Amerigroup

New Jersey FamilyCare (NJFC)

LIBERTY®
DENTAL PLAN

Provider Reference Guide

www.libertydentalplan.com

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LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

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

The intent of this Provider Reference Guide is to aid each Participating Provider and their staff members in becoming familiar with the administration of LIBERTY Dental Plans. Please note that this Provider Reference Guide serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY Dental Plan and that additional terms and conditions of the Provider Agreement may apply. In the event of a conflict between a term of this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall supersede this Provider Reference Guide. You received a copy of the fully executed Provider Agreement at the time of your activation on LIBERTY Dental Plan's network or when you were oriented to the Plan; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to prinquiries@libertydentalplan.com or by contacting **Professional Relations** at **888.352.7924**.

In order to provide the most current information, updates to the Provider Reference Guide will be available by logging in to the Provider Portal at www.libertydentalplan.com.

OUR MISSION

LIBERTY Dental Plan is committed to be the industry leader in providing quality, innovative and affordable dental benefits with the utmost focus on member satisfaction.

PROVIDER CONTACT AND INFORMATION

Visit www.libertydentalplan.com or contact Customer Service, Monday-Friday 8a.m- 5p.m. EST at:

Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039)

Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039)

<table>
<tr><th colspan="4">PROVIDER CONTACT & INFORMATION GUIDE</th></tr>
<tr><th>Important Phone Numbers & General Information</th><th>Eligibility & Benefits Verification</th><th>Claims Inquiries</th><th>Provider Web Portal (i-Transact)</th></tr>
<tr>
<td rowspan="3">LIBERTY Provider Service Line
833.276.0854
Eligibility & Benefits: option 1
Specialty Referrals: option 2
Claims: option 3
Contracting: option 4

Hours:
An adequate number of live representatives are available M-F, 8 am EST to 8 pm EST

Professional Relations Department
833.276.0854option 4
800.268.0154 (fax)

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

email:
prinquiries@libertydentalplan.com</td>
<td>Provider Portal (i-Transact)
www.libertydentalplan.com
or
Telephone
833.276.0854option 1</td>
<td>Provider Portal (i-Transact)
www.libertydentalplan.com
or
Telephone
833.276.0854option 3</td>
<td rowspan="3">www.libertydentalplan.com

LIBERTY Dental Plan offers 24/7 real-time access to important information and tools through our secure online system
• Electronic Claims and Prior Authorization Submission
• Claims Inquiries
• Real-time Eligibility Verification
• Member Benefit Information
• Referral Submission
• Referral Status
Please visit:
www.libertydentalplan.com
to register as a new user and/or login.

Your “Access Code” can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call: 833.276.0854for assistance, or email:
support@libertydentalplan.com</td>
</tr>
<tr><th>Referral Submission & Inquiries</th><th>Claims Submissions</th></tr>
<tr>
<td>Provider Portal (i-Transact)
www.libertydentalplan.com

Telephone
888.352.7924 option 2

Regular Referrals by Mail:

LIBERTY Dental Plan
ATTN: Referral Department
PO Box 15149
Tampa FL 33684-5149

Emergency Referrals
All requests for emergency specialty care should be made by calling:
833.276.0854option 2</td>
<td>Provider Portal (i-Transact)
www.libertydentalplan.com

EDI
Payer ID #: CX083

Paper Claims by Mail:

LIBERTY Dental Plan
ATTN: Claims Department
PO Box 15149
Tampa FL 33684-5149</td>
</tr>
</table>

PROFESSIONAL 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 to assist with the following:

- Plan Contracting
- Escalated Claim Payment Issues
- Education on Amerigroup Members and Benefits
- Opening, Changing, Selling or Closing a Location
- Adding or Terminating Associates
- Credentialing Inquiries
- Change in Name or Ownership
- Tax Payer Identification Number (TIN) Change

To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes 30 days in advance and in writing to:

	LIBERTY Dental Plan **ATTN: Professional Relations** P.O. Box 26110 Santa Ana, CA 92799-6110		**Professional Relations Team** M-F from 8 am – 5 pm 833.276.0854, press option 4
	Email at prinquiries@libertydentalplan.com		

PROVIDER COMPLIANCE

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

Provider Training can be accessed at www.libertydentalplan.com/Providers/Provider-Training-1.aspx

Trainings include but are not limited to:

- CMS General Compliance
- CMS Fraud, Waste and Abuse
- Code of Conduct
- Critical Incidents
- Cultural and Linguistic Competency

Providers must maintain supporting documentation of training for a period of 10 years for all office staff supporting LIBERTY's government business and can furnish the document upon request.

PROVIDER GRIEVANCES AND APPEALS

Providers may submit payment dispute grievances for matters including billing or payment, or for other administrative issues such as disputes regarding the Plan's policies, procedures or services, lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider, inappropriate or unapproved referrals initiated by providers, or for any other reason. Provider inquiries may be resolved informally via phone by calling LIBERTY Member Services at:

Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039)
Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039)

Formal provider grievances address issues where a provider is not satisfied with LIBERTY's policies and procedures, or with a decision made by LIBERTY, or when the provider disagrees with LIBERTY's decision as to whether a service, supply or procedure is a covered benefit, is medically necessary or is performed in the appropriate setting. Provider grievances are not applicable to disputes between LIBERTY and the provider regarding the terms, conditions or termination or any other matter arising under contract between LIBERTY and the provider. The provider grievance must be submitted in writing and must be filed no later than thirty (30) days from the date that the issue occurred that initiated the grievance. Provider

grievances will be acknowledged in writing within five (5) calendar days and resolved within forty-five (45) calendar days.

LIBERTY Dental Plan
ATTN: Quality Management Department – Grievance and Appeals
P.O. Box 26110
Santa Ana, CA 92799-6110

PROVIDER APPEALS

Providers who are not satisfied with the LIBERTY's utilization or claim denial decision, or the Plan's resolution to a grievance may appeal in writing within ninety (90) days of the date of the grievance determination, or the date of the Explanation of Payment or Denial Letter. Cases appealed after that ninety (90) day period will be denied for untimely filing. If the Provider feels they have filed their case within the appropriate timeframe, documentation may be submitted to affirm their assertion. LIBERTY has thirty (30) days to review the case for Medical Necessity and conformity to applicable guidelines. Cases submitted without the necessary documentation will be denied for lack of information, and the Provider must submit the requested documentation within sixty (60) calendar days of the denial to re-open the case. The case will remain closed if documents and records are received after the sixty (60) calendar day timeframe. Providers may not file a Grievance or an Appeal on behalf of a Member without written consent from the Member as the Member's representative.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

LIBERTY Dental Plan takes pride in the fact that we administer our dental plan in an effective and innovative manner while safeguarding Amerigroup 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.

Our commitment is demonstrated through our actions.

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

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 Dental Plan has disseminated its Notice of Privacy Practices to all required entities.

ANTI-DISCRIMINATION

Discrimination is against the law. LIBERTY Dental Plan ("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: 888-273-2718
Email: compliance@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 complaint 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://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint 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 PROGRAM (LAP)

The purpose of the Language Assistance Program is 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 patients (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:

  Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039), or
  Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039),

- 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.

- If member needs interpretation services at the time the member is ready to receive services, please call LIBERTY's Member Services Department. You will need the member's full name, date of birth and ID number, to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance. An eligible member shall be entitled to twenty-four (24)-hour access to interpreter services, where available, either through telephone language services or in-person interpreters. 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.

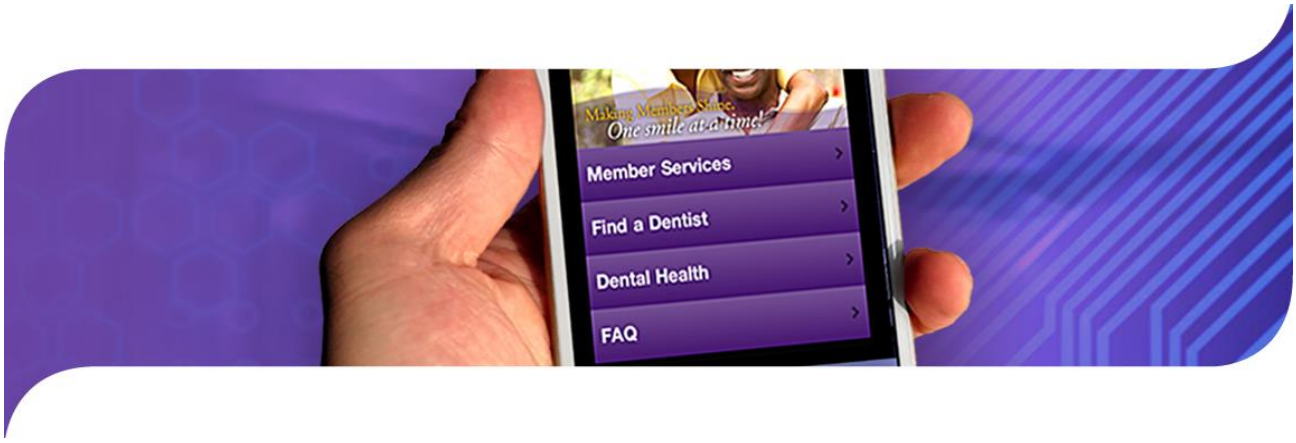
- If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative 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.

ONLINE SERVICES



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

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

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

ON-LINE ACCOUNT ACCESS

To register and obtain immediate access to your office's account, visit: www.libertydentalplan.com. 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 Online 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 office.

If you are unable to locate your Office Number and/or Access Code, please contact our **Professional Relations Department** at 833-276-0854 or email support@libertydentalplan.com for assistance.

For more detailed instructions on how to utilize the Provider Portal, please reference the Online Provider Portal User Guide.

ELIGIBILITY

HOW TO VERIFY ELIGIBILITY

There are several options available to verify eligibility:

- **Provider Portal**: www.libertydentalplan.com - The Member's Last Name, First Name and any combination of Member Number, Policy Number, or Date of Birth will be required *(DOB is recommended for best results)*
- **Telephone:** Speak with a live Representative from 8 a.m. to 5 p.m. EST, Monday through Friday by contacting our **Provider Service Line** at 833-276-0854, press option 1

Monthly Eligibility Rosters (Capitation Programs Only)

At the beginning of each month, your office will receive an updated *Roster* (eligibility list) of Amerigroup members who have selected your office for their dental care. This list will provide your office with the following information:

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

This listing is in alphabetical order and the dependents are listed individually. 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 19. Children may continue to be eligible up to age of 26 if they are full time students.

In the event a member does not appear on the monthly Roster please contact LIBERTY Dental Plan's **Member Services Department** at:

Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039)
Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039)

Upon verification of eligibility LIBERTY Dental will fax confirmation of eligibility to your office.

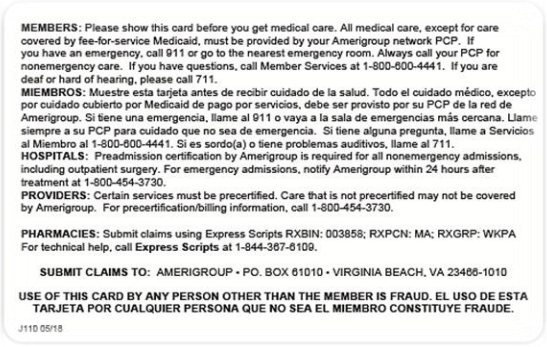
MEMBER IDENTIFICATION CARDS

Amerigroup members should present their ID card at each appointment. Providers are encouraged to validate the identity of the person presenting an ID card by requesting some form of photo identification. The presentation of an ID card does not guarantee eligibility and/or payment of benefits. In such cases, providers should check a photo ID and check against an eligibility list or contact Member Services or the online web portal for verification of eligibility.


Amerigroup
An Anthem Company
Amerigroup Community Care

Effective Date:
Date of Birth:
Subscriber #:
RXGRP #: WKPA
RXPCN #: MA
RXBIN #: 003858

Member Name:
Primary Care Provider (PCP):
PCP Address:
PCP Telephone #:
Vision: 1-800-879-6901 Dental: 1-833-276-0848
Behavioral Health: BILL MEDICAID FEE-FOR-SERVICE
Amerigroup Member Services: 1-800-600-4441


MEMBERS: Please show this card before you get medical care. All medical care, except for care covered by fee-for-service Medicaid, must be provided by your Amerigroup network PCP. If you have an emergency, call 911 or go to the nearest emergency room. Always call your PCP for nonemergency care. If you have questions, call Member Services at 1-800-600-4441. If you are deaf or hard of hearing, please call 711.
MIEMBROS: Muestre esta tarjeta antes de recibir cuidado de la salud. Todo el cuidado médico, excepto por cuidado cubierto por Medicaid de pago por servicios, debe ser provisto por su PCP de la red de Amerigroup. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Llame siempre a su PCP para cuidado que no sea de emergencia. Si tiene alguna pregunta, llame a Servicios al Miembro al 1-800-600-4441. Si es sordo(a) o tiene problemas auditivos, llame al 711.
HOSPITALS: Preadmission certification by Amerigroup is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Amerigroup within 24 hours after treatment at 1-800-454-3730.
PROVIDERS: Certain services must be precertified. Care that is not precertified may not be covered by Amerigroup. For precertification/billing information, call 1-800-454-3730.

PHARMACIES: Submit claims using Express Scripts RXBIN: 003858; RXPCN: MA; RXGRP: WKPA For technical help, call **Express Scripts** at 1-844-367-6109.

SUBMIT CLAIMS TO: AMERIGROUP • PO. BOX 61010 • VIRGINIA BEACH, VA 23466-1010

USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD. EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.

J110 05/18

PRIMARY CARE DENTAL ASSIGNMENT

Amerigroup members can choose a Primary Care Dentist at any time. Upon initial enrollment, LIBERTY will assign Amerigroup members to the nearest Primary Care Dentist based on such factors as language, cultural preference, previous history of the member or another family member, etc. Amerigroup members can change Primary Care Dentists at any time by either calling LIBERTY, going onto the LIBERTY website, or by being seen by the Primary Care Dentist.

MEDICAID PROGRAM GUIDELINES

DEFINITION OF MEDICAL NECESSITY

Medically Necessity Services as defined by State of New Jersey and Amerigroup contract, refers to services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all.

We approve care that is "medically necessary" or "needed" including but not limited to:

- The treatment or supplies are needed to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition and that meet accepted standards of dentistry;

- Treatment that meets EPSDT guidelines and regulations, following accepted medical and dental practices, provide services in an appropriate clinical setting, and as medically necessary.

- 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 patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual;
- Services are provided in a safe, proper and cost-effective place, reflective of the services that can be safely provided consistent with the diagnosis;
- Services are not performed for convenience only; and
- Services are provided as needed when there is no better or less costly covered care, service or place available.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)--a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered, pursuant to Federal Regulations found in Title XIX of the Social Security Act.

Dental services may not be limited to emergency services. Dental screening by the primary care physician in this context means, at a minimum, observation of tooth eruption, occlusion patterns, presence of caries, and/or oral infection. The Primary Care Physician is required to refer a child to the dentist by one year of age or soon after the eruption of the first primary tooth for a minimum of two dental visits a year. It is mandated that the PCP follow up during well child visits to ensure that all needed preventive and definitive dental services are provided thereafter through the age of twenty (20).

Primary Care Physician (PCP)--a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical

care, record maintenance, and initiation of referrals to specialty providers described in this contract and the Benefits Package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements.

A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a primary care dentist requires a consultation for services by that specialty provider.

Dental Service by Dental Professional	0-1 yr	2-6 yrs	7-20 yrs
A1. Oral Evaluation (Exam)	yes	yes	yes
2. Caries/Cavities Risk Assessment	yes	yes	yes
B. Fluoride Supplements	yes	yes	yes
C. Fluoride Varnish*	yes	yes	yes
D. Prophylaxis with Fluoride		yes	yes
E. Sealants (Permanent teeth to age 16 yrs)		yes	yes
F. Radiographs/x-rays (Non-emergency)	yes	yes	yes
G. Dental Treatment	yes	yes	yes

- **Oral Evaluations** (including oral hygiene instructions), **Fluoride varnish** and **Cleanings** with fluoride can be provided twice a year or more frequently based on medical necessity and for children with special health care needs.
- A prescription for **fluoride supplements** may be given by either your dentist or primary care provider (PCP) to help prevent cavities.
- *The application of **fluoride varnish** to protect teeth from cavities can also be done for children through the age of 5 by their PCP followed by a referral to the dentist for an oral evaluation, X-rays as needed, cleaning and dental treatment.
- A **Caries/Cavities Risk Assessment** – should be done once a year to determine your child's risk of developing cavities. The visit includes an oral evaluation, instructions on brushing, oral health, safety and nutritional counselling to parents/caregivers and children.
- **Sealants and repairs of sealants** should be provided to premolars and permanent molars of children between the ages of 6 through 16 to help prevent cavities
- **Dental treatment** services for primary "baby teeth" and permanent teeth include: **fillings, stainless steel crowns, treatment for toothache and extractions** and should be provided when recommended by your child's dentist.

