



PROVIDER REFERENCE GUIDE FLORIDA MEDICAID



www.libertydentalplan.com

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SECTION 1 –LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

Welcome to LIBERTY Dental Plan’s Medicaid network of Participating Providers for the Managed Medical Assistance (MMA) program in Florida. 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 as it pertains to the MMA program.

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

OUR MISSION FOR THE MMA PROGRAM FOR MEDICAID RECIPIENTS

LIBERTY Dental Plan’s mission is to be the industry leader in improving access to quality oral health care services for the Florida Medicaid Population. LIBERTY seeks to increase annual patient visits through member outreach and education. Our continued expansion is an outgrowth of our commitment to exceptional service and expertise in our industry while providing a positive, rewarding, and enjoyable professional relationship with our network providers, the Medicaid beneficiaries and LIBERTY staff members.



PROVIDER CONTACT AND INFORMATION GUIDE

LIBERTY Dental Plan

IMPORTANT PHONE NUMBERS AND GENERAL INFORMATION	ELIGIBILITY & BENEFITS VERIFICATION	CLAIMS INQUIRIES	PROVIDER WEB PORTAL (i-TRANSACTION)
<u>LIBERTY PROVIDER SERVICE LINE</u>	Provider Portal (i-Transact)	Provider Portal (i-Transact)	www.libertydentalplan.com
(888) 352-7924	www.libertydentalplan.com	www.libertydentalplan.com	LIBERTY Dental Plan offers 24/7 real-time access to important information and tools through our secure online system
Eligibility & Benefits: Press Option 1	or	or	<ul style="list-style-type: none"> • Electronic Claims Submission • Claims Inquiries • Real-time Eligibility Verification • Member Benefit Information • Pre-approval Submission • Pre-approval Status
Claims: Press Option 2	TELEPHONE (888) 352-7924 Press Option 1	TELEPHONE (888) 352-7924 Press Option 2	Please visit: www.libertydentalplan.com to register as a new user and/or login.
Pre-Estimates: Press Option 3	PRE-APPROVAL, SUBMISSION & INQUIRIES	CLAIMS SUBMISSIONS	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 (888) 352-7924 for assistance or email support@libertydentalplan.com .
Referrals & Specialty Pre-Authorizations: Press Option 4			Provider Web Portal (i-Transact) www.libertydentalplan.com
Request Materials: Press Option 5	TELEPHONE (888) 352-7924 Press Option 4	EDI Payor ID #: CX083	APPEALS
<u>HOURS</u>	Email referrals@libertydentalplan.com	Email Floridaclaims@libertydentalplan.com	Providers have the right to file an appeal regarding provider payment or contractual issues.
Live representatives are available Monday – Friday, 5 a.m. – 8 p.m. EST	Regular Referrals by Mail	TELEPHONE (888) 352-7924 General Information Press Option 6 Fax (888) 401-1129	Appeals must be in writing and mailed to:
<u>PROFESSIONAL RELATIONS DEPARTMENT</u>	LIBERTY Dental Plan Attn: Referral Department P.O. Box 15149 Tampa, FL 33684-5149	Paper Claims by Mail or Corrected Claims by Mail	LIBERTY Dental Plan Attn: Appeals P.O. Box 26110 Santa Ana, CA 92799-6110
(888) 352-7924	Emergency Referrals and Hotline Phone (888) 359-1087 Fax (888) 334-6033	LIBERTY Dental Plan Attn: Claims Department P.O. Box 15149 Tampa, FL 33684-5149	
Fax: (949) 313-0766	Hours Monday- Friday 8 a.m. EST – 8 p.m. EST	Corrected Claims by Fax (888) 700-1727	
LIBERTY Dental Plan Attn: Professional Relations P.O. Box 26110 Santa Ana, CA 92799-6110			
prinqueries@libertydentalplan.com			

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
- Providing training and orientation to new and existing providers
- 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 to prinquiries@libertydentalplan.com or in writing to:

LIBERTY Dental Plan
P.O. Box 15149
Tampa, FL 33684-5149
Attention: Professional Relations

Our Professional Relations team is available to assist you Monday – Friday, from 8 a.m. – 8 p.m. (Eastern) by calling (888) 352-7924, Press Option 3, or by email at prinquiries@libertydentalplan.com.



SECTION 3 – ONLINE SERVICES

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

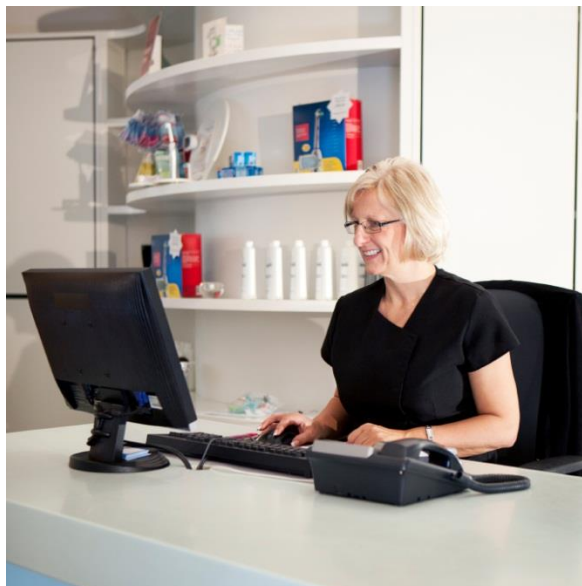
We offer free of charge 24/7 real-time access to important information and tools through our secure on-line Provider Portal. Registered users will be able to:

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

To register and obtain immediate access to your office's account, visit: www.libertydentalplan.com. Your "Access Code" and "Office Number" can be found on your LIBERTY Welcome Letter. The first person to register is considered to be the administrator by default. Administrators can give access to additional users in their office.

