



PROVIDER REFERENCE GUIDE CALIFORNIA



www.libertydentalplan.com

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SECTION 1 – LIBERTY DENTAL PLAN INFORMATION



INTRODUCTION

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

The intent of this Provider Reference Guide is to aid each Participating Provider and their staff members in becoming familiar with the administration of LIBERTY Dental Plan. Please note that this Provider Reference Guide serves only as a summary of certain terms of the Provider Agreement between you (or the contracting dental office/facility) and LIBERTY Dental Plan and that additional terms and conditions of the Provider Agreement apply. In the event of a conflict between a term of this Provider Reference Guide and a term of the Provider Agreement, the term of the Provider Agreement shall control. You will receive a copy of the fully executed Provider Agreement at time of your activation on LIBERTY Dental Plan's network; however, you may also obtain a copy of the Provider Agreement at any time by submitting a request to prinqueries@libertydentalplan.com or by contacting Professional Relations at 800-268-9012.

LIBERTY shall not refuse to contract with, or pay, an otherwise eligible Dental Office for the provision of Covered Services solely because such Dental Office has in good faith communicated with, or advocated on behalf of, one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the member's LIBERTY benefit plan.

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

OUR MISSION

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



Provider Contact and Information Guide

LIBERTY Dental Plan ♦ *Simply Better Coverage*

IMPORTANT PHONE NUMBERS AND GENERAL INFORMATION	ELIGIBILITY & BENEFITS VERIFICATION	CLAIMS INQUIRIES	PROVIDER WEB PORTAL (i-TRANSACTION)
<p><u>LIBERTY PROVIDER SERVICE LINE</u></p> <p>(800) 268-9012</p> <p>Eligibility & Benefits for General Dentistry: Press Option 1</p> <p>Claims: Press Option 2</p> <p>Pre-Estimates: Press Option 3</p> <p>Referrals & Specialty Pre-Authorizations: Press Option 4</p> <p>Request Materials: Press Option 5</p> <p><u>HOURS</u></p> <p>Live representatives are available Monday – Friday, 8 a.m. PST – 5 p.m. PST</p> <p><u>PROFESSIONAL RELATIONS DEPARTMENT</u></p> <p>(800) 268-9012</p> <p>(800) 268 – 0154 (fax)</p> <p>LIBERTY Dental Plan Attn: Professional Relations P.O. Box 26110 Santa Ana, CA 92799-6110</p> <p>pinquiries@libertydentalplan.com</p>	<p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>Or</p> <p>TELEPHONE (800) 268-9012 Press Option 1</p> <p>REFERRAL SUBMISSION & INQUIRIES</p> <p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>TELEPHONE (800) 268-9012 Press Option 4</p> <p>Regular Referrals by Mail</p> <p>LIBERTY Dental Plan Attn: Referral Department P.O. Box 26110 Santa Ana, CA 92799-6110</p> <p>*Emergency Referrals* All requests for emergency specialty care should be made by calling:</p> <p>(800) 268-9012 Press Option 4</p>	<p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>Or</p> <p>TELEPHONE (800) 268-9012 Press Option 2</p> <p>CLAIMS SUBMISSIONS</p> <p>Provider Portal (i-Transact) www.libertydentalplan.com</p> <p>EDI Payor ID #: CX083</p> <p>TELEPHONE (800) 268-9012 General Information (i.e. Claims Mailing Address or Payor ID): Press Option 6</p> <p>Paper Claims by Mail</p> <p>LIBERTY Dental Plan Attn: Claims Department P.O. Box 26110 Santa Ana, CA 92799-6110</p>	<p>www.libertydentalplan.com</p> <p>LIBERTY Dental Plan offers 24/7 real-time access to important information and tools through our secure online system</p> <ul style="list-style-type: none"> • Electronic Claims Submission • Claims Inquiries • Real-time Eligibility Verification • Member Benefit Information • Referral Submission • Referral Status <p>Please visit: www.libertydentalplan.com to register as a new user and/or login.</p> <p>Your “Access Code” can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call (800) 268-9012 for assistance.</p>

SECTION 2 – PROFESSIONAL RELATIONS

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

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

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

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

Our Professional Relations team is available to assist you Monday – Friday, from 8 a.m. – 5 p.m. by calling (800) 268-9012, Press Option 4, or by email at prinquiries@libertydentalplan.com.



SECTION 3 – ONLINE SERVICES

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

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

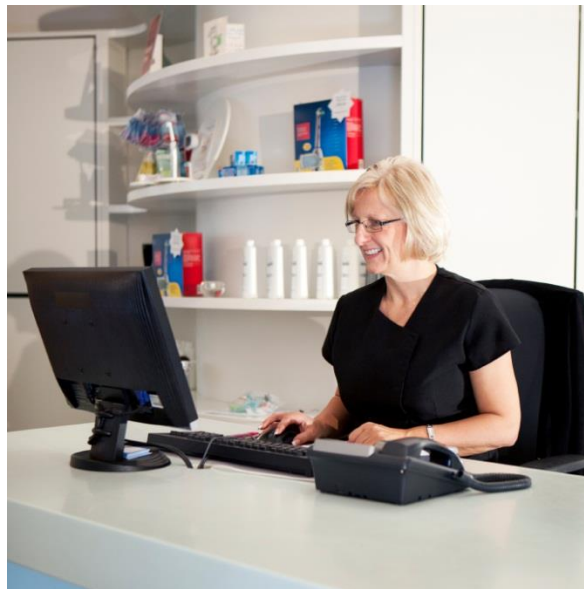
- Submit Electronic Claims
- Verify Member Eligibility and Benefits
- View Office and Contract Information
- Submit Referrals and Check Status
- Access Benefit Plans and Fee Schedules
- Print Monthly Eligibility Rosters
- Perform a Provider Search

To register and obtain immediate access to your office's account, visit: www.libertydentalplan.com. All contracted network dental offices are issued a unique **Office Number** and **Access Code**. These numbers can be found on your LIBERTY Dental Plan Welcome Letter and are required to register your office on LIBERTY's Online Provider Portal.

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

If you are unable to locate your Office Number and/or Access Code, please contact our Professional Relations Department at (800) 268-9012 or email support@libertydentalplan.com for assistance.

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



SECTION 4 – ELIGIBILITY

HOW TO VERIFY ELIGIBILITY

There are several options available to verify eligibility:

Provider Portal: www.libertydentalplan.com - The Member's Last Name, First Name and any combination of Member Number, Policy Number, or Date of Birth will be required (*DOB is recommended for best results*)

Telephone: Speak with a live Representative from 8 a.m. to 5 p.m. PST, Monday through Friday by contacting our Provider Service Line at (800) 268-9012, Option 1

Monthly Eligibility Rosters (Capitation Programs Only)

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

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

This listing is in alphabetical order and the dependents are listed individually. Dependents include spouse and eligible children. In most cases, eligible children are those who are unmarried and dependent upon the member, including natural children, stepchildren, and foster children under the age of 19. Children may continue to be eligible up to age of 26, if they are full time students.

In the event a member does not appear on the monthly Roster please contact LIBERTY Dental Plan's Member Services Department at (800) 268-9012. Upon verification of eligibility LIBERTY Dental will fax confirmation of eligibility to your office.

MEMBER IDENTIFICATION CARDS

Members should present their ID card at each appointment. Providers are encouraged to validate the identity of the person presenting an ID card by requesting some form of photo identification. The presentation of an ID card does not guarantee eligibility and/or payment of benefits.

SECTION 5 - SUMMARY OF PLAN OFFERINGS

DHMO - Select

Dental Health Maintenance Organization Network (DHMO) - Dentist compensation consists of fixed monthly payments (capitation), member charges (copayments) and procedural guarantee payments for specific plans. Monthly capitation payments are issued on the 20th day of each month and will reflect the members listed on the monthly roster. Members can select any contracted participating provider in the DHMO network as their primary care dentist. A referral from the member's primary care dentist will be required to see a specialist, unless specifically noted otherwise.

DHMO (Copayment only)

Dental Health Maintenance Organization Network (DHMO) - Dentist compensation consists of member charges (copayments). Dependent on member's plan benefits, additional reimbursement from LIBERTY Dental Plan may be available for specific services.

DHMO - Choice

DHMO – Choice Network dentists are compensated on a contracted fee schedule, less applicable member's copayment. Offices are encouraged to submit claims each month to ensure timely payment.

DHMO Benefit Copayment Schedules

Benefit Copayment Schedules are available by logging into the Provider Portal or by contacting the Provider Service Line at (800) 268-9012.

SECTION 6 – CLAIMS AND BILLING

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

ELECTRONIC SUBMISSION

LIBERTY strongly encourages the electronic submission of claims. This convenient feature assists in reducing costs, streamlining administrative tasks and expediting claim payment turnaround time for providers. There are two options to submit electronically - directly through the Provider Portal or by using a clearinghouse.

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

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

LIBERTY EDI Vendor	Phone Number	Website	Payer ID
DentalXchange	(800) 576-6412	www.dentalxchange.com	CX083
Emdeon	(877) 469-3263	www.emdeon.com	CX083
Tesia	(800) 724-7240 ext. 6	www.tesia.com	CX083

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

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

PAPER CLAIMS

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

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

CLAIMS SUBMISSION REQUIREMENTS

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

1. All claims must be submitted to LIBERTY for payment for services no later than 6 months or (180 days) after the date of service.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.

- All claims must include the name of the program under which the member is covered and all the information and documentation necessary to adjudicate the claim.

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

CLAIMS STATUS INQUIRY

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

- Provider Portal: www.libertydentalplan.com
- Telephone: (800) 268-9012, Press Option 3

Claims Status Explanations

CLAIM STATUS	EXPLANATION
Completed	<i>Claim is complete and one or more items have been approved</i>
Denied	<i>Claim is complete and all items have been denied</i>
Pending	<i>Claim is not complete. Claim is being reviewed and may not reflect the benefit determination</i>

CLAIMS RESUBMISSION

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

- Missing documentation
- Incorrect coding
- Processing errors

MEDICARE AND DUALS PRIOR-AUTHORIZATION OUTREACH

LIBERTY complies with applicable law and contractual obligations, including Center for Medicare and Medicaid Services (CMS) guidelines, state and federal regulations, and accreditation standards. LIBERTY processes all written or verbal requests for Expedited/Urgent (“Expedited”) UM authorization decisions within the required timeframes.

When LIBERTY receives a Medicare or Duals member authorization request which lacks the information necessary to make a medical necessity determination, LIBERTY will make reasonable provider outreach attempts to obtain the information needed to make a determination as early in the decision-making process as possible. Examples of reasonable provider outreach attempts include attempts to contact a provider via telephone, fax, email and mail as appropriate, and within acceptable timelines determined by whether the initial authorization request relates to a standard, or expedited determination.

Each provider outreach attempt will clearly identify the information and/or documents LIBERTY needs to make a medical necessity authorization decision and will include LIBERTY’s contact information for the provider to respond to the outreach request.

If LIBERTY does not receive a response to the request for additional information, LIBERTY will make a determination based on the available information. Denials may be appealed.

CLAIMS OVERPAYMENT

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

Claims submitted by any contracted provider who is not licensed when the services were rendered will be considered overpayments.

Notice of Overpayment of a Claim

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

Contested Notice

If the provider contests LIBERTY's notice of overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment of a claim, must send written notice to LIBERTY stating the basis upon which the provider believes that the claim was not overpaid. LIBERTY will process the contested notice in accordance with LIBERTY's contracted provider dispute resolution process described in the section titled Provider Dispute Resolution Process.

