2026 Mercy Care Arizona Medicare & Medicaid Provider Reference Guide

LIBERTY DENTAL PLAN®

Section 1. Liberty Dental Plan Information

Getting Started

We are excited to welcome you as a valued provider in Liberty Dental Plan's network of participating providers for the State of Arizona. By joining our Liberty family, you have become part of a State-wide network comprised of individual and group practices, hospitals, dental schools, FQHCs, and community-based clinics.

Welcome to the Liberty team!

Purpose

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

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

Our Mission

We deliver quality, innovative, and affordable dental benefits that support health, strengthen communities, and enhance lives. Liberty seeks to increase annual patient visits and improve the overall health of the Medicaid and Medicare populations through Member outreach and education.

Our continued expansion is an outgrowth of our commitment to exceptional service and expertise in our industry while providing a positive, rewarding, and enjoyable professional relationship with our network providers, members, and Liberty staff.

Why Join Liberty?

Ease of Enrollment – Liberty's online contracting and credentialing platform makes it easy to enroll as a Liberty provider and we make credentialing decisions within **three (3) weeks** on average.

Dedicated Support – We use a dedicated Provider Relations Team and pair each provider office with an experienced Network Representative to provide one-on-one support.

Access to Provider Services – When members face challenges contacting their dental office, our dedicated Member Services and Provider Relations Team is prepared to assist in securing emergency or urgent care appointments within **24 to 72 hours**, as appropriate.

Resources and Training – We are a trusted resource to our provider network on the latest industry trends and regulatory actions. We offer providers the opportunity to earn continuing education credits

and access to our library of online training, quarterly provider newsletters, and videos, among other resources.

Liberty's Concierge-Style Customer Service – We answer the phone! Our call center provides live first call resolution using qualified staff with dental backgrounds. Our experienced team is trained in first-call resolution to address issues in real time. We took over **550,000 provider calls** last year, answering **95%** of them in **under 20 seconds** with a **91%** first call resolution rate. That means less time on the phone and more time serving patients!

Provider-friendly Tools – Our state-of-the-art provider portal includes real-time eligibility, benefits, and improved history search for claims and prior authorizations.

Provider Recognition – Our programs identify providers whose performance meets our quality-of-care expectations so we can recognize and reward these offices with reduced administrative requirements, among other benefits.

Data Exchange and Interoperability – We provide real-time information with a seamless, coordinated healthcare experience to reduce administrative burden. This environment creates higher operational efficiency, thereby increasing provider capacity and output.

Increased Opportunity – We currently administer dental plans from all lines of business, including Commercial, Healthcare Exchange, Medicare Advantage, and Medicaid. Additionally, the Medicare Advantage population is one of the fastest growing market segments in the country. Many of our Plans function similarly to PPO Plans with quarterly and annual maximums that allow more flexibility in the types of treatment you can render to your patients. Becoming a Liberty Medicare Advantage provider will open your office up to a new segment of the population with great dental benefits who are looking for a dental home.

Provider Enrollment Assistance

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

Phone: **888.352.7924**,
Press star (*) to speak to a Provider Service Representative about joining the Liberty network.

Email **provider@libertydentalplan.com**, enter "**Enrollment Assistance**", the state abbreviation, and the county for the location you want to contract in the subject line of the email. For example: "**Enrollment Assistance, TX, Harris**."

The appropriate Network Manager will respond within **one to two (1-2)** business days.

Provider Enrollment Overview

Liberty has a simple 5-step process for enrolling in our networks:

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

Required Documents List

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

Contracting Documents – These documents are required for each location.

- Facility Application: Provides relevant location and payee data to set up an in-network location.
- Provider Agreement: An agreement to accept payment on behalf of Liberty Dental Plan's contracted members.
- Medicaid and/or Medicare Addenda: Contains the required regulatory language for the applicable government programs.
- Fee Addendum: Represents the agreement to accept specific compensation arrangements (i.e., Fee for Service, Value Based, Capitation, etc.)
- W-9: Required to generate a 1099 for tax purposes and must have the address registered with the IRS listed as your corporate billing address for multiple locations with the same tax ID.
- Provider Compliance Attestation: Indicates that your office and all relevant staff have completed the required annual compliance training to participate in our networks.
- Payment Options Form: Used to select from available options regarding how payments will be processed. Payment options vary depending on state and appropriate state forms should be included in the package that is sent by your Network Manager or viewable on the Provider Online Enrollment site.
- Authorized Signatory form: Optional form signed by the CEO/owner delegating another employee (i.e., Office Manager, Management Company Contact, etc.) to sign enrollment documents on their behalf.
- State Required Documents: Some states have specific contracting requirements. Additional state requirements will be included on the checklist contained in your state's Contracting & Credentialing package.

Credentialing Documents – These are required for each Dentist/Hygienist/Denturist.

- Provider Credentialing Application: Allows each participating provider to provide the required credentialing information for third party verification. CAQH applications are allowed in most states but may require additional information or completion of a state-mandated application.
- Current Dental License: Successful credentialing requires a non-expired dental license. If your license expires prior to the completion of credentialing, an updated copy of your dental license will be required prior to credentialing approval.
- Current Federal DEA Certificate or waiver: Waivers are mandatory if you do not have a DEA Certificate and expire after 65 days from the signature date.
- Current Malpractice insurance certificate declaration page showing professional liability
    - Proves the dentist has the required liability insurance in place prior to enrollment. If certificate expires prior to the completion of credentialing, an updated copy of your declaration page will be required prior to credentialing approval. (Please note: Liability limits may vary per state and line of business)
- State Required Documents: Some states have specific credentialing requirements. Additional state requirements will be included on the checklist contained in your state's Contracting and Credentialing package.
- Copy of Specialty Certificate or Board Certification (if applicable)
- Copy of Internship/Residency/Fellowship Certificate (if applicable)
- Work History and Educational: Gaps may require explanations (vary by state)

Provider Online Enrollment (POE)

Liberty's Provider Online Enrollment allows providers, or their delegates, to complete enrollment and re-enrollment, using an online application. The website is accessed from Liberty's website at **www.libertydentalplan.com** or click this link to **join our network**.

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

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

- A change in ownership
- An adverse legal action
- A change in practice location

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

Required Annual Compliance Training

Liberty monitors and ensures all participating offices, and their staff operate in compliance with applicable laws and regulations. Contracted and leased network offices have the option to complete Liberty's required training courses located on the Liberty website or other comparable trainings on the required topics within **thirty (30) days** of initial hiring, contracting, and annually thereafter.

Providers can access all compliance training modules on the Liberty website. Training modules, the attestation form, and access to a completion certificate are available at **www.libertydentalplan.com** or via the QR code. Paper or PDF versions of the attestation may be submitted to Liberty at **provider@libertydentalplan.com**.

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

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

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

Mail
Liberty Dental Plan
ATTN: Provider Relations
P.O. Box 26110
Santa Ana, CA 92799-6110

Email
provider@libertydentalplan.com

Fax
800.268.0154

Web
CMS Website Link

Credentialing/Recredentialing

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

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

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

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

Enrollment FAQs

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

Getting Started as a Liberty Contracted Provider

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

Liberty is dedicated to meeting the needs of our providers by utilizing leading-edge technology to increase your office'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 through our secure online **Provider Portal**.

Registered users will be able to:

- Submit electronic claims
- Request for prior authorizations
- Verify member eligibility and benefits
- Verify provider eligibility status
- View office and contract information
- Submit referrals and check status
- Access benefit plans
- Print monthly eligibility rosters
- Perform a provider search
- Check the status of a claim

Adverse Incidents

Providers are responsible for reporting adverse incidents to Liberty within **forty-eight (48) hours** of the incident. Adverse incidents include members who show self-harm, threat to another person, threat to Liberty and those listed below.

- Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and
- Is not consistent with or expected to be a consequence of service provision; or
- Occurs because of service provision to which the patient has not given his informed consent; or
- Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

Arizona Provider Contact and Information Guide

Liberty provides a twenty-four (24) hour helpline to respond to requests for prior authorization. In addition, Liberty staff are available from 8:00 a.m. to 5:00 p.m. EST Monday through Friday to answer provider questions and respond to provider complaints, emergencies, and notifications.

After regular business hours the provider service line is answered by an automated system with the capability of providing callers with information about operating hours and instructions about how to verify enrollment for a member with an emergency or urgent medical condition. The requirement that Liberty provides information to providers about how to verify enrollment shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

Please refer to the Liberty contact information guide on the following page.

Liberty makes every effort to maintain accurate information in this manual; however, we will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

Contact Information

Phone
888.352.7924 or **877.855.8039** (TDD/TTY)
Monday-Friday 8:00 a.m.- 5:00 p.m. PST

- Eligibility & benefits
- Claims
- Prior authorizations
- Referrals
- Request materials
- General information

Email
provider@libertydentalplan.com

Website
www.libertydentalplan.com

Mailing Address
Liberty Dental Plan
P.O. Box 401086
Las Vegas, NV 89140

Fax
800.268.0154

Provider Portal (iTransact)

Go to the **Liberty Provider Portal** to create an account.

iTransact allows you:

- Electronic Claims Submission
- Claim Status & Inquiries
- Real-time Eligibility Verification
- Member Benefits
- Referral Submission & Status

Eligibility & Benefits

Use iTransact for real-time status at the **Liberty Provider Portal.**

Referral Submissions & Inquiries

Use iTransact for submissions & to check the status at the **Liberty Provider Portal**.

Mail
Use our mailing address, ATTN: Referrals Department

Claim Submissions & Inquiries

Use iTransact for submissions & to check the status on the **Liberty Provider Portal**.

EDI Payor ID#
CX083

Mail
Use our mailing address ATTN: Claims Department

Provider Dispute Resolution (PDR)

Mercy Care Dental Appeals

Attn: Appeals Department

4750 S. 44th Place,

Suite150

Phoenix, AZ 85040

Mercycareappeals@mercycareaz.org

Fax: 860-907-3511

Member Grievances & Appeals (G&A)

Mercy Care
Grievances System Dept.
4750 S. 44th Place, Suite 150
Phoenix, AZ 85040

Phone: 602.586.1719
Fax: 602.351.2300
Email: mcandg@mercycareaz.org

Section 2. Provider Relations and Training

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

- Plan contracting
- Escalated claim payment issues
- Education on Liberty Policies and member benefits
- Provider training and orientations
- Directory validation
- Changes in office demographics
- Opening, changing, selling, or closing a location
- Adding or terminating associates
- Credentialing and recredentialing of owner and associate dentist inquiries
- Change in name or ownership
- Taxpayer Identification Number (TIN) change
- Changes in office hours

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

Phone
888.352.7924
Monday – Friday
8am – 5pm PST

Mail
Liberty Dental Plan
ATTN: Provider Relations
P.O. Box 26110
Santa Ana, CA 92799-6110

Email
provider@libertydentalplan.com

Section 3. Online Self-Service Tools

Online Account Access

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

All contracted network dental offices are issued a unique office number and access code. These numbers can be found on your Liberty Dental Plan Welcome Letter and are required to register your office on Liberty's Provider Portal.

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

If you are unable to locate your office number and/or access code, please contact the Provider Relations Department at **888.352.7924**, or email **provider@libertydentalplan.com**. For technical assistance, email **portalsupport@libertydentalplan.com**.

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

System Requirements

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

Directory Information Verification (DIV) Online

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

Anytime you have changes, including, but not limited to, appointment times, office hours, address, phone number, fax number, associate dentists, etc., you will be able to update or attest that no changes were made no less than once per quarter by going online. We also highly recommend you set a calendar reminder in your system to go to the website every **three (3) months** and validate the information. To ensure that your information is displayed accurately, and claims are processed efficiently, please submit all changes **thirty (30) days** in advance. The easiest way to update your office information is through our Provider Directory Information Verification (DIV) website at **Provider DIV**. You may also contact Provider Relations for further instructions on updating your provider demographics and associate dentists that are available to Liberty members.

The benefits of online DIV updates:

- Fix what's wrong with the click of a button.
- No filling out paper forms and faxing or emailing.
- Provide the most up-to-date information to existing and new members so they can make educational decisions about their provider office choices.

You will need to have your office Access Code to use the online feature. This number can be found in your Liberty Welcome Letter. If you are unable to locate your access code, please contact the Provider Relations Department at **888.352.7924** for assistance.