Detailed instructions on how to utilize our online services can be found in the On-Line Provider Portal User Guide by visiting www.libertydentalplan.com.

If you cannot locate your access code or need assistance with the login process, please call (888) 352-7924 or email support@libertydentalplan.com.



SECTION 4 – ELIGIBILITY

Anti-Discrimination Notice: LIBERTY Dental Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

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 #, Policy #, or Date of Birth will be required (*DOB is recommended for best results*)

Telephone: LIBERTY Dental Plan Automated Phone System from 8 a.m. to 8 p.m. EST, Monday through Friday by contacting our Provider Service Line at (888) 352-7924, Option 1.

Member Identification Cards:

Members will receive a plan ID card showing their assigned Dental Home. Members are able to seek care at any contracted LIBERTY Dental Medicaid provider regardless of assignment. Participating 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

Verification of network participation:

Offices may be linked to child and/or adult programs. If you are unsure which programs you are currently linked to please contact your local Network Manager.

SECTION 5 – 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. Payment will be denied for claims submitted more than 180 days from the date of service. Following are the ways to submit a claim:

- HIPAA Compliant “837D” file
- Electronic submissions via clearinghouse
- Electronic submissions via LIBERTY’s Provider Portal
- Paper Claims

HIPAA COMPLIANT 837D FILE

LIBERTY currently accepts HIPAA Compliant 837D files. If you would like to set up or inquire about this option, please contact our I.T. Department at (888) 401-1128.

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 LIBERTY’s Provider Portal or by using a third party clearinghouse.

1. **PROVIDER PORTAL** www.libertydentalplan.com
2. **THIRD PARTY CLEARING HOUSE**

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 any one of the choices listed below 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, as well as LIBERTY’s policies and procedures.

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

PAPER CLAIMS

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

LIBERTY Dental Plan
P.O. Box 15149
Tampa, FL 33684-5149
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 with the Member ID number, first and last name and pre- or post-treatment documentation, if required.
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY identifier in electronic health care claims and other transactions.
 - If you do not have an NPI number, you must register for one at the following website: <http://nppes.cms.hhs.gov>
3. All claims must include the name of the program (such as Florida Medicaid) 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 detailed explanation of the emergency circumstances.

CLAIMS STATUS INQUIRY

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

1. Provider Portal: www.libertydentalplan.com
2. Telephone: (888) 352-7924, Press Option 2

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

- Missing documentation
- Incorrect coding
- Processing errors

CLAIMS OVERPAYMENT

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

Notice of Overpayment of a Claim

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

Contested Notice

If the provider contests LIBERTY notice of overpayment of a claim, the provider may dispute the notice of overpayment within 30 working days of the receipt of the notice of overpayment of a claim. Any such dispute must be received by LIBERTY in writing 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 Provider Dispute Resolution Process described elsewhere in this guide.

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) in accordance with the LIBERTY provider contract, which 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.

PROMPT PAYMENT OF CLAIMS

LIBERTY Dental Plan processing policies, payments, procedures and guidelines follow applicable State and Federal requirements. In particular, please reference Florida Statutes 641.3155 Provider Contracts; payment of claims.

In accordance with Florida law, electronic clean claims must be paid in 15 days and paper claim paid in 20 days. Interest penalty for overdue claims is 12% per year.

DIRECT DEPOSIT OF FUNDS

LIBERTY Dental Direct Deposit Forms can be located on our provider portal at www.libertydentalplan.com or in the Forms section at the back of this Reference Guide.

ENCOUNTER /CLAIMS DATA REPORTING REQUIRED ON ALL MEDICAID PLANS

All contracted LIBERTY general dentistry providers must submit encounter/claims data for all service rendered, regardless of reimbursement methodology on a regular basis. The information should be submitted on a standard ADA claim form for all services provided to the member. State law requires that aggregated encounter/claims data is submitted to the state on a regular basis for utilization review and analysis by Florida Medicaid Management Information System (MMIS) to ensure that the Medicaid program is properly providing care to its beneficiaries. **LIBERTY strongly recommends that you provide claims following each and every visit.**

Peer to Peer Communication

If you have questions or concerns about a referral, pre-authorization and/or claim determination and would like to speak with LIBERTY's Dental Director, or the Dental Consultant responsible for the determination, you may call 888-352-7924 or send correspondence to:

LIBERTY Dental Plan
Attn: Dental Director
P.O. Box 15149
Tampa, FL 33684-5149

Please note that when calling the phone number listed above, your call will be transferred to the Dental Director or designated Dental Consultant responsible for the determination, depending upon their availability. If the Dental Director or Dental Consultant is/are unavailable, please leave a detailed message including the Member ID and claim number and your call will be returned no later than the next business day.