No Contest

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

Offsets to Payments

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



SECTION 7 – COORDINATION OF BENEFITS

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

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

Identify the Primary Carrier

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

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

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

PATIENT IS THE MEMBER	PRIMARY
Member has dental coverage through employer	Member coverage is always primary
Member has dental coverage as an active employee and through the spouse	Member coverage is primary
Member has two active insurance carriers, both provide dental coverage	The carrier with the earliest effective date is primary
Member has dental coverage through a group plan and COBRA coverage	Group plan is primary
Member has dental coverage through a group plan and individual or supplemental coverage through another carrier Note: Supplemental/Individual plans are purchased by the member for added coverage Examples: <ul style="list-style-type: none"> • Student Accident Plans • Supplemental Plans (Western Dental) • Prepaid Trust Plans • Individual Plan (AFLAC) • Reimbursement Plans • Copayment Plans 	Group plan is primary
Member has dental coverage as an active employee of one plan and as retired employee of another plan	The active coverage is primary
Member has two retiree plans	The plan that covered the member longer is primary
Member has a retiree plan and spouse holds a group plan	Spouse’s group plan is primary

PATIENT IS THE MEMBER	PRIMARY
Member has a government funded plan and individual or supplemental coverage through another carrier	Individual/Supplemental coverage is primary
Member has two government funded plans. One is Federal (Medicare) and the other is State (Medicaid, Medi-Cal or Value Add)	Federal coverage is primary
Member has dental coverage through a group plan and a government funded plan	Group plan is primary
Member has dental coverage through a retiree plan and a government funded plan	Government funded plan is primary
Member has two Medicare plans	The Plan with the earliest effective date is considered primary

PATIENT IS THE DEPENDENT	PRIMARY
Dependent Child and the Birthday Rule	<p>The plan of the parent whose birthday falls earlier in the calendar year (month and day only) holds the primary coverage for dependent children.</p> <p>If both parents have the same birthday, the plan that has covered either of the parents the longest is the primary plan. However, if the other plan follows the “gender rule” with male coverage always primary, LIBERTY will follow the rules of that plan.</p> <p>These rules may be superseded by a court order that establishes the responsible party for the child’s coverage. When determining the primary carrier for dependents with dual coverage, verify that both parents are the biological parents before applying the birthday rule.</p> <p>Coverage through the biological parent is primary.</p>
If coverage is through a biological parent and a step-parent residing in the same household	The biological parent’s plan is primary
If parents are divorced or separated and there are two dental plans	The parent with custody to be the primary
If coverage is through both biological parents and stepparent, in absence of a court order, if the biological parents are legally separated or divorced	<ol style="list-style-type: none"> 1. The plan covering the parent with custody or with whom the child resides is primary. 2. The plan covering the stepparent residing in the same household is secondary. 3. The plan covering the other biological parent’s coverage is third (tertiary). 4. The plan covering the other stepparent’s coverage is fourth.

PATIENT IS THE DEPENDENT	PRIMARY
<p>If child has a government funded plan and group plan through child's parent</p> <p>Examples of Government Funded Plans:</p> <ul style="list-style-type: none"> • Healthy Families • Denti-Cal • Medicaid • Medi-Cal • Medicare • Healthy Kids • Viva • Scan • Coventry • TRICARE (see note below) <p>Note: TRICARE is a self-funded government plan and does not follow the Active vs. Retiree guidelines. TRICARE follows the effective date regardless of the plan's active or retiree status. The plan with the earliest effective date is considered prime. If enrollee has a group plan and TRICARE; the group plan will be primary</p>	<p>Group plan through parent is primary</p>

Scenarios of COBs:

1. When Member has two Managed Care Plans (DHMO-cap program)

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

Examples:

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

2. When LIBERTY is Primary Carrier

When LIBERTY is the primary carrier, payment is made for covered services without regard to what the other plan might pay. The secondary carrier, then, depending upon its particular 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 patient's coinsurance, any amounts exceeding the annual or lifetime maximums and/or any amounts applied towards the patient's deductible or non-covered services.

3. When LIBERTY is Secondary Carrier

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

When LIBERTY is secondary, payment is based on the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out-of-pocket cost payable under the primary carrier for benefits covered under the secondary carrier (according to AB895). That means whatever amount remains on the member's bill that was not paid by the member's primary carrier is now the responsibility of the secondary carrier to pay with the following conditions:

- The remaining amount is for procedures that are benefits of the secondary plan
- The secondary carrier is responsible for an amount only up to what it is contracted to pay under its primary responsibility of coverage to the enrollee; and only up to what the actual out-of-pocket responsibility of the member is with their primary carrier.

When LIBERTY is secondary and does not cover a service, although the service is covered under the Primary Carrier, the member's responsibility for that procedure is deducted from the amount of the member's responsibility from the Primary Carrier's EOB.

When LIBERTY is secondary and the service was performed at a specialist, the member will need an authorization from the primary carrier and from LIBERTY, only if the group requires pre-authorization.

LIBERTY will not refuse to pay a dental office solely because a dental office has in good faith communicated with a prospective, current, or former member regarding the method by which the dental office is compensated by LIBERTY.

Example #1:

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

After applying COB:

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

Example #2:

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

After applying COB:

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



SECTION 8 – PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

Network providers have the right to contact a LIBERTY dental director for a peer to peer discussion. LIBERTY dental directors can be reached by calling 1-888-703-6999.

LIBERTY encourages our network of dental providers to, when necessary; refer members with signs of behavioral health issues and/or substance abuse issues, to their medical plans for appropriate treatment.

PROVIDER RESPONSIBILITIES AND RIGHTS

- Provide and/or coordinate all dental care for member;
- Perform an initial dental assessment;
- Work closely with specialty care provider to promote continuity of care;
- Maintain adherence to LIBERTY’s Quality Management and Improvement Program;
- Identify dependent children with special health care needs and notify LIBERTY of these needs;
- Notify LIBERTY of a member death;
- Arrange coverage by another provider when away from dental facility;
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week through primary care dentist;
- Maintain scheduled office hours;
- Maintain dental records for a period of five years;
- Provide updated credentialing information upon renewal dates;
- Provide requested information upon receipt of member grievance/complaint within 10 days of receiving a notice letter;
- Provide encounter data on standard ADA claim form in a timely manner (for capitation plans);
- Notify LIBERTY of any changes regarding practice, including location name, telephone number, address, associate additions / terminations, change of ownership, plan terminations, etc.
- Providers may not close, or otherwise limit, their acceptance of members as patients unless the same limitations apply to all commercially insured members.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES & RIGHTS

- Provide specialty care to members;
- Work closely with primary care dentists to ensure continuity of care;
- Maintain adherence to the LIBERTY’s QMI Program;
- Bill LIBERTY Dental Plan for all dental services that were authorized;
- Maintain dental records for 10 years;
- Provide credentialing information upon renewal dates.

ANTI-DISCRIMINATION

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

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

If you need these services, please contact us at 1-888-844-3344.

If you believe LIBERTY has failed to provide these services or has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LIBERTY’s Civil Rights Coordinator:

- Phone: 888-704-9833
- TTY: 800-735-2929
- Fax: 888-273-2718
- Email: compliance@libertydentalplan.com
- Online: <https://www.libertydentalplan.com/About-LIBERTY-Dental/Compliance/Contact-Compliance.aspx>

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

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 1-800-368-1019, 800-537-7697 (TDD)
 Online at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
 Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

NATIONAL PROVIDER IDENTIFIER (NPI)

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), beginning **May 23, 2008**, LIBERTY Dental Plan requires a National Provider Identifier (NPI) for all HIPAA related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals and claim status.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

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

How to Apply for an NPI

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

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

VOLUNTARY PROVIDER CONTRACT TERMINATION

Providers must give LIBERTY at least 90 days advance notice of intent to terminate a contract. Provider must continue to treat members until the last day of the month following the date of termination. Affected members are given advance written notification informing them of their transitional rights. Providers are also responsible for assisting LIBERTY with transfer of care.

STANDARDS OF ACCESSIBILITY

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

Type of Appointment	Appointment Waiting Time
Routine Care	Within 36 days
Preventive Care	Within 40 days
Urgent Care	Within 24 hours / 7 days a week
After-Hours / Emergency Availability	<p>24 hours a day, 7 days a week. All providers must have at least one of the following:</p> <ul style="list-style-type: none"> • Answering service that will contact provider on behalf of the member • Call forwarding system that automatically directs members call to the Provider • Answering system with explicit instructions on how to reach the provider and emergency instructions
Scheduled Appointment Wait Time	Not to exceed 30 minutes. Offices must maintain records indicating member appointment arrival time and the actual time the member was seen by provider
Office Hours	Minimum of 3 days / 30 hours per week
<p>“Appointment waiting time” means the time from the initial request for health care services by a member or the member’s treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.</p>	

AFTER HOURS AND EMERGENCY SERVICES AVAILABILITY

The provider’s after-hours response system must enable members to reach an on-call dentist 24 hours a day, seven days a week. In the event the primary care provider is not available to see an emergency patient within 24 hours, it is his/her responsibility to make arrangements to ensure that emergency services are available. Members requiring after-hours emergency dental services must receive an assessment by telephone from the provider within one hour of the time the member contacts the provider’s “after hours” telephone service. Member must be scheduled within 24 hours and should be informed that only the emergency will be treated at that time. If the member is unable to access emergency care within our guidelines and must seek services outside of your facility, you may be held financially responsible for the total costs of such services. Additionally, if your office is unable to meet LIBERTY Dental Plan guidelines, LIBERTY Dental Plan has the right to transfer some or all capitation programs enrollment or close your office to new enrollment.



FACILITY PHYSICAL ACCESS FOR THE DISABLED

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

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

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

APPOINTMENT RESCHEDULING

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

INTERPRETER SERVICES

Interpreter services shall be coordinated with scheduled appointments for dental services in a manner that ensures the provision of interpreter services at the time of the appointment.

COMPLIANCE WITH THE STANDARDS OF ACCESSIBILITY

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

TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate written treatment plan containing an explanation of benefits and related costs. If there are alternate treatments available the treating dentist must also present those treatment plans and the related costs for covered and non-covered services.

Alternate and/or Elective/non-covered Procedures and Treatment Plans: LIBERTY Dental members cannot be denied their 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. Note: Most plans allow for an upgrade to noble and high noble metal and for porcelain on molar teeth with an informed consent by the Member.

SECOND OPINIONS

Members may request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan. Dentist should refer these members to the Member Services Department at (800) 268-9012, Monday through Friday, 8 a.m. to 5 p.m. PST. Second Opinions may be requested on non-covered services.

Recall, Failed or Cancelled Appointments

Contracted dentists are expected to have an active recall system for established patients who fail to keep or cancel appointments. Failed appointment charges may apply; copayments will vary based on the members' plan benefits. Missed or cancelled appointments should be noted in the patient's record.

CONTINUITY AND COORDINATION OF CARE

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

A panel of network dentists shall be available in currently assigned counties from which members may select a provider to coordinate all their dental care. All care rendered to LIBERTY members must be properly documented in the patient's dental charts according to established documentation standards. Communication between the primary care dentist (Provider) and dental specialist shall occur when members are referred for specialty dental care. LIBERTY Dental enforces QMI Program policies and procedures that will ensure:

- An enrollment packet contains a list of Providers that shall be given to all members upon enrollment;
- A current list of Providers is maintained on LIBERTY's web site at www.libertydentalplan.com;
- If a member has not selected Provider within 30 days of enrollment, a reminder postcard notifying the member of their "automatic assignment" shall be sent 10 days after assignment of his/her Provider (**for capitation plans**);

- Members who do not select a Provider shall be assigned one, based on the member’s geographic location (for capitation plans);
- Dental chart documentation standards are included in this provider guide;
- Dental chart audits will verify compliance to documentation standards;
- Guidelines for adequate communications between the referring and receiving providers when members are referred for specialty dental care are included in this provider guide;
- During facility on-site audits, LIBERTY Dental monitors compliance with continuity and coordination of care standards;
- When a referral to a specialist is authorized, the 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 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 QM Committee, and corrective action shall be implemented when deficiencies are identified.

MEMBER RIGHTS AND RESPONSIBILITIES

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

- A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A member has the right to a prompt and reasonable response to questions and requests.
- A member has the right to know who is providing medical services and who is responsible for his or her care.
- A member has the right to know what member support services are available, including whether an interpreter is available if he or she does not speak English.
- A member has the right to know what rules and regulations apply to his or her conduct.
- A member has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A member has the right to refuse any treatment, except as otherwise provided by law.
- A member has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for dental care.
- A member has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A member has the right to express grievances regarding any violation of his or her rights, as stated in the applicable state law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

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

- A member is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A member is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A member is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A member is responsible for following the treatment plan recommended by the health care provider.