NJ SMILES PROGRAM

Non-dental, trained PCP staff may provide annual carries dental risk assessment, fluoride varnish application and dental referral for children through the age of six (6) as part of a required well-child visit.

- Communication is required between PCP's and PCD's to facilitate the requirement of referral to a dentist for a dental visit by twelve (12) months of age.
- Fluoride varnish may be applied by any trained medical staff who have proof of training for this service. Primary care physicians (pediatricians or physicians seeing pediatric enrollees), physician assistants and nurse practitioners can receive this training.
- Fluoride varnish application will be combined with risk assessment and referral to a dentist that treats children under the age of six (6) and will be linked to well child visits for children through the age of six (6).
- These three non-dental provider services will be reimbursed as an all-inclusive service billed as a CPT code and can be provided up to four (4) times a year. This frequency does not affect the frequency of this service by the dentist.
- Amerigroup must provide training to all primary care physicians on the requirement of referral to a dentist for a dental visit by twelve (12) months of age.
- Amerigroup must notify primary care physicians and primary care dentists of their referral process and required communications between the primary care physician and primary care dentist provider groups.
- Amerigroup must provide training to all primary care dentists and primary care physicians on prescribing fluoride supplements (based on access & use to fluoridated public water) and their responsibility in counseling parents and guardians of young children on oral health and age appropriate oral habits and safety to include what dental emergencies are and use of the emergency room for dental services.
- Amerigroup maintains a directory of dental providers for children on their website. It can be used as a resource to refer children under the age of six (6).

NEW JERSEY FAMILYCARE PROGRAM

New Jersey's FamilyCare programs provide medical and dental coverage to eligible children and adults based on income levels. LIBERTY Dental Plan provides dental services for eligible members in the FamilyCare A, ABP, B, C, D, MLTSS, FIDE-SNP, and DDD programs on behalf of Amerigroup. All New Jersey FamilyCare members in the aforementioned groups have comprehensive dental benefits which include

diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral surgical and other services. Some procedures require prior authorization.

Orthodontic services are age restricted and only approved with adequate documentation of medical necessity. Participating providers are responsible for working with the Plan to ensure anticipated treatment is completed prior to the loss of benefit eligibility due to age. Provider are required to obtain a signed Informed Consent Form and advise the member and parent or guardian of the following:

- The age limit for orthodontic coverage
- Length of treatment
- Consequences of excessive breakage of appliance(s) and/or other behavior that is not conducive to completing treatment in a timely manner
- Their financial responsibilities should coverage be lost.

NJFAMILYCARE
Affordable health coverage. Quality care.

Income Chart effective 2018

1-800-701-0710
TTY: 1-800-701-0720
www.njfamilycare.org

FAMILY SIZE *	Adult(s) (Age 19-64)	Pregnant Women (Any Age)	Children (Under Age 19)					
	Federal Poverty Level % (FPL)							
	0 - 138%	0 - 205%	0 - 147%	> 147 - 150%	> 150 - 200%	> 200 - 250%	> 250 - 300%	> 300 - 355%
	Maximum Monthly Income							
1	$1,397	N/A	$1,488	$1,518	$2,024	$2,530	$3,035	$3,592
2	$1,893	$2,812	$2,017	$2,058	$2,744	$3,430	$4,115	$4,870
3	$2,390	$3,550	$2,546	$2,598	$3,464	$4,330	$5,195	$6,148
4	$2,887	$4,288	$3,075	$3,138	$4,184	$5,230	$6,275	$7,426
5	$3,384	$5,026	$3,604	$3,678	$4,904	$6,130	$7,355	$8,704
6	$3,881	$5,764	$4,134	$4,218	$5,624	$7,030	$8,435	$9,982
Each Additional	$497	$738	$530	$540	$720	$900	$1,080	$1,278
Monthly Premium	No premium	No premium	No premium	No premium	No premium	$43.00 per family	$86.00 per family	$144.50 per family
Copayments	No copay	No copay	No copay	No copay	$5 - $10	$5 - $35	$5 - $35	$5 - $35

* The size of your family may be determined by the **total number** of parent(s) or caretaker(s), and all blood-related children under the age of 21 **who are tax dependent, as well as any other tax dependent** residing in the home.

CARE FOR MEMBERS WITH SPECIAL NEEDS

Children with Special Health Care Needs - those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally. This includes all children who are MLTSS Members.

Enrollee with Special Needs - for adults, special needs include complex/chronic medical conditions requiring specialized health care services and persons with physical, mental/substance abuse, and/or developmental disabilities, including persons who are eligible for the MLTSS program.

We offer care management services to children and adults with special health care needs, including referrals by the primary care dentist to a dental specialist when a consultation with a specialist is required. Our care management programs are offered to members who:

- Are developmentally disabled
- Are home-bound
- Are identified as needing assistance in accessing or using services; and
- Have long-term or complex health conditions, like asthma, diabetes, HIV/AIDS and high-risk pregnancy.

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

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

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

Developmental Disabilities. While Amerigroup must assure that enrollees with special needs have access to all medically necessary care, the State considers dental services to be an area meriting particular attention. Liberty, therefore, shall accept for network participation dental providers with expertise in the

dental management of enrollees with developmental disabilities. All current providers of dental services to enrollees with developmental disabilities shall be considered for participation in the Liberty's dental provider network. Credentialing and re-credentialing standards must be maintained. Liberty shall make provisions for providers of dental services to enrollees with developmental disabilities to allow for limiting their dental practices at their choice to only those patients with developmental disabilities. Liberty and/or Amerigroup shall develop specific policies and procedures for the provision of dental services to enrollees with developmental disabilities in accordance with Section 4.5.1.F of the MCO Contract. At a minimum, the policies and procedures shall address:

a. Special needs/issues of enrollees with developmental disabilities, including the importance of providing consultations and assistance to patient caregivers.

b. Provisions in the dental reimbursement system for initial and follow-up dental visits which may require up to 60 minutes on average to allow for a comprehensive dental examination and other services to include, but not limited to: a visual examination of the enrollee; appropriate radiographs; dental prophylaxis, including extra scaling and topical applications, such as fluoride treatments; non-surgical periodontal treatment, including root planing and scaling; the application of dental sealants on permanent molars and premolars; thorough inquiries regarding patient medical histories; and most importantly, consultations with patient caregivers to establish a thorough understanding of proper dental management during visits.

c. Standards for dental visits that recognize the additional time that may be required in treatment of patients with developmental disabilities. Standards should allow for up to four (4) visits annually without prior authorization.

d. Provisions for home visits when medically necessary and where available.

e. Policies and procedures to ensure that providers specializing in the treatment of enrollees with developmental disabilities have adequate support staff to meet the needs of such patients.

f. Provisions for use and replacement of fixed as well as removable prosthetic devices as medically necessary and appropriate.

g. Provisions in the dental reimbursement system to reimburse dentists for the costs of preoperative and postoperative evaluations associated with dental surgery performed on patients with developmental disabilities. Preauthorization shall not be required for dental procedures performed during surgery on these patients for dentally appropriate restorative care provided under general anesthesia. Informed consent,

signed by the enrollee or authorized person, must be obtained prior to the surgical procedure. Provisions should be made to evaluate such procedures as part of a post payment review process.

h. Provisions in the dental reimbursement system for dentists to receive reimbursement for the cost of providing oral hygiene instructions to caregivers to maintain a patient's overall oral health between dental visits. Such provisions shall include designing and implementing a "dental management" plan, coordinated by the Care Manager, for overseeing a patient's oral health.

i. The Care Manager of an enrollee with a developmental disability shall coordinate authorizations for dentally required hospitalizations by consulting with the plan's dental and medical consultants in an efficient and time-sensitive manner.

NEW JERSEY FAMILYCARE SCOPE OF BENEFITS

Dental Coverage	FamilyCare A	FamilyCare ABP, MLTSS, FIDE-SNP	FamilyCare B	FamilyCare C	FamilyCare D
Diagnostic Services** Preventive Services** Restorative Services Endodontic Services Periodontic Services** Prosthodontic Services Oral Maxillofacial Surgical Services Orthodontic Services Adjunctive Services Emergency Dental Services	Covered*			Covered* - $5 copay applies except for diagnostic and preventive visits	Covered* - $5 copay applies except for diagnostic and preventive visits

* NJFC covered services are listed on www. njmmis.com, and are updated regularly.

** Additional benefits for diagnostic, preventive and some periodontal services shall be available (beyond the frequency limitations) as often as every three months to enrollees with special needs.

Services requiring prior authorization are orthodontics, periodontics, endodontics, occlusal guards, crowns, removable dentures, fixed bridge work and implants, oral surgery (except for D7111 and D7140), general anesthesia, and hospital certification surgical cases.

NEW JERSEY FAMILYCARE (NJFC) REIMBURSEMENT

Contracted New Jersey FamilyCare (NJFC) network dentists are compensated on a fee for-service reimbursement model. Offices are required to submit claims for all services rendered. It is recommended that claims be submitted each month or each visit to ensure timely payment. As per Section B.4.1.22 of the MCO Contract, Amerigroup shall pay on a prorated basis for dental services that have a dental lab component, including cast crowns, fixed and removable prosthetics, retainers, and habit appliances based on stage of completion, if an enrollee dies or does not return to complete these services within three months from the last office visit for that service. For cast restorative and fixed prosthodontics, the

prorate shall be 10 percent of the total payment for preparation of tooth with or without temporary, 85 percent of the total payment for impression and 95 percent of the total payment for completed not inserted. For removable prosthodontics, the prorate shall be 10 percent of the total payment for impression, 55 percent of the total payment for bite registration, 75 percent of the total payment for "try-in" stage and 85 percent of the total payment for completed not inserted. For appliances and retainers, the prorate shall be 10 percent of the total payment for impression and 85 percent of the total payment for completed and not inserted. For additional information regarding payment and eligibility, please visit the on-line Provider Portal, or contact the Member Services Monday through Friday, 8a.m- 5p.m. EST, at:

Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039)
Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039)

CONTINUITY OF CARE

Reimbursement for dental services in progress that require multiple visits to complete and are provided to eligible NJFC members who have a change in enrollment between NJFC Fee for Service non–managed care program (NJFC FFS) and a NJFC MCO or between NJFC MCOs. These dental services will include those services that require more than one visit to complete and will include but are not limited to crowns (cast, porcelain fused to metal and ceramic), cast post and core, endodontic treatment and fixed and removable prosthetics. Payment is based on service being provided on or before 90 days of this change or beyond 90 days after this change. Information for orthodontic services begins on page 81.

a. **For services started while member is enrolled in NJFC FFS Program**

1. The NJFC FFS will provide reimbursement for those dental services approved to and initiated by a NJFC FFS dental provider prior to enrollment change and completed within 90 days of change to NJFC MCO enrollment.

2. The NJFC MCO of enrollment will provide reimbursement for those dental services approved to and initiated by a NJFC FFS dental provider prior to NJFC MCO enrollment change and completed more than 90 days after change to NJFC MCO enrollment.

b. **For services started while member is enrolled in a NJFC MCO**

1. The NJFC MCO of enrollment will provide reimbursement for those dental services approved to and initiated by a participating NJFC MCO dental provider prior to enrollment change and completed within 90 days of change to NJFC FFS enrollment. The NJFC MCO policy for prior authorization and reimbursement will be made available.

2. The NJFC FFS program will provide reimbursement for those dental services approved to and initiated by a participating NJFC MCO dental provider prior to enrollment change and completed more than 90 days after a change to NJFC FFS enrollment. The NJFC FFS policy for prior authorization and reimbursement will be made available.

3. The subsequent NJFC MCO will provide reimbursement for those dental services approved to and initiated by a participating NJFC MCO dental provider prior to enrollment change and completed more than 90 days after an enrollment change to the subsequent NJFC MCO. The policy for prior authorization and reimbursement of the subsequent NJFC MCO will be made available.

c. **Reimbursement will be made to the NJFC dental provider as long as they participate with either the NJFC MCO or NJFC FFS**. The provider shall be made aware of the NJFC FFS and NJFC MCO policies and requirements for obtaining a new prior authorization for the service(s) provided.

1. The dental provider shall be made aware of the NJFC FFS or NJFC MCO policies and requirements for obtaining a new prior authorization for the service provided during the period of change in enrollment and for those services not started but previously approved.

2. If the dental provider does not participate with the NJFC MCO or FFS program of enrollment, they shall be advised that they cannot provide or be reimbursed for any other services. The member must contact Member Services to locate a provider in their NJFC MCO or the MACC office to locate a provider in NJFC FFS.

d. **Continuity of care to case completion will apply with continued NJ FamilyCare/Medicaid eligibility in the event of change of Contractor enrollment or NJ FamilyCare program plan**. If a Member loses eligibility, the Contractor shall be responsible for continuity of care and reimbursement for the following dental services approved and started during a period of enrollment:

1. Endodontic, crown and prosthetic (both fixed and removable) services – the Contractor shall continue to provide coverage to completion of these services and any other associated services required for their successful completion after loss of eligibility when such endodontic, crown or prosthetic service(s) are approved and initiated under the Contractor's plan for 90 days following the loss of eligibility.

2. With loss of eligibility where endodontic treatment and associated restorative services have been approved and endodontic treatment was started, all other services required to restore the tooth to form and function shall be covered for completion.

3. Limited and interceptive orthodontics and treatment with habit appliances are reimbursed at the time of insertion and shall be covered for completion. This does not apply to comprehensive orthodontic treatment.

REFERRALS

Amerigroup shall not impose an arbitrary number of attempted dental treatment visits by a PCD as a condition prior to the PCD initiating any specialty referral requests. Neither Amerigroup nor LIBERTY shall obligate the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. Neither the Contractor nor LIBERTY shall obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. The Contractor shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD. All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

SECOND OPINIONS

Amerigroup shall have a Second Opinion program that can be utilized at the enrollee's option for diagnosis and treatment of serious medical conditions, for elective surgical procedures, when a physician recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the physician failed to diagnose. The program can also be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the LIBERTY network or Amerigroup may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into the Amerigroup medical and dental procedures and submitted to DMAHS for review and approval.

UTILIZATION MANAGEMENT

In the provision of treatment to NJ FamilyCare/Medicaid beneficiaries, N.J.A.C. 10:56 for dental services and N.J.A.C. 10:54 for physician services shall be followed for the provisions of the respective services. In addition, the following standards shall be followed:

a. There is no limit to the frequency of necessary dental services for the placement or replacement of amalgam or composite restorations or crowns. The standard of practice requires a provider to

eradicate pathology and to repair or replace defective restorations to restore form and function. Frequency limits may apply for reimbursement of these services to the same provider.

b. Frequency limits for the following diagnostic and preventive services: oral evaluations, intraoral complete series, panoramic film, bitewings, dental prophylaxis, topical fluoride application, fluoride varnish and sealants, are not transferable when the enrollee is seen by a new dentist who is not a Member of the same group or shared health care facility, or practitioners sharing a common record.

c. Additional diagnostic, preventative and periodontal services shall be available beyond the frequency limitations of every six months and be allowed every three months to enrollees with special needs when medical necessity for these services is documented and submitted for consideration. Documentation shall include the expected prognosis and improvement in the oral condition associated with the increased frequency for the requested service.

d. Replacement of partial or complete dentures cannot be denied based solely on frequency if request includes documentation of medical necessity, inability to repair the existing denture or loss resulting from theft, fire or accident.

e. When dental, medical, MH/SA or MLTSS service(s) are denied, written notice to a provider or Member must be provided and shall include the following:

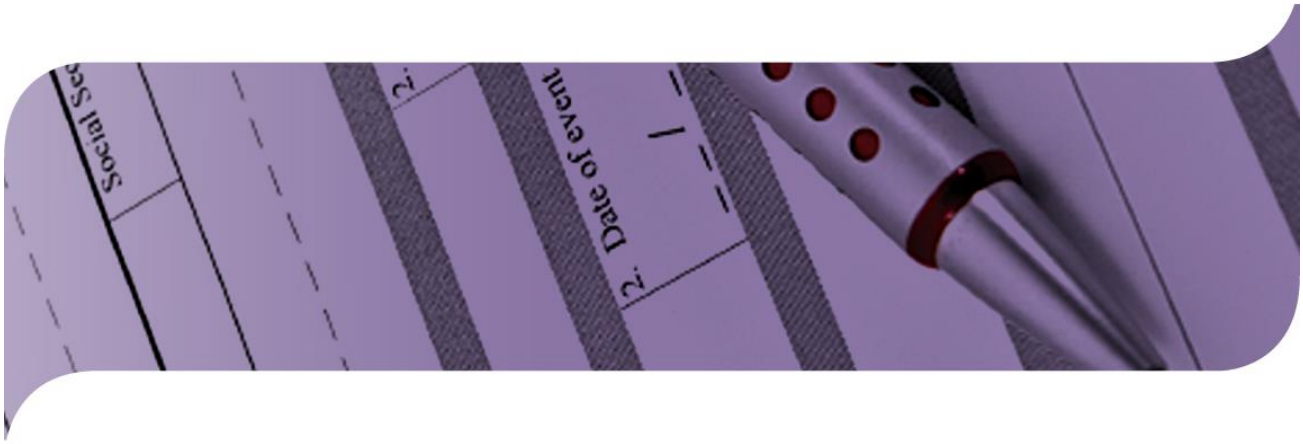
1. The specific service denied, including the tooth, quadrant or site if a dental denial;
2. The specific reason(s) for the denial, and where appropriate, reference the policy or regulation;
3. If the documentation provided supports the provision of a different service(s) than the one(s) requested for approval, the clinical peer who reviewed the service(s) may approve the service(s) which are supported by the submitted documentation.
4. The name and contact information for the dentist, physician or other clinical peer that reviewed and denied the service, in accordance with requirements of the State Board of New Jersey;
5. The process and required documentation needed for reconsideration of the service or alternative treatment and information on the availability of the reviewing dentist or physician for telephone communication to discuss denial(s) with the treating provider.
6. Information sent to the Member to describe the reason for the denial also shall be in layman terms.

f. Amerigroup and/or LIBERTY shall comply, as applicable, to the provisions of P.L. 2007, c.259 and any regulations promulgated to implement this act which concerns dental decisions.