SECTION 6 – COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies when a member has more than one source of dental coverage. The purpose of COB is to allow members to receive the highest level of benefits up to 100 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 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, or Medicare Advantage 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

NOTE: LIBERTY MEDICAID MMA plans are always the payer of last resort. If the member has any other plan, it will always be the primary coverage.

Scenarios of COBs:

1. 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.

2. When LIBERTY is Secondary Carrier

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

SECTION 7 – PROFESSIONAL GUIDELINES AND STANDARDS OF CARE

PROVIDER RESPONSIBILITIES AND RIGHTS

- Provide and/or coordinate all dental care for member;
- Perform an initial dental assessment including a risk assessment;
- Work closely with specialty care provider to promote continuity of care;
- Cooperate with, and adhere to the LIBERTY QMI Program; including grievance processes, office audits, utilization reporting requirements, etc.;
- 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 and/or information are available and accessible for patients of record 24 hours a day, 7 days a week;
- Maintain after-hours telephone coverage (such as via an answering service, machine referral to an on-call provider) with reasonable and timely call back;
- Maintain scheduled office hours;
- Maintain dental records for a period of ten years;
- Provide updated credentialing information when requested, upon renewal dates;
- Provide requested information upon receipt of patient grievance/complaint within 3 days of receiving a notice letter;
- Submit encounter data on EDI or standard ADA claims.
- Notify LIBERTY of any changes regarding the provider’s practice, including location, name, telephone number, address, associate additions / terminations, change of ownership, plan terminations, etc.
- If a member chooses to transfer to another participating dental office; there will be no charge to the member for copies of records maintained in chart. All copies of records must be provided to member within 15 days of request.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES & RIGHTS

- Provide necessary and appropriate specialty consultation and care to members;
- Work closely with primary care dentists to ensure continuity of care;
- Bill LIBERTY timely for all dental services that were authorized;

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), LIBERTY requires a National Provider Identifier (NPI) for all HIPAA related transactions, including claims, claim payment, coordination of benefits, eligibility, referrals and claim status.

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 mailing 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.

STANDARDS OF ACCESSIBILITY

Providers are required to schedule appointments for eligible members in accordance with the Medicaid Access standards listed below. LIBERTY monitors compliance and may seek corrective action for providers that are not meeting accessibility standards.

Type of Appointment	Access to Care Standards
Non-urgent Appointments (exams, x-rays, restorative care)	Not to exceed 30 business days
Emergency Appointments (acute pain/swelling/bleeding)	24 hours a day, 7 days a week
Preventive Care/Hygiene	Not to exceed 30 business days
Lobby waiting time (for scheduled appointments)	Not to exceed 30 minutes

EMERGENCY SERVICES AND AFTER HOURS EMERGENCIES

According to the Department of Health Board of Dentistry Dental Practice and Principles Rule 64B5-17.004 Emergency Care it is the responsibility of every dentist practicing in the state of Florida to provide either personally, or through another licensed dentist to provide or make arrangements for twenty four (24) hours of emergency services for all patients of record. 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. If the patient 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 guidelines, LIBERTY has the right to transfer some or all capitation programs enrollment to another provider, or close your office to new enrollment, or take other action deemed necessary by LIBERTY to ensure timely access to all members.



TREATMENT PLAN GUIDELINES

All members must be presented with an appropriate written treatment plan containing an explanation of the prescribed treatment, the benefits available for the prescribed treatment and any related costs. Treatment plans must include covered Medicaid services. Non-covered services may be offered and presented to Medicaid beneficiaries. Treatment plans and informed consents must be signed showing patient acceptance of the treatment, and for any costs for non-covered treatment. LIBERTY Dental members cannot be denied their plan benefits. All accepted or declined treatment plans must be signed and dated by the patient or his/her guardian and the treating dentist. For members electing non-covered services please use the non-covered services document in the forms section of this Reference Manual.

NON-COVERED SERVICES: IMPORTANT NOTE: Providers who perform non-covered services must get financial and treatment consents signed by the member/patient that are clear and concise and understandable by a prudent layperson. Failure to do so may result in non-payment by the member. Medicaid members are protected from financial responsibility for charges that were not clearly presented prior to treatment. In such cases, Medicaid members who file a grievance and can prove they did not approve such services, may not be subject to collection activity. Thus, providers will not be able to bill members or collect payments for non-covered services that were not properly approved by the member/patient. Please consult the plan schedule of benefits to determine covered and non-covered services. You may also send in proposed treatment for pre-approval to determine whether or not a proposed service is covered or not. By virtue of your signed provider agreement, you agree to cooperate with corporate business practices and quality management processes such as grievances, appeals and providing care and service in accordance with plan documents.

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 (888) 352-7924, Monday through Friday, 8 a.m. to 8 p.m. (Easter).

RECALL, FAILED OR CANCELLED APPOINTMENTS

Contracted dentists are expected to have an active recall system for established patients who have completed their treatment plans, or for regularity of maintenance visits, or for patients who fail to keep or cancel appointments.

