectly fabricated inlays, onlays, and crowns of various materials; certain prefabricated restorations (i.e. stainless steel or polycarbonate type crowns), as well as the use of various temporary materials.

Amalgam Fillings, Safety, and Benefits

American Dental Association Statement: Food and Drug Administration Action on Dental Amalgam

The American Dental Association (ADA) agrees 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 cavity filling material…

Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over several decades, including two large clinical trials published in the Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as "a valuable, viable and safe choice for dental members…"

Clinical/Coverage Guideline:

[R2]: Amalgam free dental offices - If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for LIBERTY members. Any listed amalgam copayments would still apply.

Clinical/Coverage Guideline:

[R3]: Any alleged "allergies" to silver amalgam fillings must be supported in writing from a physician who is a board certified allergist. Any benefit issues related to dental materials and "allergies" will be adjudicated on a case-by-case basis by a licensed LIBERTY dentist consultant.

- The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements.
- The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite.
- The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite. Decay limited to the Incisal edge only, may be a candidate for a filling restoration if little to no other surfaces manifests caries or breakdown.
- Restorations for chipped teeth may be covered. Providers should not use an exclusion for "treatment of an accident" to deny coverage for a chipped tooth that occurs through normal function and wear of the tooth over time. "Treatment of an accident" exclusion is reserved for traumatic accidents such as automobile collisions, serious external trauma to the face, etc. requiring complex dental reconstructive procedures.

Clinical/Coverage Guideline:

[R4]: 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.

Clinical/Coverage Guideline:

[R5]: 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. (see clinical guidelines in Restorative section)

- Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months.
- For posterior primary teeth showing extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless-steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.
- When incisal edges of anterior teeth are undermined due to caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may be veneers or crowns, either porcelain fused to metal or porcelain/ceramic substrate.
- An onlay should be considered when there is sufficient tooth structure, but cusp support is needed.
- An inlay is an intracoronal restoration and should have the same indications as a filling. It may not be practical to us an inlay due to the cost and limited use in current clinical dentistry practices.

Other resin restorations:

- D1351 sealant – per tooth
  Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

Clinical/Coverage Guideline:

[R6]: If the resin restoration does not penetrate dentin, D1351 isappropriate.

Clinical/Coverage Guideline:

[R6]: If the pits and/or fissures are prepared, but remain in enamel, D1352 preventive resin restoration is appropriate.

Clinical/Coverage Guideline:

[R7]: D2990 resin infiltration of incipient smooth surface lesions is appropriate for smooth surface lesions with some or no minor enameloplasty.

D2330, D2391 or D2392 - Resin-based composites

- If the resin restoration does penetrate dentin, one of the resin-based composite codes is appropriate.

D9910/D9911 - Desensitizing

- Appropriate reporting of these procedures is clearly detailed below.

Clinical/Coverage Guideline:

[R8]: All acid etching, adhesives (including resin bonding agents), liners, bases and/or curing techniques are a part of and included in amalgam and composite restoration procedures. None of these included procedures may be unbundled and/or charged as a separate service.

D9910 – application of desensitizing medicament

[R9]: Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. As per the ADA's CDT, this code is not to be used for bases, liners, or adhesives under restorations.

D9911 – application of desensitizing resin for cervical and/or root surface, per tooth

Clinical/Coverage Guideline:

[R10]: As per the ADA's CDT, this code is not to be used for bases, liners, or adhesives used under restorations.

CROWNS AND FIXED BRIDGES

Note: Providers should report the date of delivery for crowns and bridges. However, in special circumstances, providers may document the date of service for these procedures to be the date when final impressions are completed, in special circumstances. Provider would be subject to review.

Clinical/Coverage Guideline:

[CR1]: Providers must complete any irreversible procedure started regardless of payment or coverage.

Upgrades

- Plan designs limit the total maximum amount chargeable to a member for any combination of upgrades to $250 per unit.

Typical upgrades include:

Choice of metal – noble, high noble, titanium alloy or titanium porcelain on molar teeth

porcelain margins, by report

Note: porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns

- Based on the particular plan design, porcelain margins may be charged separately. A reasonable charge should be made ($100 or less per unit). Signed informed consent accepting the optional nature of this feature must be present.

Clinical/Coverage Guideline:

[CR2]: Grievances involving charges for upgrades will be found in favor of the Provider's right to charge for upgraded features only when a signed informed consent or treatment plan is present that meets the "prudent layperson" requirement for clear disclosure of the proposed upgraded features. Members must have access to their covered benefit as well as any upgraded procedures.

Single Crowns

[CR3]: When bicuspid and anterior crowns are covered, the benefit is generally porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.

Clinical/Coverage Guideline:

[CR4]: When molar crowns are indicated due to caries, an undermined or fractured off cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a base metal crown.

Clinical/Coverage Guideline:

[CR5]: Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be susceptible to fracture during occlusal function; therefore porcelain/ceramic restorations on molar teeth should not be routinely used.

Clinical/Coverage Guideline:

[CR6]: When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, a labial veneer may not be sufficient. The treatment of choice may then become porcelain fused to a base metal crown or porcelain/ceramic substrate crown.

Clinical/Coverage Guideline:

[CR7]: Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontic procedures and such teeth should exhibit a minimum crown/root ratio of 50%. See sequencing-related clinical / coverage guidelines earlier in this document

Clinical/Coverage Guideline:

[CR8]: Crown services must be documented using valid procedure codes as found in the American Dental Association's Current Dental Terminology (CDT).

- 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 breakdown.
- Crowns may be benefited 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 when a portion of the tooth has 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.
- Replacement of existing crowns require radiographic evidence or, if not evident on radiograph, an intra-oral photo (i.e open margins or recurrent decay on buccal/lingual) supporting the necessity for replacement
- Incisal/occlusal wear that is consistent with normal attrition over time is not covered (unless meets any of the other stated criteria for coverage)
- Crowns for purposes of esthetics only are not covered (i.e diastema closure, tooth misalignment/position

Brand name dental materials/alternatives

Contracts, plan designs and benefit determinations are all based upon the CDT procedure codes, not on Brand Names. LIBERTY makes no distinction in payment for variations of material brand or quality within the same procedure code. It is the determination of the treating dentist as to what materials work best in each clinical situation. Benefit, plan payment and member copayment are per code.