Provider Resource Library

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

Section 4. Eligibility

How To Verify Eligibility

Providers are responsible for verifying member and provider eligibility before each visit. Member and Provider eligibility may be verified via Liberty's Provider Portal. Member eligibility could also be verified via the AHCCCS Portal. The member ID card does not guarantee eligibility. Checking member eligibility at the time of service will allow you access to the most up to date eligibility information and reduce the risk of denied claims. Verifying provider eligibility will ensure the provider is eligible to receive payments for the specific plan the member is enrolled in.

There are several options available to verify eligibility:

- Provider Portal - We recommend using the member's last name, first name, and date of birth for best results when checking member eligibility. Provider eligibility can be checked at the member level. Please see Liberty's Provider Portal User Guide for more details.
- Telephone - Speak with a live representative from 8am to 5pm PST, Monday – Friday by contacting 888.352.7924.

Eligibility Rosters (Capitation Programs Only)

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

- Member name
- Dependent(s) name(s) or number of dependents covered when applicable
- Member identification number
- Member date of birth
- Group name (if through employer group, name of employer)
- Type of coverage (plan number/name)
- Effective date of coverage

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

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

Member Identification Cards

Members should present their ID card at each appointment. Providers are encouraged to confirm the identity of the person presenting an ID card by requesting some form of photo identification. The presentation of an ID card does not guarantee eligibility and/or Liberty's payment of benefits. Not all Liberty plans provide printed ID cards. In such cases, providers should check a photo ID and check against an eligibility list, contact the Member Services Department, or login to the Provider Portal for verification of both the ember and provider's eligibility. Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

Any person who is enrolled in a Health Plan's dental program is eligible for benefits as described in their member handbook. Members receive identification cards from their Plan. Participating providers are responsible for verifying Members are eligible at the time services are rendered.

Mercy Care Medicaid Member Identification Cards

ACC-RBHA


ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
mercy care
Arizona Health Care Cost Containment System
Mercy Care Member Identification Card
Member Name: <MBRLAST>, <MBRFIRST> <MBRMI>
AHCCCS ID#: <AHCCCSID>
RXBIN: 610591 RXPCN: ADV RXGRP: RX8805
Arizona Behavioral Health Crisis Line: 1-844-534-4673
National Suicide and Crisis Lifeline: 988
Member Services: 602-263-3000 | 1-800-624-3879 | TTY 711

Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit mercycareaz.org.

Lleve consigo esta tarjeta todo el tiempo. Preséntela cuando reciba servicio. Es posible que le pidan una identificación con fotografía. Usar la tarjeta inapropiadamente es una violación a la ley. Esta tarjeta no es una garantía para los servicios. Para verificar los beneficios visite mercycareaz.org.

Member Services: Monday to Friday, 7 a.m. to 6 p.m.
602-263-3000 | 1-800-624-3879 | TTY 711
24-hour Nurse Line: 602-263-3000 | 1-800-624-3879
Caremark Pharmacy Help Desk: 1-855-548-5646

ACC-RBHA (SMI)


ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
mercy care
Arizona Health Care Cost Containment System
Mercy Care Member Identification Card
Member Name: <MBRLAST>, <MBRFIRST> <MBRMI>
AHCCCS ID#: <AHCCCSID>
RXBIN: 610591 RXPCN: ADV RXGRP: RX8822
Arizona Behavioral Health Crisis Line: 1-844-534-4673
National Suicide and Crisis Lifeline: 988
Member Services: 602-586-1841 | 1-800-564-5465 | TTY 711

Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit mercycareaz.org.

Lleve consigo esta tarjeta todo el tiempo. Preséntela cuando reciba servicio. Es posible que le pidan una identificación con fotografía. Usar la tarjeta inapropiadamente es una violación a la ley. Esta tarjeta no es una garantía para los servicios. Para verificar los beneficios visite mercycareaz.org.

Member Services: 24 hours a day, 7 days a week
602-586-1841 |1-800-564-5465 | TTY 711
24-hour Nurse Line: 602-586-1841 |1-800-564-5465
Caremark Pharmacy Help Desk: 1-855-319-6295

ALTCS


ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
mercy care

Arizona Health Care Cost Containment System
Mercy Care Member Identification Card

Member Name: <MBRLAST>, <MBRFIRST> <MBRMI>
AHCCCS ID#: <AHCCCSID>
RXBIN: 610591 RXPCN: ADV RXGRP: RX 8805
Arizona Behavioral Health Crisis Line: 1-844-534-4673
National Suicide and Crisis Lifeline: 988
Member Services: 602-263-3000 | 1-800-624-3879 | TTY 711

Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit mercycareaz.org.

Lleve consigo esta tarjeta todo el tiempo. Preséntela cuando reciba servicio. Es posible que le pidan una identificación con fotografía. Usar la tarjeta inapropiadamente es una violación a la ley. Esta tarjeta no es una garantía para los servicios. Para verificar los beneficios visite mercycareaz.org.

Member Services: Monday to Friday, 7 a.m. to 6 p.m.
602-263-3000 | 1-800-624-3879 | TTY 711
24-hour Nurse Line: 602-263-3000 | 1-800-624-3879
Caremark Pharmacy Help Desk: 1-855-548-5646

DDD


ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA DEPARTMENT OF ECONOMIC SECURITY
mercy care

Arizona Health Care Cost Containment System
Mercy Care Member Identification Card

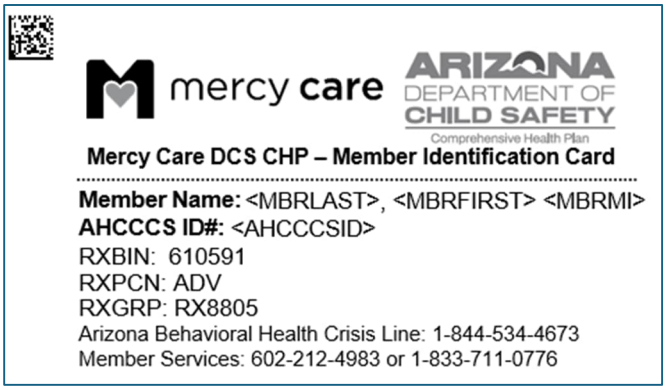
Member Name: <MBRLAST>, <MBRFIRST> <MBRMI>
AHCCCS ID#: <AHCCCSID>
RXBIN: 610591 RXPCN: ADV RXGRP: RX8805
Arizona Behavioral Health Crisis Line: 1-844-534-4673
National Suicide and Crisis Lifeline: 988
DDD Customer Service Center: 1-844-770-9500 opt. 1
Member Services: 602-263-3000 | 1-800-624-3879 | TTY 711

Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit mercycareaz.org.

Lleve consigo esta tarjeta todo el tiempo. Preséntela cuando reciba servicio. Es posible que le pidan una identificación con fotografía. Usar la tarjeta inapropiadamente es una violación a la ley. Esta tarjeta no es una garantía para los servicios. Para verificar los beneficios visite mercycareaz.org.

Member Services: Monday to Friday, 7 a.m. to 6 p.m.
602-263-3000 | 1-800-624-3879 | TTY 711
24-hour Nurse Line: 602-263-3000 | 1-800-624-3879
Caremark Pharmacy Help Desk: 1-855-548-5646

DCS CHP


mercy care
ARIZONA DEPARTMENT OF CHILD SAFETY
Comprehensive Health Plan

Mercy Care DCS CHP – Member Identification Card

Member Name: <MBRLAST>, <MBRFIRST> <MBRMI>
AHCCCS ID#: <AHCCCSID>
RXBIN: 610591
RXPCN: ADV
RXGRP: RX8805
Arizona Behavioral Health Crisis Line: 1-844-534-4673
Member Services: 602-212-4983 or 1-833-711-0776

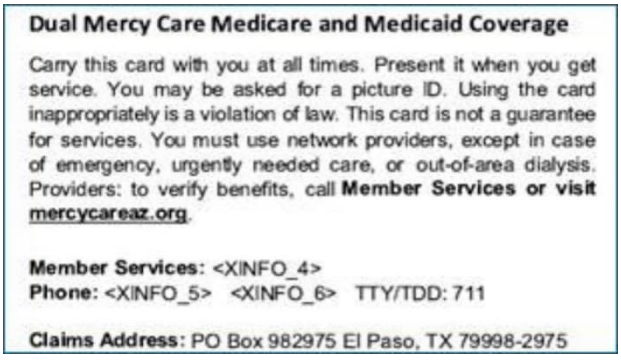
Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit mercycareaz.org.

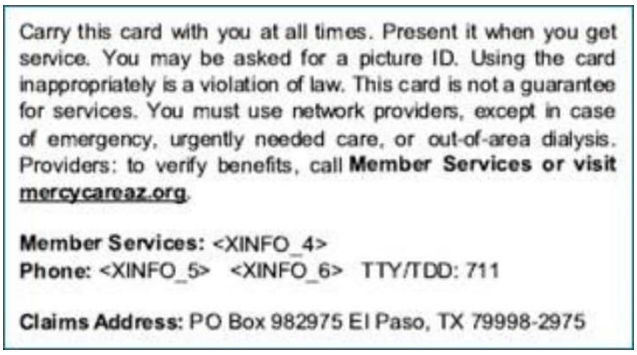
Lleve consigo esta tarjeta todo el tiempo. Preséntela cuando reciba servicio. Es posible que le pidan una identificación con fotografía. Usar la tarjeta inapropiadamente es una violación a la ley. Esta tarjeta no es una garantía para los servicios. Para verificar los beneficios visite mercycareaz.org.

Member Services: Monday-Friday, 8 a.m. to 5 p.m.
602-212-4983 | 1-833-711-0776 | TTY 711
24-hour Nurse Line: 602-212-4983 | 1-833-711-0776
Caremark Pharmacy Help Desk: 1-800-509-6854

Mercy Care Medicare Advantage and Duals Member Identification Cards

Please see Section 14 Medicare Dental Program for more information.





Eligibility Verification System (EVS)

Mercy Care Eligibility

602.263.3000

800.624.3879

Section 5. Claims and Billing

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

government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid.

Claims submitted to Liberty must reflect the date the actual treatment was rendered to a member. If the member was not seen, then no treatment was provided and therefore no claim should be submitted. The date of service indicated in Box 24 of the claim form must be the date that the service was completed and/or delivered.

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

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

Liberty receives dental claims in four possible formats:

- HPAA compliant "837D" file
- Electronic submissions via clearinghouse
- Electronic submissions via Liberty's **Provider Portal**
- Paper claims

HIPAA Compliant 837D File

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

Electronic Submission – Claims, Prior Authorizations and Referrals

Liberty strongly encourages the electronic submission of claims. This convenient feature assists in reducing costs, streamlining administrative tasks, and expediting claim payment turnaround time for providers. There are two options to submit electronically:

- **Provider Portal**
- 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
Vyne Dental	**463.218.6519**	**www.vynedental.com**	CX083

All electronic submissions must follow state and federal laws, and Liberty's policies and procedures. National Electronic Attachment, Inc. (NEA) is recommended for electronic attachment submission. For additional information regarding NEA and to register your office, please visit **www.nea-fast.com**, select FASTATTACH™, then select Providers.

Paper Claims

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

	Liberty Dental Plan	Liberty Dental Plan	Liberty Dental Plan
Products	P.O. Box 26110	P.O. Box 15149	P.O. Box 401086
	Santa Ana, CA 92799-6110	Tampa, FL 33684	Las Vegas, NV89140
Commercial	All states except FL & NV	FL	NV
Medicare	All other Medicare plans	Devoted and MMM	N/A
Exchange	All Exchange	N/A	N/A
Medicaid	CA	FL and OK	AZ, NV, NJ, NY, and TX

"Clean" Claims

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

- Provider name and address
- Member name, date of birth, and member ID number
- Date(s) of service
- CDT diagnoses code(s)
- Billed charges for each service or item provided
- Provider Tax ID number and/or social security number
- Name and state license number of dentist

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

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

Claims Submission Protocols and Standards

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

- All claims must be submitted to Liberty for payment of services with the member ID number, first and last name, and pre-or post-treatment documentation, if required.

- Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these NPIs will be rejected. All health care providers, health plans, and clearinghouses are required to use the NPI number as the only identifier in electronic health care claims and other transactions.
- All claims must include the name of the program under which the member is covered and all the information and documentation necessary to adjudicate the claims.