Medicaid Rule: Medicaid does not allow for a failed appointment charge.

CONTINUITY AND COORDINATION OF CARE

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

- All care rendered to LIBERTY members must be properly documented in the 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.
- 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 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 scheduling the member for any appropriate follow-up care;

PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that health care providers or health care facilities recognize patients' rights while receiving care and that patients respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. Patients may request a copy of the full text of this law from their health care provider or health care facility. A summary patients' bill of rights and responsibilities follows in accordance with Section 381.026, Florida Statutes. A copy of the Florida Patients' Bill of Rights and Responsibilities shall be available, upon request by a member, at each provider's office.

- 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 patient 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 has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for proposed dental services.

- 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 Florida 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 8 - 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 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
- Any other disease or condition that could affect the provider's determination of necessary, appropriate and adequate dental care.

10. Pregnancy

- Document the name of the patient'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 patient or patient's parent or guardian.

13. Dentist's notes following up on patient 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 patient'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 patient.

16. The medical history should be updated and signed by the patient and the dentist at least annually or as dictated by the patient's history and risk factors.

CONTINUITY OF CARE

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

EPSDT BENEFIT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT ensures that children and adolescents receive appropriate preventive dental and specialty dental services.

Right of Enrollees to Obtain Medically Necessary Dental Services

LIBERTY provides coverage for dental services that are listed on the Florida Medicaid benefit schedule and for children under age 21, any other dental service that is deemed to be medically necessary. The frequency guidelines for treatment allowed by LIBERTY follow the FL Medicaid Periodicity Schedule (which mirrors the American Academy of Pediatrics periodicity schedule).

Additional information can be found at:

1. AHCA Dental Coverage Policy Adoption – May 2016
https://www.flrules.org/gateway/readRefFile.asp?refId=6593&filename=59G-4.060%20Dental_Coverage_Policy_Adoption.pdf

2. American Academy of Pediatrics Periodicity Schedule

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Prior Authorization of Dental Services

For all EPSDT covered services, prior authorization is required for any dental service that is not listed on the FL Medicaid benefit schedule and for any service(s) that are listed on the Medicaid plan 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. For all prior authorization requests, medical necessity will be determined based on radiographic and/or other documented rationale.

Any EPSDT service(s) that is not prior authorized as described above, will be denied.

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, including adequate and confirmable monitoring of sterilization devices. Offices are not allowed to pass an infection control fee or any kind (including "sterile tray") 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. The provider must have a confidentiality policy to ensure privacy and security provisions according to the Health Insurance Portability and Accountability Act (HIPAA).

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 patient 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 patient. 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

As a health care provider and covered entity, you and your staff are responsible for complying with all HIPAA privacy and security provisions. Member information shall be treated as confidential and comply with all federal and state laws and regulations regarding the confidentiality of patient records.

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

For more information on HIPAA, please visit the HHS website at www.cms.hhs.gov/HIPAAgeninfo

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. Periodontal screening and evaluation must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements. Periodontal documentation may include a full mouth periodontal probing in cases where periodontal disease is identified.
- 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 patient'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*. The treating dentist should determine the radiographs necessary for each patient. Standing orders for radiographs are discouraged.
- 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. Frequency limitations exist for complete series of radiographs.

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 patient's last radiographic examination.
- E. A panoramic radiograph is a screening film and is not a substitute for periapical and/or bite wing radiographs when a dentist is performing a comprehensive evaluation.
- 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 patient refusal of radiographs should be documented.
- K. X-ray duplication fee

When a patient 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 or the patient, the patient may not be charged any X-ray duplication fees. Medicaid plans do not allow a charge for x-ray duplication.

PREVENTION

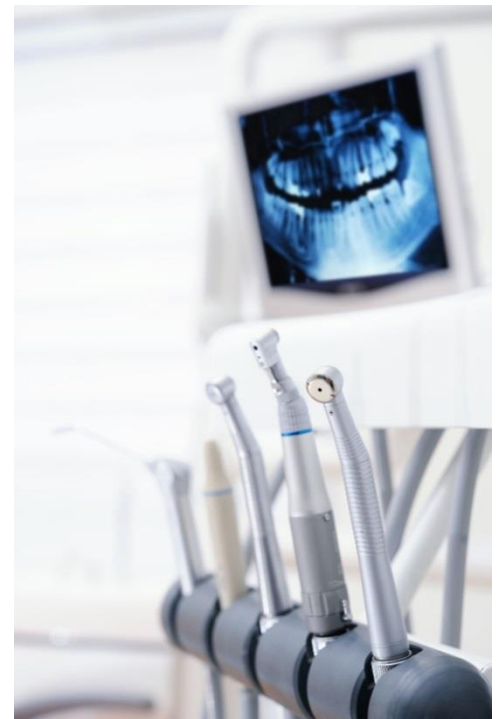
Preventive dentistry may include clinical tests, dental health education and other appropriate procedures to prevent caries and/or periodontal disease.

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

- patient education in oral hygiene and dietary instruction and tobacco cessation
- 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 including tobacco cessation
- 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 12 years old and older.

Plan Policy - Procedure D1120 applies to patients who are under 12 years old.