Benefit determination protocols utilized by LIBERTY's licensed Dental Consultants:

- Verify what procedure(s) a provider is recommending, regardless of any submitted Brand Name
- Apply the most accurate CDT code(s) to describe the verified procedure(s) Refer to the specific, applicable plan design to determine if the verified procedure:
  - is listed as covered

- would be considered some type of upgrade compared to a basic covered procedure
- is not covered at all

It is the responsibility of the provider to complete an adequate/accurate informed consent/financial disclosure process including:

- Benefits - the procedure code(s) for the member's basic benefit(s)
- Alternatives – the procedure code(s) for any recommended alternate, upgraded or non-covered service and the member's responsibility based on the application of the alternative treatment formula. Presentation of options must be clear and evident, so that a prudent layperson would understand the basic differences and the cost differences. Best practice would be for the member to sign the treatment plan sheet showing a clear indication of the choice selected, and to sign a separate financial consent indicating the agreement to pay for any alternative, optional, or non-covered services. Adoption of these practices is aimed at preventing grievances after the fact, and minimizing refunds ordered by LIBERTY on the treating provider.
- Risks – the risks of treatment as well as the risks of doing nothing
- It is expressly understood that "no treatment" is a viable option for various conditions and situations. Monitoring an area for further development is also a viable option and should be noted in the treatment plan.

Post and core procedures include buildups:

- D2952 - post and core in addition to crown, indirectly fabricated post and core are custom fabricated as a single unit.
- D2954 - prefabricated post and core in addition to crown core is built around a prefabricated post. This procedure includes the core material"

By CDT definitions, each of these procedures includes a "core". Therefore, providers may not unbundle procedure D2950 core buildup, including pins and report it separately from either of these procedures for the same tooth during the same course of treatment.

Clinical/Coverage Guideline:

[CR9]: D2950 is generally not appropriate on an endodontically treated tooth receiving a post as the code D2954 post and core includes the core build up. LIBERTY will not benefit both codes on the same tooth on the same date of service.

Outcomes

- Margins, contours and contacts must be clinically acceptable
- Prostheses should be designed with a minimum life expectance or service life of 3- 5 years or more.

Clinical/Coverage Guideline:

[CR10]: Based on the submitted materials, if the requested single crown does not appear to have sufficient periodontal support, or sufficient tooth structure to retain a crown for an expected life of 5 or more years. Radiographic images indicate that the tooth may be mobile and be lost during normal function sooner than a 5-year life expectation.

Fixed Bridges

- When a single posterior tooth is missing on one side of an arch and there are clinically adequate abutment teeth on each side of the missing tooth, the general choices to replace the missing tooth would be a fixed bridge or an implant.
- If it is also necessary to replace teeth on the opposite side of the same arch, the benefit would be a removable partial denture instead of a fixed bridge. In general, a removable partial denture would be the benefit in cases where there are multiple edentulous areas, when none of them have a bridge replacement in place.
- If an existing fixed bridge is present replacing one or more edentulous areas, the benefit is generally to replace like for like.
- If a bridge is failing, and must be replaced, and there are other edentulous areas, the dental consultant may consider the benefit to be replacement of both/all edentulous areas with a removable appliance.
- This consideration may be altered for a young person with periodontal stability. In such cases consideration may be given to replacing "like for like"; e.g. replacing a defective bridge with another one, even in the presence of other edentulous areas.

[BR2]: Fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced in Radiographs, or when a proposed abutment tooth or teeth have poor crown/root ratios.

- Dental Consultants may deny the replacement bridge and may ask for additional information regarding the treating dentist's plans for the other edentulous areas.
- Bridge abutments should generally be full coverage crowns.
- A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown. Supporting narrative should be provided for any proposed cantilever bridge.
- Replacement of Third molars is not a benefit unless other molars are also missing and the placement of an implant approximating the third molar location would provide anchorage for prosthesis. Routine replacement of non-functional third molars is not a benefit.

Clinical/Coverage Guideline:

[BR1]: When a requested fixed bridge appliance does not meet plan guidelines for missing tooth replacement due to the presence of other missing teeth in the same arch, consideration should be given for a removable appliance to replace all areas of missing teeth.

Clinical/Coverage Guideline:

[BR3]: Fixed bridges are not a benefit or considered clinically acceptable by LIBERTY in the presence of evidence of possible active periodontal disease indicating the likelihood of tooth mobility when remaining tooth structure does not provide sufficient crown/root ratio of 50% or greater; or sufficient tooth structure to properly retain the prosthesis on one or more teeth involved. Consideration should be given to a removable prosthesis.

Clinical/Coverage Guideline:

[BR4]: When up to all four incisors are missing in an arch, the potential abutment teeth are clinically adequate and implants are not appropriate, possible benefits for a fixed bridge will be evaluated on a case-by-case basis. Evaluation and diagnosis of any member's periodontal status or active disease should be documented with recent full mouth periodontal probing and submitted with any benefit determination.

- Margins, contours and contacts should be clinically acceptable
- Prognosis should be good for long term longevity
- Guidelines for the Assessment of Clinical Quality and Professional Performance of the California Dental Association shall apply.

REMOVABLE PROSTHODONTICS

Note: Providers should document the date of service for these procedures to be the date when prosthetic appliances are delivered. In some extenuating cases, LIBERTY may allow final impression date for cases where there was a difficulty in delivering the case. Any such submission must contain a narrative explanation of the complications, and is subject to review for partial payment or denial by LIBERTY.

Clinical/Coverage Guideline for all Removable Prosthodontic appliances:

[RM1]: If you did not plan for a denture or other appliance to be temporary or interim, and you find that a new denture is now necessary due to case complications including but not limited to, healing, shrinkage, appliance design, member discomfort, occlusion errors, non-refractory sore areas, etc. LIBERTY is responsible only for the coverage as listed in the dental plan benefit schedule, and may provide no additional coverage. Further, members are not responsible for paying for services that have a non-optimal substandard outcome.

Removable Partial Dentures

Clinical/Coverage Guideline:

[RM2]: A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars (i.e. no opposing occlusion).

Clinical/Coverage Guideline:

[RM3]: Partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas (missing but un-replaced natural teeth spaces) are present.

Clinical/Coverage Guideline:

[RM4]: Full or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by relining or repair.

Clinical/Coverage Guideline:

[RM5]: Full or partial dentures are not a covered benefit 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 problems.