OWNERSHIP AND CONTROL DISCLOSURE

LIBERTY is required to obtain an ownership disclosure from all participating providers. Contracted Dental Offices must provide LIBERTY with complete and accurate information regarding ownership and control of the Dental Office on the Disclosure Form specified by LIBERTY. In addition, on or before the anniversary of the Effective Date of the Provider Agreement, Dental Office must provide to LIBERTY an updated Disclosure Form or written confirmation that there has been no change in the ownership and/or control of the Dental Office as disclosed on the Disclosure Form. Failure to provide ownership and control information annually may result in termination of the Provider Agreement pursuant to Section 4.2(c)(ii) of the Provider Agreement.

CLAIMS AND BILLING



At LIBERTY, we are committed to accurate and efficient claims processing. It is imperative that all information be accurate and submitted in the correct format. Network dentists are encouraged to submit clean claims within 45 days once treatment is complete. Following are the ways to submit a claim:

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 - directly through the Provider Portal or by using a clearinghouse.

1. **PROVIDER PORTAL** www.libertydentalplan.com
2. **THIRD PARTY CLEARINGHOUSE**

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

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

All electronic submissions should be submitted in compliance with state and federal laws, and LIBERTY Dental Plan'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 the 2012 ADA Dental Claim. Please mail all paper claim/encounter forms to:

ATTN: CLAIMS DEPARTMENT

LIBERTY Dental Plan
PO Box 15149
Tampa FL 33684-5149

CLAIMS SUBMISSION

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

1. All claims must be submitted to LIBERTY for payment for services no later than 180 days after the date of service.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.
3. All claims must include the name of the program under which the Amerigroup member is covered and all the information and documentation necessary to adjudicate the claim.

NOTE: ICD-10 codes may accompany procedures performed on claims for associated disease, illness, symptoms or disorders. Dentist may select a diagnosis code based on the present condition(s) of the patient. Dentists should use their clinical education, experience and professional ethics while selecting the appropriate diagnostic code.

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

CLAIMS STATUS INQUIRY

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

	833-276-0854, press option 3		**Provider Portal:** www.libertydentalplan.com

Claims Status Explanations

CLAIMS STATUS	EXPLANATION
Completed	Claim is complete, and one or more items have been approved
Denied	Claim is complete, and all items have been denied
Pending	Claim is not complete. Claim is being reviewed and may not reflect the benefit determination

CLAIMS RESUBMISSION

Providers have 365 days from the date of service to request a resubmission or reconsideration of a claim that was previously denied for:

- Missing documentation
- Incorrect coding
- Processing errors

CLAIMS OVERPAYMENT

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

Notice of Overpayment of a Claim

If LIBERTY determines that it has overpaid a claim, LIBERTY will notify the provider in writing through a separate notice clearly identifying the claim; the name of the patient, the date of service and a clear explanation of the basis upon which LIBERTY believes the amount paid on the claim was in excess of the amount due, including interest on the claim. LIBERTY will not seek reimbursement for an overpayment later than 18 months after the date of the first payment on the claim was made with the exception of those listed at N.J.S.A 26:2J-8.1. d(10).

Contested Notice

The provider may appeal LIBERTY's request for reimbursement of an overpayment within 45 days, following the internal claims appeal process. LIBERTY shall conduct the appeal at no cost to the provider.

No Contest

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

Offset to Payments – Uncontested Notice of Overpayment

LIBERTY may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when; (1) the provider fails to reimburse LIBERTY within the timeframe set forth above, and (2) LIBERTY has the right to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, LIBERTY will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

COORDINATION OF BENEFITS

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

MULTIPLE CARRIERS

NJ FamilyCare is a federal and state funded health insurance program created to help qualified New Jersey residents of any age access affordable health insurance

Members may be enrolled in a Managed Care Organization (MCO) or have benefits through the state Fee for Service Medicaid Program.

New Jersey FamilyCare (NJFC) provides coverage to each eligible beneficiary of the state assistance program. If a Member has another coverage it would always be primary. New Jersey FamilyCare (NJFC) is always the carrier of last resort. Thus, NJFC coverage is secondary to any other coverage a Member might have.

Providers should always bill other coverage first and provide an EOB from the primary carrier with their claim to LIBERTY for NJFC coverage. The Provider should submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later. LIBERTY will pay the difference up to the NJFC fee schedule.

GENERAL DENTIST PROVIDER RESPONSIBILITIES

- Provide and/or coordinate all dental care for member;
- Perform an initial oral evaluation; Exceptions may be in the provision of diagnostic materials depending on the clinical presentation of the member;
- Provide a written treatment plan to members upon request that identifies covered services, non-covered services, and clearly identifies any costs associated of each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues;
- Provide supporting materials for dental services and procedures which document their medical necessity;
- Treatment plans and informed consent documents must be signed by the member or responsible party showing understanding of the treatment plan;
- Provide referrals with bidirectional communication between specialty care provider and PCD to ensure continuity of care;
- A financial agreement for any non-covered services shall be documented separate from any treatment plan or informed consent;
- Work closely with specialty care provider to promote continuity of care;
- Maintain adherence to LIBERTY's Quality Management and Improvement Program;
- Identify dependent children with special health care needs and notify LIBERTY of these needs;
- Notify LIBERTY of a member death;
- Arrange coverage by another provider when away from dental facility;

- Informing the enrollee that he/she must contact LIBERTY for assignment to a new office.
- Provide 48-hour access in case of emergencies, urgent dental treatment no later than 3 days of referral, or earlier as the condition warrants and urgent care appointments within 3 days of referral;
- Maintain scheduled office hours;
- Maintain dental records in accordance with New Jersey State Board of Dentistry regulations (NJAC 13:30-8.7);
- Provide updated credentialing information upon renewal dates;
- Provide requested information upon receipt of patient grievance/complaint within the timeframe specified by LIBERTY on the written request;
- Notify LIBERTY of any changes regarding practice, including location name, telephone number, address, associate additions / terminations, change of ownership, plan terminations, etc. at least 30 days in advance;
- Provide dental services in accordance with peer reviewed clinical principles, criteria, guidelines and any evidence-based parameters of care;
- Provider will not discriminate or retaliate against an enrollee or attempt to dis-enroll an enrollee for filing a grievance or appeal;
- Provide dental services in accordance with the State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and Amerigroup Contract.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES

LIBERTY's specialty providers are Board eligible or Board Certified in accordance with NJ State Board of Dentistry Regulations. Providers who wish to advertise an area of dental specialty must meet the NJ Board requirements for that dental specialty and have a current "specialty permit".

- All the Responsibilities & Rights of the General Dentist listed above;
- Provide specialty care to members;
- Work closely with primary care dentists to ensure continuity of care;
- Bill LIBERTY Dental Plan for all dental services that were provided;
- All Dentists must have or have confirmation of application submission of valid DEA and CDS certificates as applicable;
- Provide credentialing information upon renewal dates.

OFFSET TO PAYMENTS

LIBERTY may offset the payment of a future claim or claims against a provider's current claim submission(s) when the provider fails to reimburse LIBERTY or a Member within an appropriate timeframe, as determined by LIBERTY, for the provider's failure to comply with LIBERTY's applicable administrative policies, procedures and/or determinations relating to dental plan administration issues, including, but not limited to those involving balance billing, incorrect charges, and complaint or treatment resolution decisions. LIBERTY will provide the provider with a detailed written explanation identifying the payments that have been offset against the specific current claim or claims.

NATIONAL PROVIDER IDENTIFIER

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

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI 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:

- Web based application: https://nppes.cms.hhs.gov/NPPES/Welcome.do
- Dental providers can agree to have an Electronic File Interchange (EFI) Organization submit application data on their behalf
- 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.

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must give LIBERTY at least 90 days advance notice of intent to terminate a contract. Provider must continue to treat members when medically necessary until the last day of the fourth month following the date of termination. Provider must continue to treat members for postoperative care when medically necessary until the last day of the sixth month following the date of termination. Affected members are given advance written notification informing them of their transitional rights. Certain contractual rights survive termination, such as the agreement to furnish records during a grievance or claims review. Please consult your provider contract for your responsibilities beyond termination.

MOBILE DENTAL PRACTICES AND MOBILE DENTAL VANS

Mobile Dental Practice is a provider traveling to various locations and utilizing portable dental equipment to provide dental services to facilities, schools and residences. These providers are expected to provide on-site comprehensive dental care, necessary dental referrals to general dentist or specialists and emergency dental care in accordance with all New Jersey State Board of Dentistry regulations and the NJ FamilyCare MCO Contract. The sites served by the Mobile Dental Practice must allow Member access to treatment and allow for continuity of care. The MCO is responsible for assisting the member and facility in locating a dentist when referrals are issued. Patient records must be maintained at the facility when this is a long-term care facility or skilled nursing facility and duplicates may also be maintained in a central and secure area in accordance with State Board of Dentistry regulations. The MCO must maintain documentation for all locations that the mobile van will serve to include schedule with time and days.

Mobile Dental Van is a vehicle specifically equipped with stationary dental equipment and is used to provide dental services within the van. A mobile dental van is not to be considered a dental practice. Providers using a mobile dental van to render dental services must also be associated with a dental practice that is located in a "brick and mortar" facility located in New Jersey, that serves as a dental home offering comprehensive care, emergency care and appropriate dental specialty referrals to the mobile dental van's patients of record (Members). Patient records are to be maintained in the brick and mortar location in accordance with State Board of Dentistry regulations. The distance between the dental practice and the sites and locations served by the mobile dental van must not be a deterrent to the Member accessing treatment and allow for continuity of care by meeting the network standards for distance in miles as described in section 4.8.8 Provider Network Requirements. When a mobile dental van's use is associated with health fairs or other one-time events, services will be limited to oral screenings, exams, fluoride varnish, prophylaxis and palliative care to treat an acute condition. State Board regulations must still be followed. The MCO must maintain documentation for all locations served to include schedule of time and days.

STANDARDS OF ACCESSIBILITY AND AVAILABILITY

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

Type of Appointment	National LIBERTY Appointment Waiting Time Standards
Routine Care	**Within 28 days**
Urgent Care	Appointments must be provided within 3 days of referral
Emergency Dental Care	No later than forty-eight (48) hours, or earlier as the condition warrants
After-Hours/ Emergency Availability	**24 hours a day, 7 days a week**. All providers must have at least one of the following: • After hours calls must be answered by a person, not voicemail. • Answering service that is answered by a person, not voicemail, that will contact provider (or provider on call) on behalf of the member • Calls involving life threatening conditions or imminent loss of limb or functions conditions may be referred to the 9-1-1, emergency medical services, emergency room or urgent care facilities in the community (must be answered by a person, not voicemail), as per regionally available resources.
Scheduled Appointment In-Office Wait Time	**Not to exceed 45 minutes.** Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider
Office Hours	**Minimum of 3 days / 30 hours per week**

"Appointment Waiting Time" means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

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

A dental emergency is defined as an unforeseen dental condition such as cellulitis, a broken or knocked-out tooth, dental pain, infection or oral trauma. Most dental emergencies are best treated in a dental office and not a hospital emergency department.

A dental emergency which would be appropriately treated in a hospital emergency department would include:

- Broken jaw and/or facial bones
- Severe swelling or oral facial infection
- Uncontrolled oral bleeding

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

FACILITY PHYSICAL ACCESS FOR THE DISABLED – AMERICANS WITH DISABILITIES ACT

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

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

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

APPOINTMENT RESCHEDULING

When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice. Appointments for follow-up care are required to be scheduled according to the same standards as initial appointments.

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY AND AVAILABILITY

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

TREATMENT PLAN GUIDELINES

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

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

NJFC Plan 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 by signing a waiver.

Network dentists can refer members to the **Member Services Department**, Monday through Friday, 8 a.m. to 5 p.m. EST at:

Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039)
Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039)

SECOND OPINIONS

A Second Opinion program can be utilized at the member's option for diagnosis and treatment of serious dental conditions, for elective surgical procedures, when a dentist recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the dentist failed to diagnose. The program can also be utilized at the member's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the LIBERTY's network or LIBERTY may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into the LIBERTY's dental procedures and submitted to DMAHS for review and approval.

Network Dentist(s) should refer these members to the **Member Services Department** Monday through Friday, 8 a.m. to 5 p.m. EST. at:

Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039)
Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039)

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established patients. Recall systems should incorporate follow up on missed appointments and referrals, including referrals to address problems identified through EPSDT exams. Contact Member Services or the LIBERTY website for more information. Missed or cancelled appointments should be noted in the patient's record.

CONTINUITY AND COORDINATION OF CARE

LIBERTY Dental Plan ensures appropriate and timely continuity and coordination of care for all Amerigroup members.

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

Primary Care Dentist (PCD)--a licensed (general or pediatric) dentist who is the health care provider responsible for supervising, coordinating, and providing initial and primary dental care to patients; for initiating referrals for specialty care; and for maintaining the continuity of patient care.

Primary Care Provider (PCP)--a licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to enrollees, including periodic examinations, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of referrals to specialty providers described in this contract and the Benefits Package, and for maintaining continuity of patient care. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, CNMs or CNPs/CNSs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these contract provisions and licensure requirements.

Continuity of care between the Primary Care Dentist (PCD) and any specialty care dentist must be available and properly documented. Communication between the PCD and dental specialist shall occur when members are referred for specialty dental care. LIBERTY expects PCDs to follow up with the Member and with the Specialist to ensure that referrals are occurring as per the best interest of the

Member. Specialist providers are encouraged to send treatment reports back to the referring PCD to ensure that continuity of care occurs as per generally accepted clinical criteria.

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

MEMBER RIGHTS AND RESPONSIBILITIES

LIBERTY Dental Plan complies with the Managed Care Organization Member Handbook Rights and Responsibilities and Evidence of Coverage. Amerigroup members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to members in the member's Member Handbook and Evidence of Coverage.

THE DENTAL PATIENT 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 enrollees participating dentist and in the records of a facility for enrollees in a facility.

As required by the NJ State Board of Dentistry (N.JA.C. 13.30-8.7), patient records, including all radiographs, shall be maintained for at least seven years (or 10 as required by the NJ FamilyCare contract) from the date of the last entry, except that diagnostic and study models used for definitive treatment shall be maintained for at least three years from the date the model is made. Working models may be maintained.

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. To the extent that the record is illegible or prepared in a language other than English, the licensee shall provide a typed or written transcription and/or translation at no additional cost to the patient.

Services not recorded in the patient record in accordance with the requirements of this section shall be presumed not to have been performed. It shall be the responsibility of the licensee to produce evidence to establish that the non-recorded services were actually performed.

LIBERTY requires that Contracted dentists make available copies of all patient records to the Plan upon request. Records may be requested for grievance resolutions, second opinions or for state/federal compliance. 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.

DENTAL RECORDS AVAILABILITY

Member dental records must be kept and maintained in compliance with and as required by the NJ State Board of Dentistry (N.JA.C. 13.30-8.7). 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. To the extent that the record is illegible or prepared in a language other than English, the licensee shall provide a typed or written transcription and/or translation at no additional cost to the patient.

Upon receipt of a written request from a patient or the patient's authorized representative and within 14 days thereof, legible copies of the patient record including, if requested, duplicates of models and copies of radiographs, shall be furnished to the patient, the patient's authorized representative, or a dentist of the patient's choosing. "Authorized representative" means a person who has been designated by the patient or a court to exercise rights under this section. An authorized representative shall include the patient's attorney or an agent of an insurance carrier with whom the patient has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the patient is a minor, a parent or guardian who has custody (whether sole or joint) shall be deemed an authorized representative. Licensees shall not charge a patient for a copy of the patient's record when the licensee has affirmatively terminated a patient from the practice.