D. D1208 – topical application of fluoride procedures and D1206 – fluoride varnish

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
- occlusal guards for athletics or occlusal traumatism

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

DIAGNOSTIC

D0190 and D0191

Florida Medicaid is striving to increase dental preventative screenings for children ages 0-20 years. The inclusion of CDT codes D0190 and D0191 will allow Registered Dental Hygienists (RDH), within their scope of practice, to render oral health services to Medicaid recipients through health access settings, as defined by s. 466.003(14), F.S. These procedure codes are reimbursable when services are rendered within a school or mobile unit associated with a specific health access setting. The use of these codes allows health access settings to document screening and assessment services. Each code may be billed once per year, per recipient and may not be billed together. Please note that these codes are not evaluation codes.

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. Treatment Plans for Medicaid beneficiaries must include covered services. Other non-covered services may be discussed. Members must have access to their benefits.

E. Informed Consent Process

1. Dentists must document that all recommended treatment options have been reviewed with the patient and that the patient understood the risks, benefits, alternatives, expectancy of success, the total financial responsibilities for all proposed procedures.
2. In addition, the patient should be advised of the likely results of doing no treatment.
3. Appropriate informed consent documentation must be signed and dated by the patient and dentist for the specific treatment plan that was accepted.
4. If a patient refuses recommended procedures, the patient must sign a specific “refusal of care” document. Refusal of non-covered services in lieu of covered services is not grounds for patient dismissal.

F. 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 as best determined by the presenting radiographs, narrative and any history on file.

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

Members have the right to elect extraction of a tooth requiring treatment over restoring it.

- G. Covered services are available to the enrollee at no charge. In the event the patient elects to select a non-covered alternate treatment they are fully responsible for such services. Documentation must clearly show that the enrollee was offered a plan benefit and elected to pay for NON-Covered Services.

REQUEST FOR PRE-ESTIMATE

Review Medicaid Plan Benefits to determine which procedures require pre-approval.

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.
- G. Transcription of illegible progress notes may be required and is the responsibility of the treating dentist/dental office. Requests for transcription may be ordered by LIBERTY as part of grievance resolution, peer review or other quality management processes. Providers agree to cooperate with any such requests by virtue of their contract.

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 patient 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 patient's eligibility with the Plan, completion of the root canal therapy may not be covered. Refer to Continuity of Care Guidelines.

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 patient 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
- Patients have the right to elect extraction as an alternative to endodontic therapy.

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 Dental Plan 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 provide services for covered root canal procedures. The choice of endodontic irrigants is made by the treating dentist. Medicaid members cannot be charged for endodontic irrigation materials (such as *BioPure*).

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

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

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

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 patient’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 approaching the pulp

9. Endodontic surgical treatment, if covered, 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 patient.
- 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, patient 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. Documentation of a surgical procedure should include the tooth number, tissue removed, 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.

THIRD MOLAR EXTRACTIONS AND BENEFIT DETERMINATION

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

Third molar extractions are only covered when listed as a Plan Benefit and there is active pathology present.

Definition of Active Pathology: Pain, swelling, bleeding, or infection. Each tooth must qualify individually.

Definition of Impacted Tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.”

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

The removal of asymptomatic, unerupted, third molars in the absence of active pathology is not 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.

All suspicious lesions should be biopsied and examined microscopically.

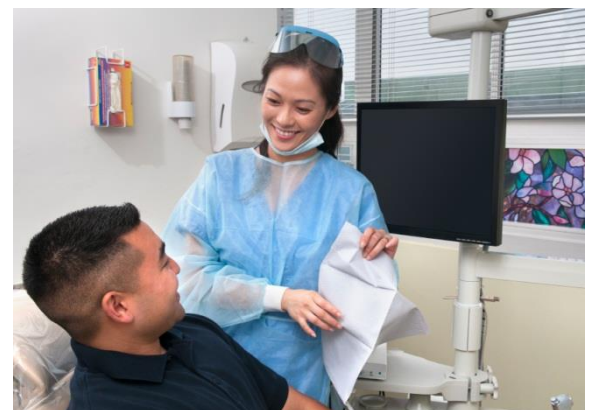
D9220 – deep sedation / general anesthesia

Medical necessity and/or special needs patients

PERIODONTICS

All children, adolescents and adults should be evaluated for evidence of periodontal disease. However, in most cases pocket depths less than 4 mm do not indicate the presence of periodontal disease. The determination of the presence of periodontal disease may also rely on the presence of bleeding on probing or evidence of radiographic bone loss (loss of attachment). In the absence of active periodontal disease, it is appropriate to document the patient’s periodontal status as being within normal limits (WNL).

Comprehensive oral evaluations should include an assessment of the 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.”

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. This procedure also follows full visualization of the teeth for a comprehensive examination of the teeth as well as the periodontium.