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

Date of Insertion

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

Claims Status Inquiry

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

Phone
888.352.7924

Online
Provider Portal

Claims Status Explanations

Claim Status	Explanation
Completed	Claim is complete and one or more items have been approved
Denied	Claim is complete and all items have been denied
Pending	Claim is not complete and is being reviewed for benefit determination

Claims Resubmission

Providers have **three hundred sixty-five (365) calendar days** from the original request a resubmission or reconsideration of a claim that was previously denied for:

- Missing documentation
- Incorrect coding
- Processing errors

Claims Overpayment

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

Notice Of Overpayment of a Claim

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

Contested Notice

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

No Contest

If the provider does not contest Liberty's notice of a claim overpayment, the provider must reimburse Liberty **within thirty (30) working days** of the provider's receipt of Liberty's notice of claim overpayment. If the provider does not contest the overpayment notice and fails to reimburse Liberty **within thirty (30) working days** of the receipt of Liberty's notice of claim overpayment, Liberty may offset the amount of the overpayment from any amounts due to the provider for current and/or future claim submissions as described below.

Offset To Payments – Uncontested Notice of Overpayment

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

Prompt Payment of Claims

Liberty's processing policies, payments, procedures, and guidelines follow applicable state and federal requirements.

Electronic Funds Transfer (EFT) And Optum Echo Platform

For accurate and timely reimbursements, Liberty offers direct deposit services.Our Electronic Fund Transfer (EFT) platform enables providers to receive payments faster and access funds quicker than traditional paper check reimbursements. This provides levels of security that are not possible with paper checks as items cannot be lost or stolen out of the mail, misused, misplaced, or incorrectly deposited into wrong accounts. To utilize our EFT services, complete the **EFT form** located on our website.

Liberty uses the Optum ECHO platform in several states for payment processing. To enroll in ECHO please complete the **ECHO Electronic Fund Transfer and Remittance Advice Form** located on our website. For more information, please reference the **ECHO EFT-ERA Reference Guide**.

Your state's **Provider Resource Library** houses the applicable forms and guides for your office needs.

Paper Checks

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

Peer-To-Peer Communication

If you have questions or concerns about a referral, prior authorization and/or claim determination and would like to speak to a licensed clinical reviewer, you may contact the number listed on the Explanation of Payment.

Please leave a detailed message and your call will be returned by a licensed clinical reviewer.

Filing Limits - Medicaid

In accordance with ARS §36-2904, an initial claim for services must be received by Liberty no later than six (6) months from the date of service. Claims initially received beyond the 6-month time frame will be denied.

If a claim is originally received within the 6-month time frame, you have up to 12 months from the date of service to correctly resubmit the claim to achieve clean claim status or to adjust a previously processed claim. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, Liberty is not required to pay the claim.

If a claim is denied for "untimely filing", the provider cannot bill the member.

As defined by ARS §36-2904 a "clean claim" is a claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Claim Disputes

Claim Disputes are processed in accordance with established law, rules, and procedures set forth by AHCCCS (ARS §36-2903.01 and AAC R9-34-401 et seq). If you disagree with a decision made on your claim by the licensed Dental Consultant, you can file a written Claim Dispute. The claim dispute will be reviewed by a different licensed Dental Consultant and a Mercy Care Dental Director. Per AHCCCS rules, claim disputes challenging claim payments, denials or recoupment must be filed in writing no later than twelve (12) months from the date of service, twelve (12) months from the date of eligibility posting or **within sixty (60) days after the date of denial of a timely claim submission**, whichever is later. Untimely disputes will be denied as untimely, and the merits of the dispute will not be addressed.

Please submit the following documentation with the written claim dispute:

- Cover letter stating the problem and the relief requested.
- Name of the person filing the dispute and that person's phone number.

- Provider mailing address.
- Copy of the claim (including EOB's from any primary payors, if applicable).
- Copies of all supporting documentation, which may include, but is not limited to:
- Medical records to support your argument.
- Documentation of phone calls or other correspondence to support your argument.
- Documentation of reference materials (such as policies, medical standards, or coding information) to support your argument

Claim disputes MUST be sent to:

Mercy Care Plan Dental Appeals
Attn: Appeals Department
4755 S. 44th Place, Ste 150
Phoenix, AZ 85040

State Fair Hearing

If you are not satisfied with the claim dispute decision, you may submit a *Request for State Fair Hearing*. The Request for State Fair Hearing must be received, in writing, by the **health plan**, within thirty (30) calendar days from the receipt of the Notice of Decision. The Health plan will forward a copy of the Request for State Fair Hearing and the health plan's file to the AHCCCS Office of Administrative Legal Service within five (5) working days. AHCCCS is responsible for scheduling the hearing. Hearings are held in person at the Office of Administrative Hearings (OAH). Alternatively, telephonic hearings are also available. It is important that you know that a hearing means you must appear, or your case will be dismissed. If you want to appear telephonically, you must submit that request to OAH. Additional information about hearings can be found at the OAH website: https://www.azoah.com If at any time you wish to withdraw your request for hearing, it must be in writing and sent to OAH and to the health plan. Motions can be sent to OAH either by fax or through their website.
Office of Administrative Hearings fax: 602-542-9827.
Mercy Care fax: 602-351-2300
If you win the hearing, Liberty will reprocess the claim in a manner consistent with the Decision within 15 business days of the date of the Director's Decision.

Section 6. Coordination of Benefits

Coordination of Benefits (COB) applies when a member has more than one source of dental coverage. The purpose of COB is to allow members to receive the highest level of benefits **up to 100%** of the cost of covered services. COB also ensures that providers do not collect more than the actual cost of the member's dental expenses.

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

Identifying the Primary Carrier

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

When there is a break in coverage Liberty will be primary based on Liberty's effective date versus the new group effective date. The table below can assist your office in determining the primary carrier.

Patient is the Member	Primary
Member has dental coverage through employee	Member coverage is always primary
Member has dental coverage as an active employee and coverage through the spouse	Member coverage is primary
Member has two active insurance carriers; both provide dental coverage	The carrier with the earliest effective date is primary
Member has dental coverage through a group plan and COBRA coverage	Group plan is primary
Member has dental coverage as an active employee of one plan and as a retired employee of another plan	The active coverage is primary
Member has two retiree plans	The carrier with the earliest effective date is primary
Member has a retiree plan, and spouse holds a group plan	Spouse's group plan is primary
Member has dental coverage through a group plan and individual or supplemental coverage through another carrier Examples: • Student Accident Plans • Supplemental Plans (Western Dental) • Prepaid Trust Plans • Individual Plan (AFLAC) • Reimbursement Plans	Group plan is primary

Member has a Discount/Reduced Fee Plan	Liberty does not coordinate discount/reduced fee plans.
Member has a government funded plan and individual or supplemental coverage through another carrier	Government funded plan is primary
Member has two government funded plans. One is Federal (Medicare), and the other is State (Medicaid, Medi-Cal or Value Add)	Federal coverage is primary
Member has dental coverage through a group plan and a government (Medicaid/Medicare) funded plan	Group plan is primary
Member has dental coverage through a retiree plan and a government funded plan	Government funded plan is primary
Member has COBRA coverage and a Medicare plan	Medicare plan is primary
Member has two Medicare plans	The Plan with the earliest effective date is considered primary
Member has a government funded plan and spouse holds a group plan	Spouse's group plan is primary
Member is a Medicare beneficiary aged 65 or older and has Group Health Plan	Individual is age **65 or older**, is covered by a group plan through current employment or spouse's current employment and the employer has less than **20 employees**: Medicare pays primary, Medicaid is payor of last resort.

Figure 6.1

Coordination of Benefits Scenarios

When Liberty is Primary Carrier

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

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

When Liberty is Secondary Carrier

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

When Liberty is secondary, payment is based on the lesser of either:

- the amount that Liberty would have paid in the absence of any other dental benefit coverage, or
- the member's total out-of-pocket cost payable under the primary carrier for benefits covered under Liberty. (That means whatever amount remains on the member's bill that was not paid by the member's primary carrier is now the responsibility of Liberty to pay as long as the remaining amount is for procedures that are covered benefits of Liberty.)

When the Member has Two Managed Care Plans (DHMO-CAP Program)

When the member is eligible under two managed care programs and assigned to the same contracted dentists, the member would be responsible for the copayment of the plan with the lesser copayment (Plan #2 fig 6.2) for the covered benefit. The member can be charged for copayment under one program only. If the treatment is a benefit under one program only, the applicable copay for that program applies (Plan #1 fig 6.3).

Examples:

CDT Code	Carrier	Copayment	Member's Portion	Determination
D7240	Plan #1 Plan #2	$150 $125	$125	The plan with the lesser copayment

Figure 6.2

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

Figure 6.3

Section 7. Professional Guidelines and Standards of Care

Primary Care Dentist (PCD) Responsibilities

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

- Provide and/or coordinate all dental care for the member
- Follow CMS "Plan Directed Care" requirements
- Ensure the services you are furnishing are covered by the member's plan. For services not covered by the member's plan, the provider must obtain pre-approval and wait for determination prior to services being rendered.
- Verify provider eligibility to provide covered services for the member's plan and ensure members have access to an in-network dentist.

All providers shall complete the appropriate informed consents and treatment plans for members, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member or the member's Health Care Decision Maker.

Mercy Care Appointment Guidelines

Dental Provider Appointments:

- **Urgent** appointments as expeditiously as the member's health condition requires, but no later than three (3) business days of request.
- **Routine** care appointments within 45 calendar days of request.
- **Comprehensive Health Program (CHP) routine care appointments within 30 calendar days of request.**

Dental Specialty Provider Appointments:

- **Urgent** appointments as expeditiously as the member's health condition requires, but no later than three (3) business days of request, and
- **Routine** care appointments within 45 calendar days of referral.

Mercy Care Advantage – For additional information, please see Section 14, Medicare Dental Program

- **Emergency** appointments – within 24 hours of request
- **Urgent** appointments – within 3 days of request
- **Routine** appointments – within 45 days of request

After Hours Coverage

Each provider must have 24 hours per day, 7 days per week coverage.

Covering Providers

When a contracted provider is going to be out of the office for an extended period of time, the provider is responsible for arranging emergency coverage. The provider should make every attempt to arrange for another contracted provider to provide that coverage. If the covering provider is not contract with Liberty, you should notify your Provider Relations Representative in advance. Liberty must authorize services before the non-contracted covering provider can render services. Reimbursement to non-contracted covering physicians is based on the Liberty Fee Schedule.

Appointment Availability Non-Compliance

In accordance with AHCCCS policy, contracted dentists will be accessible to enrolled members to provide routine and emergency care on a timely basis. Providers will be asked to implement a corrective action plan when appointment availability standards are not met.

Telephone surveys will be conducted to ensure appointment availability compliance. If your office fails to comply with any of the three (3) areas of routine, urgent, or emergency access standards, your office will be notified, and a corrective action plan must be submitted.

Section 8. Specialty Care Referral Guidelines

A member requiring a referral to a dental specialist can be referred directly to any specialist contracted with Liberty without authorization from Liberty. The dental specialist is responsible for obtaining prior authorization for services according to the policies of this manual. If you are unfamiliar with the Liberty contracted specialty network or need assistance locating a certain specialty, please contact Liberty's Member Services Department at 888.352.7924.

Section 9. Clinical Dentistry Guidelines

Liberty's Clinical Criteria, Guidelines and Practice Parameters (CCGs) are developed by Liberty's Dental Directors with input from participating panel general dentists and specialists. Liberty utilizes the American Dental Association's (ADA) "Dental Practice Parameters", American Academy of Pediatrics (AAP), American Association of Oral and Maxillofacial Surgeons (AAOMS), American Association of Endodontics (AAE), clinical principals within community dental standards.

Disclaimer

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

The Clinical Criteria Guidelines are available on Liberty's website at the **following link** or by scanning the QR code.

Participating general dentists and specialists agree to comply with these Clinical Criteria, Guidelines and Practice Parameters by virtue of their signed Liberty Provider Agreement or by reference to this document in their applicable provider manual, if participating through a leased network.

Section 10. Quality Management

Purpose, Goals, And Objectives

Purpose, Goals, And Objectives

Liberty's Quality Improvement and Oral Health Access Program[1] ensures that members receive safe, timely and appropriate dental care. The program aligns with all AHCCCS and CMS regulations, and applicable contract requirements and focuses on improving clinical quality, member safety, preventive care and overall dental experience. Through ongoing monitoring feedback, and collaboration with providers, Liberty works to identify opportunities for improvement and promote high standards of care across the network.

Program Description

The QM Program evaluates the quality and effectiveness of dental care delivered to members. Activities include reviewing clinical documentation, evaluating access to care and services, utilization of preventative services, continuity of care, and responding to member and provider feedback. The QM Program is reviewed and updated annually with an emphasis on monitoring the provisions and utilization of services to ensure the quality and safety of member care delivery against standards and performance goals. These efforts help ensure that services meet clinical standards and support positive oral health outcomes.