LIBERTY requires that Contracted dentists make available copies of all patient records to the Plan upon request. Records may be requested for grievance resolutions, second opinions or for state/federal compliance. 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.

MEDICAL REFERRALS

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

INFECTION CONTROL

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

REFERRAL AND PRIOR AUTHORIZATION GUIDELINES

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

PRIOR AUTHORIZATION GUIDELINES FOR GENERAL DENTISTS

When submitting a prior authorization, the PCD should submit all necessary information regarding the treatment, including pre-operative radiograph(s) and narratives to LIBERTY through its Provider Web Portal. A dental specialist submitting a prior authorization or receiving a referral which includes services requiring prior authorization is to submit all necessary information regarding the treatment, including pre-operative radiograph(s) and narratives along with a prior authorization request to the plan. If an emergency endodontic service is needed for pain relief, the General Dentist performing the root canal should contact **LIBERTY's Referral Unit** at **833-276-0854**, press option 2 for an emergency authorization number. This will provide conditional authorization. Any service added to an existing prior authorization by virtue of phoning the Referral Unit, will require pre-operative x-ray and narrative when you submit for payment. Any emergency endodontic service must qualify for authorization and will receive clinical review by a Dental Consultant at the time it is reviewed for payment. Upon receipt of a LIBERTY authorization, you may proceed with the services that were approved. After completion of treatment, submit your claim for payment with any post-operative radiographs, when appropriate and required. X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality or paper copies of digitized images are acceptable.

LIBERTY shall consider the overall general health, patient compliance and dental history, condition of the oral cavity and complete treatment plan when reviewing prior authorizations. Providers may submit several prior authorization requests, for each of the various stages of treatment for complex treatment plans.

Should a provider have a question regarding a denial of a prior authorization request, they may contact the Dental Consultant who rendered the decision. Their name and contact information is included on the EOB.

REFFERALS

The PCD may directly refer the member to a contracted specialist or LIBERTY will assign the referral to a contracted specialist within a reasonable distance to the member. A full listing of contracted specialists can be located at www.libertydentalplan/Amerigroup[URLTBD].If a member does not have access to a contracted specialist within a reasonable distance from their home or work, LIBERTY will make the necessary accommodations for covered dental services to be rendered by a non-contracted dentist within a reasonable distance to them at no additional cost other than any applicable copay (if any). In these instances, LIBERTY Member Services may coordinate with the member to identify a desired provider and will confirm that the out of network specialist is within an acceptable distance from their home or workplace. Additionally, they will ensure that member will not incur any costs for covered services.

Services That Require Prior Authorization:

- Orthodontics, periodontics, endodontics, occlusal guards, crowns, removable dentures, fixed bridge work, implants, oral surgery (except D7111 and D7140, general anesthesia, and hospital certification surgical cases.
- Approved Prior Authorizations are valid for 180 days.
- If the documentation provided supports the approval of a different service than the one submitted for approval, the clinical peer reviewer who evaluated the request for the submitted service(s) may approve a different service which is supported by the submitted documentation

NON-EMERGENCY SPECIALTY REFERRAL

General Dentists are encouraged to communicate the indication for a referral, along with any relevant medical information, in writing to the specialist to whom the member has been referred. It is not necessary to submit referral forms to LIBERT Dental Plan (LIBERTY) and LIBERTY does not accept any type of referral form for referrals to Non-Participating specialists.

If there is no contracted LIBERTY specialist available within a reasonable proximity to your office, Member Services will provide assistance to re-route the member to another provider for specialty services. The use of an out-of-network dentist must be pre-approved by LIBERTY. At times, LIBERTY Members Services may consult with the member's PCD to identify an OON specialist. The PCD should provide coordination

and monitoring as appropriate. LIBERTY will authorize the out-of-network referral and issue a pre-authorization for services only if the provider accepts reimbursement from LIBERTY as payment in full and if the requested treatment meets benefit guidelines. LIBERTY Member Services will educate the provider on claim submission protocols to ensure timely payment for services rendered.

A PCD may not be held financially responsible for referral to a non-participating specialist. Failure to use the proper forms and submit accurate information may cause delays in processing or payment of claims.

Referring dentists should assume that any X-rays and other supporting documentation given to the member to take to a referral or sent to a referral specialist will not be returned. It is highly recommended that the General Dentist not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitalized images, should be appropriate for this purpose.

Narrative statements as to the reasons for the specialty referral, and the exact services requested, whenever possible, may be of great assistance to the referral specialist. For out-of-network referral requests to LIBERTY, narrative of the reason that an out-of-network dentist is needed is required to process the out-of-network referral.

All final decisions regarding denials of referrals, prior authorizations, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a New Jersey licensed dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for non-emergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.

EMERGENCY REFERRAL

If emergency specialty care is needed, the Referral Unit can assist with locating a specialist. By calling **LIBERTY** at **833-276-0854**, press option 2.

If an emergency endodontic service is needed, the Specialist should contact **LIBERTY's Referral Unit** at **833-276-0854**, press option 2 for an emergency authorization number. This will provide tentative conditional authorization. Any service added to an existing prior authorization by virtue of phoning the Referral Unit, will require a pre-operative x-ray and narrative when you submit for payment. Any emergency service must qualify for authorization and will receive clinical review by a Dental Consultant at the time it is reviewed for payment.

Upon receipt of a LIBERTY authorization, you may proceed with all specialty services that were approved. After completion of treatment, submit your claim for payment with any post-operative radiographs, when

appropriate and required. **X-rays and other supporting documentation will not be returned. Please do not submit original x-rays. Diagnostic quality x-ray copies or paper copies of digitized images are acceptable.**

REFERRALS TO SPECIALISTS BY THE PRIMARY CARE DENTIST

General dentists may but are not obligated to provide a complete list of requested services or documentation to the specialist. A list of participating specialists can be located at www.libertydentalplan.com/AmerigroupNJ.

The referring dentist is not responsible to inform the member of non-covered services provided elsewhere. Unless the member is informed by LIBERTY or Amerigroup that a particular service to be provided in a referral is not covered, the member cannot be asked to reimburse the specialty provider.

1. Primary Care Dentists may refer directly to a specialist or submit a referral request to LIBERTY. There are three options to submit a specialty care referral to LIBERTY:
   Provider Portal: www.libertydentalplan.com

   Telephone: 833-276-0854, Press Option 2

   Mail:

   LIBERTY Dental Plan
   PO Box 15149
   Tampa, FL 33684-5149
   Attn: Referral Department

2. Complete a Specialty Care Referral Request Form and provide the:
   - Member name, Identification Number and Group Name and Group Numbers
   - Name, address and telephone number of the contracted LIBERTY Specialist (if known)
   - LIBERTY requests that you provide notification to the specialist as to what conditions you want evaluated and treated and any other recommended procedures involved, e.g., Procedure code(s), tooth number(s).
   - It is also recommended that you provide any narrative or available radiographic materials to assist the specialist.
3. If there is no contracted LIBERTY specialist available within a reasonable proximity to your office, the Referral Unit will provide assistance to refer the member to a non-contracted Specialist.

4. The Amerigroup member may not be held financially responsible in cases of a referral error, where the assigned Primary Care Dentist does not receive prior approval when referring to a non-contracted specialist. Failure to use the proper forms and submit accurate information may cause delays in processing or payment of claims.

5. The LIBERTY Specialty Care Referral Request Form or an Attending Dentist Statement prepared by the referring provider which may be in the form of a letter or as remarks included on an ADA form may be completed and used when making a referral. The LIBERTY form may be photocopied and duplicated in your office as needed.

6. X-Rays and other supporting documentation will not be returned. Please do not submit original x-rays. X-ray copies of diagnostic quality, including paper copies of digitalized images, are acceptable.

7. The NJFC Program has a Direct Referral provision which does not require the use of a specific form. You may refer to any participating Specialist for specialty services. You should provide notification to the specialist as to what conditions you want evaluated and treated and any other recommended procedures involved. You should provide any narrative or available radiographic materials to assist the specialist.

8. If you cannot locate a participating specialist, please contact Member Services for assistance, or submit a Specialty Care Referral to LIBERTY. In some cases, a member may be redirected to another Primary Care Dentist that may be able to provide the specialty services.

   (LIBERTY must ensure that its policies and procedures involving referrals are in compliance with 4.6.3: Referral Systems).

9. Inform the member that:

   - The Specialist will evaluate their necessary services and the services will be subject to prior authorization by LIBERTY unless emergency or urgent in nature.

10. Referral Guidelines for the Specialists:

    - Obtain the appropriate prior authorizations which may include the LIBERTY Specialty Care Authorization and appropriate radiograph(s) from LIBERTY Dental Plan, General Dentist or member directly.

    - For services requiring prior authorization, you must submit a preauthorization request to LIBERTY with a copy of any appropriate documentation, e.g., pre-operative periapical radiograph(s) or panoramic radiograph along with the member's Specialty Care Authorization.

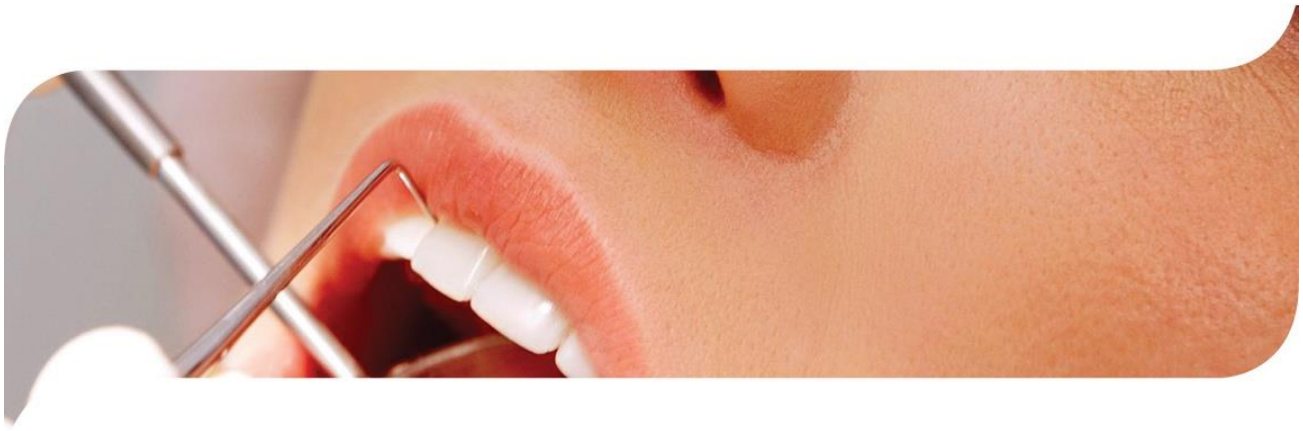
- After completion of treatment, submit your claim for payment along with the appropriate supporting documentation, e.g., for endodontic care, a copy of pre-operative and post-operative periapical radiographs, for oral surgery services, for biopsy, attach a copy of the laboratory's report, etc. To avoid delays in claim payment, please attach a copy of the member's Specialty Care Authorization if you received one, or the Plan's authorization form as appropriate.
- Reimbursement of specialty services is contingent upon the member's eligibility with Amerigroup at the time of service.

PRIOR AUTHORIZATION GUIDELINES FOR PROCEDURES WHICH MAY BE PROVIDED BY EITHER A DENTAL SPECIALIST OR A PHYSCIAN

Specialty care providers, i.e., physician specialists, maxillofacial or oral surgeons or prosthodontists, may provide covered services that are beyond the scope of a general dentist. The specialty care provider must obtain prior authorization from LIBERTY by submitting necessary x-rays and documentation by mail or electronically through the LIBERTY provider web portal.

LIBERTY has a second opinion program that requires prior authorization that can be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. Member may receive the second opinion within LIBERTY's network or the Plan may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into LIBERTY's dental procedures.

CLINICAL DENTISTRY PRACTICE PARAMETERS



The following clinical dentistry criteria, processing guidelines and practice parameters represent the view of the Peer Review Committee of LIBERTY Dental Plan and represent LIBERTY's processing guidelines, benefit determination guidelines and the generally acceptable clinical parameters as agreed upon by consensus of the Peer Review Committee to be professionally recognized best practices and to be in compliance with the NJFC Contract as well as the NJ State regulations which govern the practice of dentistry and the NJ FamilyCare (Medicaid) program, the NJMMIS website and associated DMAHS Newsletters and Alerts.

NEW PATIENT INFORMATION

A. A contemporaneous, permanent patient record shall be prepared and maintained by a dentist for each person seeking or receiving dental services, regardless of whether any treatment is actually rendered or whether any fee is charged. Dentists also shall maintain records relating to charges made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Such records shall include, at a minimum:

   1. The name, address, and date of birth of the patient and, if a minor, the name of the parent or guardian;
   2. The patient's medical history;
   3. A record of results of a clinical examination where appropriate or an indication of the patient's chief complaint;
   4. A diagnosis and a treatment plan, which shall also include the material treatment risks and clinically acceptable alternatives, and costs relative to the treatment that is recommended and/or rendered;

5. The dates of each patient visit and an accurate description of all treatment or services rendered and the materials used at each visit;

6. Radiographs, if any, of a diagnostic quality and a description of all diagnostic models made, identified with the patient's name and the date. If the radiographs are sent out of the dental office, the dentist shall retain the originals or a diagnostic copy of the radiographs in the patient record;

7. The date and a description of any medications prescribed, dispensed or sold including the dosage or a copy of any written prescriptions;

8. Copies of any prescriptions to laboratories for dental prostheses;

9. Complete financial data concerning the patient's account, including each amount billed to or received from the patient or third-party payor and the date of each such bill and payment;

10. Copies of all claim forms submitted to third party payors by a licensee or the licensee's agent or employee;

11. Payment vouchers received from third party payors;

12. A record of any recommendations or referrals for treatment or consultation by a specialist, including those which were refused by the patient;

13. The name of the dentist of record consistent with the requirements of N.J.A.C. 13:30-8.15; and

14. If written notations appear in the patient record, the notations shall be legible, written in ink and contain no erasures or white-outs. If incorrect information is placed in the record, it shall be crossed out with a single non-deleting line and shall be initialed and dated by the licensee on the date the change was made. If additions are made to the record, the additions shall be initialed and dated by the licensee on the date the change was made.

B. Each dentist or dental auxiliary shall sign or initial each entry on the patient record pertaining to the treatment he or she rendered. If no such signature or initialing appears on the patient record, it shall be presumed that such treatment was rendered by the dentist of record, unless the latter shall establish, to the satisfaction of the Board, the identity of the individual who rendered such treatment.

C. A patient record may be prepared and maintained on a personal or other computer provided that the licensee complies with all of the following requirements:

1. The licensee shall use a computer system which contains an internal, permanently activated date recordation for all entries;

2. The computer system shall have the capability to print on demand a hard copy of all current and historical data contained in each patient record file;

3. The licensee shall identify each patient record by the patient's name and at least one other form of identification so that the record may be readily accessed;

4. The licensee shall post record entries at least once a month so that the entries are permanent and cannot be deleted or altered in any way. The licensee may subsequently make a new entry to indicate a correction to a permanent entry, provided that the new entry generates a permanent audit trail which is maintained in the patient record. The audit trail shall show the original entry, the revised entry, the date of the revised entry, the reason for the change and the identity of the person who authorized the change;

5. The licensee shall prepare a back-up of all computerized patient records at least quarterly, except that if a licensee changes computer systems or software programs, the licensee shall prepare a back-up as of the last date when the system to be replaced shall be used.

    i. For purposes of this section, "back-up" shall include data files and the software programs required to retrieve those files including the operating system and the program file.

    ii. The back-ups shall be clearly dated and marked with an external label as "Backup of computerized data as of (date)."

    iii. The licensee shall maintain and store at least the last three quarterly back-ups onsite.

    iv. The licensee shall maintain and store the fourth quarter (annual) back-up offsite; and

6. The licensee shall provide to the Board upon request any back-up data maintained off premises, together with the following information:

    i. The name of the computer operating system containing the patient record files and instructions on using such system;

    ii. Current passwords;

    iii. Previous passwords if required to access the system; and

    iv. The name of a contact person at the practice management company, if any, that provides technical support for the licensee's computer system.

D. Patient records, including all radiographs, shall be maintained for at least seven years from the date of the last entry, except that diagnostic and study models used for definitive treatment shall be maintained for at least three years from the date the model is made. Working models may be maintained.

E. Licensees shall provide patient records to the patient or the patient's authorized representative or another dentist of the patient's choosing in accordance with the following:

1. Upon receipt of a written request from a patient or the patient's authorized representative and within 14 days thereof, legible copies of the patient record including, if requested, duplicates of models and copies of radiographs, shall be furnished to the patient, the patient's authorized representative, or a dentist of the patient's choosing. "Authorized representative" means a person who has been designated by the patient or a court to exercise rights under this section. An authorized representative shall include the patient's attorney or an agent of an insurance carrier with whom the patient has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the patient is a minor, a parent or guardian who has custody (whether sole or joint) shall be deemed an authorized representative.