Note, this procedure:

1. must be supported by radiographic evidence of heavy calculus
2. is not a replacement code for procedure D1110

B. D4341/D4342 – Periodontal scaling and root planing (SRP) – Refer to Plan Benefits for Pre-approval Guidelines

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.
- In general, only 2 quadrants may be performed on any date of service.
- Sufficient time to properly and judiciously perform meticulous calculus and plaque removal on all aspects of the root must be allowed.
- SRP is not intended for a “difficult cleaning” or to be used “because it has been a long time since the last cleaning.” Rather it is a judicious and meticulous treatment procedure to clean the roots of the tooth. **Evidence of loss of attachment must be present.**

Definitive Treatment vs. Pre-Surgical scaling and root planing:

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

Note: LIBERTY 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 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 patient'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 planning should be performed. This re-evaluation should be performed at least 4-6 weeks later and include: a description of tissue response; pocket depths changes; sites with bleeding or exudate; evaluation of the patient's homecare effectiveness.

D1110 and D4341

It is generally 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.

Soft Tissue Management Programs (STMP)

Any collection of periodontal and other services bundled together as a "soft tissue management" program must preserve the member's right to their Medicaid benefit. Members have the benefit for all the periodontal and other codes listed in this provider guide. Only non-covered service may be presented to the Medicaid member for additional payment. Patients must sign a non-covered services form if they choose to accept soft tissue management procedures in addition to any covered procedures listed in the plan designs.

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.
- 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's or deeper, following soft tissue responses to scaling and root planing.
- Osseous surgery procedures may not be covered if:
 - Pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)
 - 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.

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 patient.

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 for continued function 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, crowns, and other cast or milled restorations, 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 an 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 include crowns.
 - ix. Crowns should only be considered when cusp support is needed and tooth cannot be treated with a filling restoration.
 - x. Inlays and Onlays are not covered on FL Medicaid plans.
- 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 dentist consultant.

BEHAVIORAL MANAGEMENT

Narratives explaining the need for Behavioral Management under Medicaid plans must accompany claims submitted for procedure code D9920. Providers may utilize Appendix F from the Florida Medicaid Dental Services Coverage and Limitations Handbook.

Dental Coverage and Limitations Handbook NOVEMBER 2011 F-1. See form in section 13 of this Provider Reference Guide.

ORTHODONTICS

Orthodontic procedures are limited to recipients under the age of 21 who meet the orthodontic requirements as stated in the Florida Medicaid and Dental Services Coverage and Limitations Handbook. Prior authorization is required for all orthodontic services. If you are requesting a benefit which exceeds the standard orthodontic benefit, please submit the request on an ADA Claim Form with a narrative explaining why the additional service is needed.

A copy of the ADA Claim Form can be found in Section 13 of this Provider Reference Guide.

RESTORATIVE CODE GUIDELINES D1351 - Sealant – per tooth

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

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

D2330, D2391 or D2392 - Resin-based composites

If the caries and hence the resin restoration penetrates 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.

CROWNS

Single Crowns – REFER TO PLAN BENEFITS FOR PRE-APPROVAL REQUIREMENTS

- A. When bicuspid and anterior crowns are covered, the Medicaid benefit includes a porcelain-fused-to-base-metal crown or a porcelain/ceramic substrate crown.
- B. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be more susceptible to fracture than full metal crowns.
- C. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, the treatment of choice may then become a porcelain fused to a base metal crown or porcelain/ceramic substrate crown.
- D. 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%.
- E. Crown procedures should always be reported and documented using valid procedure codes as found in the *American Dental Association’s Current Dental Terminology (CDT)*.

Post and core procedures include buildups

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

“D2954 prefabricated post and core in addition to crown core is built around a prefabricated post. This procedure includes the core material”

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

Outcomes

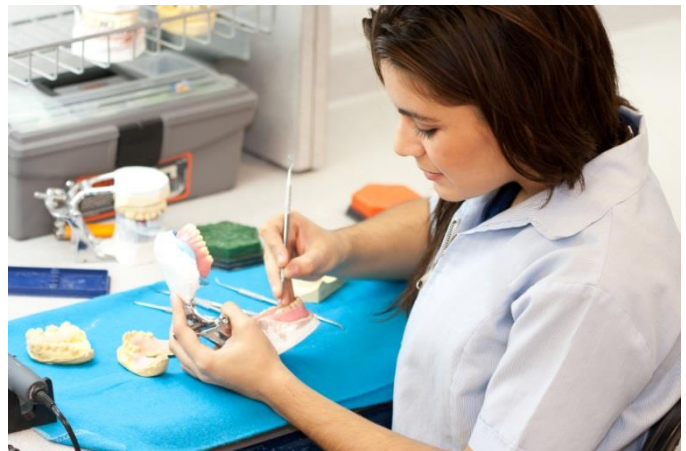
- Margins, contours and contacts must be clinically acceptable
- Prognosis for continued function should be good for a minimum of 5-years

Removable Prosthodontics (Partial dentures)

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. Abutment teeth should be restored prior to the fabrication of a removable appliance and may be covered if such teeth meet the same stand-alone benefit requirements of a single crown.
6. Partials should be designed to minimize any harm to the remaining natural teeth.
7. 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.
8. Appliances should be designed to minimize any harm to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.



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.

FL Medicaid allows one denture per arch per lifetime.

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. The need for replacement of an interim or immediate denture is not evidence of inappropriate care or wrong doing. However, the management of patient expectation must be performed by the treating dentist to ensure that the member understands the need for replacement dentures so soon after having the first set, including the acceptance of any additional cost.