Provider Responsibilities in the Quality Program

Providers play a critical role in Liberty's ability to maintain a strong quality program. Providers are expected to deliver evidence-based care, maintain complete dental records, and support quality activities when requested. These responsibilities help ensure members receive appropriate, effective, and timely care.

Providers must:

- Follow AHCCCS, CMS, ADA, and evidence-based guidelines, including the EPSDT periodicity schedule.
- Maintain accurate, complete, legible clinical documentation
- Provide records when requested for quality review
- Support corrective actions when needed
- Ensure timely access to appointments and follow-up
- Report quality or safety concerns to Liberty Dental Plan.

[1] For AZ, Quality Improvement and Oral Health Access Program is referred to as the Quality Management Program

Records Review

Liberty Dental Plan conducts routine dental record reviews to evaluate documentation quality, treatment planning, radiographic support, and compliance with EPSDT requirements for members under 21. These reviews help identify improvement opportunities and guide quality feedback to providers.

Records Review evaluate:

- Accuracy and completeness of documentation
- Medical necessity and justification of services
- Appropriateness of treatment plans
- Preventive service delivery and EPSDT adherence.

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

Utilization Management

Liberty's Dental Plan Utilization Management Program ensures that dental services are medically necessary, appropriate, and consistent with AHCCCS-covered benefits. UM decisions are based on evidence-based clinical criteria, AHCCCS guidelines, ADA standards, and the member's individual needs. The program supports appropriate utilization of service while ensuring members have access to effective, high-quality care.

As required by AHCCCS Medical Policy 431, Liberty conducts periodic chart reviews to assess delivery of EPSDT services for members under 21. These reviews evaluate documentation of preventative care, diagnosis, treatment planning, and adherence to AHCCCS EPSDT periodicity requirements.

A link to AHCCCS Medical Policy 431 is provided here for reference:

AHCCCS Medical Policy 431

Providers play a key role in the UM process by submitting complete documentation and requesting prior authorization (PA) when required. UM decisions for members under 21 also consider AHCCCS EPSDT requirements and appropriate preventive care expectations. Submitting accurate information helps support timely decision making and ensures members receive necessary services without delay.

Providers are expected to:

- Submit complete prior preauthorization requests
- Include radiographs, chart notes, and treatment plans
- Respond promptly to requests for additional information
- Follow Liberty's covered benefits and PA requirements
- Notify members when services are non-covered or require PA

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

Liberty determines which dental services require prior authorization based on:

- Clinical Standards of practice: Liberty's Clinical Criteria Guidelines are key components to the medical necessity decision-making process and ensure that decisions are based on sound

clinical evidence. The CCGs are developed, updated, and reviewed by clinicians through our Peer Review Committee, which consists of both Liberty and network dentists, and reports directly to the Liberty Quality Improvement and Oral Health Access Committee. The Clinical Criteria Guidelines are updated annually for formal adoption and adhere to all state and federal regulations and guidelines. The CCGs are developed with guidance from the American Dental Association, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatric Dentistry, American Association of Endodontics, American Association of Orthodontics, and the American College of Prosthodontists. In addition, our Peer Review Committee utilizes contemporary research, practice trends, and literature reviews to help inform any updates or necessary edits, changes, or additions.

Utilization Review: We include ongoing results of our Utilization management and review processes to determine which services should be reconsidered for prior authorization. In situations where services might seem to be excessive or abused without prior authorization occurring, we will consider changing the requirements for that procedure for the following plan year. When doing so, provider notification would occur prior to the effective date of the new plan year.

Medical Necessity Determination

Liberty identifies which procedures require medical necessity determination. Liberty's definition of medical necessity aligns with all federal and state requirements, and nationally accepted clinical criteria and practices.

We approve care that is "medically necessary" and "appropriate," meaning:

- The treatment or supplies are needed to evaluate, diagnose, correct, alleviate, ameliorate/prevent the worsening of, or cure a physical condition and meet accepted standards of dentistry
- Will prevent the onset of an illness, condition, or disability
- Will prevent the deterioration of a condition
- Will prevent or treat a condition that endangers life or causes suffering, pain, or results in illness or infirmity
- Will follow accepted medical practices
- Services are member-centered and consider the individual's needs, clinical and environmental factors, and personal values. The criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual

Processes to Ensure Consistent Application of Review Criteria

Liberty uses standardized review tools, AHCCCS policies, and evidence-based guidelines to ensure consistent and fair decision-making, Providers help support consistent reviews by submitting complete clear and accurate documentation. All authorization requests received are scanned and included in Liberty's electronic prior authorization process within our MIS. The Staff Dentist reviews each procedure for evidence of need and prognosis electronically through our HSP system.

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

Documentation
Written policies and procedures and Provider and Member Handbooks clearly identify the

procedures subject to prior authorization and how to process initial and continuing authorizations of services.

- Staff Dentist/ Dental Consultant Training: Receive ongoing and continuous training on state and plan specific medical necessity and prior authorization requirements, including our written policies and procedures. All Staff Dentists and Dental Consultants have extensive experience in both clinical practice and Utilization Review and receive continuing education and calibration to ensure that Liberty is current on all new and emerging trends in clinical dentistry.
- Monthly Quality Assurance reviews completed by the State Dental Director to ensure all UM decisions align with Liberty Clinical Criteria Guidelines.
- Quarterly Inter-Rater Reliability calibration exercises reviewing real authorizations. Internal goals/requirements require 89% agreement by all clinicians. Any clinician who performs UM review and fails to meet this goal is required to undergo one on one training with the Liberty National Director of Clinical Oversight and the State Dental Director until competency is achieved.

Program Standards and Guidelines

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

Provider Access Surveys

For all provider offices, Liberty conducts quarterly random office contacts to assess availability of appointments.

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

Corrective Action

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

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

Mercy Care Member Inquiries, Appeals, Request for State Fair Hearing, Complaints, and Grievances

Member Grievances and Appeals

Mercy Care/Liberty members have the right to file grievances or appeals when they are dissatisfied with the Plan, a provider, a service or a decision. All member grievances and appeals are processed by the Health Plan in conjunction with Liberty. Providers are expected to assist members with filing grievances and appeals when requested.

Member Grievances

Member Grievances include but are not limited to:

- Members' grievances to service quality
- The quality of care provided or recommended treatment
- Interpersonal relations with dental office staff
- Access to appointments and treatment
- Concerns with costs of treatment
- Access to interpreters and language barriers

Concerns about discrimination or harassment: A member can file a grievance (complaint) with their health plan regarding dissatisfaction with any aspect of their care (other than the appeal of actions). The Health Plan is available to assist members who need help in filing a grievance. Members can also seek assistance by contacting Liberty.

- Member Appeals: Members have the right to request a review of an adverse benefit determination or action issued by Liberty. An adverse benefit determination can mean any of the following: A denial or limited authorization of a requested service, including determinations based on the type or level of service; medical necessity, appropriateness, settings, or effectiveness of a covered service.
- The education, suspension, or termination of a previously authorized service.
- The denial, in whole or in part of payment for service. A denial in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an adverse benefit determination.
- The failure to provide services in a timely manner as defined by the state.
- The failure of the Plan to act within the required timeframes for the processing of member grievances and appeals (expedited and standard).
- The failure of the Plan to allow rural area residents with limited access, the opportunity to exercise their right to obtain services out-of-network.
- The email of a rural member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

When Liberty denies a request for authorization, or claim payment, a Notice of Adverse Benefit Determination (NABD) is mailed to the member, and an explanation letter is mailed to the requesting provider. The notices issued to both the members and the requesting provider will include instructions on how to file an appeal. **Expedited (Fast) Appeals**

Members, authorized representatives, or providers who believe that waiting for the standard resolution timeframe could seriously harm the member's life, health, or ability to function, have the right to request an expedited appeal. For a member to qualify for an expedited review, the criteria

must first be met. The expedited criteria include but is not limited to severe pain, bleeding swelling, and/or loss of bodily function. Expedited cases will be resolved as fast as the member's condition requires but no later than 72 hours from the time of the request. Cases that do not qualify for expedited review will continue through the standard process outlined above.

Member Grievance and Appeals Submissions

Members, authorized representatives can file grievances and appeals, in writing, electronically, over the phone, or in person. If a member grievance or appeal is received by Liberty, the Plan will ensure that the request is forwarded to the Health Plan in a timely manner.

Medicaid Members:

- Grievances can be filed at any time and do not have a filing limit.
- Appeals must be filed within sixty (60) calendar days from the date of the NABD.

Medicare Members:

- Grievance must be filed within sixty (60) calendar days from the date of the issue
- Appeals must be filed within sixty-five (65) calendar days from the date of the NABD

Providers and other representatives can only file grievances and appeals on behalf of members with appropriate written consent from the member. The written consent must expressly state that the member is allowing the individual to represent them during the grievances and appeals process and include the member's signature. Liberty provides a PHI Disclosure Form on our website for your reference. Member grievances and appeals should be submitted directly to the Health Plan by:

- **Phone:** 602.586.1719
- **Fax:** 602.351.2300
- **Email:** mcandg@mercycareaz.org
- **Mail/In Person:** Mercy Care, Grievances System Department, 4750 S. 44th Place, Ste. 150, Phoenix, AZ 85040

Once the member grievances and appeals processes have been initiated, the health plan will send the member or authorized representative an acknowledgment letter by mail. The health plan will respond to all member grievances and appeals directly with a Notice of Appeal Resolution letter within the required regulatory timeframes as determined by state and federal laws.

If the health plan requires more time, and it is in the best interest of the member, an extension of up to fourteen (14) calendar days may be requested. If this is necessary, the health plan will notify the member and/or authorized representative, verbally and in writing.

Medicaid Member State Fair Hearing

Members and authorized representatives who are not satisfied with the appeal decision have the right to request a State Fair Hearing. Request for a State Fair Hearing must be received, in writing, by the **health plan**, within sixty (60) calendar days from the receipt of the Notice of Appeal Resolution Letter.

The health plan will forward a copy of the request for a State Fair Hearing and a copy of the member's appeal file with all relevant documents to the AHCCCS Office of Administrative Legal Service within five (5) working days. AHCCCS is responsible for scheduling the State Fair Hearing. State Fair Hearings are typically held in person at the Office of Administrative Hearings. Telephonic hearings are also available. It is important that the member appears at the State Fair Hearing or the case will be dismissed.

Requests for State Fair Hearings must be in writing can be requested by:

- Faxing the request to the Health Plan at: 866-821-6628
- Faxing the Office of Administrative Hearings at: 602-277-0026

For more information about the member State Fair Hearing process go to the OAH website at: https://www.azoah.com/. The outcome of the State Fair Hearing will be issued to the member in writing within ninety (90) calendar days after the request. Cases in which the State Fair Hearing decision overturns the Plan's previous decisions will be processed as soon as the member's condition requires but no later than five (5) business days from receipt.

Expedited (Fast) State Fair Hearings

In some cases, members, authorized representatives, and providers can request an Expedited State Fair Hearing from the Office of Administrative Hearings. All requests for an Expedited State Fair Hearing must be in writing and meet the necessary criteria, which state that waiting for the standard resolution time would put the member's life, health or ability to function in jeopardy. Requests for an Expedited State Fair Hearing that meets the criteria will be resolved in writing within three (3) working days.

Provider Complaint and Dispute (Appeal) Resolution Process

Important Note: All pre-treatment authorization appeals are processed in accordance with the member appeals processes outlined above. Pre-treatment authorization appeals will not be reviewed through the Provider Complaint and Dispute process.

Medicaid and Medicare providers have the right to submit a complaint or a dispute regarding operational issues, claim denials, payment issues, recoupments, or other contractual or payment-related matters.

- Provider Complaints are a dissatisfaction with any aspect of the health plan's operations, polices, procedures, or staff that does not involve a claim denial, claim payment amount or recoupment.
- Provider Disputes are appeals involving a processed claim that is denied, paid incorrectly, recoupment efforts, or a sanction.

Provider Complaint and Dispute Submissions

Provider complaints and disputes must be submitted in writing to the health plan within the following timeframes:

- Medicaid providers must submit within 12 months after the date of service or posted eligibility or within sixty (60) calendar days of a denial of a timely claim submission.

- Medicare providers must submit within sixty (65) calendar days from the payment.

All requests must include supporting documentation, including but not limited to remittance advice(s), claim form, medical records, if applicable, and a written statement on why the provider is not in agreement with the initial decision. Requests that do not include all the required information may be returned or dismissed.