- LIBERTY considers "Best Practice" to replace unilateral missing teeth with a fixed bridge or implant. Unilateral removable partial dentures are rarely appropriate.
- LIBERTY considers "Best Practice" that abutment teeth should be restored with crown or filling prior to the fabrication of a removable appliance. LIBERTY provides coverage for the abutment teeth if the teeth meet the same standalone benefit requirements of a single crown.
- Partials should be designed so that they do not harm the remaining teeth.
- Materials used for removable of 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 or adjacent soft tissues.
- Appliances should be designed to cause no damage to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.
- Flexible partial dentures (D5225/D5226) include the following brands: Valplast, Thermoflex, Flexite, etc.
- Partial dentures with acrylic clasps (such as Valplast or others, also known as "Combo Partials") are considered under the coverage for D5213/D5214.
- Proper member education and orientation to the use of removable partial dentures should be part of the diagnosis and treatment plan.
- Educational materials regarding these prostheses are highly encouraged at the treatment planning phase as well as at the delivery of the appliance to avoid misunderstandings and grievances, and to manage member expectation.

Complete Dentures

- Complete dentures are the appliances of last resort, particularly in the mandibular arch. Members should be fully informed of their significant limitations.
- Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.

  Proper member education and orientation on how to the use of removable partial dentures should be part of the diagnosis and treatment plan.

Educational materials regarding these prostheses are highly encouraged at the treatment planning phase aswell as at the delivery of the appliance to avoid misunderstandings and grievances, and to manage memberexpectation.

"Interim" Complete Dentures

- These appliances are only intended to replace teeth during the healing period, prior tofabrication of a subsequent, covered complete denture. Benefit may not exist for both an interim and definitive (final or "permanent") complete denture.
- Discussion of coverage and benefits for any interim appliances that are planned to be interim or temporary should be clearly discussed and agreed by the member before proceeding with optional, elective, upgraded or non-covered service. Evidence of such a discussion would be member signature on informed consent forms, treatment plan documents, chart progress notes and/or financial consent forms.

Immediate Complete Dentures

- These covered dentures are inserted immediately after a member's remaining teeth are removed. While immediate dentures offer the benefit of never having to be without teeth, in many cases, immediate dentures are discarded and replaced after full healing with standard complete dentures within the first six months. Often these second dentures are not covered or have limited coverage. See Clinical/Coverage Guideline at the beginning of this section.
- Discussion of coverage and benefits for interim appliances that are planned to be interim or temporary should be clearly discussed and agreed by the member before proceeding with any optional, elective, upgraded or non-covered service. Evidence of such a discussion would be member signature on informed consent forms, treatment plan documents, chart progress notes and/or financial consent forms.

Clinical/Coverage Guideline:

[RM6]: LIBERTY understands that Immediate Denture(s) may be designed to be the permanent set of dentures, or are planned to be interim/temporary for the post-extraction healing phase only. Clear understanding of the intent of the provider regarding whether or not the immediate denture(s) will be the final definitive dentures or just usedas an interim appliance should be clearly stated in the treatment plan that is signed by the member. The providerand member shall work together to create a treatment plan that is mutually acceptable.

Proper member education and orientation to the use of removable 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.

Adjustments, Repairs, and Relines

- Adjustment, repair or reline of a partial or complete denture (or any appliance) should result in a serviceable functional appliance.
- The coverage of Repairs and Relines may be subject to various limitations, such as early follow-up repairs or relines after recent delivery.
- Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of a removable appliance. A reline of a partial or complete denture would be covered (subject to plan limitations if the procedure would result in a serviceable appliance.)

Clinical/Coverage Guideline:

[RM7]: LIBERTY discourages the performance of relines of recently placed appliances in an attempt to treat pain or dissatisfaction with the recently delivered appliance. A reline or rebase should only be placed when there is a definitive reason for altering the fit and retention of the flanges. If there has been no shrinkage or other identified problems with the appliance, the reline or rebase should not be performed and may not be a benefit. A narrative demonstrating medical necessity for the procedure along with other documentation should be provided for any reline or rebase of a standard appliance within 6 months of initial placement.

Clinical/Coverage Guideline:

[RM8]: Reline or rebase of an immediate denture after 12 months of initial placement is generally indicated and would be covered without need for narrative. Any needed reline or rebase prior to 12 months will be considered with inclusion of documentation of medical necessity for the procedure(s).

IMPLANTS (D6010-D6050)

General Guidelines

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. Implants may be a covered benefit when considered appropriate, logical treatment consistent with professional industry standards given the patients current oral condition and the following guidelines are met:

- Full mouth x-rays required
- Considerable coverage includes but not limited to; implant(s) placed in the posterior region must oppose fixed dentition thereby creating increased functionality for the patient once the implant is restored
- Fixed dentition is defined as:
    - Natural tooth
    - Existing or approved full partial denture
    - Existing or approved Implant

Any planned fixed partial denture/implant must be on the same pre-authorization and approved to be considered for occlusion purposes

- If missing two (2) or more teeth (not including 3rd molars) in arch: Above criteria, including the following.

1. Anterior Region
    - Criteria required that the utilization of the implant benefit must result in a full complement of anterior teeth for that arch; No anterior teeth can remain missing in the same arch.

2. Posterior Region
    - Criteria requires, there must be at least 8 points of posterior contact at the time of request for services.
        - Contact defined as occlusion between fixed dentition
        - Contact of one upper and one lower tooth equals 2 points of contact

**Exceptions to these criteria may be considered on a case-by-case basis for implant coverage

Bone Graft at Time of Implant Placement (D6104)

- For this service to be covered at an existing edentulous site, bone grafting at the time of implant placement requires intra-oral photos or CBCT supporting the need for additional bone when it is not evident on xrays alone.

Alveoloplasty (D7310/11, D7320/21)

- Must be in preparation for a prosthesis (conventional or implant supported partial/CD) to be considered for coverage

- Any minor bone leveling or removal at the implant site is considered inclusive of the surgical placement of the implant (D6010)

Removable Appliances
- D5211-D5228 - Are not covered in the same arch as approved posterior implants or fixed partial denture
- D5820, D5821- Interim Removable Partial Dentures will only be covered in such scenarios

Implant Supported Fixed Partial Denture (D6068-D6123)
- Are a covered benefit when the criteria for implant placement has been met
- Implant Fixed Partial Denture that utilize a natural tooth as an abutment are not covered under the plan

Implant Supported Dentures (D6110-D6117)
- Full Dentures (Removable: D6110,D6111; Fixed:D6114,D6115)
    - Opposing occlusion not considered for implant placement for implant supported full dentures
- Partial Dentures (Removable: D6112, D6113; Fixed: D6116, D6117)
    - Periodontal prognosis of existing dentition is favorable
    - Are not covered in the presence of untreated moderate to severe periodontal disease
    - Implant placement for support of an implant supported partial denture is covered only when there is insufficient existing teeth to support a removable partial denture

A conservative treatment plan should be considered prior to providing a member with one or more implants.