- A member is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A member is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A member is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A member is responsible for following health care facility rules and regulations affecting patient care and conduct.



SECTION 9 - CLINICAL DENTISTRY GUIDELINES

NEW PATIENT INFORMATION

- A. Registration information should minimally include:
1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number
 2. Name and telephone number of person(s) to contact in an emergency
 3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above.
- B. Pertinent information relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment should always be documented.
- C. Medical History - There should be a detailed medical history form comprised of questions which require a "yes" or "no" responses, minimally including:
1. Patient's current health status
 2. Name and telephone number of physician and date of last visit
 3. History of hospitalizations and/or surgeries
 4. History of abnormal (high or low) blood pressure
 5. Current medications, including dosages and indications
 6. History of drug and medication use (including Fen-Phen/Redux and bisphosphonates)
 7. Allergies and sensitivity to medications or materials (including latex)
 8. Adverse reaction to local anesthetics
 9. History of diseases:
 - Cardio-vascular disease, including heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.
 - Pulmonary disorders including tuberculosis, asthma and emphysema
 - Nervous disorders
 - Diabetes, endocrine disorders, and thyroid abnormalities
 - Liver or kidney disease, including hepatitis and kidney dialysis
 - Sexually transmitted diseases
 - Disorders of the immune system, including HIV status/AIDS
 - Other viral diseases
 - Musculoskeletal system, including prosthetic joints and when they were placed
 10. Pregnancy
 - Document the name of the member's obstetrician and estimated due date.
 - Follow guidelines in the *ADA* publication, *Women's Oral Health Issues*, November 2006.
 11. History of cancer, including radiation or chemotherapy
 12. The medical history form must be signed and dated by the member or member's parent or guardian.
 13. Dentist's notes following up on member comments, significant medical issues and/or the need for a consultation with a physician should be documented on the medical history form or in the member's progress notes.

14. Medical alerts reflecting current significant medical conditions must be uniform and conspicuously visible on a portion of the chart used during treatment.
15. The dentist must sign and date all baseline medical histories after review with the member.
16. The medical history should be updated and signed by the member and the dentist at least annually or as dictated by the member's history and risk factors.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) BENEFITS

As required by federal law, LIBERTY provides comprehensive, diagnostic and preventive dental services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or better a defect, condition, or a physical or mental illness that exceeds the state's Medicaid benefit. This includes emergency, preventive and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures. Enrollees have the right to EPSDT benefits that ensure children and adolescents receive appropriate preventive dental and specialty dental services. For more information please refer to your applicable state Medicaid Periodicity Schedule.

Prior Authorization of EPSDT Dental Services

For all EPSDT covered services, prior authorization is required for any dental service that is not listed on the state Medicaid benefit schedule and for any service(s) that are listed on the Medicaid benefit schedule but are otherwise subject to frequency limitations or are subject to periodicity schedule guidelines and the service(s) being requested would otherwise exceed the listed limitations and/or guidelines. Any EPSDT service(s) that is not prior authorized as described above will be denied and you may not balance bill the member for such services. For all prior authorization requests, medical necessity will be determined based on radiographic and/or other documented rationale.

CONTINUITY OF CARE

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

INFECTION CONTROL

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

DENTAL RECORDS

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract.

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

Contracted dentists must make available copies of all member records to the Plan 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 the Plan 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 by the Plan.

LANGUAGE ASSISTANCE PROGRAM (LAP)

In accordance with Section 1367.04 of the California Health and Safety Code and the Department of Managed Health Care (DMHC) Regulations, California Code of Regulations, Title 28, Section 1300.67.04, LIBERTY maintains an established Language Assistance Program (LAP) for members who are Limited English Proficient (LEP). This California law requires that as a participating provider you cooperate and comply with this law.

The Language Assistance Program's purpose is to establish and maintain an ongoing language assistance program to ensure Limited English Proficient (LEP) enrollees have appropriate access to language assistance while accessing dental care.

LIBERTY requires that services be provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.



Interpretation services for Limited English Proficient patients effective January 1, 2009:

- Interpreting services, including American Sign Language, are available to members 24 hours a day, 7 days a week at no cost by contacting LIBERTY's Member Services Department at (800) 268-9012.
- Members who reside in the state of California have the right to an interpreter when receiving treatment and services.
- LIBERTY Dental is offering free telephonic interpretation through our language service vendor. The member must be fully informed that an interpreter is available to him or her at no cost.
- To engage an interpreter once the member is ready to receive services, please call 1-888-703-6999. 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 Dental discourages the use of family or friends as interpreters and strongly discourages the use of minors as interpreters for members except in an emergency situation if the minor demonstrates the ability to interpret complex dental information.
- Providers must also fully inform the member that he or she has the right not to use family, friends or minors as interpreters.
- If a member prefers not to use the interpretation services after s/he has been told that a trained interpreter is available free of charge, the member's refusal to use the trained interpreter shall be documented in the member's dental record, when in a provider setting, or the member's administrative file (call tracking record) in the Member Services setting.
- Language preferences of members will be available to directly contracted dentists upon request through telephone inquiries.
- Written Member Informing Materials in threshold languages and alternative formats are available to members at no cost and can be requested by contacting LIBERTY's Member Services Department at (800) 268-9012.
- Assistance in working effectively with members using in-person and telephonic interpreters and other media such as TTY/TDD and remote interpreting services can be obtained by contacting LIBERTY's Member Services Department at (800) 268-9012.

Additional complaint, grievance and Independent Medical Review information is available in English and Non-English languages on the Department of Managed Health Care's website: www.hmohelp.ca.gov. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

We appreciate your cooperation in this process, and your participation in the LIBERTY Dental network(s). If you have any questions regarding this update or the new California requirements, please call Professional Services at 1-800-268-9012. **Health Insurance Portability and Accountability Act (HIPAA)**

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

BASELINE CLINICAL EVALUATION DOCUMENTATION

- A. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment(s), fixed and removable appliances.
- B. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented.
- C. Full mouth periodontal probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.
- D. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented.
- E. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the member's history and risk factors, and must be done at least annually.

RADIOGRAPHS

- A. An attempt should be made to obtain any recent radiographs from the previous dentist.
- B. An adequate number of initial radiographs should be taken to make an appropriate diagnosis and treatment plan. Refer to the current, published ADA/FDA radiographic guidelines: *The Selection of Patients for Dental Radiographic Examinations*.
- C. D0210 Intraoral – complete series (including bitewings)

“A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.” *CDT 2011/2012, page 7.*

Benefits for this procedure are determined within each plan design.

Any combination of covered radiographs that meets or exceeds a provider’s fee for a complete series may be adjudicated as a complete series, *for benefit purposes only.*

In addition, any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) may be considered as a complete series, *for benefit purposes only.*

- D. Decisions about the types of recall films should also be made by the dentist and based on current *ADA/FDA* radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the member’s last radiographic examination.
- E. A panoramic radiograph is a screening film and is not a substitute for periapical and/or bitewing radiographs when a dentist is performing a comprehensive evaluation.
- F. Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
- G. Radiographs should exhibit good contrast.
- H. Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.
- I. Recent radiographs must be mounted, labeled left/right and dated.
- J. Any member refusal of radiographs should be documented.

K. X-ray duplication fee

When a member is transferred from one provider to another, diagnostic copies of all x-rays less than two years old should be duplicated for the second provider.

If the transfer is initiated by the provider, the member may not be charged any X-ray duplication fees.

If the transfer is initiated by the member, many plans allow the provider to charge for the actual cost of copying the X-rays up to a maximum fee of \$25.

NOTE: Under some benefit plans, x-ray duplication fees may not be allowed. Refer to the specific benefit plan to determine if a duplication fee is allowable.

PREVENTION

Preventive dentistry may include clinical tests, dental health education and other appropriate procedures to prevent caries and/or periodontal disease.

- A. Caries prevention may include the following procedures where appropriate:

- Patient education in oral hygiene and dietary instruction
- Periodic evaluations and prophylaxis procedures
- Topical or systemic fluoride treatment
- Sealants and/or preventive resin restorations

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

- Oral and systemic health information
- Oral hygiene and dietary instructions
- Prophylaxis procedures on a regular basis
- Occlusal evaluation
- Correction of malocclusion and malposed teeth
- Restoration and/or replacement of broken down, missing or deformed teeth

C. D1110 and D1120 – prophylaxis procedures

Plan policy- Procedure D1110 applies to patients who are 14 years old and older.

Plan Policy - Procedure D1120 applies to patients who are 13 years old and younger.

D. D1203 and D1204 – topical application of fluoride procedures

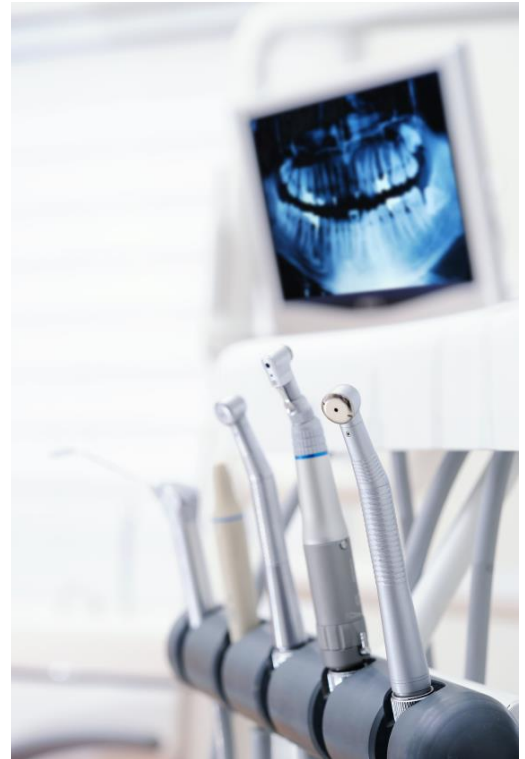
Plan Policy - Procedure D1203 applies to patients who are 13 years old and younger.

Plan Policy - Procedure D1204 applies to patients who are 14 years old and older.

E. Other areas of prevention may include:

- Smoking cessation programs
- Discontinuing the use of smokeless tobacco
- Good dietary and nutritional habits for general health
- Elimination of mechanical and/or chemical factors that cause irritation
- Space maintenance in children where indicated for prematurely lost posterior teeth

F. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the patient’s physician



TREATMENT PLANNING

A. Treatment plans should be comprehensive and documented in ink.

B. Treatment plans should be consistent with the clinical evaluation findings and diagnosis.

C. Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing would include relief of

pain, discomfort and/or infection, treatment of extensive caries and pulpal inflammation including endodontic procedures, periodontal procedures, restorative procedures, replacement of missing teeth, prophylaxis and preventive care and establishing an appropriate recall schedule.

D. Informed Consent Process

1. Dentists must document that all recommended treatment options have been reviewed with the member and that the member understood the risks, benefits, alternatives, expectancy of success, the total financial responsibilities for all proposed procedures.
2. In addition, the member should be advised of the likely results of doing no treatment.
3. Appropriate informed consent documentation must be signed and dated by the member and dentist for the specific treatment plan that was accepted.
4. If a member refuses recommended procedures, the member must sign a specific “refusal of care” document.

E. Poor Prognosis

Procedures recommended for teeth with a guarded or poor prognosis (endodontic, periodontal or restorative) are not covered.

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

LIBERTY’s licensed dental consultants adjudicate prognosis determinations for the above procedures on a case-by-case basis.

LIBERTY will reconsider poor prognosis determinations for the above procedures upon receipt of a new claim with appropriate documentation and new diagnostic x-ray(s) taken a minimum of six (6) months after the original date of service.

F. Some upgraded procedures (i.e. metals and porcelain on molars) may not be covered.

G. If more than one procedure would be considered appropriate in treating a dental condition, the Alternate Treatment Plan Formula should be utilized and presented: This Formula credits the member’s benefited procedure against the cost of the alternative procedure and the member’s responsibility is calculated as follows: The usual total cost of the alternate treatment minus (–) the usual cost of the covered procedure plus (+) any listed copayment for the covered procedure.