Provider can submit complaints and disputes in writing or electronic submission by:

- **Fax:** 833.250.1814
- **Email:** GandA@libertydentalplan.com
  Mail: Liberty Dental Plan, Attn: Grievances and Appeals Department, PO Box 26110 Santa Ana, CA 92799-6110

Medicare out-of-network providers must include a signed Waiver of Liability form with any provider disputes stating the member will not be balance billed. The Waiver of Liability form is available on the Liberty website for your reference.
For more information on the required documentation and information in support or provider complaints and disputes, see your Explanation of Payment.

The health plan will issue an acknowledgement confirming receipt within five (5) business days, followed by a written determination with thirty (30) calendar days from the date of receipt. The health plan may request an extension up to forty-five (45) days if needed.

Provider State Fair Hearings

Providers have the right to request a State Fair Hearing when the matter cannot be resolved through the health plans internal provider complaints and disputes process. This does not replace the health plans' internal processes and is only intended as a form of escalation.

Providers must participate in and exhaust the health plans; internal complaints and disputes processed before a State Fair Hearing can be requested.

Providers can only request a State Fair Hearing when the provider is aggrieved by a decision, action, denial, recoupment, or other actions impacting the provider’s right to payments or participation.

Provider State Fair Hearing Submission

Providers must request a state fair hearing in writing, clearly marked as a “State Fair Hearing Request”. All requests must include necessary identifying information, including the provider's name, identification/NPI number, contractor name, dates of service, claim numbers, and a factual/legal basis for the dispute.

- State fair hearing request must be submitted within thirty (30) calendar days after the notice that was not fully in the provider's favor or if the health plan did not issue a timely decision.

The outcome of the state fair hearing will be issued to the provider in writing within ninety (90) calendar days after the request. Cases in which the state hair hearing decision overturns the Plan’s previous decisions Liberty will approve or issue payment for those services are promptly and expeditiously as possible.

Section 11. Fraud, Waste, And Abuse

Fraud, Waste, And Abuse Program Description

Liberty's Special Investigative Unit's primary responsibilities include the detection, prevention, investigation, and reporting of fraud, waste, and abuse.

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

Examples of fraud may include:

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

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Examples of waste may include:

- Over-utilization of services
- Misuse of resources

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of abuse may include:

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

Both fraud and abuse can expose providers to criminal and civil liability.

Liberty expects all providers and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statue
- Physician Self-Referral Law (Stark Law)

- HIPAA
- Social Security Act
- US Criminal Codes

State & Federal False Claims Laws:

Federal False Claims Act (31 U.S.C. §§ 3729 - 3733) & Florida False Claims Act, Florida Statute (F.S. 68.081-68.09) The Federal False Claims Act is a law that prohibits a person or entity, from "knowingly" presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal government, and from "knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal government. The Act also prohibits a person or entity from conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. These prohibitions extend to claims submitted to Federal health care programs, such as Medicare or Medicaid. The Federal False Claims Act broadly defines the terms "knowing" and "knowingly." Specifically, knowledge will have been proven for purposes of the Federal False Claims Act if the person or entity: (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. The law specifically provides that a specific intent to defraud is not required in order to prove that the law has been violated.

Whistle Blower Protection Act: Private persons are permitted to bring civil actions for violations of the Federal False Claims Act on behalf of the United States (also known as "qui tam" actions) and are entitled to receive percentages of monies obtained through settlements, penalties and/or fines collected. Persons bringing these claims, also known as relators or whistleblowers, are granted protection under the law.

Specifically, any whistleblower who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by his or her employer because of reporting violations of the Federal False Claims Act will be entitled to reinstatement with seniority, double back pay, interest, special damages sustained as a result of discriminatory treatment, and attorneys' fees and costs.

Anti-Kickback Statute: What is the Anti-Kickback Statute The Anti-Kickback Statute is the popular name for The Medicare and Medicaid Fraud and Abuse Statute, 42 U.S.C. § 1320a-7b (b). The AKS is a federal criminal law. It prohibits offering or accepting kickbacks to generate health care business.

The Anti-Kickback Statute or AKS is a healthcare law that prohibits individuals and entities from a willful and payment of "remuneration" or rewarding anything of value – such as position, property, or privileges – in exchange for patient referrals that involve payables by the Federal healthcare programs. These payables include, but are not limited to, drugs, medical supplies, and healthcare services availed by Medicare or Medicaid beneficiaries.

Under the provisions of the Anti-Kickback Statute, the law prohibits the soliciting, receiving, offering, or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or kind.

Stark Law Physician Self-Referral Law: The Physician Self-Referral Law- the Stark Law refers to Section 1877 of the Social Security Act (the Act) 42 U.S.C. 1395nn.

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians (including dentists) from referring patients to receive "designated health/dental services" payable by Medicare or Medicaid from entities with which the physician (including dentist) or immediate family member has a financial relationship.

Law now insists that any medical professional who provides such a referral to a Medicare or Medicaid patient must concurrently provide written notice of that patient's right to go elsewhere along with a list of nearby alternatives.

Finalizing new, permanent exceptions for value-based arrangements to that will permit physicians and other health care providers to design and enter into value-based arrangements without fear that legitimate activities to coordinate and improve the quality of care for patients and lower costs would violate the physician self-referral law. This supports CMS' broader push to advance coordinated care and innovative payment models across Medicare, Medicaid, and private plans.

Liberty requires all its providers and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all Medicaid enrollees. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, illegal remuneration schemes, identity theft, or enrollees' medication fraud.

FWA Training is available via our company website – we have a training program providers can download in PDF format. We also include training for Fraud, Waste, and Abuse in our Provider Orientation packets. Liberty has posted Liberty's SIU Policy "Reporting Fraud, Waste, Abuse & Physical Abuse, Neglect, Exploitation, Unlicensed Activity" under provider compliance training resources.

This policy contains phone numbers for reporting fraud, waste, and abuse. State and federal regulations require mandatory Compliance and FWA Training to be completed by providers and subcontractors, as well as their employees, within 30 days of hire/contracting and annually thereafter. Records of the training must be maintained and readily available at the request of Liberty's Compliance Officer, State Medicaid Agencies, CMS. Note: An attestation for the completion of the FWA Training must be submitted as part of the credentialing process. If you or your employees have not taken Compliance and/or FWA Training, please log onto Liberty website: Annual Compliance Training. Please contact Provider Relations for additional instructions as needed. It is your responsibility and part of your contractual obligation to comply with all state and federal program requirements for your continued participation with Liberty dental plans.

Training and Documentation

As a contracted provider, you are required to train your staff and document training on the following components of the False Claims Act:

- Detailed information about the Federal False Claims Act
- Administrative remedies for false claims and statements

- Any State laws relating to civil or criminal penalties for false claims and statements
- The whistleblower protections under such laws.

Detailed information on the Deficit Reduction Act and False Claims Act can be found on both the CMS (https://www.cms.gov/) and AHCCCS websites (https://www.azahcccs.gov/).

Additionally, contracted providers must train their staff on recognizing, discovering and preventing Fraud, Waste and Abuse.

If a provider discovers or is made aware of any incidences of suspected Fraud, Waste or Abuse, this must be reported immediately. This should be reported directly to Liberty or the provider can also report directly to AHCCCS OIG by the following methods:

- AHCCCS fraud hotline: 602-417-4045 (in Arizona) or 888-ITS-NOT-OK (888-487-6686)
- OR via the online form on the AHCCCS website - https://www.azahcccs.gov/Fraud/ReportFraud/

Reports to AHCCCS OIG must be made within 10 calendar days of discovery of any suspected Fraud, Waste or Abuse. No action shall be taken on any claims that are noted to be potentially Fraud, Waste, or Abuse once referred to AHCCCS OIG.

Reporting Fraud, Waste and Abuse

Liberty has established several options which allow for confidential reporting of violations to Liberty. These options include the following internal mechanisms:

- Liberty's Corporate Compliance Hotline: (888) 704-9833
- Liberty's Compliance Unit email: compliancehotline@libertydentalplan.com
- Liberty's Special Investigations Unit Hotline: (888) 704-9833
- Liberty's Special Investigations Unit email: SIU@libertydentalplan.com
- AHCCCS OIG by the following methods:
    - AHCCCS fraud hotline: 602.417.4045 or 888.ITS-NOT-OK (888.487.6686)
    - OR via the online form on the SHCCCS website - https://azahcccs.gov/Fraud/ReportFraud/

Reports to AHCCCS OIG must be made within 10 days of discovery of any suspected Fraud, Waste, or Abuse. No action shall be taken on any claims found to be fraudulent in nature once referred to AHCCCS OIG.

FWA may be confidentially reported to the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG) Whistle Phone number at 1-800-HHS-TIPS 1-800-377-4950 or TTY 1-800-377-4950.

Providers must report all instances of suspected fraud, waste, and abuse.

Provider Self-Disclosure

The provider has an obligation to ensure that claims are submitted accurately. Section 1128J(d) of the Social Security Act requires providers to report and return overpayments to Liberty Dental Plan within sixty (60) days from the date the overpayment is identified. Examples of appropriate self-disclosure may include, but are not limited to:

- Billing errors
- Systemic errors
- Any self-audit which identifies an overpayment was made to the dental office by Liberty Dental Plan.

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

Section 12. Forms and Resources

Forms

Electronic forms are available for download including, but not limited to the following from the Provider Forms tab at Liberty 's website at:

1. Provider Resource Library
2. Select your state from the drop-down menu
3. Click "**Continue**" and then click on the document

Accessible resources include, but are not limited to the following:

- Provider Portal (iTransact) registration
- Secure email portal access
- Mandatory Annual Provider Compliance Training
- Liberty's Clinical Criteria and Guidelines
- Teledentistry Resources
- Value-based Program information
- Directory Information Validation (DIV)
- Americans with Disabilities Act (ADA) Survey
- Opioid Risk Tool

Accessible forms include, but are not limited to the following:

- ADA Claim Form
- CMS Appointment of Representative Form
- Electronic Fund Transfer (EFT) Form
- ECHO Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) Form
- Grievance Form - English
- Grievance Form - Spanish
- Informed Consent for Alternative Treatment Form - English
- Informed Consent for Alternative Treatment Form - Spanish
- Informed Consent for Alternative Treatment Form - Chinese
- Justification of Need for Prosthodontics
- Provider Complaint and Dispute Form (fillable)
- Provider Compliance Training & Attestation
- Specialty Care Referral Form

General Definitions

The following definitions apply to this Provider Reference Guide. Please note, AHCCCS has a list of definitions accessible via their website at: AHCCCS Definitions Weblink

"AHCCCS" means the Arizona Health Care Cost Containment System, as described in A.R.S. Section 36-2901, *et seq*., which is composed of the Administration, contractors, subcontractors and other providers entering into arrangements through which health care services are provided to eligible persons.

"Contract" means the document specifying the services provided by Liberty to:

- an employer, directly or on behalf of the State of Arizona, as agreed upon between an employer or Plan and Liberty (a "Commercial Contract")
- a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Arizona or its regulatory agencies or Plan and Liberty (a "Medicaid Contract")
- a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Centers for Medicare and Medicaid Services ("CMS"- formerly HCFA) or Plan and Liberty (a "Medicare Contract

"Covered Services" is a dental service or supply that satisfies all the following criteria:

- Provided or arranged by a Participating Provider to a Member;
- Authorized by Liberty in accordance with the Plan Certificate; and
- Submitted to Liberty according to Liberty's filing requirements

"Liberty Service Area" shall be defined as the State of Arizona

"Medically Necessary" means those Covered Services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law to prevent disease, disability and other adverse health conditions or their progression, or prolong life. To be Medically Necessary, the service or supply for medical illness or injury must be determined by Plan or its designee in its judgment to be a Covered Service which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of medical practice in the community.

"Member" means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A Member enrolled pursuant to a Medicaid Contract is referred to as a "Medicaid Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."

"Participating Provider" is a dental professional or facility or other entity, including a Provider that has entered into a written agreement with Liberty, directly or through another entity, to provide dental services to selected groups of Members.

"Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care, and which provides basic health services to enrolled members for a fixed prepaid fee.

"Provider" means the undersigned health professional or any other entity that has entered into a written agreement with Liberty to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

"Provider Dentist" is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

Section 13. Benefit Plans and Fee Addenda

Benefit Plans

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

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

Accessing My Contract Fees

Liberty

- Liberty's secure Provider Portal under "**My Resources**"
- Call Provider Services at **888.352.7924**
- Contact your assigned Provider Relations Network Manager
- Request via email at **provider@libertydentalplan.com**

Leased Network Partners

- Liberty is not able to fulfill requests for fee schedules from our leased network participating providers.
- Please contact the payor your provider/practice is directly contracted with to obtain copies of fee schedules.