Treatment plans utilizing implants must consider the prognosis of the existing teeth in that arch. If existing dentition reveals poor periodontal prognosis, implants may not be covered. Implants are not covered benefits in the presence of untreated moderate to severe periodontal disease.

Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:

- Adverse systemic factors such as diabetes and history of recent smoking habit
- Poor oral hygiene and tissue management by the member
- Inadequate osseo-integration of the dental implant(s) (mobility)
- Excessive para-function or occlusal loading
- Poor positioning of the dental implant(s)
- Excessive loss of bone around the implant prior to its restoration
- Mobility of the implant(s) prior to placement of the prosthesis
- Inadequate number of implants or poor bone quality for long span prostheses
- Need to restore the appearance of gingival tissues in high esthetic areas
- When the member is under sixteen (16) years of age, unless unusual conditions prevail Restoration

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.

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 ofthe implant system itself.

- 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.
- Jaw relationship and inter-arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

Outcomes

- The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.
- The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the member.
- The appearance and shape of the fixed prosthesis must exhibit contours that are in functional harmony with the remaining hard and soft tissues of the mouth.
- They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.
- Fixed implant prostheses must incorporate a strategy for removal of the appliance without damage to the implant, or adjacent dentition, so that the implant can be utilized in cases where there is further loss of teeth, or where repair of the appliance is necessary.
- Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.
- It is a contra-indication to have a fixed dental prosthesis abutted by both dental implant(s) and natural teeth (tooth) without incorporating a design to alleviate the stress from an osseo-integrated (non- movable) abutment to a natural tooth supported by the periodontal ligament allowing slight movement.
- It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with a restoration.
- It is the responsibility of the restoring dentist to instruct the member in the proper care and maintenance of the implant system and to evaluate the member's care initially following the final placement of the prosthetic restoration.
- Fixed partial prostheses, as well as a single unit crowns, are expected to have a minimum life expectancy or service life of five (5) years.

SECTION 12. SPECIALTY CARE REFERRAL GUIDELINES

The following guidelines outline the specialty care referral process. Failure to follow these guidelines may result in financial penalties against provider's office such as through capitation adjustment or financial recoupment processes from future claims or other means.

*All codes listed in this section may not be covered under all benefit plans. Referrals are subject to a member's plan-specific benefits, limitations, and exclusions. Please refer to the Member Benefits Schedule for plan- specific details regarding procedure codes and specialty referral protocols.

Reimbursement of specialty services is contingent upon the member's eligibility at the time of service.

NON-EMERGENCY SPECIALTY REFERRAL SUBMISSION AND INQUIRIES

General Dentist must submit a referral request to LIBERTY for prior approval. There are three options to submit a specialty care referral:

	LIBERTY Dental Plan ATTN: Referral Department P.O. Box 26110 Santa Ana, CA 92799-6110		888.352.7924, press option 2
	Provider Portal		

If there is no contracted LIBERTY specialist available within a reasonable proximity to the General Dentist's office, provider's office staff may contact LIBERTY's Member Services Department who will provide assistance to refer the member to a non-contracted Specialist.

If a referral is made to a non-LIBERTY specialist by the member's assigned General Dentist without prior approval, the referring office may be held financially responsible for any additional costs. Failure to use the proper forms and submit accurate information may cause delays in processing or claim payment.

The LIBERTY Specialty Care Referral Request Form or an Attending Dentist Statement must be completed and

used when making a referral. The form may be photocopied and duplicated in provider's office as needed.

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

Provider must include a narrative statement as to the reasons for the specialty referral may be of great assistance to LIBERTY in processing the specialty referral.

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, 5am – 5pm PST.
- Emergency referrals are valid for thirty (30 days). Extensions can be requested by a member or provider.

ENDODONTICS

Referral Guidelines for the General 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, group name ;
- Name, address, and telephone number of the contracted LIBERTY network Endodontist. If provider and provider's staff are unfamiliar with network Endodontists, contact LIBERTY's Member Services for specialty referral assistance
- Procedure code(s), tooth number(s) and member copayments for the covered endodontic treatment, which requires referral

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist
- The member will be financially responsible for non-covered and non-approved services provided by the Endodontist, as well as the copayment for the covered services
- 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.

LIBERTY's Dental Consultant (a licensed dentist) 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, General Dentist, or member.

For any services, other than those listed on the original authorization form from LIBERTY, you must submit a preauthorization request to LIBERTY with a copy of pre-operative periapical radiograph(s) and justifying narrative, as well as 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 for an emergency authorization number. This will provide tentative authorization. However, any such service added to an existing prior authorization by virtue of phoning the Referral Unit, will require pre-operative radiograph and narrative when Specialist submit for payment. Any emergency service must qualify for authorization and will receive clinical review by a LIBERTY Dental Consultant at the time it is reviewed for payment.

After completion of treatment, submit claim for payment with 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. Radiograph copies of diagnostic quality or paper copies of digitized images are acceptable.**

Your office is responsible for the collection of any applicable copayments from the member.

ORAL SURGERY

Referral Guidelines for the General 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 and group number;
- Name, address, and telephone number of the contracted LIBERTY network Oral Surgeon. If you are unfamiliar with network Oral Surgeons, contact LIBERTY's Member Services Department for specialty referral assistance.
- Procedure code(s) and, tooth number(s)/quadrant(s), which require referral.

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist;
- The member will be financially responsible for non-covered and non-approved services provided by the Oral Surgeon, as well as any copayment for the covered services.
- 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.

LIBERTY Dental Consultant (a licensed dentist) 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, General Dentist, or member.

For any services, other than those listed on the referral form the member's General Dentist, you must submit a preauthorization request to LIBERTY with a copy of pre-operative periapical radiograph(s) or panoramic radiograph, and any justifying narrative, as well as the member's LIBERTY Specialty Care Authorization.

If an emergency oral surgery service is needed but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Oral Surgeon should contact LIBERTY's Referral Unit for an emergency authorization number. Any such services added to the Referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative radiographs for these services to the claim form.