H. If the dentist recommends or the member chooses between two covered procedures, the chosen procedure would be covered. Example: if an extraction is agreed to instead of an endodontic procedure, the extraction would be covered.

I. Alternative treatment plans and options should be documented with a clear and concise indication of the treatment the member has chosen. In such cases, the Alternate Treatment Plan Formula should be presented and documented.

- J. Should a dentist not agree with a procedure requested by a member, the dentist may decline to provide the procedure and request that the member be transferred. In such cases, the dentist is responsible for completion of treatment-in-progress and emergencies until the transfer request is effective.
- K. Consultations, referrals and their results should be documented

REQUEST FOR PRE-ESTIMATE

To confirm benefits and member copayments for LIBERTY Dental Plan programs, it is highly recommended that a pre-estimate be submitted for large or complex treatment plans.

Following are some treatment examples where a pre-estimate would be highly recommended:

- Three or more crowns in the treatment plan
- Bridges (fixed partial dentures)
- Extensive treatment plans involving seven or more teeth
- Treatment plans that include elective or non-covered services
- Multiple arches receiving prosthetic replacement

PROGRESS NOTES

- A. Progress notes constitute a legal record and must be detailed, legible and in ink
- B. All entries must be signed or initialed and dated by the person providing treatment. Entries may be corrected, modified or lined out, but require the name of the person making any such changes and the date.
- C. The names and amounts of all local anesthetics must be documented, including the amount of any vasoconstrictor present. If no local anesthetic is used for a procedure that normally requires it (i.e. scaling and root planing), the related rationale should be documented.
- D. All prescriptions must be documented in the progress notes or copies kept in the chart, including the medication, strength, amount, directions and number of refills.
- E. Copies of all lab prescriptions should be kept in the chart.
- F. For paperless dental records, computer entries cannot be modified without identification of the person making the modification and the date of the change.

ENDODONTICS

Palliative Treatment

Responsibility for palliative treatment, even for procedures that may meet specialty care referral guidelines, is that of the contracted dentist. Palliative services are applicable per visit, not per tooth, and include all the treatment provided during the visit other than necessary x-rays. A description of emergency and palliative treatment should be documented.

Endodontic Pulpal Debridement and Palliative Treatment

If root canal therapy (RCT) is continued at the same facility, initial pulpal debridement is an integral part of the RCT. The member's copayment for the RCT is considered to be payment in full. Hence, no separate fee may be charged for pulpal debridement (D3221) or palliative treatment (D9110).

If a member is referred to a specialist for RCT after "opening" a tooth, the General Dentist may appropriately report either procedure D3221 or if that procedure is not listed, the procedure D9110 for palliative treatment.

Procedure D3332 is appropriate to report if, after "opening" a tooth a dentist determines that RCT is contradicted due to a cracked tooth or poor prognosis.

If a member had a tooth chamber "opened" during an out-of-area emergency, root canal therapy may remain a covered benefit.

If RCT was started prior to the member's eligibility with the Plan, completion of the root canal therapy may not be covered.

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

1. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:
 - Pain and the stimuli that induce or relieve it by the following tests:
 1. Thermal
 2. Electric
 3. Percussion
 4. Palpation
 5. Mobility
 - Non-symptomatic radiographic lesions
2. Treatment planning for endodontic procedures & prognosis may include consideration of the following:
 - Strategic importance of the tooth or teeth
 - Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered
 - Presence and severity of periodontal disease
 - Restorability and tooth fractures
 - Excessively curved or calcified canals
 - Following an appropriate informed consent process, if a member elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements.
 - Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.
 - Occlusion

3. Clinical Guidelines

- Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.
- A rubber dam should be used and documented (radiographically or in the progress notes) for most endodontic procedures. Documentation is required for any inability to use a rubber dam.
- Gutta percha is the endodontic filling material of choice and should be densely packed and sealed. All canals should be obturated.
- Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.
- In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals.

4. Endodontic referral necessity

In cases where a defect or decay is seen to be “approaching” the pulp of a tooth and the need for endodontic treatment is not clear, LIBERTY expects the General Dentist to proceed with the decay removal and possible temporization prior to any referral to an Endodontist.

5. Endodontic Irrigation

Providers are contractually obligated to charge no more than the listed copayment for covered root canal procedures whether the dentist uses *BioPure*, diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal.

Providers may not unbundle dental procedures in an attempt to overcharge enrollees. The provider agreement and plan addenda determine what enrollees are to be charged for covered dental procedures. Even if the facility offered *BioPure* as an alternative to diluted bleach and the enrollee agreed to pay more for it, it would be an overcharge.

Note regarding inappropriate unbundling/coding for endodontic irrigation:

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

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

6. D3331 treatment of root canal obstruction; non-surgical access

LIBERTY Dental Plan acknowledges that procedure D3331 is a separate, accepted procedure code. However, this additional treatment is not automatically needed to complete every endodontic procedure. In addition, this procedure should not be submitted with endodontic retreatment procedures D3346, D3347 or D3348.

LIBERTY Dental Plan will not approve a benefit for this procedure when submitted as part of a pre-determination request, prior to actual treatment.

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

7. Pulpotomy

- A pulpotomy may be indicated in a primary or permanent tooth when pulpal pathology is limited to the coronal pulp and the tooth has a reasonable period of retention and function.
- Apexification may be indicated in a permanent tooth when there is evidence of a vital and normal pulp with an incompletely developed root or roots to allow maturation and completion of the root apex. Endodontic treatment should be completed when the root is fully formed.

8. Pulp Cap

- This procedure is not to be used for bases and liners
- Direct pulp capping is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be indicated in the presence of a small, exposed vital or normal pulp
- Indirect pulp capping (re-mineralization) is indicated to attempt to minimize the possibility of pulp exposure in very deep caries in vital teeth

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

- The root canal system cannot be instrumented and treated non-surgically
- There is active root resorption
- Access to the canal is obstructed
- There is gross over-extension of the root canal filling
- Periapical or lateral pathosis persists and cannot be treated non-surgically
- Root fracture is present or strongly suspected
- Restorative considerations make conventional endodontic treatment difficult or impossible

10. Endodontic procedures may not be covered when a tooth or teeth have a poor prognosis due to:

- Untreated or advanced periodontal disease
- Gross destruction of the clinical crown and/or root decay at or below the alveolar bone
- A poor crown/root ratio

ORAL SURGERY

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

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

1. Uncomplicated extractions & emergency palliative care

2. Routine surgical extractions
 3. Incision and drainage of intra-oral abscesses
 4. Minor surgical procedures and postoperative services
- C. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.
 - D. When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth (or teeth) is not removed, member notification must be documented.
 - E. Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.
 - F. Minor contouring of bone and soft tissues during a surgical extraction is considered to be a part of and included in a surgical extraction, D7210.
 - G. Bone grafting (D7953) for ridge preservation may be indicated in preparation for implant placement or where alveolar contour is critical to planned prosthetic reconstruction.
 - H. Documentation of a surgical procedure should include: recording the tooth number, tissue removed and a description of the surgical method used; a record of unanticipated complications such as: failure to remove planned tissue/root tips; displacement of tissue to abnormal sites; unusual blood loss; presence of lacerations and other surgical or non-surgical defects.
 - I. Third molar extractions & benefit determinations

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

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

“Impacted tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.” (CDT 2011-2012, p. 216)

The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology may not be covered.

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

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

By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.

- J. All suspicious lesions should be biopsied and examined microscopically.
- K. D9220 – deep sedation / general anesthesia

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

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

1. Medical necessity and/or special needs patients
2. The extent and/or number of infected teeth
3. Alveoloplasty and/or procedures involving the excision of bone

L. D7953 bone replacement graft for ridge preservation – per site

“Osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction).” (CDT 2011-2012, p. 67)

This oral surgery procedure should be reported when the bone graft “is placed in an extraction site at the time of the extraction . . .” to preserve ridge integrity. (See above for indications.) (CDT 2011-2012, p. 159)

M. D4263 bone replacement graft – first site in quadrant

This periodontal procedure is primarily used to report a bone graft performed to stimulate periodontal regeneration when the disease process has led to deformity of the bone around an existing tooth. “This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone...”. (CDT 2011-2012, p. 27)

PERIODONTICS

All children, adolescents and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 3 mm and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the member’s periodontal status as being within normal limits (WNL).

Comprehensive oral evaluations should include the quality and quantity of gingival tissues. Additional components of the evaluation would include documenting: six-point periodontal probing for each tooth, the location of bleeding, exudate, plaque and calculus, significant areas of recession, mucogingival problems, mobility, open or improper contacts, furcation involvement, and occlusal contacts or interferences. Following the completion of a comprehensive evaluation, a diagnosis and treatment plan should be completed.

Periodontal treatment sequencing:

A. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis

“The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.” (CDT 2011-2012, p. 30)



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

Note, this procedure:

1. Must be supported by radiographic evidence of heavy calculus
2. Is not a replacement code for procedure D1110
3. Is not appropriate on the same day as procedure D0150 or D0180

B. D4341/D4342 - Scaling and root planing

Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, biofilm and stains from these surfaces. The absence of calculus should be evident on post treatment radiographs. These procedures are:

- considered to be within the scope of a General Dentist or a dental hygienist
- Supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. It is common for radiographs to reveal evidence of bone loss and/or the presence of interproximal calculus.
- Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for 2 years following initial completion of these services. In the interim, any localized scaling and root planing would be included within periodontal maintenance procedure D4910.

Definitive vs. Pre-Surgical scaling and root planing:

1. For early stages of periodontal disease, this procedure is used as definitive treatment and the member may not need to be referred to a Periodontist based upon tissue response and the member's oral hygiene.
2. For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the member may need to be referred to a Periodontist, again based on tissue response and the member's oral hygiene.

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

Two quadrants per appointment

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

As a guideline, LIBERTY Dental Plan benefits only two quadrants per appointment. If a clinician recommends and/or completes more than two quadrants per appointment, documentation supporting the additional quadrant(s) must be included with any claim and in the member's progress notes.

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

D1110 and D4341

It is usually not appropriate to perform D1110 and D4341 on the same date of service. LIBERTY's licensed dental consultants may review documented rationale for any such situations on a case-by-case basis.

- Periodontal maintenance at regular intervals should be instituted following scaling and root planing if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically.
- The patient's homecare compliance and instructions should be documented.

Soft Tissue Management Programs (STMP)

The following benefited procedures may not be bundled within fees for soft tissue management programs:

Periodontal evaluation/pocket charting/re-evaluation (these procedures are considered part of and included in the evaluation codes);

Gross debridement and scaling/root planing.

Plans may cover two prophylaxis procedures in a 12-month period or one every six months, which includes oral hygiene instructions (refer to the plan-specific benefits, limitations and exclusions). Prophylaxis is not appropriate on the same date as root planing or full mouth debridement.

Patients must sign an elective treatment form if they choose to accept soft tissue management procedures in addition to the procedures listed above.

Irrigation, periodontal/**D4999** - by report

If an enrollee elects not to have elective irrigation with other procedures (i.e. D1110, D4355, D4341, D4342 or D4910), contracted dentists may not limit the enrollee's access to other benefited procedures.

A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer.

Notes on appropriate coding:

D4999 – The American Dental Association recommends using this generic procedure code when reporting irrigation (chlorhexidine). (CDT 2011-2012, p. 161)

D9630 – The American Dental Association implies that providers should not use this procedure code when reporting irrigation (chlorhexidine).

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

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

Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients as an adjunct to procedures D4341/D4342 (scaling and root planing) AFTER the following steps:

1. A clinician has completed D4341/D4342 and allowed a minimum 4-week healing period. Then, the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing.
2. Re-evaluation confirms that several teeth were non-responsive to scaling and root planing, with localized residual pocket depths of 5 mm or deeper plus inflammation.

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

1. In such cases, benefits may be approved for two teeth per quadrant in any twelve month period
2. Other procedures, such as systemic antibiotics¹ or surgery, should be considered when multiple teeth with 5 mm pockets or deeper exist in the same quadrant.