Benefit Tables

The Benefit Tables identify covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Members. They are all inclusive for covered services.

Each category of service is contained in a separate table and lists:

- The ADA approved service code to submit when billing,
- A brief description of the covered service,
- Any age limits imposed on coverage,
- A description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
- An indicator of whether the service is subject to prior authorization or prepayment review
- Any other applicable benefit limitations.

When to submit documentation for the Liberty Authorization Process

For those procedures that require Authorization, the "Authorization Required" field will indicate "Y" for Pre-Authorization or "PPR" for Pre-Payment Review on the Benefits Table.

The type of documentation to be submitted will be under the "Documentation Required" field on the Benefits Table. Please note below when to submit documentation:

When documentation is requested **prior to beginning treatment or for Emergency treatment**:

"Authorization Required"	**"Documentation Required"**	**Treatment**	**When to Submit**
Yes	Documentation Requested	Non-emergency (routine)	Send documentation prior to beginning treatment
Yes	Documentation Requested	Emergency	Send documentation with claim after treatment

When documentation is requested **"with claim:"**

"Authorization Required"	**"Documentation Required"**	**Treatment Condition**	**When to Submit Documentation**
Yes	Documentation requested with claim	Non-emergency (routine) or emergency	Send documentation with claim after treatment

Providers with benefit questions should contact Liberty's Customer Service Department directly 888.352.7924

Emergency Treatment

Liberty recognizes that emergency situations may arise that may not permit authorization to be obtained prior to treatment. Treatment under these conditions is to alleviate member of a major source of pain and not meant to be comprehensive treatment. In these situations, services that require authorization, but are rendered under emergency conditions, should be submitted as a Claim for a Pre-Payment Review that requires the same "documentation" as required for pre-treatment authorization, as well as post treatment labeled x-rays, and chart notes. It is essential that the participating provider understand that claims sent without this "documentation" to support the emergency treatment rendered, will be denied for payment.

Adult Medicaid $1000 Annual Emergency Benefit Maximum

Effective 10/1/2017, Adult Medicaid members will have a $1000 Annual Emergency Benefit Maximum.

- The annual benefit begins each year on October 1st and runs through the following year, until 9/30. The annual max is renewed every year beginning October 1st with *no carryover*.
- The New Adult $1000 Annual Emergency Benefit is for all AZ Adult Medicaid

members, in addition to their current benefits. The Emergency Benefit includes a list of specific codes, when rendered in an Emergency situation and will be paid up to the Annual $1000 Max.

- For ALTCS, RBHA Tribal Benefits, DDD ICF, and DDD Adult members, this benefit is in addition to their current $1000 annual max benefit.
- Cancer, Transplant & Medical Exception Cases. Services approved and

  covered for Cancer, Transplant & Medical Exceptions cases are not subject to the $1000 Adult Emergency dental benefit.
- This is for *True Emergency services ONLY*.

  ➢ *A Dental Emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma*.

  - Please submit a claim for Emergency Services for pre-payment review as follows:
    - Box 35/Remarks area is required to have the word, "**Emergency**" in it.
    - In addition, please supply any documentation, narrative, or labeled x-rays to support the reason for the emergency services.
    - If not a TRU"E dental emergency as defined above, services will then be reviewed under the member's regular Adult plan guidelines.
  - The member's Benefit Maximum information, including the available balance can be verified when checking the member's eligibility via the Internet using Liberty's Provider Web Portal, or by contacting our provider services team at 888.352.7924.
  - Although Liberty permits the submission of a Prior Authorization, we encourage treating the emergency the day the patient presents with severe pain and/or infection.
  - Please review the member's specific benefit plan located on the Provider Portal.

The updated AHCCCS policy for ALTCS and the Emergency Adult benefits can be found at the AHCCCS website under the ACOM policy Chapter 310 Covered Services sections 310-D1 and 310-D2. You can use the following link: https://www.azahcccs.gov/shared/MedicalPolicyManual/. We request that you review the policies to ensure complete understanding of the benefits.

Mercy Care Department of Child Safety Comprehensive Health Plan Prior Authorization

The Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP) is a program administered by the Arizona Department of Child Safety (DCS). Mercy Care DCS CHP is the health plan for Arizona's children and youth placed in out-of-home care.

Members are enrolled with Mercy Care DCS CHP by their custodial agency (the agency that placed them in out-of-home care). Custodial agencies are:

- Arizona Department of Child Safety (DCS)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Court/ Juvenile Probation Office (AOC/JPO)

Prior-Authorizations

The Prior-Authorization request with any additional documentation is reviewed by the Clinical Review Specialist in the Utilization Management Department following the processes outlined above.

Pre-Payment Review for Claims

Liberty will allow claims submitted with the Prior Authorization procedure codes to process without a prior authorization for the child under 21 plans for pre-payment review ONLY if there is a true dental emergency or treatment changes under sedation.

All retrospective claims submitted for the Pre-Payment Review are determined in compliance with Utilization Management standards established by NCQA. Providers must submit the same supporting documentation with a claim submitted for a Pre-Payment Review as they would for a Prior-Authorization. The retrospective review claim is reviewed by the Clinical Review Specialist to determine coverage and to certify that the services were medically necessary. The clinical criteria utilized in the retrospective review are the same criteria utilized in the Prior-Authorization process to determine medical necessity and appropriateness of care. An Arizona licensed dentist reviews all services denied for medical necessity.

Please review the member's specific benefit plan located on the Provider Portal.

General Anesthesia Authorization Process/Anesthesia for Dental Services

Anesthesia for dental services can be done in different settings; either the dental office or a facility setting (Operating Room, Short Procedure Unit, Ambulatory Surgical Center, Outpatient Facility). The process is different for the two settings. Below you will find a summary and process for each.

In Office Requests

Requests for deep sedation/general anesthesia that will be performed in the dental office should be sent directly to Liberty for review. These requests may be submitted as a pre-payment review. Liberty will review the requested services and approve appropriate anesthesia based on the medical necessity of the specific member. An approval or denial will be based on the documentation submitted. The provider will receive a Provider Determination Letter notifying them of the approval or denial.

After the services have been rendered, the claim should be sent to Liberty for standard claim processing and adjudication. Anesthesia services provided without prior authorization and submitted for post payment review, must meet criteria for medical necessity or be subject to denial for payment.

Outpatient/Hospital Facility Requests

Requests for services to be performed in a facility or outpatient setting other than the dental office (such as: Operating Room, Short Procedure Unit, Ambulatory Surgical Center, Outpatient Facility) should be sent directly to Liberty for review. Such requests require prior authorization and are not allowed to be submitted retrospectively. In some cases, the provider may need to coordinate services with Mercy Care's Oral Health Care Liaison. The provider should submit their request with the following documentation:

- The treatment plan on a 2024 ADA claim form
- Documentation of medical necessity for OR/Hospital facility
- X-rays (if applicable)
- Planned date of service
- "Place of Treatment" (OR, Surgi center, Hospital, etc.) noted on Section 38 of ADA claim form
- Requests to be sent to:

Liberty Dental Plan – Attn: UM Dept.

P.O. Box 401086

Las Vegas, NV 89140

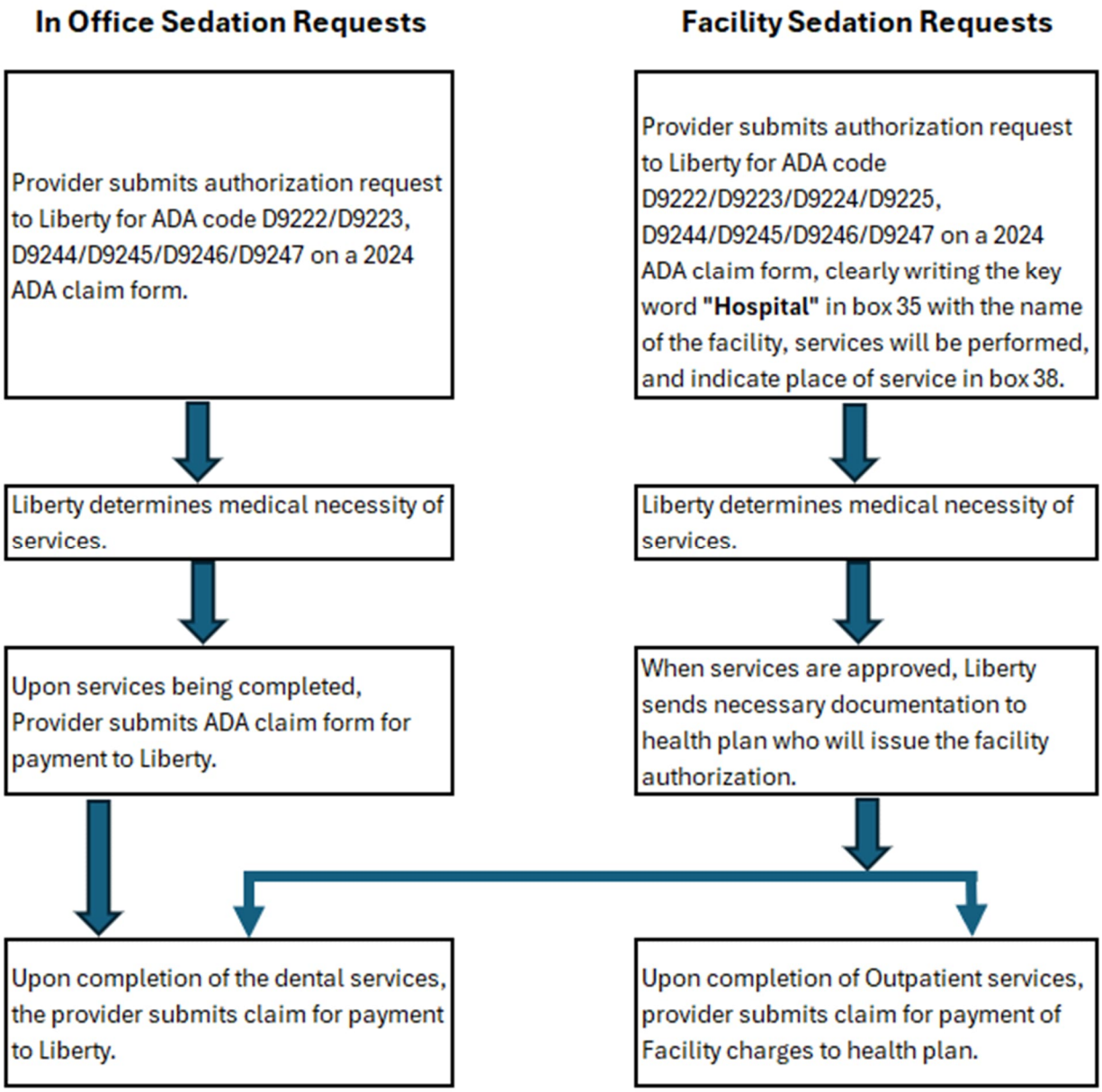
Fax: 800.268.0154

Email: **Provider@libertydentalplan.com**

Phone: 888.352.7924 or (TDD/TTY) 877.855.8039

Liberty will review the necessity to perform the services in an outpatient/hospital setting and will approve or deny the request.

Facility Authorizations for Sedation



Payment for Non-Covered Services

Participating Providers shall hold Members, Liberty, Plan and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. Provider may bill a Member for non-Covered Services if the Provider obtains a written and signed waiver from the Member prior to rendering such service that indicates:

- The services to be provided;
- Liberty, Plan and Agency will not pay for or be liable for said services;
- Member will be financially liable for such services.

Electronic Attachments

Radiographs

Liberty accepts dental x-rays electronically via **FastAttach™** for prior authorization requests. Liberty, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for x-rays, perio charts, intraoral pictures, documentation and EOBs.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with any claims clearinghouse or practice management system.

For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at: (800) 782-5150.

Orthodontic Models

Liberty does not require orthodontic models to be sent.

Mercy Care Pre-Service Appeals Process

Payment is contingent upon clinical criteria and/or the member's eligibility and benefit allowance on the date of determination. All pre-service appeals should be directed in writing to the Mercy Care Grievance and Appeals Department within sixty (65) calendar days. All documents, records and other information to support the appeal, including any written comments, should accompany the written appeal request.