2. A licensee may require any unpaid balance for diagnostic services only to be paid prior to release of such records. Where treatment of a patient whose dental expenses are paid through Medicaid is discontinued by the dentist prior to completion of the treatment, no charge for the records shall be made, nor shall any payment be required.

3. The licensee may charge a reasonable fee for:

    i. The reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.); and/or

    ii. The reproduction of radiographs or any other material within a patient record, which cannot be routinely copied or duplicated on a commercial duplicating machine. The fee for duplication for a set of up to nine radiographs shall not exceed $15.00. The fee for duplication for a set of up to 18 radiographs shall not exceed $30.00. The fee for duplication of a panorex shall not exceed $30.00.

4. Licensees shall not charge a patient for a copy of the patient's record when the licensee has affirmatively terminated a patient from the practice.

5. To the extent that the record is illegible or prepared in a language other than English, the licensee shall provide a typed or written transcription and/or translation at no additional cost to the patient.

F. Licensees shall maintain the confidentiality of patient records, except that:

1. The licensee shall release patient records as directed by the Board of Dentistry or the Office of the Attorney General, or by a Demand for Statement in Writing under Oath, pursuant to N.J.S.A. 45:1-18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full patient names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed or written transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All radiographs, models, and reports maintained by the licensee, including those prepared by other dentists, shall also be provided. The costs of producing such records shall be borne by the licensee.

2. The licensee, in the exercise of professional judgment and in the best interests of the patient (even absent the patient's request), may release pertinent information about the patient's treatment to another licensed health care professional who is providing or who has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.

3. The licensee shall release information as required by statute or rule, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, or when the patient's treatment is the subject of peer review.

G. If a licensee ceases to engage in the practice of dentistry or it is anticipated that he or she will remain out of practice for more than six months, the licensee or a designee shall:

1. Establish a procedure by which patients may obtain treatment records or agree to the transfer of those records to another licensee who is assuming the responsibilities of that practice;

2. If the practice will not be attended by another licensee, publish a notice of the cessation and the established procedure for the retrieval of records in a newspaper of general circulation in the geographic location of the licensee's practice, at least once each month for the first three months after the cessation;

3. File a notice of the established procedure for the retrieval of records with the Board of Dentistry;

4. Make reasonable efforts to directly notify any patient treated during the six months preceding the cessation of the practice to provide information concerning the established procedure for retrieval of records; and

5. Conspicuously post a notice on the premises of the procedure for the retrieval of records.

H. Patient records need not be maintained in situations where no patient-dentist relationship exists, such as where the professional services of a dentist are rendered at the behest of a third party for the purposes of examination and evaluation only, at the behest of the Board or for dental screenings.

I. Services not recorded in the patient record in accordance with the requirements of this section shall be presumed not to have been performed. It shall be the responsibility of the licensee to produce evidence to establish that the non-recorded services were actually performed.

CLINICAL ORAL EVALUATIONS

A. Periodic oral evaluations (Code D0120) of an established patient may only be provided for a patient of record who has had a prior comprehensive examination. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the patient's history and risk factors, and should be done at least annually.

B. A problem-focused limited examination (Code D0140) must document the issue substantiating the medical necessity of the examination and treatment. (MM014)

C. An oral evaluation of every patient should include documentation of the oral and physical health history, evaluation of caries susceptibility and development of an oral health regimen.

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

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

2. Assessment of TMJ status and classification of occlusion should be documented.

3. Full mouth periodontal screening must be documented for all patients; for child patients with an indication of periodontal disease and all adult patients, probing and diagnosis must be

documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.

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

E. A post-operative office visit for re-evaluation should document the patient's response to the prior treatment. (MM014)

F. A comprehensive periodontal evaluation (D0180) is for patients showing signs or symptoms of periodontal disease or significant risk factors such as diabetes or smoking. It includes evaluations of periodontal conditions, probing and charting, evaluation of the dental and medical history and general health assessment and a periodontal treatment plan.

INFORMED CONSENT

A. The dentist should have the member sign appropriate informed consent documents and financial agreements.

B. Following an appropriate informed consent process, if a patient elects to proceed with a procedure that is not covered, and has been denied as such by LIBERTY, the member is responsible for the dentist's usual fee.

DIAGNOSTIC IMAGING

Based on the dentist's determination that there is generalized oral disease or a history of extensive dental treatment, an adequate number of images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines to minimize the patient's exposure. Photographic images may also be needed to evaluate and/or document the existence of pathology in instances where the patient cannot tolerate radiographs, when radiographs do not adequately document pathology or when indicated for orthodontic treatment.

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

B. An adequate number of initial radiographic images should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines. This includes the ALARA Principle (As Low As Reasonably Achievable) to minimize the patient's exposure. It is important to limit the number of radiographic images obtained to the minimum necessary to obtain essential diagnostic information. (MM020)

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

D. Intraoral – complete series (including bitewings) (Code D0210)

Note: D0210 is a radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

1. Any benefits for periapical and/or bitewing radiographs taken on the same date of service will be limited to a maximum reimbursement of the provider's fee for a complete series.

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

3. 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 patient's last radiographic examination.

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

F. Radiographs should exhibit good contrast.

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

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

I. Intra or extra-oral photographic images should only be taken to diagnose a condition or demonstrate a need for treatment that is not adequately visualized radiographically. (MM0350)

J. Any patient refusal of radiographs should be documented.

K. Radiograph duplication fees:

1. Radiographic image duplication fees are not allowed.

2. When a patient is transferred from one contracted provider to another, diagnostic copies of all radiographic images less than two years old should be duplicated for the second provider.

L. Diagnostic casts (Code D0470) are only considered medically necessary as an aid for treatment planning specific oral conditions. (MM047)

TESTS, EXAMINATIONS AND REPORTS

A. Tests, examinations and reports may be required when medically necessary to determine a diagnosis or treatment plan for an existing or suspected oral condition or pathology. (MM041, MM047)

B. Oral pathology laboratory procedure/report may be required when there is evidence of a possible oral pathology problem. (MM0472).

PREVENTIVE TREATMENT

A. Dental prophylaxis (Code D1110 and D1120) is covered twice in a twelve-month period for all members, and as often as once every three months for members with special needs and documentation of medical necessity.

B. Topical fluoride (Code D1208) treatment is covered twice in a twelve-month period for all members, and as often as once every three months for members with special needs and documentation of medical necessity.

C. Preventive resin restoration (Code D1352) may be medically necessary to prevent decay in a pit or fissure or as a conservative restoration in a cavitated lesion that has not extended into dentin on a permanent tooth in a moderate to high caries risk patient. (MM135)

D. A space maintainer may be medically necessary to prevent tooth movement and/or facilitate the future eruption of a permanent tooth. (MM150)

E. Interim caries arresting medicament application (Code D1354) Silver Diamine Fluoride (SDF) is an interim caries arresting liquid medicament clinically applied to control and prevent the further progression of active dental caries. Treatment with Silver Diamine Fluoride will not eliminate the need for restorative dentistry to repair function or aesthetics, but this alternative treatment allows oral health care professionals to temporarily arrest caries with noninvasive methods, particularly with young children that have primary teeth or members with special health care needs. This should be submitted on a per tooth basis.

RESTORATIVE TREATMENT

A. 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. (MMPROG_) (MMPROGR)

Amalgam Restorations (Codes D2140-D2161)

1. 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 the past several decades, including two large clinical trials published in the April 2006 Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 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 patients…"

2. On July 28, 2009, the American Dental Association (ADA) agreed with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material:

    a. 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.

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

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

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

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

    f. An amalgam restoration may be medically necessary when a tooth has a fracture, defective filling or decay penetrating into the dentin. (MM214)

g. An amalgam restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident. (MM241)

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

1. 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 still be a candidate for a filling restoration if little to no other surfaces manifest caries or breakdown.

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

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

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

5. A resin-based composite restoration may be medically necessary when a tooth has a fracture, defective filling, recurrent decay or decay penetrating into the dentin. (MM230) (MM231)

6. A composite restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident. (MM232)

7. If LIBERTY determines that there is a more appropriate procedure code to describe the restoration provided, either number of surfaces, or material used, an alternate procedure code may be approved. (MM230M) (MM232M) (MM240M) (MM241M)

C. Restorations for primary teeth are covered only if the tooth is expected to be present for at least six months. (MM290)

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

E. An inlay is an intracoronal restoration and has similar indications as a filling. Inlays are restricted to dental school and dental residency programs. (MM2410)

F. A metallic onlay may be considered when there is sufficient tooth structure, but additional cusp support is needed.

G. Crowns/Onlays - Single Restorations Only (Codes D2510 – D2794)

1. Administrative Issues

a. Providers may document the date of service for these procedures to be the date when crowns inserted or for prorated services, when final impressions are completed (subject to review).

b. Providers must make every attempt to complete any irreversible procedure started regardless of payment or coverage and only bill for indirect restorations when the service is completed (permanently cemented) or subject to prorate.

c. Crown services must be documented using valid procedure codes in the American Dental Association's Current Dental Terminology (CDT).

2. A crown or onlay may be medically necessary when the tooth is present and:

a. The tooth has evidence of decay undermining more than 50% of the tooth (making the tooth weak), when a significant fracture is identified, or when a significant portion of the tooth has broken or is missing due to severe attrition, abrasion and/or erosion and has good endodontic, periodontal and/or restorative prognoses (MM272) (MM273) (MM237R) (MM274) (MM274E) (MM275) (MM275P).

b. There is a significantly defective crown or onlay (defective margins or marginal decay) or there is recurrent decay. (MM270)

c. The tooth is in functional occlusion or will serve as an abutment for a fixed or removable partial denture. (MM271)

d. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off. The treatment of choice may be a porcelain fused to base metal crown or a porcelain/ceramic substrate crown. (MM296)

e. The tooth has a good endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50%

3. Enamel "craze" lines or "imminent" or "possible" fractures: Anterior or posterior teeth that show a discolored line in the enamel indicating a non-decayed defect in the surface enamel and are not a through-and through fracture should be monitored for future changes. Crowns may be a

benefit only when there is evidence of true decay undermining more than 50% of the remaining enamel surface, or when there is a through-and-through fracture identified radiographically or photographically, or when a portion of the tooth has actually fractured off and is missing. Otherwise, there is no benefit provided for crown coverage of a tooth due to a "suspected future or possible" fracture. (MM272)

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

5. Types of Crowns

    a. Stainless steel crowns are primarily used on deciduous teeth and only used on adult teeth due to a patient's disability/inability to withstand typical crown preparation.

6. Core Buildup, including any pins when required (Code D2950), must show evidence that the tooth requires additional structure to support and retain a crown. (MM291)

    a. Core buildup refers to building up of coronal structure when there is insufficient retention for an extra-coronal restorative procedure.

    b. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.

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

    a. The tooth is functional, has had root canal treatment and the tooth requires additional structure to support and retain a crown. (MM295) (MM299)

    b. Post and core in addition to crown (Code D2952), is an indirectly fabricated post and core custom fabricated as a single unit separate from the crown.

    c. Prefabricated post and core in addition to crown (Code D2954) is built around a prefabricated post. This procedure includes the core material.

8. Pin retention (Code D2951) or restorative foundation may be medically necessary when a tooth requires an additional retention for a restoration. (MM2951)

9. A coping (Code D2975) or crown under a partial denture (Code D2971) may be required when submitted documentation demonstrates the medical necessity of the procedure. (MM297)

10. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure. (MM298)

11. Outcomes: Guidelines for the Assessment of Clinical Quality and Professional Performance, published by The California Dental Association, and standards set by the specialty boards shall apply. (MMPROGR)

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

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

ENDODONTICS

A. Assessment

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

    a. Pain and the stimuli that produce or relieve it by the following tests:

        i. Thermal

        ii. Electric

        iii. Percussion

        iv. Palpation

        v. Mobility

    b. Non-symptomatic radiographic lesions

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

1. Strategic importance of the tooth or teeth

2. Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered (MMPROG_)

    a. Excessively curved or calcified canals

b. Presence and severity of periodontal disease

c. Restorability and tooth fractures

3. Occlusion

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

C. Clinical Guidelines

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

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

3. Gutta percha is the endodontic filling material of choice and should be densely packed and sealed. All canals should be completely obturated.

4. Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.

5. In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals.

6. For a pulpotomy (Code D3220) or pulpal therapy (Code D3221), documentation is required that shows pulpal pathology and a good prognosis that the tooth has a reasonable period of retention and function or was provided as an emergency measure when extraction was not possible. (MM320) (MM232)

7. For endodontic treatment (Codes D3310 – D3330), documentation is required that shows the treatment is medically necessary (i.e., tooth is broken, decayed or previously restored, functional with an unhealthy nerve and more than 50% of the tooth structure is sound) and the tooth has a good endodontic, periodontal and/or restorative prognosis. (MM330) (MM300) (MM331E) (MM331P) (MM331R)

Note: LIBERTY may determine that a different, more appropriate procedure code better describes the endodontic treatment performed and may make our determination based on the alternate code (MM330M)

8. For incomplete endodontic treatment (Code D3332), documentation is required that shows endodontic treatment has been started and that a subsequent determination has been made that it cannot be successfully completed. (MM332)

9. Treatment of a root canal obstruction (Code D3331) may be needed when radiographic evidence shows a canal that is at least 50% closed or blocked. (MM321)

10. For internal root repair (Code D3333), documentation is required that shows the need to repair a non-iatrogenic perforation. (MM3333)

11. For endodontic retreatment (Codes D3346 – D3348), documentation is required that shows a tooth with previous endodontic treatment that is symptomatic or shows evidence of periapical pathology. (MM334)

12. For apexification/recalcification (Code D3351), documentation is required that shows the apex of the tooth root(s) is/are incompletely developed. (MM335)

13. For treatment of root canal obstruction (Code D3331), documentation is required that shows a non-negotiable root canal blocked by foreign bodies, including but not limited to separated instruments, broken posts or calcification of 50% or more of the root. (MM338)

    a. It is not generally known that a canal obstruction is present until the time of the root canal treatment. Therefore, LIBERTY will not approve a benefit for this procedure when submitted as part of a predetermination request, and/or prior to actual treatment.

    b. LIBERTY acknowledges that the treatment of a root canal obstruction (Code D3331) is a separate, accepted procedure code. This procedure should not be submitted in conjunction with endodontic retreatment procedures Codes D3346, D3347 or D3348, as treatment of a root canal obstruction is considered to be included in endodontic retreatment. (MM339)

14. For apical surgery (Codes D3410 – D3426), documentation is required that shows apical or lateral pathosis that cannot be treated non-surgically and that the tooth has a good periodontal (MM340P) and restorative (MM340R) prognosis. (MM340) Endodontic apical surgical treatment should be considered only in specific circumstances, including:

    a. The root canal system cannot be instrumented and treated non-surgically.

    b. There is active root resorption.

    c. Access to the canal is obstructed.

d. There is gross over-extension of the root canal filling.

e. Periapical or lateral pathosis persists and cannot be treated non-surgically.

f. Root fracture is present or strongly suspected.

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

Note: LIBERTY may determine that the apical surgery requested could have a better/equivalent outcome with a different endodontic procedure code (MM340M)

15. For a periradicular bone graft (Code D3428), documentation is required that shows the disease process has resulted in a deformity and loss of bone. (MM342)

16. For a retrograde filling (Code D3430), documentation is required that shows evidence of medical necessity for a retrograde filling during periradicular surgery. (MM3430)

17. For a surgical or endodontic implant procedure, documentation is required that shows evidence of medical necessity for the procedure. (MM345)

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 patient's periodontal status as being "within normal limits" (WNL).

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 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 and may be provided on the same date of service.

Note, this procedure:

- is not a replacement code for procedure D1110

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. These procedures are:
- Considered to be within the scope of a PCD 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 covered once per quadrant every 3 years or at shorter intervals with documentation of medical necessity.

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 patient may not need to be referred to a periodontist based upon tissue response and the patient's oral hygiene.
- For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the patient may need to be referred to a periodontist, again based on tissue response and the patient's oral hygiene.

Two quadrants per appointment, unless otherwise indicated by medical necessity.

Clinical / Coverage Guideline:

[PR3]: If a clinician recommends and/or completes more than two quadrants per appointment, documentation supporting the additional quadrant(s) must be included in the patient'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 this 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 least 4-6 weeks later and include: a description of tissue response; pocket depths changes; sites with bleeding or exudate; evaluation of the patient'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 rationale for any such situations on a case-by-case basis.
  - Periodontal maintenance D4910 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.
    - The patient's homecare compliance and instructions should be documented.

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:

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 patient's clinical response confirms that D4381 failed to control periodontitis (i.e. a reduction of localized pocket depths)
- Anatomical defects are present (e.g., infrabony defects)
- Periodontal Surgical Procedures (D4240/41, D4260/61 and related surgical procedures)

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

- The patient 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, including patient motivation to comply with treatment and oral hygiene status, should be documented (history, narrative and/or progress notes may help to indicate this).