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 form. If emergency care was provided after obtaining a LIBERTY 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. Radiograph copies of diagnostic quality or paper copies of digitized images are acceptable.**

Your office is responsible for the collection of any applicable copayments from the member.

ORTHODONTICS

Referral Guidelines for the General 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 Orthodontist. If you are unfamiliar with network Orthodontists, contact LIBERTY's Member Services Department for specialty referral assistance
- Comments concerning the member's malocclusion

Inform the member that:

- Referrals are subject to a member's plan-specific benefits, limitations and exclusions
- The member will be financially responsible for non-covered services provided by the Orthodontist as well as

any copayments for the covered services

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

Referral Guidelines for the Orthodontist

Obtain the LIBERTY Specialty Care Authorization from LIBERTY, the General Dentist or member.

Contact LIBERT's Membership Services Department to obtain member's copayments and plan-specific benefits, limitations and exclusions for:

- Limited orthodontic treatment (D8020-40)
- Interceptive orthodontic treatment (D8050-60)
- Comprehensive orthodontic treatment (D8070-90)

After the pre-treatment visit, arrangements for initial records should be made. If the member requires further general dentistry prior to banding, refer them back to the assigned General Dentist.

After member is banded, submit your claim to LIBERTY for payment. Net payable claim amounts in excess of $300.00 will be paid over the period of active orthodontic treatment.

PEDIATRIC DENTISTRY

Referral Guidelines for the General Dentist

Confirm the need for a referral and that the Referral Criteria listed below are met. Complete a 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 pediatric dentist. If you are unfamiliar with network Pediatric Dentists, contact LIBERTY's Member Services Department for specialty referral assistance
- Procedure code, tooth number/quadrant and member copayments for each service, which require referral

If the General Dentist is unable to perform an adequate examination due to limited member cooperation, the procedure codes for an examination and radiographs should be listed.

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist
- The member will be financially responsible for non-covered and non-approved services provided by the Pediatric Dentist, as well as any copayment for covered services
- 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.

LIBERTY's Dental Consultant (a licensed dentist) will review the referral to ensure requested procedures meet

referral guidelines and plan benefits.

Referral Guidelines for the Pediatric Dentist

Obtain the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY, General Dentist or member.

For any services, other than those listed on the referral from the member's assigned General Dentist, you must submit a prior authorization request to LIBERTY with a copy of pre-operative periapical radiograph(s) and any justifying narrative and of the member's LIBERTY Specialty Care Authorization.

If an emergency pediatric service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Pediatric Dentist should contact the LIBERTY's Referral Unit for an emergency authorization number. Any such services added to the Referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative radiographs for these services to the claim form.

After completion of treatment, submit your claim for payment with justifying narrative and radiographs for any treatment that has not been prior authorized. To avoid delays in claim payment, please always attach a copy of the LIBERTY Specialty Care Authorization for treatment when applicable. **Radiographs and other supporting documentation will not be returned. Please do not submit original Radiographs. Radiograph copies of diagnostic quality, including paper copies of digitized images, are acceptable.**

Your office is responsible for the collection of any applicable copayments from the member.

PERIODONTICS

Referral Guidelines for the General 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. If you are unfamiliar with network Pediatric Dentists, contact LIBERTY's Member Services Department for specialty referral assistance.
- Procedure code(s), tooth number/quadrant(s) and member copayments for the covered periodontal treatment, which require referral

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist
- The member will be financially responsible for non-covered and non-approved services provided by the Periodontist, as well as any copayment for the covered services
- Payment by LIBERTY is subject to eligibility at the time services are rendered

- Submit referral to LIBERTY with appropriate documentation/radiographs through the **Provider Portal** or via standard mail service
- LIBERTY's Dental Consultant (a licensed dentist) 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, General Dentist or member.

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

- Pre-operative radiographs
- Complete periodontal charting showing six-point probing of each natural tooth and any furcation involvements, abnormal mobility, areas of little-to-no attached gingiva or areas of recession. Submit radiographs that were enclosed with original authorization form (or copies) and any justifying narrative
- The member's LIBERTY Specialty Care Authorization.

If an unforeseen periodontic service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Periodontist should contact the LIBERTY's Referral Unit for an emergency authorization number. Any such services added to the Referral via telephone will be subject to clinical review at the time of submission for payment. Enclose any narrative and supportive pre-operative radiographs for these services to the claim form.

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

Your office is responsible for the collection of any applicable copayments from the member.

Referral Coverage Based on Diagnosis Gingivitis

- Sulcus depths of 1 – 3 mm with the possibility of an occasional 4 mm pseudo pocket
- Some bleeding upon probing
- No abnormal tooth mobility, no furcation involvements and no radiographic evidence of bone loss (i.e., the alveolar bone level is within 1 – 2 mm of the cemento-enamel junction area)

Referral to a Periodontist covered only for a problem-focused evaluation and hard tissue clinical crown lengthening or soft tissue grafting.

Slight Chronic/Aggressive Periodontitis (localized or generalized)

- 4 - 5 mm pockets and possibly an occasional 6 mm pocket with 1 - 2 mm of clinical attachment loss
- Moderate bleeding upon probing, which is more generalized than in gingivitis
- Normal tooth mobility with possibly some Class 1 (+/- 1.0 mm) mobility
- No furcation involvement or an isolated Grade 1 involvement (i.e., can probe into the concavity of a root trunk)

- Radiographic evidence of localized loss crestal lamina dura and early to very moderate (10% - 20%) bone loss, which is usually localized

Referral to a Periodontist covered only for a problem-focused evaluation and hard tissue clinical crown lengthening, soft tissue grafting or, if there are isolated 5 mm pockets, periodontal surgery.

Moderate Chronic/Aggressive Periodontitis, (localized or generalized)

- Pocket depths of 4 – 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)
- Radiographic evidence of moderate (20%-40%) bone loss, which is usually horizontal in nature Referral to a
- Periodontist covered for a problem-focused examination and possible periodontal surgery.
- Moderate Chronic/Aggressive Periodontitis may be eligible for direct specialty referral.

Referral to a Periodontist **may be** covered, **if indicated**, after scaling and root planing by the General Dentist, for a problem-focused examination and possible periodontal surgery.

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)
- Radiographic evidence of severe (over 40%) bone loss, which may be horizontal and vertical in nature Severe Chronic/Aggressive Periodontitis is eligible for direct specialty referral.
- Referral to a Periodontist covered for a problem-focused evaluation, scaling and root planing and possible periodontal surgery.