Treatment alternatives such as systemic antibiotics or periodontal surgery instead of procedure D4381 may be considered when:

- Multiple teeth with pocket depths of 5 mm or deeper exist in the same quadrant
- Procedure D4381 was completed at least 4-weeks after D4341 but a re-evaluation of the patient's clinical response confirms that D4381 failed to control periodontitis (i.e. a reduction of localized pocket depths)
- Anatomical defects are present (i.e. intrabony defects)

***American Academy of Periodontology Position Paper, Systemic Antibiotics in Periodontics. November, 2004*

WARNINGS/PRECAUTIONS: This procedure may be contra-indicated during pregnancy.

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

C. Periodontal surgical procedures

- The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures.
- Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.
- Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens.

¹ (American Academy of Periodontology Position Paper, Systemic Antibiotics in Periodontics, November, 2004)

- In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the pre-authorization for periodontal surgery.
- Consideration for a direct referral to a Periodontist would be considered on a by report basis.
- Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected.
- Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm or deeper, following soft tissue responses to scaling and root planing.
- Osseous surgery procedures may not be covered if:
 1. Pocket depths are 4 mm or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)
 2. Patients are smokers or diabetics whose disease is not being adequately managed
- Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
- Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
- Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.

D4249 Clinical crown lengthening – hard tissue

“This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area.” *CDT 2011/2012, page 27*

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

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

Lasers

- Lasers are considered to be instruments, not procedures.
- Any use of a laser is considered to be a part of and included in the fee for the more inclusive provided procedure.
- A valid *ADA/CDT* procedure code for the more inclusive procedure should be reported.

LASER-MEDIATED SULCULAR AND/OR POCKET DEBRIDEMENT

If one considers the clinical parameters of reductions in probing depth or gains in clinical attachment level, the dental literature indicates that when used as an adjunct to SRP, mechanical, chemical, or laser curettage has little to no benefit beyond SRP alone. The available evidence consistently shows that therapies intended to arrest and control periodontitis depend primarily on effective debridement of the root surface and not removal of the lining of the pocket soft tissue wall, i.e., curettage. Currently, there is minimal evidence to support use of a laser for the purpose of subgingival debridement, either as a monotherapy or adjunctive to SRP.”

American Academy of Periodontology, April 2011

RESTORATIVE

Diagnosis and Treatment Planning

It is appropriate to restore teeth with radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or for post-endodontic purposes. Sequencing of treatment must be appropriate to the needs of the member.

Restorative procedures must be reported using valid/current *CDT* procedure codes as published by *The American Dental Association*. This source includes nomenclature and descriptors for each procedure code.

Treatment results, including margins, contours and contacts, should be clinically acceptable. The long-term prognosis should be good (estimated at 5 years or more).

- A. Restorative dentistry includes the restoration of hard tooth structure lost as a result of caries, fracture, erosion, attrition, or trauma.
- B. Restorative procedures in operative dentistry include amalgam, composites, inlays, onlays, crowns, as well as the use of various temporary materials.

Operative Dentistry Guidelines

Placement of restoration includes:

- Local anesthesia;
- Adhesives;
- Bonding agents;
- Indirect pulp capping;
- Bases and liners;
- Acid etch procedures;
- Polishing;
- Temporary restorations;
- Replacement of defective or lost fillings is a benefit, even in the absence of decay;
- Amalgam fillings, safety & benefits.

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

“WASHINGTON, July 28, 2009—*The American Dental Association (ADA)* agrees with the *U.S. Food and Drug Administration’s (FDA)* decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material.

Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the April 2006 Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients..."

- A. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements.
 - i. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite.
 - ii. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite.
 - iii. Restorations for chipped teeth may be covered.
 - iv. The replacement of clinically acceptable amalgam fillings with alternative materials (composite, crown, etc.) is considered cosmetic and is not covered.
 - v. Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the clinical crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered.
 - vi. Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months.
 - vii. For posterior primary teeth that have had extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.
 - viii. When incisal edges of anterior teeth are undermined because of caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may be veneers or crowns, either porcelain fused to metal or porcelain/ceramic substrate.
 - ix. An onlay should be considered when there is sufficient tooth structure, but cusp support is needed. An inlay is usually not a restoration of choice.
 - x. An inlay is usually not a restoration of choice.

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

Amalgam free dental offices

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

D1351 sealant – per tooth

Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

If the resin restoration does not penetrate dentin, D1351 is appropriate.

D2330, D2391 or D2392 - Resin-based composites

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

D9910/D9911 - Desensitizing

Appropriate reporting of these procedures is clearly detailed below.

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

D9910 – application of desensitizing medicament

Includes in-office treatment for root sensitivity. Typically reported on a “per visit” basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives under restorations.

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

Typically reported on a “per tooth” basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations.” *CDT 2011/2012, page 76*

CROWNS AND FIXED BRIDGES

Note: Providers may report the dates of service for these procedures to be the dates when the crowns and/or fixed bridges are cemented, subject to review.

Upgrades

Individual plan designs may limit the total maximum amount chargeable to a member for any combination of upgrades to a specified dollar amount.

Typical upgrades may include:

- Choice of metal – noble, high noble, titanium alloy or titanium
- porcelain on molar teeth
- porcelain margins, by report
(porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns)

Single Crowns

- A. When bicuspid and anterior crowns are covered, the benefit is usually a porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.
- B. When molar crowns are indicated due to caries, an undermined or fractured off cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a base metal crown.
- C. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be more susceptible to fracture than full metal crowns.
- D. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, a labial veneer may not be sufficient. The treatment of choice may then become a porcelain fused to a base metal crown or porcelain/ceramic substrate crown.

- E. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontic procedures and such teeth should exhibit a minimum crown/root ratio of 50%.
- F. Crown procedures should always be reported and documented using valid procedure codes as found in the *American Dental Association's Current Dental Terminology (CDT)*.

Brand name dental materials/alternatives

The American Dental Association publishes the Current Dental Terminology once every two years.

CDT includes the Code on Dental Procedures and Nomenclature.

"The Code is designated by the Federal Government under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as the national terminology for reporting dental services, and is recognized by third-party payers nationwide." (CDT 2011-2012 Introduction, page i)

Contracts, plan designs and benefit determinations are based upon the CDT procedure codes, not on Brand Names.

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

- 1) Verify what procedure(s) a provider is recommending, regardless of any submitted Brand Name
- 2) Apply the most accurate CDT code(s) to describe the verified procedure(s)
- 3) Refer to the specific, applicable plan design to determine if the verified procedure:
 - a. is listed as covered
 - b. would be considered some type of upgrade compared to a basic covered procedure
 - c. is not covered at all

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

- 1) Benefits - the procedure code(s) for the member's basic benefit(s)
- 2) Alternatives – the procedure code(s) for any recommended alternate/upgraded service and the member's responsibility based on the application of the alternative treatment formula
- 3) Risks – the risks of treatment as well as the risks of doing nothing

Post and core procedures include buildups

"D2952 post and core in addition to crown, indirectly fabricated post and core are custom fabricated as a single unit.

"D2954 prefabricated post and core in addition to crown core is built around a prefabricated post. This procedure includes the core material" *CDT 2011/2012, page 18*.

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

Outcomes

- Margins, contours and contacts must be clinically acceptable
- Prognosis should be good for a minimum of 5 years

Fixed Bridges

- A. When a single posterior tooth is missing on one side of an arch and there are clinically adequate abutment teeth on each side of the missing tooth, the general choices to replace the missing tooth would be a fixed bridge or an implant.

If it is also necessary to replace teeth on the opposite side of the same arch, the benefit would generally be a removable partial denture instead of the fixed bridge.

- B. Fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced in x-rays, or when a proposed abutment tooth or teeth have poor crown/root ratios.
- C. When up to all four incisors are missing in an arch, the potential abutment teeth are clinically adequate and implants are not appropriate, possible benefits for a fixed bridge may will be evaluated on a case-by-case basis. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and then submitted for any benefit determination request.
- D. Bridge abutments would generally be full coverage crowns.
- E. A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.
- F. Third molars should generally not be replaced, particularly if the replacement would not be functional.
- G. Outcomes
- i. Margins, contours and contacts should be clinically acceptable
 - ii. Prognosis should be good for long term longevity

REMOVABLE PROSTHODONTICS

Note: Providers may report the dates of service for these procedures to be the dates when these removable appliances are actually delivered, subject to review.

A. Partial Dentures

1. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars.
2. Partial dentures may be covered when posterior teeth require replacement on both sides of the same arch.
3. Full or partial dentures may not be covered for replacement if an existing appliance can be made satisfactory by relining or repair.

4. Full or partial dentures may not be covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.
5. Unilateral removable partial dentures are rarely appropriate, as they may be readily swallowed or inhaled into a patient's lungs.
6. Abutment teeth should be restored prior to the fabrication of a removable appliance and may be covered if such teeth meet the same standalone benefit requirements of a single crown.
7. Partials should be designed to minimize any harm to the remaining natural teeth.
8. Materials used for removable partial dentures should be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.
9. Appliances should be designed to minimize any harm to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.
10. Flexible partial dentures (D5225/D5226) include the following brands: *Valplast*, *Thermoflex*, *Flexite*, etc.
11. *Combo Partials* – because these appliances may include cast metals, they would be appropriately reported as D5213/D5214.



B. Complete Dentures

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

C. Interim Complete Dentures

These non-covered appliances are only intended to replace teeth during the healing period, prior to fabrication of a subsequent, covered complete denture.

D. Immediate Complete Dentures

These covered dentures are inserted immediately after a patient's remaining teeth are removed. While immediate dentures offer the benefit of never having to be without teeth, they must be relined (refitted on the inside) during the healing period after the extractions have been performed. The reason for such relining is that the shape of the supporting soft tissues and bone changes significantly during healing, causing the denture to become loose. In many cases, immediate dentures may need to be discarded and replaced with non-covered (limitation) complete dentures within the first six months.

E. Repairs and Relines

1. Repair of a partial or complete denture is covered if it results in a serviceable appliance, subject to limitations.
2. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance. A reline of a partial or complete denture would be covered (limitations may apply) if the procedure would result in a serviceable appliance.

IMPLANTS

A. General Guidelines

1. A thorough history and clinical examination leading to the evaluation of the member's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.
2. A conservative treatment plan should be considered prior to providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:
 - Adverse systemic factors such as diabetes and smoking
 - Poor oral hygiene and tissue management by the patient
 - Inadequate osseointegration (movable) of the dental implant(s)
 - Excessive para-function or occlusal loading
 - Poor positioning of the dental implant(s)
 - Excessive loss of bone around the implant prior to its restoration
 - Mobility of the implant(s) prior to placement of the prosthesis
 - Inadequate number of implants or poor bone quality for long span prostheses
 - Need to restore the appearance of gingival tissues in high esthetic areas
 - When the patient is under 16 years of age, unless unusual conditions prevail

B. Restoration

1. The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.
2. Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.
3. Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
4. Jaw relationship and intra arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

C. Outcomes

1. The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.

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

SECTION 10 - SPECIALTY CARE REFERRAL GUIDELINES

The following guidelines outline the specialty care referral process. Failure to follow any of these guidelines may result in financial penalties against your office through capitation adjustment.

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

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

NON-EMERGENCY REFERRAL SUBMISSION AND INQUIRIES

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

Provider Portal: www.libertydentalplan.com

Telephone: (800) 268-9012, Press Option 2

Mail:

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

If there is no contracted LIBERTY specialist available within a reasonable proximity to your office, the Referral Unit will provide assistance to refer the member to a non-contracted Specialist.

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

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

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

EMERGENCY REFERRAL

If emergency specialty care is needed, the Referral Unit can issue an emergency authorization number to the General Dentist by calling LIBERTY's Referral Unit at (800) 268-9012, Option 2.

ENDODONTICS

Referral Guidelines for the General Dentist

Confirm the need for a referral and that the Referral Criteria listed below are met.

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

- Member's name, the Primary Member's name, LIBERTY identification number, group name and group number;
- Name, address and telephone number of the contracted LIBERTY network Endodontist;
- Procedure code(s), tooth number(s) and member copayments for the covered endodontic treatment, which requires referral.