Mercy Care Grievance and Appeals Department

4750 S. 44th Place, Ste. 150

Phoenix, AZ 85040

FAX: 860.907.3511

All post service appeals should be directed to Liberty in writing via fax 833-250-1814 or email ganda@libertydentalplan.com within sixty (60) calendar days. You may also send via mail at Liberty Dental Plan Grievances and Appeals Department, P.O. Box 26110, Santa Ana, CA 92799-6110 All documents, records and other information to support the appeal, including any written comments, should accompany the written appeal request.

The provider may appeal on behalf of the member, with member consent as an authorized representative. The provider or member may request the appeal be expedited. A written notice of appeal determination will be sent within thirty (30) calendar days from receipt, or seventy-two (72) hours for expedited requests. If a Provider has a question or concern regarding the determination, they may speak with a dental director during regular business hours. Providers and members may request a written copy of the clinical criteria or benefit provision used in the determination by calling Liberty at 888.352.7924.

Mercy Care Participating Hospitals:

All Hospitals are registered with AHCCCS.

Tooth Numbering

Liberty recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary primary teeth should be designated by the tooth number closest to its location followed by “S”. Supernumerary permanent teeth are identified by the numbers 51 through 82 as shown in the chart below:

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super" #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
"Super" #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Supernumerary teeth in the **primary** dentition are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (for example, supernumerary “AS” is adjacent to “A”; supernumerary “TS” is adjacent to “T”). This enumeration is illustrated in the following chart:

Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	A	B	C	D	E	F	G	H	I	J
‘Super’#	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Arch

Tooth “#”	T	S	R	Q	P	O	N	M	L	K
Super “#”	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.

For reimbursement, Liberty providers should bill only per unique surface regardless of location. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA code 2140. Furthermore, Liberty will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

The Liberty claim system can only recognize dental services described using the current American Dental Association CDT code list. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
(800) 947-4746

Liberty subscribes to the definition of services performed as described in the American Dental Association CDT manual.

Section 14. Medicare Dental Program

Providers and their staff members must coordinate care with an in-network associate within the member's primary care office. If an in-network associate is not available, the office must work with Liberty to obtain permission for the out-of-network associate to provide treatment as an in-network dentist.

Contact Liberty's Member Services Department to identify a contracted provider prior to referring a member to an out-of-network provider to ensure that members are receiving medically necessary services that are covered by the Plan.

If a referral is made to an out-of-network specialist by the member's in-network Dentist without prior approval, the referring office may be held financially responsible for any additional costs.

Guidelines

- Perform an oral evaluation
- Provide a written treatment plan to members that identifies covered services, non-covered services, and clearly identifies any costs associated with each treatment plan that is understandable by a prudent layperson with general knowledge of oral health issues
- Provide supporting materials for dental services and procedures which document their medical necessity
- Provide an informed consent discussion and supporting materials for all dental services and procedures for which the member has questions or concerns
- Treatment plans and informed consent documents must be signed by the member or responsible party demonstrating an understanding of the treatment plan and an agreement with a treatment plan and the associated financial terms
- A financial agreement for any non-covered service to be documented separately from any treatment plan or informed consent
- Work closely with specialty care provider to promote continuity of care
- Cooperate with, and adhere to Liberty's Quality Improvement and Oral Health Access
- Transformation Program
- Identify dependent children with special health care needs and notify Liberty of these needs
- The provider has the right to dismiss a member in writing to Liberty stating the reasons for dismissal.
- Dismissal may not include the following reasons:
    - Because the member's attempt to exercise his or her rights under the grievance system
    - Adverse change in the member's health status
    - Member's utilization of services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs
- Notify Liberty of a member death
- Arrange coverage by another provider when away from the dental facility
- Ensure that emergency dental services and/or information are available and accessible for members of record 24 hours a day, 7 days a week
- Maintain scheduled office hours
- Maintain dental records for a period of **ten (10) years**
- Post the availability of language assistance services signage in provider office

- Coordinate and provide language assistance services, which include telephonic and onsite interpretation services for members, when necessary
- Document member's preferred language and request/refusal of interpreting services in dental chart
- Provide Liberty with updated credentialing information upon request
- Provide requested information upon receipt of member grievance/complaint/appeal within **three (3) business days** of receiving the notice letter from Liberty
- Provide claim or encounter data on standard ADA claim form within timely filing requirements
- Capitation plans require disclosure of services rendered
- Notify Liberty of any changes regarding his or her practice, including location name, telephone number, address, associate additions/terminations, change of ownership, plan terminations, etc.
- If a member chooses to transfer to another participating dental office, there will be no charge to the member for copies of records maintained in their chart. All copies of records must be provided to the member within **fifteen (15) calendar days** of the request
- Provide dental services in accordance with peer-reviewed clinical principles, criteria, guidelines and any evidence-based parameters of care
- Providers may not close, or otherwise limit, their acceptability of members unless the same limitations apply to all commercially insured members
- Providers understand and agree that assignment of delegation by provider of services under its agreement with Liberty is null and void unless prior written approval is obtained from Liberty and, to the extent required, by Liberty from relevant Health Plan Partners

Specialty Care Dentist (SCD) Responsibilities

- All the responsibilities of the SCD listed above
- Provide specialty care to members
- Work closely with PCDs to ensure continuity of care
- Submit claims to Liberty for all dental services that were authorized
- Dentists with certification in the following specialties: Endodontics, Oral Surgery/OMFS, Periodontics, and Prosthodontics must have, or have confirmation of application submission, of valid DEA or waiver and CDS certificates
- Provide credentialing information upon renewal dates.

Mercy Care Advantage Provider Claim Issues

Whenever possible, Liberty attempts to informally resolve issues raised by contracted providers at the time of initial contact. If the issue cannot be handled informally, you may challenge the claim denial or adjudication by filing a request for reopening, in writing.

The requests for reopening will be handled by a reviewer who was not involved in the initial decision. Decisions will be consistent with Medicare rules and regulations; the Provider's contract terms and/or the Member's benefit plan. To request a reopening write to:

Liberty Dental Plan

P.O. Box 26110

Santa Ana, CA 92799-6110

Member Rights and Responsibilities

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

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

- Medicare eligible members have the right to know, upon request and in advance of treatment, whether the health care provider or facility accepts the Medicare assignment rate.
- Use Advance Directives (such as a living will or a durable health care power of attorney)

Voluntary Termination of the Provider Contract

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

National Provider Identifier (NPI)

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

As outlined in HIPAA, covered providers must also share their NPIs with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

How to Apply for an NPI

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

- **CMS Website**
- Dental providers can agree to have an Electronic File Interchange (EFI) Organization submit the application data on their behalf
- The provider can obtain a copy of the paper NPI application/update form (CMS-10114) by visiting **www.cms.gov** and mail the completed, signed application to the NPI Enumerator.

Standards of Accessibility and Availability

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

Availability Standards

Non-urgent appointments (exams, x-rays, restorative)	Not to exceed **Forty-five (45) business days**
Emergency appointment (acute pain/swelling/bleeding)	24 hours a day, 7 days a week
Preventive Care (Prophys or periodontal care)	Not to exceed **Forty-five (45) business days**
Lobby Waiting Time (for scheduled appointments)	Not to exceed **thirty (30) minutes**

After Hours and Emergency Services Availability

The provider's after-hours response system must enable members to reach an on-call dentist **twenty-four (24) hours a day, seven days a week**. In the event the primary care provider is not available to see an emergency for a member of record within **twenty-four (24) hours**, it is his/her responsibility to ensure that emergency services are available. Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider's "**after hours**" telephone service. Members must be scheduled within **twenty-four (24) hours** and should be informed that only the emergency treatment will be provided at that time. If the member is unable to access emergency care within these guidelines and must seek services outside of your facility, provider may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet Liberty guidelines, Liberty has the right to transfer some or all capitation programs enrollment to another provider or close your office to new enrollment.

Recall, Failed, or Cancelled Appointments

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

Please note that members who are eligible for both Medicare and Medicaid (duals) cannot be charged for a no show or missed appointment.

Appointment Rescheduling

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

Compliance With the Standards of Accessibility and Availability

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

Facility Physical Access for the 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
- Making reasonable modifications to policies, practices, and procedures, when necessary, to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e., alter the essential nature of the services).

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

Treatment Plan Guidelines

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

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

Non-Covered Services

Non-covered services can be discussed with the member.

Important Notice: Any non-covered services selected by a member must be clearly presented on a separate treatment plan clearly stating that the service is not covered, and that the member has been informed of covered services and elects the non-covered service and understands and accepts the financial responsibility. Liberty recommends that payment agreements with members be recorded in writing and agreed to by the member before any treatment is rendered. The member is responsible for **100% of the entire fee**.

Advanced Beneficiary Notice: Providers must notify members prior to service when a service may not be covered. Notice must state: The service being performed, the reason it may not be covered and estimated cost. The member must sign the notice before the service is provided. A copy must be given to the member for their records.

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

- Liberty must issue a denial of the prior-authorization request, and the member must exhaust their appeal rights.

- The provider must enter into a private-pay financial agreement with the member prior to rendering the service.
- The agreement should be a mutual and voluntary decision, and the member must consent in writing.
- The consent should include the specific codes, description, and dollar amount that the member is agreeing to pay the provider.
- The provider must maintain a record of the member's signed consent (for example, in the member's medical record). You may access the Consent for Non-Treatment Services in the **Provider Resource Library**.
- Treatment plans and **informed consent documents** must be signed by the member or responsible party demonstrating an understanding of the treatment plan and an agreement with a treatment plan and the associated financial terms.

Please note most Liberty commercial (non-governmental) plans allow for an upgrade in materials to noble or high noble metal and for porcelain on molar teeth with a signed treatment plan and informed consent by the member.

Second Opinions

Members may request a consultation with another network dentist for a second opinion to confirm a diagnosis and/or treatment plan at no cost. Providers should refer these members to the Member Services Department at **888.352.7924**, Monday through Friday, 8 a.m. to 5 p.m. PST.

Continuity And Coordination of Care

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

All care rendered to Liberty members must be properly documented in the member's dental charts according to established documentation standards. Communication between the PCDs and dental specialists shall occur when members are referred for specialty dental care. Liberty expects general dentistry providers to follow up with the member and with the specialist to ensure that referrals are occurring consistent with the best interests of the member. Specialist providers are encouraged to send treatment reports back to the referring general dentist providers to ensure that continuity of care occurs consistent with generally accepted standards of practice.

Liberty enforces Quality Improvement and Oral health Access Transformation (QIOHATP) Program policies and procedures that will ensure:

- An enrollment packet contains a list of providers that shall be given to all members upon enrollment
- A current list of providers is maintained on Liberty's web site at Find a Dentist
- Members who do not select a provider shall be assigned one, based on the member's geographic location (for capitation plans)
- Dental chart audits will verify compliance with documentation standards
- Guidelines for adequate communication between the referring and receiving providers when members are referred for specialty dental care are included in this provider guide
- During facility on-site audits, Liberty monitors compliance with continuity and coordination of care standards

- When a referral to a specialist is authorized, the general dentist provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and schedule the member for any appropriate follow-up care
- When a specialty care referral is denied, the general dentist provider is responsible for the evaluation of the need to perform the services directly, and schedule the member for appropriate treatment
- The results of site audits shall be reported to the Peer Review and Quality Improvement and Oral health Access Transformation Committees, and corrective action shall be ordered when deficiencies are identified

Alternative Treatment

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

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

Definition Of Alternative Treatment

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

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

Provider's usual fee for the alternative treatment (i.e., fixed bridge)	$2,100.00
Provider's usual fee for the covered treatment (i.e., partial denture)	$975.00

Difference between alternative treatment and covered treatment ($2,100.00-$975.00)	$1,125.00
Copayment for the covered treatment	$125.00
Total member's responsibility* ($1,125.00+$125.00)	$1,250.00

*This does not include any upgraded treatment.

Upgraded Treatment

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

When a member selects an upgraded treatment or material, they are responsible for the cost of the upgrades. The cost of upgraded materials should be based on the actual lab or material costs of such materials. For example: Provider's usual fee for the alternative treatment (i.e., fixed bridge)	$2,100.00
Provider's usual fee for the covered treatment (i.e., partial denture)	$975.00
Difference between alternative treatment and covered treatment ($2,100.00-$975.00)	$1,125.00
Copayment for the covered treatment	$125.00
Upgraded material (Total cost of material)	$500.00
Total member's responsibility* ($1,125.00+$125.00+$500)	$1,625.00

*Please refer to specific benefit plan designs for additional information

Infection Control

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

The Member's Dental Record

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

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

Dental records must be comprehensive, organized, and legible. All entries should be in ink, signed and dated by the treating dentist or other licensed health care professional who performed services. Electronic dental records must capture the dentist's identification (signature, initials, or other indication showing that the dentist has approved the chart entry in the electronic dental record).