Refractory Chronic/Aggressive Periodontitis

- Defined as a periodontitis case that 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.
- Refractory Chronic/Aggressive Periodontitis is eligible for direct specialty referral.
- 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.

PROSTHODONTIST

Referrals for this type of specialist are not covered under LIBERTY Dental Capitation, DHMO-EPO and Discount Programs. Consult individual Benefits Schedule for Evidence of Coverage to determine if prosthodontic referrals are available.

SECTION 13. QUALITY MANAGEMENT

PURPOSE, GOALS, AND OBJECTIVES

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

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 care dentists 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. 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 patients 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 patients 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 patient.

PROGRAM CONTENT AND COMMITTEES

- **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.
- **Access and Availability (AA)**: 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 are monitored and CAPs are developed if deficiencies occur. Activity is reviewed by the QMI Committee quarterly, or more frequently, if necessary.
- **Credentialing**: LIBERTY's 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 is 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. Potential quality issues 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, office onsite assessments with deficient critical or structural indicators, aberrant 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 (G&A):** The Grievance and Appeals Committee monitors and reviews member and provider grievances and appeals to identify systemic issues, patterns, opportunities for improvements and corrective action plans. The Committee makes recommendation to the Dental Director regarding a dentist, facility, member or group.

  Any dentist or facility with two or more grievances of a similar nature in a six-month period, are referred to the Grievances & Appeals Committee for review. If the Committee determinations that correction actions are necessary, the matter will be referred to the Dental Director for implementation.

  Any dentist or facility identified with systemic deficiencies, will receive corrective actions, which may include, but are not limited to, counseling by the Network Manager and/or Dental Director, referral to the Peer Review Committee, closure to new members, or termination from the LIBERTY network.
- **Dental Advisory Committee (DAC):** The DAC Committee purpose is to join forces with the dental network and involve them in the oversight of LIBERTY operations, programs, activities and to provide related activities and metrics as provided by LIBERTY. LIBERTY's network may provide input regarding provider relations issues that will allow LIBERTY to identify areas for continuous improvement activities.

UTILIZATION MANAGEMENT

LIBERTY's Utilization Management (UM) Program is designed to meet contractual requirements 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 identifies determines which dental services require prior authorization based on:

- Clinical Standards of practice: LIBERTY's Clinical Criteria Guidelines 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 claims history especially for procedures that do not have frequency limitations.

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.
- Quarterly Inter-Rater Reliability calibration exercises reviewing real authorizations. Internal goals/requirements require 89% 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.

PROGRAM STANDARDS AND GUIDELINES

LIBERTY understands and supports that high quality dental care is dependent, in part, on the ability of both the Primary Care Dentist (Provider) and specialty care providers to see members promptly when they need care, and to spend a sufficient amount of time with each of their members.

Provider Access Surveys

For all Provider offices, LIBERTY conducts quarterly random office contacts to assess availability of appointments.

Member Satisfaction Surveys

Surveys can be generated to members in response to trending information, reports or potential access problems with specific dental offices.

CORRECTIVE ACTION

Negative findings resulting from the above activities may trigger further investigation of the provider facility by the Dental Director or his/her designee. If an access to care problem is identified, corrective action must be taken including, but not limited to, the following:

- Further education and assistance to the provider
- Provider counseling
- Closure to new membership enrollment
- Transfer of members to another provider
- Contract termination
- Investigation results from subcommittees must be reported to QMI

PROVIDER QMI PROGRAM RESPONSIBILITIES

Typically, when a member enrolls with LIBERTY, they select a Provider from the network who is responsible for providing or coordinating all dental care for that member, including referrals to participating specialty care providers. In order to ensure that the care provided to members is given under the appropriate requirements, including covered benefits and referrals, provider's and participating specialty care providers have certain responsibilities.

RECORDS REVIEW

LIBERTY has established guidelines for the delivery of dental care to Plan members. In summary, all providers are expected to render dental care in accordance with community standards. The guidelines begin below and conclude with the form that our dental consultants use to evaluate member records.

Chart Selection: A minimum of ten (10) randomly selected member charts shall be reviewed.

GRIEVANCES, APPEALS, AND PROVIDER CLAIM DISPUTES

As part of our commitment, LIBERTY works to ensure that all members have every opportunity to exercise their right to a fair and timely resolution to any grievance and/or appeals. Providers are **contractually required** to provide LIBERTY with copies of all member records requested because of a member grievance and/or appeal. All providers are obligated to response to LIBERTY with a written response/narrative to the member's concerns and include supporting documentation, i.e., clinical notes, treatment plans, financial ledgers, radiographs, etc. Failure to cooperate/comply with the grievances and appeals process may lead to disciplinary actions, including but not limited to, terminations from the LIBERTY network.

The LIBERTY member Grievances and Appeals (G&A) process encompasses investigation, review, and resolution of member issues submitted to LIBERTY and/or contracted providers. LIBERTY members, as well as members of some of LIBERTY's Health Plan partners, may submit grievances and/or appeals by telephone by calling LIBERTY's Member Services Department toll-free at 888.352.7924, or by fax, online through LIBERTY's website, letter, or grievances and appeals form. **Members can locate information on grievance and appeals filing and resolution timeframes outlined in their Member Handbooks/Evidence of Coverage/Certificate of Coverage**.

LIBERTY's G&A process also addresses the cultural and linguistic needs of our members, as well as the needs of members with disabilities. The system is designed to ensure that all Plan members have access to and can fully participate in the grievances and appeals process. LIBERTY's members' participation in the G&A process, for those with linguistic, cultural, or communicative impairments, is facilitated through LIBERTY's coordination of translation, interpretation, and other communication services to assist in communicating the procedures, process, and findings of the G&A system.

LIBERTY provides members whose primary language is not English with translation services. We currently provide translation services in 150 languages. The G&A form can be obtained from LIBERTY's Member Services Department, from a dental provider facility, or from the LIBERTY website. All contracted provider facilities are required to display member grievances and appeals forms. All member quality of care grievances, benefit complaints, and appeals are received and processed by LIBERTY.