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist;
- The member will be financially responsible for non-covered and non-approved services provided by the Endodontist;
- Payment by the Plan is subject to eligibility at the time services are rendered.

For non-emergency referrals, submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service.

The Plan's Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Endodontist:

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

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

If an emergency endodontic service is needed, but has not been listed on the original authorization form, the Endodontist should contact LIBERTY's Referral Unit at (800) 268-9012, Option 2 for an emergency authorization number.

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

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

Endodontic Referral Guidelines					
Endodontic Referrals General Dentist Specialty Care Guidelines (Subject to plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria (teeth must have a good prognosis & be restorable)	Emergency Referral Criteria	Qualifies for Emergency Referrals
D0220	Intraoral - periapical first film	No	N/A	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	If no diagnostic PA x-ray is available
D3310	Root canal - anterior (excluding final restoration)	No	When excessive root curvature or calcification evident on x-rays precludes General Dentist from treating		Extraordinary circumstances considered on a case-by-case basis
D3320	Root canal - bicuspid (excluding final restoration)	No			Extraordinary circumstances considered on a case-by-case basis
D3321	Pulpal Debridement	No	This procedure would only be covered for General Dentists who then refer to an Endodontist to continue treatment		No
D3330	Root canal - molar (excluding final restoration)	Yes	Attending General Dentist documents procedure to be "outside the scope" of his or her skills		Yes
D3331	Treatment of root canal obstruction; non-surgical access	No	Endodontist's claims for this procedure evaluated on a case-by-case		No
D3332	Incomplete endodontic therapy; inoperable, non- restorable or fractured tooth	No	N/A		No
D3333	Internal root repair of perforation defects	B/R	Case-By-Case		Yes

Endodontic Referral Guidelines					
Endodontic Referrals General Dentist Specialty Care Guidelines (Subject to plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria (teeth must have a good prognosis & be restorable)	Emergency Referral Criteria	Qualifies for Emergency Referrals
D3346	Retreatment of previous root canal therapy - anterior	Yes	Case-By-Case	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment.	Yes
D3347	Retreatment of previous root canal therapy - bicuspid	Yes			Yes
D3348	Retreatment of previous root canal therapy - molar	Yes			Yes
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Yes			Extraordinary circumstances considered on a case-by-case basis
D3410	Apicoectomy/periradicular surgery - anterior	Yes			
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	Yes			
D3425	Apicoectomy/periradicular surgery - molar (first root)	Yes			
D3426	Apicoectomy/periradicular surgery (each additional root)	Yes			
D3430	Retrograde filling - per root	Yes			
D3450	Root Amputation - per root	Yes			
D3910	Surgical procedure for isolation of tooth with rubber dam	No			
D3920	Hemisection (including any root removal), not including root canal therapy	No			
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes			

ORAL SURGERY

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

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

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

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist;
- The member will be financially responsible for non-covered and non-approved services provided by the Oral Surgeon.
- Payment by the Plan is subject to eligibility at the time services are rendered.

For non-emergency referrals, submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service.

The Plan Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Oral Surgeon:

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

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

If an emergency oral surgery service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Oral Surgeon should contact LIBERTY's Referral Unit at (800) 268-9012, Option 2 for an emergency authorization number.

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

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

Oral Surgery Referral Guidelines				
Oral Surgery Referrals		Procedures Usually Approved For Referral	Referral Criteria	Qualified for Emergency Referral
D0220	Intraoral - periapical first film	B/R	Non-diagnostic x-rays sent by referring dentist	B/R
D0330	Panoramic film	B/R	Non-diagnostic x-ray(s) sent by General Dentist	B/R
D7111	Extraction, coronal remnants - deciduous tooth	No	N/A	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	N/A	No
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth	B/R	General Dentist's x-ray(s) supports the procedure to be "outside the scope" of his or her skills and/or five (5) or more teeth to be extracted.	B/R
D7220	Removal of impacted tooth - soft tissue	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7230	Removal of impacted tooth - partially bony	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7240	Removal of impacted tooth - completely bony	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Yes	Most plans only allow a benefit with documented active pathology	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	B/R	X-ray must support the use of this code	Yes
D7280	Surgical access of an unerupted tooth	Yes		Yes

Oral Surgery Referral Guidelines				
Oral Surgery Referrals		Procedures Usually Approved For Referral	Referral Criteria	Qualified for Emergency Referral
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Yes	Not covered under most plans	Yes
D7283	Placement of device to facilitate eruption of impacted tooth	Yes		Yes
D7285	Biopsy of oral tissue - hard (bone, tooth)	Yes		Yes
D7286	Biopsy of oral tissue - soft	Yes		Yes
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	B/R	May be included in multiple surgical extractions	Yes
D7311	Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	B/R		Yes
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	B/R	B/R	Yes
D7321	Alveoloplasty not in conjunction with extractions 1 to 3 teeth or tooth spaces, per quadrant	B/R	B/R	Yes
D7471	Removal of lateral exostosis (maxilla or mandible)	Yes	B/R	Yes
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	Yes	B/R	Yes

Oral Surgery Referral Guidelines				
Oral Surgery Referrals		Procedures Usually Approved For Referral	Referral Criteria	Qualified for Emergency Referral
D7970	Excision of hyperplastic tissue - per arch	Yes	B/R	Yes
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes	Not payable when rendered on the same day of other services	Yes



ORTHODONTICS

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Authorization and provide the:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number;
- Name, address and telephone number of the contracted LIBERTY network Orthodontist;
- Comments concerning the member's malocclusion.

Inform the member that:

- Referrals are subject to a member's plan-specific benefits, limitations and exclusions; and
- The member will be financially responsible for non-covered services provided by the Orthodontist;
- Payment by the Plan is subject to eligibility at the time services are rendered.

Referral Guidelines for the Orthodontist:

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

Contact the Plan's Membership Service department at (800) 268-9012 to obtain member's copayments and plan-specific benefits, limitations and exclusions for:

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

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

After patient is banded, submit your claim to the Plan for payment.²

² Net payable claim amounts in excess of \$300.00 will be paid over the period of active orthodontic treatment.

Orthodontic Referral Guidelines			
Orthodontic Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		Generally Approved For Referral	Referral Criteria
D8010	Limited orthodontic treatment of the primary dentition	Yes	General Dentist feels orthodontic treatment may be appropriate for patient
D8020	Limited orthodontic treatment of the transitional dentition	Yes	
D8030	Limited orthodontic treatment of the adolescent dentition	Yes	
D8040	Limited orthodontic treatment of the adult dentition	Yes	
D8050	Interceptive orthodontic treatment of the primary dentition	Yes	
D8060	Interceptive orthodontic treatment of the transitional dentition	Yes	
D8070	Comprehensive orthodontic treatment of the transitional dentition	Yes	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Yes	
D8090	Comprehensive orthodontic treatment of the adult dentition	Yes	
D8210	Removable appliance therapy	Yes	
D8220	Fixed appliance therapy	Yes	
D8660	Pre-orthodontic treatment visit	Yes	
D8670	Periodic orthodontic treatment visit (as part of contract)	Yes	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) - to age 18	Yes	
D8690	Orthodontic treatment (alternative billing to a contract fee)	Yes	
D8691	Repair of orthodontic appliance	Yes	
D8692	Replacement of lost or broken retainer	Yes	
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	Yes	
D0210	Intraoral - complete series	Yes	
D0330	Panoramic Film	Yes	
D0340	Cephalometric Film	Yes	N/A
D0350	Oral / facial photographic images	Yes	N/A

Orthodontic Referral Guidelines		
Orthodontic Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)	Generally Approved For Referral	Referral Criteria
D0470	Diagnostic casts	N/A



PEDIATRIC DENTISTRY

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a Specialty Care Authorization and provide the:

- Patient's name, the Primary Member's name, LIBERTY identification number, group name and group number;
- Name, address and telephone number of the contracted LIBERTY network Pediatric Dentist;
- Procedure code, tooth number/quadrant and member copayments for each service, which require referral. (If the General Dentist is unable to perform an adequate examination due to limited patient cooperation, the procedure codes for an examination and radiographs should be listed).

Inform the member that:

- Referral is only approved for services listed on the request from the referring General Dentist;
- The member will be financially responsible for non-covered and non-approved services provided by the Pediatric Dentist;
- Payment by the Plan is subject to eligibility at the time services are rendered.

For non-emergency referrals, submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service.

The Plan Dental Consultant will review the referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Pediatric Dentist:

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

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

If an emergency pediatric service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Pediatric Dentist should contact the LIBERTY's **Referral Unit** at (800) 268-9012, Option 2 for an emergency authorization number.

After completion of treatment, submit your claim for payment with pre and post periapical radiographs. To avoid delays in claim payment, please always attach a copy of the LIBERTY Specialty Care Authorization or the Plan's authorization for treatment when applicable. **X-rays and other supporting documentation will not be returned. Please do not submit original X-rays. X-ray copies of diagnostic quality, including paper copies of digitized images, are acceptable.**

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

Pediatric Referral Guidelines				
Pediatric Referrals General Dentist Specialty Care Guidelines (Subject to Plan Benefits)		Procedures Usually Approved For Referral	Criteria for Referral	Qualifies for Emergency Referral
D0145	Oral evaluation for a patient under 3 years of age	Yes	General Dentist has attempted to see child: Children 0-4 minimum of one attempt made by General Dentist. Children 4-7 two attempts made by General Dentist. Pediatric Referrals are limited to Children under the age of 7, unless the qualify under Americans with Disabilities Act "ADA"	
D0150	Comp oral evaluation - new/= or established patient	Yes		Yes
D0210	Intraoral - complete series	Yes		
D0220	Intraoral - periapical first film	Yes		Yes
D0230	Intraoral - periapical each additional film	Yes		Yes
D1120	Prophylaxis – child	Yes		Yes
D1203	Topical application of fluoride – child	Yes		Yes
D3110	Pulp Cap – direct	Yes		Yes
D3120	Pulp Cap – indirect	Yes		Yes
D3220	Therapeutic pulpotomy	Yes		Yes
D3221	Pulpal debridement primary and permanent teeth	Yes		Yes
D3230	Pulpal therapy - anterior primary tooth	Yes		Yes
D3240	Pulpal therapy - posterior primary tooth	Yes		Yes
D7140	Extraction erupted tooth or exposed root	Yes		Yes
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes	Yes	



PERIODONTICS

Referral Guidelines for the General Dentist:

Confirm the need for a referral and that the Referral Criteria listed below are met.

Complete a LIBERTY Specialty Care Authorization and provide the:

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

Inform the member that:

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

Submit referral to LIBERTY Dental Plan with appropriate documentation/x-rays through i-Transact or via standard mail service;

The Plan's Dental Consultant will review referral to ensure requested procedures meet referral guidelines and plan benefits.