- Patient motivation should be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient 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 for complex treatment planning purposes. However, the performance of SRP, OHI and other pre- and non-surgical procedures should be performed by the PCD (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 for the forces to which they are, or will be, subjected.

- Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm's or deeper, following soft tissue responses to scaling and root planing. Consideration should be given for long-standing pockets of 5 mm following previous surgical intervention, which may or may not require further surgical intervention.

- Gingival hypoplasia due to prescribed medications can be documented.

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)

- patients are users of tobacco products or diabetics whose disease is not being adequately managed

- 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.
    - D4249 clinical crown lengthening – hard tissue

Note: "This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity. 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]: It would not be considered good clinical practice to perform 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. 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.

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 patient 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 patients.

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 patient's treatment record (by report, by LIBERTY record, or by narrative).

REMOVABLE PROSTHETICS

Note: Providers must document the date of service for these procedures to be the date when prosthetic appliances are completed unless services need to be prorated.

Removable prosthodontic services shall be provided as follows:

1. Dentures, both partial and complete, may be prior authorized when submitted evidence indicates masticatory deficiencies likely to impair the general health of the beneficiary. Prefabricated dentures or dentures that are temporary in nature shall not be reimbursable. When submitting a Dental Claim Form for reimbursement of approved complete or partial dentures, the date of service used shall be the date of insertion of the denture(s) unless services are to be prorated.
2. The following factors should also be considered when requesting prior authorization for dentures (including immediate dentures);
    i. Age, school status, employment status and rehabilitative potential of the beneficiary (for example, provision of dentures will enhance vocational placement);
    ii. Medical status of beneficiary (nature and severity of disease or impairment) and psychological predisposition;
    iii. Condition of the oral cavity, including abnormal soft tissue or osseous conditions;
    iv. Condition of present dentures, if applicable.
3. Generally, prior authorization for partial dentures to replace posterior teeth will not be granted if there are at least eight posterior teeth which in the opinion of a dental consultant are in reasonably good periodontal condition, occlusion and position, or where a prosthesis in one arch will produce equivalent dentition. A partial denture may also be considered when there is at least one missing anterior tooth in the arch.
4. With the exception of immediate complete dentures, there shall be a three month wait for healing between the date of the last extraction and the initiation of the denture(s), partial or complete.
    i. Should the provider initiate the denture treatment (that is, take final impressions) prior to the expiration of the three-month healing period, the dentist shall be responsible for all subsequent relines, rebases and/or remaking of the denture(s) if necessary for a six-month period following insertion.
    ii. When all services are to be performed by the same practitioner, the total treatment plan for the extractions, denture(s) and any other dental services shall be submitted and will be reviewed for prior authorization in toto. As soon as the extractions are completed, the claim should be submitted for payment for the diagnostic and/or surgical services. After the required period of time for healing

has taken place and the denture provided, a second claim should be completed (for the dentures only) and submitted to the fiscal agent marked "continuation of previously authorized treatment plan."

5. The fee for a partial denture shall include payment for all necessary clasps and rests. A minimum of two clasps and rests shall be provided.
6. The fee for complete maxillary and/or mandibular dentures shall include necessary adjustments for a six-month period following insertion.
    i. The fee for immediate dentures shall include the necessary adjustments and relines for a six-month period following insertion.
7. Partial dentures shall be described, indicating material used, position of clasps and teeth to be replaced. Fee includes necessary adjustments for a six-month period following insertion.
8. Payment for dentures will be denied or recovered unless all dental procedures are completed in both arches before impressions are taken.
9. Dentures shall not be prior authorized when:
    i. Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remedial because of physiological or psychological reasons; or
    ii. Dental history reveals that a denture was provided through any New Jersey State, county, or municipal agency in the seven and one-half year period prior to the date of the current request; or
    iii. Repair, relining, or rebasing (jumping) of the beneficiary's present denture will make it serviceable.
10. Reimbursement for repairs to complete or partial dentures shall include adjustments for three months. Prior authorization shall be required when the repair exceeds $ 165.00 for a specialist or $ 150.00 for a non-specialist.
11. Denture relining, rebasing (jumping) or repairing services, except as noted in this section, are reimbursable.
    i. Rebasing is the process of refitting a denture by the complete replacement of the denture base material without changing the occlusal relationship of the teeth.
    ii. Relining is the process of resurfacing the tissue side of a denture with new base material to make it fit more accurately.

iii. The fee for relining and rebasing shall include all necessary adjustments for a six-month period following insertion.

iv. Adjustments prior to and in conjunction with denture relining, rebasing (jumping) and repair shall not be reimbursable. Adjustments, repairs, relining, and rebasing shall not be reimbursable when new or replacement dentures have been prior authorized.

v. Rebases and relines shall not be reimbursable within 12 months of initial insertion of a denture without prior authorization and shall thereafter be limited to once every 12 months without prior authorization.

vi. The beneficiary's name (first and last names or, where space is a limiting factor, first initial and last name) must be processed into all dentures during the original fabrication or where possible during any subsequent processing, such as repair, relining and rebasing. The social security number shall also be included if space permits. This requirement is consistent with the "Denture I.D. Law" (N.J.S.A. 45:6-19.1 et seq.) and N.J.A.C. 13:30-8.11.

12. A maxillofacial prosthetics procedure (Code D5911-D5999 – See Benefit Schedule) may be required when documentation shows medical necessity for functional and/or esthetic augmentation of the mouth or face. This procedure would generally be covered under Amerigroup's medical benefits.

IMPLANTS

Implant services shall be provided as follows:

1. Implants will not normally be considered for reimbursement. Prior authorization for implants will be limited to requests that demonstrate that a beneficiary has a facial anomaly, deformity or has been unable to function with a complete denture for at least two years and other oral surgical corrections have been unsuccessful in improving the retention of the denture.
2. If extenuating circumstances exist, a prior authorization request shall be submitted to a dental consultant with all supporting documentation and a complete restorative treatment plan, including denture services.
3.

FIXED PROSTHODONTICS

Fixed prosthodontic services shall be provided as follows:

1. Fixed bridges will not normally be reimbursed. If extenuating circumstances exist, any request must be submitted accompanied by recent diagnostic full mouth radiographs and written documentation of the circumstances.
2. In extenuating circumstances, if a patient is mentally or physically compromised to the extent that a removable prosthesis cannot be tolerated, a request accompanied by documentation from the physician should be submitted.
3. Replacement of an existing defective fixed bridge will only be considered for reimbursement if there are no other missing teeth in that arch, there is no radiographic evidence of a periodontal pathology present on recent radiographs and the abutment teeth have a favorable long-term prognosis.
4. If there are fewer than eight posterior teeth in reasonably good occlusion and periodontal condition, a partial denture will be recommended by the Division dental consultant.

ORAL SURGERY

A. Extractions (Codes D7111 – D7251)

1. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.
2. For extraction of a deciduous tooth (Codes D7111 and D7140) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon (MM710) or a patient complaint of acute pain.
3. 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, providing compelling justification to eliminate existing or potential sources of oral infection. (MM721)

    a. Extractions of erupted teeth

        i. An uncomplicated extraction (Code D7140) of an erupted or exposed root includes removal of all tooth structure, minor smoothing of socket bone and closure, as necessary. Extraction of an erupted tooth may be needed when the tooth has significant decay, is

causing irreversible pain and/or infection, or is impeding the eruption of another tooth. (MM700)

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

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

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

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

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

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

c. Removal of residual tooth roots (Code D7250) requires cutting of soft tissue and bone and includes closure.

d. Coronectomy (Code D7251) is an intentional partial removal of an impacted tooth when a neurovascular complication is likely if the entire impacted tooth is removed.

e. The prophylactic removal of an impacted or unerupted tooth or teeth that appear(s) to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered. (MM722) During our clinical review of requests for extraction of impacted and/or erupted teeth, LIBERTY may determine that treatment better fits the description of a different, more appropriate procedure code. In that situation, LIBERTY may approve the extraction under a different code. (MM722M)

i. The removal of asymptomatic, unerupted, third molars in the absence of active pathology may not be covered.

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

iii. Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic or photographic presentation will be the determining factor in the determination of coverage.

B. Other Surgical Procedures

1. Removal of residual tooth roots (Code D7250) may be needed when the residual tooth root is pathological or is interfering with another procedure. (MM725)

2. Sinus perforation or oroantral fistula closure (Code D7260) requires documentation that there is a pathological opening into the sinus. (MM726)

3. Tooth re-implantation and/or stabilization of an accidentally evulsed or displaced tooth (Code D7270) requires documentation that a tooth or teeth have been accidentally evulsed or displaced. (MM727)

4. A biopsy of oral tissue (Codes D7285 and D7286) requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the harvesting of oral tissue. (MM728)

5. A surgical procedure to facilitate tooth movement (Codes D7292 – D7295) requires documentation that demonstrates the medical necessity of a surgical procedure to facilitate appropriate tooth positioning. (MM729)

C. Alveoloplasty-Preparation of Ridge (Codes D7310 – D7321) requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus. (MM731)

D. Vestibuloplasty (Codes D7340 and D7350) (a surgical procedure to increase relative alveolar ridge height) requires documentation that demonstrates the medical necessity of enhancing the alveolar ridge to facilitate successful prosthetic restoration. (MM734)

E. Excision of soft tissue or intra-osseous lesions (Codes D7410 – D7461) requires documentation of the presence of an intra-oral lesion and the medical necessity to remove it. (MM741)

F. Excision of bone tissue (Codes D7471 – D7473) (an exostosis) requires documentation that a bony growth interferes with the ability to function or wear a prosthesis. (MM747)

G. Reduction of an osseous tuberosity (Code D7485) requires documentation that shows a large tuberosity that interferes with the ability to wear a prosthesis. (MM7485)

H. Incision and drainage of an abscess (Codes D7510 - D7521) requires documentation that shows an oral infection that requires drainage. (MM751)

I. Removal of a foreign body (Code D7530), non-vital bone or a tooth fragment requires documentation that it is medically necessary to remove it. (MM753)

J. Open/closed reduction of a fracture (Codes D7610 – D7640) requires documentation that demonstrates evidence of a broken jaw. (MM760)

K. Reduction of dislocation (Codes D7810 and D7820) and management of other temporomandibular joint dysfunctions require documentation showing a dislocation or other pathological condition of the temporomandibular joint. (MM781)

L. Repair of traumatic wounds (Code D7910) and other repair procedures requires documentation showing that it is medically necessary to suture a traumatic wound and/or other repair procedures. (MM791)

M. A bone replacement graft (Code D7950) requires documentation that demonstrates the need for ridge preservation for planned implants or prosthetic reconstruction. (MM795)

N. A frenulectomy (Code D7960) requires documentation that demonstrates evidence that a muscle attachment is interfering with proper oral development or treatment. (MM796)

O. Excision of hyperplastic tissue (Code D7970) or reduction of a fibrous tuberosity (Code D7972) requires documentation that demonstrates the medical necessity of removing redundant soft tissue to facilitate a removable prosthesis. (MM797)

P. Excision of pericoronal gingiva (Code D7971) requires documentation that demonstrates the medical necessity of removing inflammatory or hypertrophied tissues surrounding partially erupted or impacted teeth. (MM7971)

ORTHODONTICS

The following standards and procedures apply to the provision of orthodontic services for children in the Medicaid/NJ FamilyCare (NJFC) programs.

Orthodontic Consultation - A visual examination and completion of the HLD (NJ-Mod2) assessment tool by the attending provider or a provider in the same group who will be providing the service will be considered a consultation (D9310) and does not require prior authorization. The consultation can be provided once a year and will be linked to the provider and not to the patient which allows for a second opinion with a different provider.

Pre-orthodontic Treatment Visit D8660 (for diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod2) assessment tool) is required for consideration of interceptive and comprehensive orthodontic treatment. It is provided by the attending provider or a provider in the same group who will be providing the service and includes the visual examination and completion of the HLD (NJ-Mod2) assessment tool.

For comprehensive orthodontic treatment, if the total score on the HLD (NJ-Mod2) Assessment Tool is equal to or greater than 26 the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod2) assessment tool requires that documentation of the extenuating functional difficulties and/or medical anomaly is included in the submission.

• The pre-orthodontic treatment visit does not require prior authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;

• This service can be provided once a year and will be linked to the provider and not to the patient;

• The pre-orthodontic treatment visit includes the consultation; therefore, consultation will not be reimbursed separately.

The new HLD (NJ-Mod2) Index and instructions are attached.

Orthodontic Treatment Services

Limited, Interceptive and Comprehensive orthodontic services **must be prior authorized**. Limited and Interceptive orthodontic services will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition. Comprehensive orthodontic services will be considered for treatment of the permanent dentition.

Prior authorization determinations shall be made, and notice provided to the provider within ten (10) days of receipt of all necessary information.

In cases where prior authorization is denied, the denial documentation must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. Additionally, denial documentation must include the name and contact information of the dental consultant that reviewed and denied the treatment request which will allow the provider an opportunity to discuss the case.

An approved case must be started within six (6) months of receiving the approval.

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for minor treatment to control harmful habits in the primary dentition or mixed dentition and for correction of anterior crossbite in the permanent dentition that demonstrates severe conditions as noted under 4.2.11A.

For prior authorization the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time;
- Diagnostic photographs;
- Diagnostic X-rays or digital films of the entire dentition;
- Diagnostic study models or diagnostic digital study cast images with measuring tool in place to demonstrate measurement as noted on assessment tool; and,
- The referring dentist must provide on letterhead attestation that all needed preventive and dental treatment services have been completed. A copy must be submitted with the orthodontic treatment request.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits. As a result, the case shall be completed even if eligibility is terminated. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered once for each arch without additional cost to the patient.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan for the permanent dentition, it will be considered as part of the comprehensive case and not approved or reimbursed separately. In this case the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Interceptive and Comprehensive Orthodontic Treatment

For prior authorization requests the following shall be submitted:

- The completed HLD (NJ-Mod2) assessment tool;
- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- The comprehensive orthodontic treatment plan and estimated treatment time;

- Attestation from the referring dentist that all needed preventive and dental treatment services have been completed;
- Diagnostic study models or diagnostic digital study models with measuring tool in place to demonstrate measurement as noted on HLD (NJ-Mod2) assessment tool;
- Diagnostic photographs;
- Diagnostic x-rays, digital x-rays or cephlometric film with tracing (when applicable); and,
- When applicable: Medical diagnosis and surgical treatment plan

o Detailed documentation from **a mental health professional** as described in the managed care contract indicating the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition establishing medical necessity.

Interceptive Orthodontics

Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, all adjustments, repairs, removal, retention and treatment visits and initial retainers. As a result, the case shall be completed even if eligibility is terminated. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered once for each arch without additional cost to the patient.

If it is determined that interceptive orthodontic treatment is part of a comprehensive treatment plan, it will be considered as part of the comprehensive case and not approved or reimbursed separately. In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the interceptive treatment phase.

Upon completion of the case, pre-treatment and post-treatment diagnostic photographs must be submitted.

Comprehensive Orthodontics

Eligibility should be checked prior to each visit.

The comprehensive case will include all appliances, insertion, all adjustments, repairs and removal as well as the retention phase of treatment. Initial retainer(s) are included with the service; however, replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered once for each arch without additional cost to the patient.

Reimbursement for orthodontic services includes the placement and removal of all appliances and brackets; therefore, should it become necessary to remove the bands due to loss of eligibility, non-compliance or elective discontinuation of treatment by the parent, guardian or patient the appliance can be removed at no additional charge because reimbursement for comprehensive orthodontics includes this service. In cases where treatment is discontinued, a "Release from Treatment" form must be provided by the dental office which documents the reason for discontinuing care and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by parent/guardian and patient and a copy maintained in the patient's records.

Beginning a case

Prior authorization for comprehensive orthodontic treatment will only be considered for the permanent dentition. As an exception, cases with late mixed dentition will require documentation of the planned treatment for the existing primary teeth and the reason for starting treatment prior to their natural exfoliation.

In addition to submission requirements already noted, the following must be met:

- The prior authorization request to start a case must include treatment visits. Treatment visits will be considered for intervals of 12 months or visits. The maximum number of treatment visits to be considered on any one prior authorization is twelve (12);
- Attestation from referring general dentist that all needed preventive and dental treatment services have been completed;
- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- Twenty-four (24) visits of active treatment are expected to be adequate to complete most cases. This includes active and retention phase of treatment and is based on eligibility and age limit for the benefit.