To provide excellent service to our members, LIBERTY maintains a process by which members can obtain timely resolution to their inquiries and complaints. This process allows for:

- The receipt of correspondence from members, in writing or by telephone;
- Thorough research;
- Member education on plan provisions;
- Timely resolution

MEMBER GRIEVANCES

Members may file a grievance following any incident or action that is the subject of their dissatisfaction. All members have the option to submit a grievance in writing; either by composing a letter or completing a grievance

form. The timeframe for members to submit a grievance varies by the line of business and/or Plan program. Members can locate information on grievance filing and resolution timeframes outlined in their Member Handbooks/Evidence of Coverage/Certificate of Coverage. A LIBERTY G&A Analyst will compile all the information on file and any additional information received and forwarded by the member or the provider to coordinate a fair, timely decision to the member's grievance ensuring that only a LIBERTY licensed dentist renders a decision on any clinical case, i.e., quality of care cases.

Commercial Plan Member Grievances

LIBERTY commercial business members have the right to file a grievance within a **specific timeframe**, in accordance with specific state regulations, following any incident or action that is the subject of their dissatisfaction. Members can submit a grievance by telephone by calling LIBERTY's Member Services Department at 888.352.7924, or by fax, online through LIBERTY's website, letter, or G&A form.

Medicaid and Medicare Member Grievances

LIBERTY Medicaid and Medicare members do not have a filing limitation and have the right to file a grievance at any time, in accordance with federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS). Members can submit a grievance by telephone by calling LIBERTY's Member Services Department at 888.352.7924, or by fax, online through LIBERTY's website, letter, or grievances and appeals form.

MEMBER APPEALS

All members have the right to submit an appeal by telephone by calling LIBERTY's Member Services Department at 888.352.7924, or by fax, online through LIBERTY'S website, letter, or G&A form. The timeframe for members to submit an appeal varies by the line of business and/or Plan program. Members can locate information on appeal filing and resolution timeframes outlined in their Member Handbooks/Evidence of Coverage/Certification of Coverage.

Providers who submit appeals on behalf of a member, must obtain and supply LIBERTY with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If LIBERTY does not receive such a document, the appeal cannot be processed.

A LIBERTY G&A Analyst will compile all the information used in the initial adverse determination and any additional information received and forwarded by the member or the provider to coordinate a fair, timely decision to uphold (partially or in full) or overturn LIBERTY's initial determination. LIBERTY personnel involved in determining a member's appeal, must have had no prior involvement in the initial decision. This rule extends to both the G&A Analyst coordinating the appeal, and to the licensed dentist rendering any clinical determination on the case.

Expedited member appeals may be available, if the member's life, health, or ability to maintain maximum function would be in jeopardy by waiting the standard turnaround time for resolution. Expedited appeals are resolved within seventy-two (72) hours. Expedited appeal requests that do not meet the criteria will automatically be process in as a standard/non-urgent appeal.

Commercial and Exchange Plan Member Appeals

LIBERTY Commercial/Exchange business members have the right to file an appeal within a **specific timeframe**, in

accordance with specific state regulations, following an adverse determination issued by LIBERTY. Members can submit an appeal by telephone by calling LIBERTY's Member Services Department at 888.352.7924, or by fax, online through LIBERTY's website, letter, or G&A form. Based on the state and/or line of business, Commercial/Exchange members may have two levels of internal appeals with LIBERTY.

In certain types of cases, Commercial/Exchange members can request an external review with and **Independent Review Organization (IRO)** but only after they have exhausted LIBERTY's internal appeal processes. The completion of LIBERTY's internal appeal process is not required if: a) we fail to meet our internal appeal process timelines, or b) the member has a life-threatening situation files an external review before exhausting our internal appeal process, or c) LIBERTY decides to waive the appeal process requirements.

Medicaid and Medicare Member Appeals

LIBERTY Medicaid and Medicare members have **sixty (60) calendar days** from the date of the adverse determination issued by LIBERTY to file an appeal, in accordance with federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS). Medicaid and Medicare members can submit an appeal by telephone by calling LIBERTY's Member Services Department, or by fax, online through LIBERTY's website, letter, or G&A form.

LIBERTY Medicaid and Medicare members who are currently receiving treatment and want to continue receiving treatment, must file an appeal within **ten (10) calendar days** from the date the adverse benefit determination was postmarked or delivered, or prior to the date LIBERTY as indicated services will stop. The member must state in the appeal that he/she wants to continue receiving treatment during the appeal process.

LIBERTY Medicaid and Medicare members who do not receive a written resolution to their appeal within the required timeframes, or are dissatisfied with the resolution of their appeal, may request a **State Fair Hearing** from his/her appropriate state agency but only after they have exhausted LIBERTY's appeal process. LIBERTY Medicaid and Medicare members also have the right to request a review by an IRO or **Independent Review Entity (IRE)**.

LIBERTY Medicare members have multiple levels of appeal. Once LIBERTY's internal appeal process has been exhausted, Medicare members have **one hundred twenty (120) calendar days** from the date of LIBERTY's adverse determination that is not fully in their favor to request a review with an external **IRE**. Members may represent themselves, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements.

LIBERTY Medicaid members may request an **IRO** and **State Fair Hearing** at the same time, or separately. However, if the Medicaid member requests and completes the State Fair Hearing process first, an IRO cannot be requested and the determination made at the State Fair Hearing is final. If the IRO is requested first, a State Fair Haring maybe requested later. **Neither an IRO, nor a State Fair Hearing, should be pursed until the LIBERTY appeal process has been exhausted,** except in the certain cases where the member's health is in immediate danger or the request was denied because treatment is considered experimental of investigational.

Medicaid Member State Fair Hearings

LIBERTY Medicaid members have one level of appeal, once LIBERTY's internal appeal process has been exhausted, Medicaid members have **one hundred twenty (120) calendar days** from the date of LIBERTY's adverse determination that is not fully in their favor to request a State Fair Hearing. Members may represent themselves at the State Fair Hearing, or be represented by a friend, lawyer, or any other person. If they want someone else to represent them, they are responsible for making the arrangements. Members are informed that they are eligible for free legal assistance by contracting the appropriate state agencies.

The State Fair Hearing process could take up to **ninety (90) calendar days** for the member to receive a final decision. If a member feels his/her health is in danger and will be harmed by waiting **ninety (90)** calendar days, an **"expedited hearing"** can be requested, which may result in a decision within **seventy-two (72) hours**. The member should ask his/her doctor to submit a letter detailing how waiting the ninety (90) calendar days for a decision on the case could seriously harm the member's life, health, ability to attain, maintain, or regain maximum function. This letter should be provided to the member's request for State Fair Hearing.