Referral Guidelines for the Periodontist:

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

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

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

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

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

Periodontic Referral Guidelines				
Periodontal Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria	Items to be sent to LDP and specialist
D0180	Comprehensive periodontal evaluation	Yes	General Dentist has completed non-surgical services + follow-up evaluation, patient exhibits good motivation & oral hygiene habits	Diagnostic Full Mouth x-rays & Full Mouth periodontal probings
D0210	Intraoral - complete series (including bitewings)	No	No	Yes
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	B/R	Diagnostic Full Mouth x-rays & Full Mouth periodontal probings	Diagnostic Full Mouth x-rays & Full Mouth probings
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	B/R		
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	B/R		
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	B/R		
D4245	Apically positioned flap	B/R		
D4249	Clinical crown lengthening - hard tissue	B/R	PA x-ray confirms necessity to retain a crown on a restorable tooth	PA x-ray showing entire root
D4260	Osseous surgery (including flap entry & closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	B/R	When approved, limited to no more than two quadrants on the same date of service	Full Mouth x-rays, Full mouth periodontal probing's, dates of SRP's & follow-up evaluation

Periodontic Referral Guidelines				
Periodontal Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		Procedures Usually Approved For Referral	Referral Criteria	Items to be sent to LDP and specialist
D4261	Osseous surgery (including flap entry & closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	B/R	B/R	Full Mouth x-rays, Full mouth periodontal probing's, dates of SRP's & follow-up evaluation
D4263	Bone replacement graft - first site in quadrant	B/R	B/R	
D4264	Bone replacement graft - each additional site in quadrant	B/R	B/R	
D4270	Pedicle soft tissue graft procedure	B/R	Most plans do not benefit this procedure	
D4271	Free soft tissue graft procedure (including donor site surgery)	B/R	B/R	
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	B/R	B/R	
D4341	Periodontal scaling & root planing - 4 or more teeth per quadrant	No	For moderate to severe periodontitis, "may" be considered for referral	
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	No	For moderate to severe periodontitis, "may" be considered for referral	If approved, limited to no more than two quadrants on the same date of service
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Yes	Not payable when rendered on the same day of other procedures	B/R

Periodontics

Referral Coverage Based on Diagnosis

Gingivitis associates with dental plaque

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

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

Slight Chronic/Aggressive Periodontitis (localized or generalized)

- 4 - 5 mm pockets and possibly an occasional 6 mm pocket with 1 - 2 mm of clinical attachment loss;
- Moderate bleeding upon probing, which is more generalized than in gingivitis;
- Normal tooth mobility with possibly some Class 1 (0.5 mm - 1.0 mm) mobility;
- No furcation involvement or an isolated Grade 1 involvement (i.e., can probe into the concavity of a root trunk); and
- Radiographic evidence of localized loss crestal lamina dura and early to very moderate (10% - 20%) bone loss, which is usually localized.

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

Moderate Chronic/Aggressive Periodontitis, (localized or generalized)

- Pocket depths of 4 – 6 mm with the possibility of localized greater pocket depths with 3 - 4 mm of clinical attachment loss;
- Generalized bleeding upon probing;
- Possible Class 1 to Class 2 (1 – 2 mm) tooth mobility;
- Class I furcation involvement with the possibility of some early Class II (i.e., can probe between the roots); and
- Radiographic evidence of moderate (20%-40%) bone loss, which is usually horizontal in nature.
- Referral to a Periodontist covered for a problem-focused examination and possible periodontal surgery.
- Moderate Chronic/Aggressive Periodontitis is eligible for direct specialty referral.

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

Severe Chronic/Aggressive Periodontitis (localized or generalized)

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

Referral to a Periodontist covered for a problem-focused evaluation, scaling and root planing and possible periodontal surgery.

Refractory Chronic/Aggressive Periodontitis

- Defined as a periodontitis case that treatment fails to arrest the progression of periodontitis – whatever the thoroughness or frequency – as well as patients with recurrent disease at single or multiple sites
- Refractory Chronic/Aggressive Periodontitis is eligible for direct specialty referral.
- Referral to a Periodontist covered to confirm the diagnosis of Refractory Chronic/Aggressive Periodontitis and to advise you on the patient’s management and care.

PROSTHODONTIST

Referrals for this type of specialist are typically not covered under LIBERTY’s benefits plans.

SECTION 11- QUALITY MANAGEMENT

PROGRAM DESCRIPTION

LIBERTY Dental Plan's Quality Management and Improvement (QMI) Program is organized to ensure that the quality of dental care provided is being reviewed by dentists, quality of care problems are identified and corrected, and follow-up is planned when indicated. LIBERTY Dental Plan's QMI Program addresses essential elements including quality of care, accessibility, availability and continuity of care. The provision and utilization of services are closely monitored to ensure professionally recognized standards of care are met.

QMI Program Policy

The purpose of LIBERTY Dental Plan's QMI Program is to ensure the highest quality, cost effective dental care for its members, with emphasis on dental prevention and the provision of exceptional customer service to all involved in the program; our providers, our clients and their members.

QMI Program Scope

The scope of the QMI Program activities includes continuous monitoring and evaluation of primary and specialty dental care provided throughout the dental network. In addition, the scope includes systematic processes for evaluating and monitoring all clinical and non-clinical aspects of dental care delivery.

QMI Program Goals and Objectives

The LIBERTY Dental Plan QMI Program goals and objectives are comprehensive and support the overall organizational goal of providing the highest quality dental care to LIBERTY members in a cost effective manner. LIBERTY's QMI Program focuses on a proactive problem solving and continuous monitoring and improvement approach to ensure access to quality dental care. The process may include:

- Standards and criteria development;
- Problem and trend identification and assessment;
- Development and implementation of QMI Program studies, performance, measure monitoring and member/provider surveys;
- Credentialing and Recredentialing of providers;
- Monitoring of dental office staff and provider performance;
- Infection control monitoring;
- Facility review audits;
- Dental chart audits;
- Utilization management and monitoring of over- and under-utilization;
- Monitoring of member and provider grievance/appeals and follow-up;
- Disenrollment, enrollment, and primary care dentist transfer request tracking;
- Provider/member education;
- Staff orientation;
- Corrective action plan development, implementation and monitoring effectiveness, including disciplinary actions and terminations of any provider for serious quality deficiencies and reporting the same to the appropriate authorities;
- Other QMI Program activities identified during monitoring process.

COMMITTEES

Oversight of the QMI Program is provided through a committee structure, which allows for the flow of information to and from the Board of Directors. The QMI Program employs five major Committees and

additional sub-committees to ensure that the dental care delivery decisions are made independent of financial and administrative decisions. They are the:

- Quality Management & Improvement Committee;
- Credentialing Committee;
- Network Management Sub-Committee;
- Peer Review Committee;
- Utilization Management Committee;
- Grievance Committee.

The **Quality Management & Improvement Committee** reviews, formulates, and approves all aspects of dental care provided by LIBERTY Dental Plan's Network Providers, including the structure of care, the process and outcome of care, utilization and access to care, availability, referrals to specialists, continuity of care, safety, appropriateness, and any problem resolution in the dental delivery system identified by the Peer Review, Utilization Management or Grievance Committees.

The QMI Committee's oversight responsibilities include monitoring the activities of other QMI components and participants to assure that approved policies and procedures are followed and those policies and procedures are effective in meeting the needs of LIBERTY Dental Plan and its members.

The **Credentialing Committee** is responsible for reviewing, accepting, or rejecting the professional credentials of each applicant dentist and contracted dental provider. This committee follows the approved policies and procedures of the Quality Management Improvement Committee in determining whether a provider will be approved or denied as a participant in LIBERTY's provider network.

Dentists are recredentialed on a three-year cycle and as needed. Sixty days before the provider's assigned recredentialed date, the dentist will receive a written request to submit required documents to LIBERTY's Credentialing Verification Organization (CVO). If the dentist does not respond, a report is generated by the CVO for LIBERTY to assist in obtaining the missing or expired information. Failure to comply with recredentialed requests will result in termination from the network.

The **Network Management Sub-Committee** is responsible for monitoring the number and distribution of primary care and specialty care dentists to ensure an adequate network of providers. Quarterly, this sub-committee reports on the geographic distribution and members to dentist ratio as well as the analysis of data regarding appointment availability, wait times and grievances/appeals to determine shortcomings in the network and submits the finding to the QMI Committee for review.

The **Peer Review Committee (PRC)** ensures that dental care is rendered in accordance with the policies, procedures and standards set by the Quality Management Committee. The PRC is responsible for:

- Provider quality of care issues identified through various means, including but not limited to, member grievances and on-site audits and chart reviews;
- Potential or pending malpractice issues, National Practitioner's Data Bank reports and Dental Board of the specified State reports, when requested to do so by the Quality Management Committee;
- Provider appeals (i.e., grievance resolution, terminations, denial for panel participation);
- Member appeals as they relate to grievances or other dental care issues;
- Annual review and update of the Specialty Referral Criteria and Guidelines.

The **Utilization Management Committee (UMC)** is responsible for reviewing the utilization data as reported by network providers and the subsequent analytical reports to ensure proper utilization and delivery of care.

The UM Committee evaluates a summary of treatment provided by the entire contracted General Dentist network. The analysis is intended to provide an indication of the numbers of members seeking treatment and the types of treatment they receive. Further evaluation of specific provider offices allows a determination of how those offices compare to the overall experience of the entire network and how individual provider offices compare to the established network norms.

The Dental Director assesses over- and under-utilization of specialty referral trends and reports the findings to the UM Committee. From these reports, this committee can also monitor trends in specialty referral denials and make recommendations to the QMI Committee.

The UM Committee also reviews access and availability and continuity of care issues by the reviewing reports of appointment availability, wait time and the number of actual appointments kept by the members. This will also include evaluation of the number and location of the general and specialty dentist providers. The committee addresses negative trends in these areas and makes recommendations for improvements that are forwarded to the Quality Management Improvement Committee.

The **Grievance Committee** reviews member/provider disputes related to LIBERTY, provider, or member. The member appeal and grievance process encompasses investigation, review, and resolution of member issues to LIBERTY and/or contracted providers. This committee accepts issues via telephone, fax, e-mail, letter, or grievance form.

As a contracting provider, you should know that LIBERTY provides translation services in 150 languages for members whose primary language is not English. Grievance forms can be obtained from LIBERTY's Member Services Department or LIBERTY's website as forms must be kept in your dental facility and given to members when appropriate.

All member quality of care grievances, benefit complaints, and appeals are received and processed by the Grievance Committee and are not delegated to any other provider group. LIBERTY's Grievance and Appeals Analyst records and reviews all member issues involving potential complaints, grievances or appeals and is responsible for the collection of all necessary and appropriate documentation needed to reach a fair and accurate resolution. Any issue relating to technical quality of dentistry rendered by a network provider is reviewed by a dentist member of the Peer Review Committee. In order to identify systemic deficiencies, the Grievance Analyst completes the case investigation and then a grievance history review is performed. If there are two or more complaints of a similar nature in a six-month period, the provider is referred to the Grievance Committee for review. If the Committee determines that a corrective action plan is necessary, it will be referred to the Dental Director for implementation.

The Grievance Committee also monitors patterns of disputes and makes recommendations to the Dental Director regarding a doctor, member or group. The Committee will meet on a quarterly basis or more frequently if problems have been identified. Quarterly reports on member complaints, grievances, and appeal activities are made to the Dental Director.

Providers may register a complaint in writing to LIBERTY Dental's Grievance Department. The complaint should include any supporting documentation that may help yield a satisfactory resolution. Issues relating to contracted or formerly contracted providers who believe they have been adversely impacted by the policies, procedures, decisions, or actions of LIBERTY may also be submitted to the Grievance Committee in accordance with LIBERTY's Provider Dispute Resolution Policy. The Grievance Committee notifies the Provider Relations Department which handles all provider disputes and in turn will log them in and process them according to plan policy. LIBERTY will respond in writing within sixty (60) days of receipt of all information necessary to make a fair and accurate decision.

Both providers and members may appeal any resolutions made by LIBERTY Dental. All appeals are logged and monitored for timely and adequate resolution. An appeal is considered to be a type of complaint and is therefore handled with the same procedures as with the grievance resolution.

PROGRAM STANDARDS AND GUIDELINES

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

Emergency Services:

Emergency Appointments (acute pain/swelling/bleeding)

- 24 hours a day, 7 days per week

Non-urgent Appointments (exams, x-rays, restorative care)

- Not to Exceed 36 business days

Preventive Care (prophylaxis or periodontal care)

- Not to exceed 40 business days

Lobby waiting time (for scheduled appointment)

- Not to exceed 30 minutes

Surveys:

Provider Access Surveys:

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

Member Satisfaction Surveys:

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

Grievance System: The Grievance Committee reports the summary of the quarterly findings of access issues reports by member's grievances or member transfers to alternate facilities.

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

- Further education and assistance to the provider;
- Provider counseling;
- Closure to new membership enrollment;
- Transfer of patients to another provider;
- Contract termination;
- Investigation results from subcommittees must be reported to Quality Management and Improvement Committee (QMI).