Continuation of treatment

After completing twelve (12) treatment visits or expiration of an approval, a prior authorization request must be submitted for the additional visits with a maximum of twelve (12) being allowed. The following shall be included with the prior authorization request:

- A copy of the treatment notes;
- Documentation of any problems with compliance;

- Attestation from referring general dentist that recall visits occurred and that all needed preventive and dental treatment services have been completed;
- Pre-treatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression;
- A copy of the initial approval if the case was started under a different NJ FamilyCare/Medicaid HMO or Fee for Service program.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC/Medicaid Program

For continuation of care for transfer cases whether they were or were not started by another NJFC/Medicaid provider, a prior authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per prior authorization to be considered. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval if applicable;
- Attestation from the referring or treating general dentist that preventive and dental treatment services have been completed;
- A copy of the orthodontic treatment notes if available from provider that started the case;
- Recent diagnostic photographs and/or panoramic radiographs and pre-treatment photographs and/or panoramic radiographs if available;
- The date when active treatment was started and the expected number of months for active treatment and retention with a maximum of 24 visits to be expected to treat a case. This includes active and retention phase of treatment and is based on eligibility and age limit for the benefit; and,
- If re-banding is planned, a new treatment plan, estimated treatment time and documentation to support the treatment change.

A case in treatment cannot be denied if the patient is eligible for orthodontic coverage based on age.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services;
- Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall come from the treating orthodontist;

- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the NJFC/Medicaid program.

Documentation for Completion of Comprehensive Cases – Final Records

Attestation of case completion must be submitted on the provider's letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention shall be submitted on the visit to remove the bands and place the case in retention.

The following **must** be submitted:

- Pre-treatment and final diagnostic photographs and panoramic radiograph; and,

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment take into consideration the patient's ability over the course of treatment to:

- Tolerate the treatment;
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen;
- Be cooperative and complete all needed preventive and treatment visits.

If it is determined that the patient is exhibiting non-compliant behavior such as: multiple missed orthodontic and general dental appointments, continued poor oral hygiene, and/or failure to maintain the appliances and/or untreated dental disease; a letter must be sent to the parent/guardian that documents the factors of concern and the corrective actions needed and that failure to comply can result in discontinuation of treatment with de-banding. A copy must be sent to the HMO. If the case is discontinued, the "Release from Treatment" form should be signed by parent/guardian. **The reimbursement for appliance placement includes their removal,** however prior authorization to allow reimbursement can be considered when removal is by a provider that did not start the case.

If you have questions, please contact the **LIBERTY's Member Services** at:

Amerigroup_CommunityCare_NJ (Medicaid) (833) 276-0848 (TTY: (877) 855-8039)
Amerigroup_Amerivantage_NJ (Medicare) (833) 276-0849 (TTY: (877) 855-8039)

ADJUNCTIVE SERVICES

A. Unclassified Treatment

1. Palliative Treatment (Code D9110)

   a. Typically reported on a "per visit" basis for emergency treatment of dental pain.

   b. The submitted documentation must show the presenting issue and/or the emergency treatment provided that was medically necessary for the procedure. (MM911)

B. Anesthesia

1. Local or regional block anesthesia in or not in conjunction with operative or surgical procedures (Code D9210):

   a. Local or regional block anesthesia is considered to be part of and included in conjunction with operative or surgical procedures.

   b. Submitted documentation must show that it is necessary to anesthetize part of the mouth when it is not in conjunction with operative or surgical procedures. (MM921)

2. Deep Sedation/General Anesthesia or Intravenous moderate sedation/analgesia (Codes D9223 and D9243)

   a. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under observation of trained personnel and the doctor may leave the room to attend to other patients or duties.

   b. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effect upon the central nervous system and not dependent on the route of administration. It is expected that dentists performing anesthesia on patients be properly licensed by their state's regulatory body and comply with all monitoring requirements dictated by the licensing body.

   c. LIBERTY provides benefits for covered General Anesthesia ("GA") or Intravenous ("IV") Sedation in a Dental Office Setting ONLY when medical necessity is demonstrated by the following requirements, conditions and guidelines (MM920):

i. A medical condition that requires monitoring (e.g., cardiac, severe hypertension);

ii. An underlying medical condition exists which would render the patient non-compliant without the GA or IV Sedation (e.g., cerebral palsy, epilepsy, developmental/intellectual disability, Down's syndrome);

iii. Documentation of failed conscious sedation (if available);

iv. A condition where severe infection would render local anesthesia ineffective.

3. Requirements for Documentation:

   a. The medical necessity for treatment with GA or IV Sedation in a dental office setting must be clearly documented in the patient's dental record and submitted by the treating dentist;

   b. Pre-authorization and submission requirements:

      i. Prior to providing GA or IV Sedation in a dental office setting, all necessary medical and dental documentation, including the dental treatment plan, must be reviewed and approved by LIBERTY.

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

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

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

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

4. Use of Nitrous Oxide (Code D9230) requires documentation of medical necessity to alleviate discomfort or anxiety associated with dental treatment (once per visit). (MM923)

5. Non-intravenous Conscious Sedation (Code D9248) (Includes non-IV minimal and moderate sedation)

a. This is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

i. The submitted documentation must demonstrate the medical necessity of non-IV conscious sedation. (MM924)

ii. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effect upon the central nervous system and not dependent on the route of administration.

C. Professional Consultation (Code D9310)

2. This is a patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; it may be requested by another practitioner or appropriate source and it includes an oral evaluation.

3. The consulted practitioner may initiate diagnostic and/or therapeutic services.

4. The submitted documentation must demonstrate the medical necessity of assistance in determining the treatment required for a specific condition. (MM931)

D. Professional Visits (Codes D9410 – D9430)

1. Hospital, house, extended care or ambulatory surgical center call

a. Includes nursing homes, long term care facilities, hospice sites, institutions, hospitals or ambulatory surgical centers.

b. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.

c. The submitted documentation must demonstrate the medical necessity of treatment outside of the dental office. (MM942)

2. Office visit for observation or case presentation during regularly scheduled hours

a. This is for an established patient and is not performed on the same day as evaluation.

b. The submitted documentation must demonstrate the medical necessity of an office visit or case presentation during regularly scheduled office hours. (MM943)

E. Drugs (Codes D9610 – D9630)

1. Administration of one or more parenteral drugs or dispensing of drugs or medicaments for home use require submitted documentation demonstrating the medical necessity of the drugs or medicaments for treating a specific condition. (MM963)

F. Miscellaneous Services

1. Application of a desensitizing medicament or resin (Codes D9910, D9911)

a. This is reported on a per visit treatment for application of topical fluoride or a per tooth basis for adhesive resins.

b. This is not to be used for bases, liners or adhesives under restorations.

c. This requires documentation demonstrating the medical necessity of a desensitizing medicament or resin.

2. Behavior Management (Code D9920)

a. This should be reported in addition to treatment provided and should be reported in 15 minute increments.

b. Documentation submitted must demonstrate the medical necessity of managing the patient's behavior, emotional and/or developmental status to allow the dentist to provide treatment. (MM900)

3. Treatment of post-surgical complications or unusual circumstances (by report) (Code D9930) must provide documentation demonstrating the medical necessity of the procedure.

4. Occlusal Guard (Code D9940)

a. This is a removable dental appliance designed to minimize the effects of bruxism and other occlusal factors.

b. This must be supported by documentation demonstrating the medical necessity fabricating, adjusting or repairing/relining an occlusal guard to minimize the effects of bruxism.

5. Occlusal analysis or adjustment (Codes D9951 – D9952) requires documentation demonstrating the medical necessity of the process to reshape occlusal surfaces. (MM995)

6. Odontoplasty (Codes D9971) requires documentation demonstrating the medical necessity of the process for other than exclusively cosmetic concerns. (Needs an MM code)

RETROSPECTIVE REVIEW

Prospective and retrospective review will require documentation that demonstrates medical necessity. This documentation can include diagnostic radiographic or photographic images (MM0350), the results of tests or examinations, descriptions of conditions in progress notes and/or a written narrative providing additional information. In cases where objective information (such as diagnostic images) conflicts with subjective information (such as written descriptions), objective information will be given preference in making a determination.

Retrospective review of services that had been previously pre-authorized will require documentation confirming that the procedure(s) was (were) completed as authorized and within the standard of care as defined by LIBERTY Dental Plan's Criteria Guidelines and Practice Parameters. (MMPROG)

In all situations applicable Plan/Program specific guidelines supersede the information contained in LIBERTY's Clinical Criteria Guidelines and Practice Parameters document.

QUALITY MANAGEMENT

COMPLIANCE STATEMENT

LIBERTY operates in compliance with all Amerigroup policies and procedures, as well as NJFC contract and all NJ DOBI HMO regulations.

FRAUD WASTE AND ABUSE

COMPLIANCE STATEMENT

LIBERTY operates in compliance with all Amerigroup policies and procedures, as well as NJFC contract and all NJ DOBI HMO regulations.

FORMS

Electronic forms are available for download from LIBERTY Dental Plan's Resource Library by visiting https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx

LIBERTY Dental Plan
Informed Consent for Alternative Treatment

Patient Name	Member ID
Subscriber (if different than Patient)	**Plan Number**

Description of Alternative services and reason for recommendation:

Tooth/ Area	Covered Services					Alternative Treatment*					Patient's Responsibility for Procedure Elected	Patient's Acceptance (Please initial)
	CDT Code	Procedure Description	Copayment	Accept	Decline	CDT Code	Procedure Description	Alternative Cost*	Accept	Decline		

*"Alternative Treatment" means an alternative or upgrade treatment that has been proposed or recommended for the same tooth or condition(s) as the corresponding "Covered Service." The Covered Service is listed as covered by your plan whereas the Alternative Treatment is not covered by your plan (meaning that if you elect the Alternative Treatment, you will incur the "Alternative Cost" specified). You have the option to choose between the two services and will be responsible for the specified "Patient's Responsibility for Procedure Elected." Formula for Alternative Cost = usual cost of Alternative Treatment minus (-) the usual cost of the Covered Service plus (+) any listed copayment for the Covered Service.

Total patient responsibility for procedure(s) elected: $ _____

I have explained to the patient: his/her treatment options, the risks and benefits of (and alternatives to) each, and that although Alternative Treatment is being proposed that those services covered under his/her benefit plan would nonetheless also meet the relevant dental standards of care.

☐ Yes ☐ No

Dentist Signature | Dentist Name | Date

By signing below, I acknowledge the following: (i) the dentist named above has explained to me the proposed alternative or upgraded treatment specified above ("Alternative Treatment") and the additional costs associated with such treatment ("Alternative Costs"); (ii) I understand that I have the right to choose either the Covered Service or the Alternative Treatment outlined above and I understand the risks, benefits and costs of each; (iii) if I have elected any Alternative Treatment specified above, I consent to such treatment and I understand: that I am solely responsible for the cost of the Alternative Treatment, that such treatment is not covered by LIBERTY Dental Plan, and that the Covered Service(s) I am declining would have also met the relevant dental standards of care; (iv) I understand that while there may be financing options available, I am under no obligation to select a specific financing option or to use one at all; and (v) if I have any questions or concerns about my dental treatment plan, copayments or additional costs, I will have contacted LIBERTY Dental Plan at 800-268-9012 or 888-700-0643 (Nevada) before signing below.

Patient Signature (Parent or Guardian) | Patient Name | Date

Revised: 6/2015

B.4.2.11 Orthodontic Services

The following standards and procedures apply to the provision of orthodontic services for children in the Medicaid/NJ FamilyCare (NJFC) programs.

Orthodontic Consultation - A visual examination and completion of the HLD (NJ-Mod2) assessment tool by the attending provider or a provider in the same group who will be providing the service will be considered a consultation (D9310) and does not require prior authorization. The consultation can be provided once a year and will be linked to the provider and not to the patient which allows for a second opinion with a different provider.

Pre-orthodontic Treatment Visit D8660 (for diagnostic workup, clinical evaluation, orthodontic treatment plan and completion of HLD (NJ-Mod2) assessment tool) is required for consideration of interceptive and comprehensive orthodontic treatment. It is provided by the attending provider or a provider in the same group who will be providing the service and includes the visual examination and completion of the HLD (NJ-Mod2) assessment tool.

For comprehensive orthodontic treatment, if the total score on the HLD (NJ-Mod2) Assessment Tool is equal to or greater than 26 the pre-orthodontic treatment work-up can proceed. A total score of less than 26 points on the HLD (NJ-Mod2) assessment tool requires that documentation of the extenuating functional difficulties and/or medical anomaly is included in the submission.

- The pre-orthodontic treatment visit does not require prior authorization and should occur with the expectation that the case will be completed prior to the client exceeding the age of eligibility for the benefit;
- This service can be provided once a year and will be linked to the provider and not to the patient;
- The pre-orthodontic treatment visit includes the consultation; therefore, consultation will not be reimbursed separately.

The new HLD (NJ-Mod2) Index and instructions are attached.

Orthodontic Treatment Services

Limited, Interceptive and Comprehensive orthodontic services **must be prior authorized**. Limited and Interceptive orthodontic services will be considered for the treatment of the primary dentition, permanent dentition or mixed dentition. Comprehensive orthodontic services will be considered for treatment of the permanent dentition.

Prior authorization determinations shall be made and notice provided to the provider within ten (10) days of receipt of all necessary information.

In cases where prior authorization is denied, the denial documentation must contain a detailed explanation of the reason(s) for denial; indicate whether additional information is needed and the process for reconsideration. Additionally, denial documentation must include the name and

contact information of the dental consultant that reviewed and denied the treatment request which will allow the provider an opportunity to discuss the case.

An approved case must be started within six (6) months of receiving the approval.

Limited Orthodontic Treatment

Limited orthodontic treatment can be considered for minor treatment to control harmful habits in the primary dentition or mixed dentition and for correction of anterior crossbite in the permanent dentition that demonstrates severe conditions as noted under 4.2.11A.

For prior authorization the following shall be submitted:

- Narrative of clinical findings, treatment plan and estimated treatment time;
- Diagnostic photographs;
- Diagnostic X-rays or digital films of the entire dentition;
- Diagnostic study models or diagnostic digital study cast images with measuring tool in place to demonstrate measurement as noted on assessment tool; and,
- The referring dentist **must** provide on letterhead attestation that all needed preventive and dental treatment services have been completed. A copy **must** be submitted with the orthodontic treatment request.

The reimbursement for the service includes the appliance, insertion, all adjustments, repairs, removal, retention and treatment visits. As a result, the case shall be completed even if eligibility is terminated. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered once for each arch without additional cost to the patient.

If it is determined that limited orthodontic treatment is part of a comprehensive treatment plan for the permanent dentition, it will be considered as part of the comprehensive case and not approved or reimbursed separately. In this case the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the limited treatment phase.

Upon completion of the case pre-treatment and post-treatment photographs must be submitted.

Interceptive and Comprehensive Orthodontic Treatment

For prior authorization requests the following shall be submitted:

- The completed HLD (NJ-Mod2) assessment tool;
- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- The comprehensive orthodontic treatment plan and estimated treatment time;
- Attestation from the referring dentist that all needed preventive and dental treatment services have been completed;

- Diagnostic study models or diagnostic digital study models with measuring tool in place to demonstrate measurement as noted on HLD (NJ-Mod2) assessment tool;
- Diagnostic photographs;
- Diagnostic x-rays, digital x-rays or cephlometric film with tracing (when applicable); and,
- When applicable:
    - Medical diagnosis and surgical treatment plan
    - Detailed documentation from **a mental health professional** as described in the managed care contract indicating the psychological or psychiatric diagnosis, treatment history and prognosis and an attestation stating and substantiating that orthodontic correction will result in a favorable prognosis of the mental/psychological condition establishing medical necessity.

Interceptive Orthodontics

Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, all adjustments, repairs, removal, retention and treatment visits and initial retainers. As a result, the case shall be completed even if eligibility is terminated. Replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered once for each arch without additional cost to the patient.

If it is determined that interceptive orthodontic treatment is part of a comprehensive treatment plan, it will be considered as part of the comprehensive case and not approved or reimbursed separately. In this case, the prior authorization should be submitted for comprehensive orthodontic treatment with an attached treatment plan that indicates the interceptive treatment phase.

Upon completion of the case, pre-treatment and post-treatment diagnostic photographs must be submitted.

Comprehensive Orthodontics

Eligibility should be checked prior to each visit.

The comprehensive case will include all appliances, insertion, all adjustments, repairs and removal as well as the retention phase of treatment. Initial retainer(s) are included with the service; however replacement of retainers or removable appliances due to loss or damage beyond repair requires prior authorization and can be considered once for each arch without additional cost to the patient.

Reimbursement for orthodontic services includes the placement and removal of all appliances and brackets; therefore should it become necessary to remove the bands due to loss of eligibility, non-compliance or elective discontinuation of treatment by the parent, guardian or patient the appliance can be removed at no additional charge because reimbursement for comprehensive orthodontics includes this service. In cases where treatment is discontinued, a "Release from Treatment" form must be provided by the dental office which documents the reason for

discontinuing care and releases the dentist from the responsibility of completing the case. The release form must be reviewed and signed by parent/guardian and patient and a copy maintained in the patient's records.