Requesting a State Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a State Fair Hearing. Members may request benefit continuation during an appeal, IRO, and/or State Fair Hearing.

Independent Review Entity/Organizations

IROs and IREs are not associated with LIBERTY, Health Plan Partners, dental providers, or members and are utilized to determine if LIBERTY's adverse determination was correct for cases that involve medical judgement (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefits or experimental/investigational treatment) and rescissions of coverage.

All members have four months from the date of the adverse determinations issued by LIBERTY to request an external review with an IRO or IRE. External appeals with an **IRO** are resolved within **forty-five (45) calendar days** from the receipt of all necessary information. Expedited external appeals may be available if member feels his/herhealth is in danger and will be harmed by waiting and will be resolved within **seventy-two (72) hours**. A Physician Certification from the members doctor is required for all requests for an expedited external review.

PROVIDER DISPUTES RESOLUTIONS

As a LIBERTY contracted or non-contracted provider, you have the right to submit a written notice challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered), a prior authorization or a decision made by LIBERTY. You may also submit disputes in writing seeking resolution of a billing determination, other contract dispute or a request for reimbursement of an overpayment of a claim.

Provider disputes, associated with a prior authorization, submitted on behalf of a member will be processed in accordance with LIBERTY's Member Appeal Process. A copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf is required. If LIBERTY does not receive such a document, the appeal cannot be processed.

Each provider dispute must contain, at a minimum, the following information:

1) Provider's name and license number
2) Provider's contact information
3) A clear identification of the issue that is subject of the dispute, i.e., date of service, procedure, etc.
4) A clear explanation/summary of the provider's position on the issue
5) Copies of all documentation relative to the subject in support of the provider's positions

Provider disputes that are not associated with a claim, require a clear explanation of the issue and the provider's position on the issue.

Provider disputes that do not include all required information may be returned to the submitted for completion. An amended provider dispute, which includes the missing information, may be submitted. In the event an amended provider dispute, with the missing information is not received, LIBERTY will uphold the initial decision and consider the provider dispute process completed.

LIBERTY will acknowledge and respond to all Provider Disputes within the applicable statutory guidelines.

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the Quality Management Department at: 888.352.7924.

Provider Disputes sent to LIBERTY must include all the required information referenced above for each dispute. All provider disputes must be sent in writing to the attention of the Quality Management Department at the following:

Mail	LIBERTY Dental Plan Attn: Quality Management Department PO Box 26110 Santa Ana, CA 92799-6110	**Fax**	833.250.1814
Email	**Use Online:** Provider Grievance Form GandA@libertydentalplan.com	**Online**	**Online Member/Provider Dispute**

SECTION 14. FRAUD, WASTE, AND ABUSE

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 Medicaid/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 15. ALTERNATIVE TREATMENT

When a member has more than one dental treatment option, it is the responsibility of the provider to advise the member of treatment alternatives that are within professionally accepted standards of care, including procedures that are and are not covered by the member's dental benefits plan. By thoroughly explaining the treatment options to the member, he/she can select the treatment that is most appropriate for him/her. The provider can make professional recommendations as to the treatment option; however, the decision remains that of the member.

LIBERTY requires that any alternative, upgraded and/or elective treatment(s) be presented to the member in writing during the informed consent process, with the statement of fact that the service is not covered. In addition, the member's signature of approval should be documented prior to initiating treatment. This process will alleviate potential member disputes. Any member covered by a Medicare or Medicaid plan must have a clear statement that the service is not covered. **Statements to the effect that "any service not covered by your plan is your responsibility" are not adequate for benefit plans that are part of Medicare or Medicaid plans.**

DEFINITION OF ALTERNATIVE TREATMENT

LIBERTY considers treatments to be alternative when more than one treatment plan is recommended for the same condition(s). In most cases, the least expensive, professionally acceptable covered alternative treatment is covered at the member's copayment. Alternative treatments should be presented to the member using the alternative treatment plan formula, as demonstrated in the sample below. Documentation must verify that all treatment alternatives were presented, and which specific treatment was accepted by the member, with a signature of approval.

When a member selects an alternative treatment plan, LIBERTY will allow the applicable benefit for the covered treatment. The member is responsible for the entire remainder of the provider's fee (the difference between alternative treatment and the covered treatment) plus the copayment for the covered treatment.

For Example:

Provider's usual fee for the alternative treatment (i.e., fixed bridge)	**$2,100.00**
Provider's usual fee for the covered treatment (i.e., partial denture)	$975.00
Difference between alterative treatment and covered treatment ($2,100.00 - $975.00)	$1,125.00
Copayment for the covered treatment	$125.00
Total member's responsibility* ($1,125.00 + $125.00)	$1,250.00

**this does not include any upgraded treatment*

UPGRADED TREATMENT

LIBERTY considers treatment to be an upgrade when similar, more expensive procedures or materials are recommended.

When a member selects an upgraded treatment or material, they are responsible for the cost of the upgrades. Cost of upgraded materials should be based on the actual lab or material costs of such materials.

For Example:

Provider's usual fee for the alternative treatment (i.e., fixed bridge)	**$2,100.00**
Provider's usual fee for the covered treatment (i.e., partial denture)	$975.00
Difference between alterative treatment and covered treatment ($2,100.00 - $975.00)	$1,125.00
Copayment for the covered treatment	$125.00
Total member's responsibility* ($1,125.00 + $125.00)	$1,250.00

**Please refer to specific benefit plan designs for additional information*

SECTION 16. FORMS AND RESOURCES

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

- Select ***your state*** from the drop-down menu

Accessible forms include, but are not limited to:

- ADA Dental Claim Form
- Consent for Non-Covered Treatment
- Electronic Funds Transfer (EFT)
- Informed Consent for Alternative Treatment
- Provider Compliance Attestation
- Specialty Care Referral Form
- On-Line Provider Portal User Guide
- Provider DIV FAQ's
- Provider Newsletters

Submitting Office/Provider Updates:

Provider Online DIV	**Provider Online Enrollment (POE)**
1. Office Demographic Updates *(languages spoken, email, phone numbers, hours of operation etc.)* 2. Verify Associates linked to office location and remove providers no longer at this location 3. Update Access and Availability Status *(appointment times, open/close panel to new patients etc.)* 4. Update Billing Information *(new W9 required)*	1. Add an Associate to an existing location *(Application will need to be completed for uncredentialed providers)* 2. Add a new location *(Complete contracting process online)* 3. Set up a new office with new associates (Complete full process online)