Provider QMI Program Responsibilities

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

CREDENTIALING / RE-CREDENTIALING

- Prior to acceptance in the LIBERTY Dental provider network, dentists must submit a copy of the following information which will be verified:
- Current State dental license for each participating dentist;
- Current DEA license, (does not apply to Orthodontists);
- 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 residency program with completion, (for specialists);
- Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist;
- Immediate notification of any professional liability claims, suits, or disciplinary actions;
- Verification is made by referencing the State Dental Board and National Practitioner Data Bank.

All provider credentials are continually monitored and updated on an on-going basis. Providers will receive notification of license/credential expiration from LIBERTY Dental Plan's delegated Certified Verification Organization (CVO), 60 days prior to expiration to allow time to submit current copies.

For all accepted providers, the local Network Manager presents a provider orientation within 30 days after activation at which time the provider receives a copy of LIBERTY's Provider Reference Guide. The Provider Reference Guide obligates all providers to abide by LIBERTY's QMI 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 60 days either in person or by telephone.

LIBERTY Dental Plan 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 Professional Relations Department, which also includes audit results. The latter contains copies of signed agreements, addenda, and related business correspondence.

RECORDS REVIEW

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

Chart Selection: A minimum of 10 randomly selected patient charts shall be reviewed.

Elements of Record Review

The criteria used for dental records review is detailed in the Forms and Exhibits Section of this Reference Guide. The criteria described shall apply to all reviews completed by LIBERTY Dental Plan.

GRIEVANCES, PROVIDER CLAIM DISPUTES & APPEALS

GRIEVANCES AND APPEALS

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

LIBERTY Dental Plan's grievance and/or appeals system also addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities. The system is designed to ensure that all Plan members have access to and can fully participate in the grievance system. LIBERTY Dental Plan's members' participation in the grievance system, for those with linguistic, cultural or communicative impairments, is facilitated through LIBERTY's coordination of translation, interpretation and other communication services to assist in communicating the procedures, process and findings of the grievance system. LIBERTY provides members whose primary language is not English with translation services. We currently provide translation services in 150 languages. Grievance and/or appeals forms can be obtained from LIBERTY's Member Services Department, from a dental provider facility, or from the LIBERTY website. All contracted provider facilities are required to display member complaint forms. All member quality of care grievances, benefit complaints, and appeals are received and processed by LIBERTY.

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

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

LIBERTY Dental Plan resolves all grievance and/or appeals within 30 days of receipt. The LIBERTY Grievance Analyst mails notification of the receipt of the grievance to the member and provider within **5 business days**. If a member feels his/her health will be harmed by waiting 30 days, an “**expedited grievance and/or appeal**” can be requested, which may result in a decision from LIBERTY within **72 hours**. In order for a member to qualify for an “**expedited appeal**” the benefit criteria must first be met. The criteria include, but is not limited to, severe pain, bleeding, swelling and/or loss of bodily functions.

The Peer Review Committee reviews member/provider disputes related to LIBERTY, provider, or member. The Peer Review Committee is responsible for hearing and resolving grievances by monitoring patterns or trends in order to formulate policy changes and generate recommendations as needed.

Commercial Business Members

LIBERTY commercial business members have the right to file a grievance for a least **180 calendar days** following any incident or action that is the subject of their dissatisfaction.

LIBERTY commercial business members have the right to file an appeal, or the provider may file an appeal on behalf of the member, within **60 days** of the decision made by LIBERTY.

Members can submit a grievance via telephone by calling LIBERTY’s Member Services Department toll-free at (888) 703-6999, or by fax, email, letter, or grievance form.

Medicaid and Medicare Members

LIBERTY Medicaid and Medicare members have the right to file a grievance at **any time** following any incident or action that is the subject of their dissatisfaction, in accordance with federal regulations set forth by the Centers for Medicare and Medicaid Services (CMS). Members can submit a grievance via telephone by calling LIBERTY’s Member Services Department toll-free at (888) 703-6999, or by fax, email, letter, or grievance form.

If a LIBERTY Medicaid or Medicare member disagrees with the decision made for his/her medical treatment or a previous determination made by LIBERTY, he/she has the right to file an appeal. Members have **60 days** from the date of the “Notice of Action” letter to file an appeal. If the member is currently receiving treatment and wants to continue getting treatment, an appeal must be requested within **10 days** from the date the letter was postmarked or delivered to them, or prior to the date the health plan states that services will stop. The member must state in the appeal that they want to continue receiving treatment during the appeal process.

Members can submit an appeal via telephone by calling LIBERTY’s Member Services Department toll-free at (888) 703-6999, or by fax, email, letter, or grievance form. Members are required to submit a written signed appeal to LIBERTY for all appeals submitted via telephone to the Member Services Department. If a Provider submits an appeal on behalf of a member, the Provider must obtain and supply LIBERTY with a copy of a signed document from the member indicating consent for the appeal to be filed on his/her behalf. If LIBERTY does not receive such a document, the appeal cannot be processed.

LIBERTY's Medicaid or Medicare members who do not receive a "Notice of Appeal Resolution" letter within **30 days**, or are dissatisfied with the resolution of their grievance, may request an Independent Medical Review (IMR) or State Fair Hearing from the State of California Department of Social Services, but only after they have exhausted the LIBERTY appeal process. LIBERTY Medicaid or Medicare members may request an IMR or State Fair Hearing at the same time, or separately. However, if a member requests and completes the State Fair Hearing process first, an IMR cannot be requested, and the determination made at the State Fair Hearing is final. If an IMR is requested first, a State Fair Hearing may be requested later. **Neither an IMR, nor a State Fair Hearing, should be pursued until the LIBERTY appeal process has been exhausted.**

An IMR must be requested within **180 days**, from the date of the "Notice of Appeal Resolution" letter. **An IMR may be granted without a member appeal being filed first, in cases where the member's health is in immediate danger or the request was denied because treatment is considered experimental or investigational.**

State Fair Hearings must be requested within **120 days** from the date of the "Notice of Appeal Resolution" letter. Members may represent themselves at the State Fair Hearing, or be represented by a friend, lawyer or any other person. If they want someone else to represent them, they are responsible for making the arrangements. Members are informed that to get free legal assistance, they may call the Public Inquiry and Response Unit of the Department of Social Services at their toll-free number, 1-800-952-5253.

After requesting a State Fair Hearing, it could take up to 90 days for the member to receive a decision. If a member feels his/her health will be harmed by waiting 90 days, an "**expedited hearing**" can be requested, which may result in a decision from LIBERTY within 72 hours. The member should ask the doctor to submit a letter detailing how waiting for up to 90 days for a decision on the case could seriously harm the member's life, health, ability to attain, maintain, or regain maximum function. This letter should be provided with the member's request for a hearing.

Requesting a State Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a hearing. Members may request benefit continuation during an appeal, IMR or State Fair Hearing by contacting LIBERTY's Member Services Department toll-free at (888) 703-6999.

PROVIDER DISPUTE RESOLUTIONS

As a LIBERTY contracted or non-contracted provider, you have the right to challenge, appeal, dispute or request reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered), pre-treatment authorization or a decision made by LIBERTY.

LIBERTY will resolve any provider dispute submitted on behalf of a member through LIBERTY's Consumer Grievance Process. A provider dispute submitted on behalf of a member will **not** be resolved through LIBERTY's Provider Dispute Resolution Process.

Time Period for Submission of Provider Disputes

Contracted provider disputes must be received by LIBERTY within **365 days** from LIBERTY's action that led to the dispute (or the most recent action if there are multiple actions). In the case of LIBERTY's inaction, contracted provider disputes must be received by LIBERTY within **365 days** after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Acknowledgment of Contracted Provider Disputes

Contracted provider disputes will be acknowledged by LIBERTY within **15 business days** of the receipt date.

Each contracted provider dispute must contain, at a minimum, the following information: 1) provider's name; 2) provider's license number, 3) provider's contact information, and:

- If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from LIBERTY to a contracted provider: 4) a clear identification of the disputed item, the date of service and 5) a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.
- If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on the issue.

Contracted provider disputes that do not include all required information may be returned to the submitter for completion. An amended contracted provider dispute, which includes the missing information, may be submitted to LIBERTY within **30 working days** of your receipt of a returned contracted provider dispute.

Contracted Provider Disputes sent to LIBERTY must include the information listed above for each contracted provider dispute. All contracted provider disputes must be sent to the attention of the Provider Dispute Resolution Mechanism Department at the following address:

LIBERTY Dental Plan
Quality Management Department
P.O. Box 26110
Santa Ana, CA 92799-6110
ATTN: Provider Dispute Resolution Mechanism Department

Contracted Provider Dispute Inquiries

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the Provider Dispute Resolution Mechanism Department at:
1-800-268-9012.

SECTION 12 - FRAUD, WASTE AND ABUSE

LIBERTY Dental Plan is committed to conducting its business in an honest and ethical manner and to operate in strict compliance with all regulatory requirements that relate to and regulate our business and dealings with our employees, members, providers, business associates, suppliers, competitors and government agencies.

The civil provisions of the FCA (False Claims Act) make a person liable to pay damages to the Government if he or she knowingly:

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

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

“Fraud”: means, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit program.

Examples of fraud may include:

- Knowingly billing for unnecessary services, for services not performed, or for more expensive services than were provided;
- Soliciting, offering or receiving a kickback, bribe or rebate

“Waste” is a misuse of resources: the extravagant, careless or needless expenditure of healthcare benefits or services that result from deficient practices or decisions.

Examples of waste may include:

- Over-utilization of services
- Misuse of resources

“Abuse” describes practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Examples of abuse **may** include:

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

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

REPORTING

All suspected cases of fraud, waste or abuse related to LIBERTY, including Medicare and Medicaid, should be reported to LIBERTY's Special Investigation Unit. The caller will have the option of remaining anonymous.

LIBERTY's Special Investigation Unit

SIU Hotline: (888) 704-9833

Email: hotline@libertydentalplan.com

U.S. Mail: LIBERTY Dental Plan
Attention: Special Investigations Unit
P.O. Box 26110
Santa Ana, CA 92799-6110

and/or

The Department of Health Care Services

DHCS Medi-Cal Fraud Hotline: (800) 822-6222

Email: stopmedicalfraud@dhcs.ca.gov

On-Line Complaint Form: <https://apps.dhcs.ca.gov/AutoForm2/default.aspx?af=1828>

and/or

U.S. Government Recovery Board

Fraud Hotline: (877) 392-3375

U.S. Mail: Recovery Accountability and Transparency Board
Attention: Hotline Operators
P.O. Box 27545
Washington, D.C. 20038-7958

On-Line Complaint Form: <http://www.recovery.gov/Contact/ReportFraud/Pages/FWA.aspx>

TRAINING

The Centers for Medicare and Medicaid Services (CMS) requires that all employees of organizations that provide health care services under Medicare Advantage or Medicare Part D programs, complete a Fraud, Waste and Abuse compliance training annually.

LIBERTY provides, free of charge, Fraud, Waste and Abuse Prevention Training for all contracted providers and any other downstream entity that you contract with to provide health, and/or administrative services on behalf of LIBERTY. This training is available on-line by visiting www.libertydentalplan.com. Upon completion, you will be able to print out a certificate/attestation that will satisfy the CMS the requirements.

If your organization has already completed a Fraud, Waste and Abuse training that meets CMS requirements, LIBERTY will accept documentation of that training. Organizations must retain a copy of all documentation related to this training for a period of no less than 10 years – including methods of training, dates, materials, sign-in sheets, etc.



SECTION 13 – 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. 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 strongly encourages that any alternative, upgraded and/or elective treatment(s) be presented to the member in writing during the informed consent process. In addition, the member's signature of approval should be documented prior to initiating treatment. This process will alleviate potential member disputes.

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 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 are recommended using upgraded materials, and these similar procedures are not a benefit under the member's copayment schedule.

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

For Example:

Benefit	Full Metal Crown (molar tooth)	\$125.00	Member's copayment
Upgrade*	Porcelain	\$75.00	Material upgrade
Upgrade*	High Noble Metal (gold)	\$125.00	Material upgrade
		\$325.00	Member's total responsibility

*Please refer to specific benefit plan designs for additional information



SECTION 14 – FORMS

ALTERNATE TREATMENT FORM

GRIEVANCE FORM

REFERRAL FORM