Contracted dentists must make available copies of all member records to Liberty upon request. Records may be requested for grievance resolutions, second opinions or for state/federal compliance. The dentist must make records available at no cost to Liberty or the member. Non-compliance may

result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

Our Commitment Is Demonstrated Through Our Actions

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

Liberty has created and implemented internal corporate-wide policies and procedures to comply with the provisions of HIPAA. Liberty has and will continue to conduct employee training and education in relation to HIPAA requirements. Liberty has disseminated its Notice of Privacy Practices to all required entities. Existing members were mailed a copy of the notice, and all new members are provided with a copy of the notice with their member materials.

Safeguarding Protected Health Information (PHI)

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

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

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

Electronic PHI - Ensure referrals, authorization requests, medical records, and other e-PHI are transmitted via a HIPAA compliant method using secure fax, secure FTP, encrypted email (which

requires member authentication to access email content), or Liberty's secure web portal*. Note the following:

- Use of PHI (including member name, ID, or other identifying information) in the subject lines of emails or to name e-files is not permitted.
- Use of free email service providers, like Gmail, Hotmail, or Yahoo, is not a permitted method for transmitting Liberty member PHI*
- Transmission of PHI via text is not permitted*
- Liberty providers may transmit e-PHI to Liberty using Liberty's HIPAA compliant, secure web portal by following these simple steps:
    - Go to **www.libertydentalplan.com**
    - Go to "**Providers**" menu at the top of the page
    - Select "**Secure Email Portal**"

Use physical and technical safeguards to ensure monitors cannot be viewed by unauthorized individuals, and screen automatically lock on devices, after a reasonable period of inactivity.

Maintain protocols to ensure faxes containing PHI are issued to the correct member, and increased precautions are applied when faxing especially sensitive information (such as sensitive diagnoses).

Review and adhere to Liberty's Secure Use and Transmission of e-PHI policy, located online in the Provider Resource Library.

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

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

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

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

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

- Close window blinds to prevent outside disclosure
- Do not overstuff mailing envelopes, and print mailing addresses accurately and clearly to minimize the possibility mail is lost in transit
- Take precautions to ensure PHI is not lost while transporting from one location to another and never leaving tangible PHI in vehicles unattended

Anti-Discrimination

Discrimination is against the law. Liberty Dental Plan (Liberty) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Liberty does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Liberty:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Liberty's Civil Rights Coordinator.

How to File a Grievance

If you believe that Liberty Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Liberty's Civil Rights Coordinator.

Liberty Dental Plan
c/o Civil Rights Coordinator
P.O. Box 26110
Santa Ana CA 92799-6110

Phone: 888.352.7924, TTY 711.
www.libertydentalplan.com

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Culturally Competent Care

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

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

Language Assistance Services

- Language Assistance services are available to ensure Limited English Proficient (LEP) members have appropriate access to language assistance including special format for hearing and visually impaired members, while accessing dental care.
- Interpretation services for Limited English Proficient members (when and where required by state law or group/client arrangement):
- Interpretation services, including American Sign Language, are available at no cost to members, 24 hours a day, 7 days a week by contacting Liberty's Member Services Department at **888.352.7924**. When and where required by law or client group requirement, Liberty offers free telephonic interpretation through our language service vendor. When required, this service is available to the member at no cost.
- To engage an interpreter once the member is ready to receive services, please call Liberty's Member Services Department. You will need the member's Liberty Dental ID number, date of birth, and the member's full name to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance. Liberty discourages the use of family or friends as interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.
- Providers must also fully inform the member that he or she has the right not to use family, friends, or minors as interpreters.

- If a member prefers not to use the interpretation services after she/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 telephonic interpreters, other media such as TTY/TDD and remote interpreting services can be obtained by contacting Liberty's Member Services Department.

Section 15. Additional Medicaid Program Information

Health Guidelines – Ages 0-20 Years

NOTE: Please refer to benefit tables for benefits and limitations.

AHCCCS Dental Periodicity Schedule

These preventative services are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.

AGE	12-24mo	2-6yrs	6-12yrs	12 yrs
Clinical oral examination including, but not limited to the following:	X	X	X	X
Assess oral growth and development	X	X	X	X
Caries-risk Assessment	X	X	X	X
Assessment of the need for fluoride supplementation	X	X	X	X
Anticipatory Guidance/Counseling	X	X	X	X
Oral hygiene counseling	X	X	X	X
Dietary counseling	X	X	X	X
Injury prevention counseling	X	X	X	X
Counseling for nonnutritive habits	X	X	X	X
Substance abuse counseling			X	X
Counseling for intraoral/perioral piercing			X	X
Assessment for pit and fissure sealants		X	X	X
Radiographic assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

First examination is encouraged to begin by age one (1). Repeat every six (6) months or as indicated by child's risk status/susceptibility to disease.

Note: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

Note: As in all medical care, dental care must be based on the individual needs of the patient and the professional judgment of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

Dental Home

The American Academy of Pediatric Dentistry and the American Dental Association recommend establishing a Dental Home by age one (1). AHCCCS requires a dental home be assigned to all members by six (6) months of age.

In dentistry, continuity of care is a critical component in ensuring a patient's oral health and well-being. Liberty's Dental Home program is modeled after the AAPD guidelines and promotes continuity of care by encouraging dental providers to manage the preventive, diagnostic and restorative dental needs of their patients.

The Dental Home is a place where a child's oral health care is delivered in a complete, accessible and family-centered manner by a licensed dentist. This concept has been successfully employed by primary care physicians in developing a "Medical Home" for their patients, and the "Dental Home" concept mirrors the "Medical Home" for primary dental and oral health care. If expanded or specialty dental services are required, the dentist is not expected to deliver the services, but to coordinate the referral and to monitor the outcome.

The American Academy of Pediatric Dentistry (AAPD) defines dental home as "inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals, and dental professionals." It constitutes the ongoing relationship between the dentist who is the Primary Dental Care Provider (PCD) and the patient, which includes comprehensive oral health care, beginning no later than age one, pursuant to ADA policy.

The Dental Home visit can be initiated as early as 6 months of age and should include the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
  Caries risk assessment
- Dental anticipatory guidance

Member Assignment to Dental Home

Members are assigned to providers based on where they were last seen or to the closest provider accepting new patients. Members are notified of their assigned Dental Home and educated on the program by mail. Although member assignment is to encourage members to use their dental home, they may go to any participating provider. Also, providers may treat any eligible member and be paid for covered benefits. If a provider has selected to be an "Existing Patients Only" provider or have other panel restrictions, they will not be assigned any additional members.

Participating Provider's Support of Dental Homes

Provider support is essential to effectively employ the Dental Home program for the members. With assistance and support from dental professionals, a system for improving the overall health of children in Arizona can be achieved.

APPOINTMENT RESCHEDULING

When a provider or Member must reschedule an appointment, the appointment must 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 must be scheduled according to the same standards as initial appointments. Missed or canceled appointments should be noted in the Member's records. Medicaid Members cannot be charged for broken or missed appointments.

Recall, Failed or Canceled Appointments

Contracted dentists are expected to have an active recall system for established patients who have not completed their treatment plans, for regular maintenance visits, or for patients who fail to keep or cancel their appointments. **Broken/Missed appointments must be tracked by billing D9986.** If an appointment is rescheduled, this does not require a billed code for tracking purposes.

Recall System Requirement

Each participating Liberty office is required to maintain and document a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any Mercy Care Medicaid Member that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. Liberty offers the following suggestions to decrease the "no show" rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

Cultural and Linguistic Competency and Health Literacy

Liberty defines health literacy as the ability to read, understand and act on health information. Health literacy relates to listening, speaking, and conceptual knowledge. Health literacy plays an important role in positive patient outcomes.

As a contracted provider with Liberty, you play a vital role in ensuring that all members—regardless of language proficiency, cultural background, or disability—receive equitable, effective, and respectful care. The Cultural and Linguistic Competency (CLC) Program is designed to support your

efforts in delivering services that meet the cultural, language, and health literacy needs of our diverse member population.

Culturally Competent Care

In accordance with state and federal regulations, providers must deliver care in a manner that respects each member's:

- Culture
- Health beliefs
- Preferred language
- Spiritual practices
- Literacy level
- Disability status
- Sexual orientation
- Socioeconomic background

This includes timely and effective communication with members who are Limited English Proficient (LEP), visually impaired, deaf/hard of hearing, or who face barriers due to health literacy or cultural differences.

Language Assistance Services

To ensure meaningful access to care, Liberty offers **free language assistance services** for eligible members, including:

- **Interpretation services** for members with LEP or disabilities, including American Sign Language (ASL).
- **Telephonic and remote interpretation services** are available 24/7 through Liberty's language service vendor.
- **TTY/TDD services** and written materials in alternative formats (e.g., braille or large font) upon request.
- **Translation services** for member informing materials in threshold languages and non-threshold languages upon request.

Provider Responsibilities

Providers must:

- **Inform Member** that free interpretation services are available and that they have a right not to use family, friends, or minors as interpreters.
- **Avoid using untrained interpreters,** especially children, due to risks to accuracy confidentiality, and clinical outcomes.
- **Document** in the member's record when an interpreter is offered and declined, noting that a trained interpreter is available at no cost.
- **Contact Liberty's Member Services** to access interpretation support, using the member's ID number, date of birth, and full name.

To request interpretation services, including on-demand or scheduled support, call Liberty's Member Services at 888.352.7924 or 877.855.8039 (TDD/TTY). Services are available 24 hours a day, 7 days a week, at no cost to the provider or member.

Cultural Competency Best Practices

- Use clear, simple language and avoid jargon,
- Be aware of non –verbal communication differences
- Respect cultural health practices and beliefs that may influence treatment decisions.
- Ensure that language needs and preferences are captured and honored across all points of care.

Transplant, Cancer, and Medical Exceptions

Adults on AHCCCS programs who are transplant patients and undergoing certain cancer treatments are eligible for additional dental services. In addition, medically compromised patients may be eligible for a medical exception to cover additional dental services. Please review the following information on what constitutes a medically compromised patient, how to submit with the appropriate keyword, and where to submit your authorization requests and subsequent claims.

Transplant and Cancer Cases

For members who require medically necessary dental services as a pre-requisite to an AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of restorations. MCP covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered.

High Risk Pregnancy (HRP) Cases

For high-risk pregnancy women who require medically necessary dental services, covered services include the elimination of oral infections and the treatment of oral disease, which include dental cleaning, treatment of periodontal disease, medically necessary extract ions and root canals. These services are **not** subject to the $1,000 adult emergency dental max if the service qualifies as a medical exception.

- CDT codes that do NOT require prior authorization for HRP members: D0120, D0150, D0210, and D1110.
- CDT codes the Do require prior authorization for HRP members: D4341, D4342, D4346, and D4355, along with the Adult Emergency covered codes.

Medical Exceptions:

Services furnished by dentists, which are covered for members 21 years of age and older, must be related to the treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction (TMJ) pain), infection, or fracture of the jaw. Covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical

procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

MCP staff will outreach to medical/dental providers for appropriate documentation of multiple dental symptoms that place the member's health at medical risk for more serious complications, and that could be alleviated with a cost-effective dental intervention. MCP Dental Director will evaluate approving dental treatment as a Medical Exception with documentation of the following:

- Presence of pain, swelling, and/or infection over a significant duration of time
- Radiographic evidence of abscess
- Multiple courses of antibiotic/pain medications
- Multiple visits to hospital ER or dental office
- Pre-existing medical condition such as hypertension, heart disease, diabetes, immune deficiency, organ transplant, etc.
- Presence of cellulitis, elevated floor of mouth, potential for airway impingement that may require hospital admission
- Current hospital admission as a result of a medical condition that may be exacerbated by oral an infection

How to Submit:

Liberty will review requests based on the documentation on file in conjunction with what is submitted with the request. Please follow the below process:

Transplant Patients - clearly write the keyword "**TRANSPLANT**" in box 35 of the ADA claim form.

Cancer Patients - clearly write the keyword "**CANCER**" in box 35 of the ADA claim form.

Medically compromised patients – clearly write the keywords "**MEDICAL EXCEPTION**" in box 35 of the ADA claim form.

The keywords are read via a scanner which guarantees additional clinical review of your submission. To ensure that the keyword is captured by the scanner, **please type the keyword or use clear, block style writing**.