Beginning a case

Prior authorization for comprehensive orthodontic treatment will only be considered for the permanent dentition. As an exception, cases with late mixed dentition will require documentation of the planned treatment for the existing primary teeth and the reason for starting treatment prior to their natural exfoliation.

In addition to submission requirements already noted, the following must be met:

- The prior authorization request to start a case must include treatment visits. Treatment visits will be considered for intervals of 12 months or visits. The maximum number of treatment visits to be considered on any one prior authorization is twelve (12);
- Attestation from referring general dentist that all needed preventive and dental treatment services have been completed;
- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- Twenty-four (24) months of active treatment are expected to be adequate to complete most cases with reimbursement for a maximum of thirty-six visits. This includes active and retention phase of treatment and is based on eligibility and age limit for the benefit.

Continuation of treatment

After completing twelve (12) treatment visits or expiration of an approval, a prior authorization request must be submitted for the additional visits with a maximum of twelve (12) being allowed. The following shall be included with the prior authorization request:

- A copy of the treatment notes;
- Documentation of any problems with compliance;
- Attestation from referring general dentist that recall visits occurred and that all needed preventive and dental treatment services have been completed;
- Pre-treatment and current treatment diagnostic photographs and/or diagnostic panoramic radiographs to show status and to demonstrate case progression;
- A copy of the initial approval if the case was started under a different NJ FamilyCare/Medicaid HMO or Fee for Service program.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the NJFC/Medicaid Program

For continuation of care for transfer cases whether they were or were not started by another NJFC/Medicaid provider, a prior authorization must be submitted to request the remaining treatment visits to continue a case with a maximum of twelve (12) per prior authorization to be considered. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval if applicable;
- Attestation from the referring or treating general dentist that preventive and dental treatment services have been completed;
- A copy of the orthodontic treatment notes if available from provider that started the case;
- Recent diagnostic photographs and/or panoramic radiographs and pre-treatment photographs and/or panoramic radiographs if available;
- The date when active treatment was started and the expected number of months for active treatment and retention with a maximum of 24 visits to be expected to treat a case with reimbursement for a maximum of thirty-six visits. This includes active and retention phase of treatment and is based on eligibility and age limit for the benefit; and,
- If re-banding is planned, a new treatment plan, estimated treatment time and documentation to support the treatment change.

A case in treatment cannot be denied if the patient is eligible for orthodontic coverage based on age.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- The surgical consult, treatment plan and approval for surgical case must be included with the request for prior authorization of the orthodontic services;
- Prior authorization and documentation requirements are the same as those for comprehensive treatment and shall come from the treating orthodontist;
- The parent/guardian and patient should understand that loss of eligibility at any time during treatment will result in the loss of all benefits and payment by the NJFC/Medicaid program.

Orthodontic Treatment for Missing Teeth due to Agenesis or Post Extraction

Requests for orthodontic treatment associated with missing permanent teeth due to agenesis or loss of space post extraction will require documentation of medical necessity and supporting diagnostic materials and be considered on a case by case review.

Documentation for Completion of Comprehensive Cases – Final Records

Attestation of case completion must be submitted on the provider's letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention shall be submitted on the visit to remove the bands and place the case in retention.

The following **must** be submitted:

- Pre-treatment and final diagnostic photographs and panoramic radiograph; and,
- Final diagnostic study models or diagnostic digital study models.

If this is not received, reimbursement provided may be recovered until required documentation is submitted.

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment take into consideration the patient's ability over the course of treatment to:

- Tolerate the treatment;
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen;
- Be cooperative and complete all needed preventive and treatment visits.

If it is determined that the patient is exhibiting non-compliant behavior such as: multiple missed orthodontic and general dental appointments, continued poor oral hygiene, and/or failure to maintain the appliances and/or untreated dental disease; a letter must be sent to the parent/guardian that documents the factors of concern and the corrective actions needed and that failure to comply can result in discontinuation of treatment with de-banding. A copy must be sent to the HMO. If the case is discontinued, the "Release from Treatment" form should be signed by parent/guardian. **The reimbursement for appliance placement includes their removal,** however prior authorization to allow reimbursement can be considered when removal is by a provider that did not start the case.

If you have questions, please contact the Bureau of Dental Services at 609-588-7136.

Instructions for Completing the New Jersey Orthodontic Evaluation HLD (NJ-Mod2) Index Form

The intent of the HLD (NJ-Mod2) Index is to measure the presence or absence and the degree of the handicap caused by the components to be scored with the index and NOT to diagnose "malocclusion". Presence of conditions 1 through 6A or a score total equal to or greater than 26 qualifies for medical necessity exception.

GENERAL INFORMATION:

- **Only cases with permanent dentition will be considered (see comprehensive orthodontics for exception).**
- A Boley Gauge or disposable ruler scaled in millimeters should be used;
- The patient's teeth are positioned in centric occlusion;
- All measurements are recorded and rounded off to the nearest millimeter (mm);
- For sections 1 to 6A and 15 an X is placed if the condition exists and no further scoring is needed;
- For sections 6B to 14, indicate the measurement or if a condition is absent, a 0 is entered;
- The use of an assistant to record the findings is recommended;
- **Diagnostic models are required** with submission of prior authorization. Casts must be properly poured, adequately trimmed without voids or bubbles and marked for centric occlusion, or
- **Diagnostic Digital models may be submitted** to show right and left lateral, frontal and posterior and maxillary and mandibular occlusal views to include view with measuring tool;
- **Diagnostic quality photographs** to show facial, frontal and profile, intra-oral front, left and right side, maxillary and mandibular occlusal views (minimum of seven views).

INSTRUCTIONS FOR FORM COMPLETION:

1. **Cleft Palate Deformity** – acceptable documentation must include at least one of the following: intraoral photographs of the palate, written consultation report by a qualified specialist or craniofacial panel. Score an X if present.

2. **Cranio-facial Anomaly** – acceptable documentation must include written report by qualified specialist or craniofacial panel and photographs. Score an X if present.

3. **Impacted Permanent Anterior Teeth** – demonstrate that anterior tooth or teeth (incisors and cuspids) is or are impacted (soft or hard tissue); not indicated for extraction and treatment planned to be brought into occlusion. Arch space available for correction. Score an X if present.

4. **Crossbite of Individual Anterior teeth** –demonstrate that anterior teeth or tooth (incisors and cuspids) is or are in crossbite resulting in occlusal trauma with excessive

wear, significant mobility or soft tissue damage. Score X if present. If these conditions do not exist it is to be considered an extopic eruption.

5. **Severe Traumatic Deviation** – damage to skeletal and or soft tissue as a result of trauma or other gross pathology. Include written report and intraoral photographs. Score an X if present.

6A. **Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5** – Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, score an X if present.

6B. **Overjet equal to or less than 9mm** – overjet is recorded as in condition in 6A. The measurement is rounded to the nearest millimeter and entered on the score form.

7. **Overbite** – A pencil mark on the tooth indicating the extent of the overlap facilitates the measurement. It is measured and rounded off the nearest millimeter and entered on the score form. "Reverse" overbite may exist and should be measured and entered on the score form.

8. **Mandibular protrusion (reverse overjet) equal to or less than 3.5mm** – Mandibular protrusion (reverse overjet) is recorded as a condition in 6A and rounded to the nearest millimeter. Enter the score on the form and multiply it by five (5).

9. **Open Bite in millimeters** – This condition is defined as the absence of occlusal contact in the anterior region. It is measured from the incisal edge of a maxillary central incisor to the incisal edge of a corresponding mandibular incisor, in millimeters. Enter the measurement on the score form and multiply by four (4). If case is such that measurement is not possible, measurement can usually be estimated.

10. **Ectopic Eruption** – Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of qualifying teeth on the score form and multiply by three (3). If anterior crowding (see condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS**. However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

11. **Deep Impinging Overbite** – destruction of soft tissue on palate is present. Submit intraoral photographs of tissue damage/impingement. The presence of deep impinging overbite is indicated by a score of three (3) on the score form.

12. **Anterior Crowding** – Arch length insufficiency must exceed 3.5mm. Mild rotations are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one for a

crowded mandibular arch. Enter the total on the score form and multiply by five (5). If ectopic eruption exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS**. However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

13. **Labio-Lingual Spread** – A Boley Gauge (or disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for the labio-lingual spread, but only the most severe individual measurement should be entered on the score form.

14. **Posterior Unilateral Crossbite** – This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score form. **NO ADDITIONAL SCORE FOR BI-LATERAL CROSSBITE.**

15. **Psychological factors affecting child's development** – This condition requires detailed documentation by a **mental health provider** as described in the managed care contract that contains the psychological or psychiatric diagnosis, treatment history and prognosis. An attestation from the mental health provider must state and substantiate that orthodontic correction will result in a favorable prognosis of the mental/psychological condition.

NJ ORTHODONTIC ASSESSMENT TOOL - HLD (NJ-Mod2)
****All needed preventive and dental treatment must be completed – attach attestation****

Name: _____ Medicaid ID # _____
Age: _____ Sex: M / F Class/Type of Case: _____
Treatment: Comprehensive / Interceptive Name of General Dentist: _____
Name of orthodontist: _____ Billing Provider #: _____

Notes: **Follow instructions for completing form found in newsletter. Conditions 1-6A are automatically qualifying conditions and need no further scoring. Indicate with an X when the conditions in 1-6A or 15 are present. Conditions 6B-14 must total 26 or more.**

	Condition	Score
1.	**Cleft palate deformity** (attach description from credentialed specialist)	
2.	**Cranio-facial Anomaly** (attach description from credentialed specialist)	
3.	**Impacted permanent anteriors** where extraction is not indicated Note the number of teeth_____	
4.	**Crossbite of individual anterior teeth**	
5.	**Severe traumatic deviations**	
6A.	**Overjet greater than 9 mm** with incompetent lips or **reverse overjet greater than 3.5 mm**	
6B.	**Overjet** (mm)	
7.	**Overbite** (mm)	
8.	**Mandibular protrusion** (mm) x 5	
9.	**Open bite** (mm) x 4	
10.	**Ectopic eruption** (# of teeth x 3)	
11.	**Deep impinging overbite** (intra-oral photos that demonstrate palatal soft tissue impingement/destruction are required) Score 3 points if present	
12.	**Anterior crowding** MX_____ MD_____ Total_____ x 5 (score **1** per arch)	
13.	**Labiolingual spread** (mm)	
14.	**Posterior unilateral crossbite** (involving molar): Score 4 if present	
15.	**Psychological factors affecting development** (**"X"** requires detailed documentation by **mental health provider** as described per contract of psychological/psychiatric diagnosis, prognosis and that orthodontic correction will improve mental/psychological condition.)	
	TOTAL	

☐ Medical exceptions with score total less than 26 (check one)
____ Dental diagnosis ____ Medical diagnosis ____ Clinical significance or functional impairment

For consultant use only:
APPROVED ☐ EXCEPTION ☐ DENIED ☐

ORTHODONTIC TRANSITION OF CARE FORM

RISK ASSESSMENT FORMS:

ADA Caries Risk Assessment Form (Age 0-6)

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age 0-6)

Patient Name:				
Birth Date:			**Date:**	
Age:			**Initials:**	
		Low Risk	**Moderate Risk**	**High Risk**
Contributing Conditions		**Check or Circle the conditions that apply**		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐	Frequent or prolonged between meal exposures/day ☐	Bottle or sippy cup with anything other than water at bed time ☐
III.	**Eligible for Government Programs** (WIC, Head Start, Medicaid or SCHIP)	☐ No		☐ Yes
IV.	**Caries Experience of Mother, Caregiver and/or other Siblings**	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
V.	**Dental Home:** established patient of record in a dental office	☐ Yes	☐ No	
General Health Conditions		**Check or Circle the conditions that apply**		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ No		☐ Yes
Clinical Conditions		**Check or Circle the conditions that apply**		
I.	**Visual or Radiographically Evident Restorations/ Cavitated Carious Lesions**	No new carious lesions or restorations in last 24 months ☐		Carious lesions or restorations in last 24 months ☐
II.	**Non-cavitated** (incipient) **Carious Lesions**	No new lesions in last 24 months ☐		New lesions in last 24 months ☐
III.	**Teeth Missing Due to Caries**	☐ No		☐ Yes
IV.	**Visible Plaque**	☐ No	☐ Yes	
V.	**Dental/Orthodontic Appliances Present** (fixed or removable)	☐ No	☐ Yes	
VI.	**Salivary Flow**	Visually adequate ☐		Visually inadequate ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Instructions for Caregiver:

ADA Caries Risk Assessment Form (Age > 6)

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age >6)

Patient Name:				
Birth Date:			**Date:**	
Age:			**Initials:**	
		Low Risk	**Moderate Risk**	**High Risk**
Contributing Conditions		**Check or Circle the conditions that apply**		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	**Primarily at mealtimes** ☐		**Frequent or prolonged between meal exposures/day** ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	**No carious lesions in last 24 months** ☐	**Carious lesions in last 7-23 months** ☐	**Carious lesions in last 6 months** ☐
IV.	**Dental Home:** established patient of record, receiving regular dental care in a dental office	☐ Yes	☐ No	
General Health Conditions		**Check or Circle the conditions that apply**		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ No	**Yes (over age 14)** ☐	**Yes (ages 6-14)** ☐
II.	**Chemo/ Radiation Therapy**	☐ No		☐ Yes
III.	**Eating Disorders**	☐ No	☐ Yes	
IV.	**Medications that Reduce Salivary Flow**	☐ No	☐ Yes	
V.	**Drug/Alcohol Abuse**	☐ No	☐ Yes	
Clinical Conditions		**Check or Circle the conditions that apply**		
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	**No new carious lesions or restorations in last 36 months** ☐	**1 or 2 new carious lesions or restorations in last 36 months** ☐	**3 or more carious lesions or restorations in last 36 months** ☐
II.	**Tooth Missing Due to Caries in past 36 months**	☐ No		☐ Yes
III.	**Visible Plaque**	☐ No	☐ Yes	
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	☐ No	☐ Yes	
V.	**Interproximal Restorations - 1 or more**	☐ No	☐ Yes	
VI.	**Exposed Root Surfaces Present**	☐ No	☐ Yes	
VII.	**Restorations with Overhangs** and/or **Open Margins; Open Contacts** with Food Impaction	☐ No	☐ Yes	
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	☐ No	☐ Yes	
IX.	**Severe Dry Mouth** (Xerostomia)	☐ No		☐ Yes

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Patient Instructions:

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name:_____ Date of Birth:_____ Date:_____

Visit: ☐ 6 month ☐ 9 month ☐ 12 month ☐ 15 month ☐ 18 month ☐ 24 month ☐ 30 month ☐ 3 year ☐ 4 year ☐ 5 year ☐ 6 year ☐ Other_____

RISK FACTORS

⚠ Mother or primary caregiver had active decay in the past 12 months
| | Yes | | No

● Mother or primary caregiver does not have a dentist
| | Yes | | No

● Continual bottle/sippy cup use with fluid other than water
| | Yes | | No

● Frequent snacking
☐ Yes ☐ No

● Special health care needs
| | Yes | | No

● Medicaid eligible
☐ Yes ☐ No

PROTECTIVE FACTORS

● Existing dental home
| | Yes | | No

● Drinks fluoridated water or takes fluoride supplements
| | Yes | | No

● Fluoride varnish in the last 6 months
☐ Yes ☐ No

● Has teeth brushed twice daily
| | Yes | | No

CLINICAL FINDINGS

⚠ White spots or visible decalcifications in the past 12 months
| | Yes | | No

⚠ Obvious decay
☐ Yes ☐ No

⚠ Restorations (fillings) present
| | Yes | | No

● Visible plaque accumulation
| | Yes | | No

● Gingivitis (swollen/bleeding gums)
☐ Yes ☐ No

● Teeth present
| | Yes | | No

● Healthy teeth
| | Yes | | No

ASSESSMENT/PLAN

Caries Risk:
☐ Low ☐ High

Completed:
| | Anticipatory Guidance
☐ Fluoride Varnish
☐ Dental Referral

Self Management Goals:

☐ Regular dental visits	☐ Wean off bottle	☐ Healthy snacks
	Dental treatment for parents	☐ Less/No juice		Less/No junk food or candy
	Brush twice daily	☐ Only water in sippy cup		No soda
☐ Use fluoride toothpaste	☐ Drink tap water	☐ Xylitol

Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

Adapted from Ramos-Gomez FJ, Crystal YO, Ng MW, Crall JJ, Featherstone JD. Pediatric dental care: prevention and management protocols based on caries risk assessment. *J Calif Dent Assoc.* 2010;38(10):746–761; American Academy of Pediatrics Section on Pediatric Dentistry and Oral Health. Preventive oral health intervention for pediatricians. *Pediatrics.* 2003; 122(6):1387–1394; and American Academy of Pediatrics Section of Pediatric Dentistry. Oral health risk assessment timing and establishment of the dental home. *Pediatrics.* 2003;111(5):1113–1116.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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National Interprofessional Initiative on Oral Health