D. 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.



SECTION 9 - SPECIALTY CARE REFERRAL GUIDELINES

DIRECT REFERRAL GUIDELINES

Primary Care Providers may refer eligible members to LIBERTY contracted specialists directly. To determine the contracted specialist in your area please contact the LIBERTY Dental Membership Service Department. There are no 'Out of Network' Plan Benefits. In the event that there is no contracted specialist available to treat a LIBERTY Medicaid enrollee in your area a Written Referral is required. Written Referrals can be submitted to LIBERTY Dental Plan via our web portal www.libertydentalplan.com or to LIBERTY Dental Plan Attention: Claims – P.O. Box 401086, Las Vegas, NV 89140. In the event of an emergency a referral can be obtained by contacting our Membership Service Department at 1-888-352-7924.

The following guidelines outline the specialty care referral expectations. Reimbursement of specialty services is contingent upon the patient's eligibility at the time of service and pre-approval for all services that indicate pre-approval are required.

ENDODONTICS

Referral Guidelines for the General Dentist

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

Network General Dentists are expected to perform basic endodontic services.

Contact LIBERTY Dental Plan Member Service for a list of Specialists in your area.

Refer to Plan Benefits for Pre-approval requirements – Pre-estimate Requirements by procedure apply to all specialists.

Pre-approvals are **highly recommended** for Endodontist Service for both the General Dentist and the Specialist. Post-treatment review is required and x-rays must be submitted with claims submission. Teeth with poor prognosis are not covered for Root Canal Therapy. If performed, no reimbursement will be made by the Plan. General Dentists are expected to perform endodontic therapy when there is no radiographic evidence of excessive root curvature or calcification. Molar endodontic treatment may be referred if deemed beyond the scope of the General Dentist.

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.

ORAL SURGERY

DIRECT REFERRAL GUIDELINES: Primary Care Providers may refer eligible members to LIBERTY contracted specialist directly. To determine the contracted specialist in your area please contact LIBERTY Dental Membership Service Department.

There are no Plan Benefits Out of Network. In the event there is no contracted specialist available to treat a LIBERTY Medicaid enrollee in your area a Written Referral is required. Written Referrals can be submitted to LIBERTY Dental Plan via our web portal www.libertydentalplan.com or to LIBERTY Dental Plan Attention: Claims – P.O. Box 401086, Las Vegas, NV 89140. In the event of an emergency a referral can be obtained by contacting our Membership Service Department at 1-888-352-7924.

Referral Guidelines for the General Dentist and Oral Surgeon

Confirm the need for a referral and that the Referral Criteria listed below are met. Network General Dentists are expected to perform basic oral surgery services. Refer to criteria in this document.

General Dentist criteria:

General Dentists are expected to perform all basic extractions and surgical extractions. If there are multiple surgical extractions (more than 4) required and the general dentist feels the treatment is beyond their scope a referral to an Oral Surgeon is appropriate.

Other covered surgical procedures are referable to the Oral Surgeon with the referral.

Third Molar Extractions – **Require Pre-Approval prior to services being rendered** – Asymptomatic extractions of prophylactic third molars are not covered benefits under Medicaid.

Contact LIBERTY Dental Plan Member Service for a list of Specialists in your area.

Refer to Plan Benefits for Pre-approval requirements – Pre-Approval Requirements apply to all General Dentists and Specialists.

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.

ORTHODONTICS

DIRECT REFERRAL GUIDELINES: Primary Care Providers may refer eligible members to LIBERTY contracted specialists directly. To determine the contracted specialist in your area please contact LIBERTY Dental Membership Service Department.

There are no Plan Benefits Out of Network. In the event there is no contracted specialist available to treat a LIBERTY Medicaid enrollee in your area a Written Referral is required. Written Referrals can be submitted to LIBERTY Dental Plan via our web portal www.libertydentalplan.com or to LIBERTY Dental Plan Attention: Claims – P.O. Box 401086, Las Vegas, NV 89140. In the event of an emergency a referral can be obtained by contacting our Membership Service Department at 1-888-352-7924.

Referral Guidelines for the General Dentist and Orthodontist: - Refer to Medicaid Child Plan Benefits – Initial Assessment Form (IAF) is required for consideration of orthodontic coverage. See Medicaid Child Plan Benefits Guidelines.

PEDIATRIC DENTISTRY

DIRECT REFERRAL GUIDELINES: Primary Care Providers may refer eligible members to LIBERTY contracted specialists directly. To determine the contracted specialist in your area please contact LIBERTY Dental Membership Service Department.

There are no Plan Benefits Out of Network. In the event there is no contracted specialist available to treat a LIBERTY Medicaid enrollee in your area a Written Referral is required. Written Referrals can be submitted to LIBERTY Dental Plan via our web portal www.libertydentalplan.com or to LIBERTY Dental Plan Attention: Claims – P.O. Box 401086, Las Vegas, NV 89140. In the event of an emergency a referral can be obtained by contacting our Membership Service Department at 1-888-352-7924.

All contracted General Dentists are expected to treat children of all ages. Children under the age of 7 with behavior issues or disabilities can be referred to pediatric dentists for care. Children over the

age of 7 should only be referred when there is documentation that the general dentist has attempted to treat them or they have a disability or verified medical condition that prohibits a general dentist from providing care.

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.

PERIODONTICS

DIRECT REFERRAL GUIDELINES: Primary Care Providers may refer eligible members to LIBERTY contracted specialist directly. To determine the contracted specialist in your area please contact LIBERTY Dental Membership Service Department.

There are no Plan Benefits Out of Network. In the event there is no contracted specialist available to treat a LIBERTY Medicaid enrollee in your area a Written Referral is required. Written Referrals can be submitted to LIBERTY Dental Plan via our web portal www.libertydentalplan.com or to LIBERTY Dental Plan Attention: Claims – P.O. Box 401086, Las Vegas, NV 89140. In the event of an emergency a referral can be obtained by contacting our Membership Service Department at 1-888-352-7924.

- Only the Child Medicaid Program covers Periodontic services – all Periodontal services require pre-approval. Refer to the plan benefits for required documentation.
- General Dentists are expected to perform basic periodontal services. If a child requires periodontal referral for surgical periodontal procedures their chart should be clearly documented with all pre-surgical care performed and the need for referral to a periodontist.
- Refer to Plan Benefits for Pre-approval requirements. Pre-approval Requirements by procedure apply to all specialists.

SECTION 10 - QUALITY MANAGEMENT

PROGRAM DESCRIPTION

LIBERTY'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'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'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 clinical and non-clinical aspects of dental care delivery.

QMI Program Goals and Objectives

The LIBERTY 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.

QUALITY MANAGEMENT OVERSIGHT COMMITTEES

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

- Quality Management & Improvement Committee;
- Credentialing Committee;
- Access and Availability 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'S Network Providers, including the structure under which care is delivered, the process and outcome of care, utilization and access to care, availability, referrals to specialists, continuity of care, safety, appropriateness, and any problem resolution in the dental delivery system identified by the Peer Review, Utilization Management 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 and its members. All other committees report their activities up to the QMI Committee, which then reports directly to the Board of Directors.

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 recredentialled on a three-year cycle and as needed. Sixty days before the provider's assigned recredentialing 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 recredentialing requests will result in termination from the network.

The **Access and Availability 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

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 potential quality issues (PQIs) including quality-of-care and quality-of-service 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, as provided by the Credentialing Committee 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 individual offices (and providers) 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 and Appeals Committee** reviews member grievances, provider disputes and appeals of claims determinations (whether from member or provider). 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. The Committee handles and resolves all grievances including any grievance patterns identified, and any corrective actions resulting of these identified patterns. The member and provider grievance processes are detailed in another section of this reference guide.

The Grievance and Appeals 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 with multiple similar complaints may be referred to the Peer Review Committee for further evaluation. If the Committee determines that a corrective action plan is necessary, it will be referred to the Dental Director for implementation, working with the Provider Relations department.

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 patients promptly when they need care, and to spend a sufficient amount of time with each of their patients.

AUDITS AND SURVEYS

Provider Access Surveys:

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

Surveys Triggered by the 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. Providers with significant grievance activity or that do not meet access and availability standards may be subject to another sanction, including removal from Dental Home Assignment.



Access and Availability Corrective Actions:

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).

Member Satisfaction Surveys:

Surveys are provided to members as part of monitoring their overall satisfaction with LIBERTY, and providers, and to ensure that members have proper and timely access to care. Surveys may be

ordered in response to trending information or reports of potential access problems with specific dental offices.

Provider QMI Program Responsibilities

LIBERTY's QMI Program handles all audits of LIBERTY by external agencies as well as conducts internal audits of various activities. LIBERTY performs chart audits and quality assessments of provider offices as part of this program. Providers may become involved in such audits due to random assignment or as a result of a focused report which identified a need for research into the provider's practice. These activities are performed as part of LIBERTY's requirement to ensure that members receive necessary and adequate care in accordance with professionally recognized standards, and to ensure that the members receive and enjoy the full range of their covered benefits. In addition, LIBERTY is concerned that continuity of care for covered members is ensured including access to specialty referrals and services. LIBERTY appreciates the fact that its general dentists and specialty providers work diligently to meet these various 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 planned or pending re-credentialing activities at least 60 days prior to the end of the 36-month period since the last credentialing cycle. This lead time allows providers an opportunity to submit current copies of the requested documents.

PROVIDER ONBOARDING AND ORIENTATION

For all accepted providers, the local Professional Relations Representative presents a provider orientation within 30 days after activation at which time the provider receives a copy of LIBERTY's Provider Reference Guide (this guide). This 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 and incorporated into the Provider Agreement by reference. 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 maintains detailed information for each provider including credentialing information, quality and utilization performance metrics, audit results, copies of signed agreements, addenda, and related business correspondence.

RECORDS REVIEW

LIBERTY 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 LIBERTY Dental Plan 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. LIBERTY may also perform focus audits for various purposes triggered by the need to verify practice parameters and/or billing and reporting patterns.

GRIEVANCES, PROVIDER CLAIM DISPUTES & APPEALS

GRIEVANCES

Member grievances are expressions of dissatisfaction about some aspect of the Member's LIBERTY dental coverage or experience. Member grievances are accepted up to 180 days from the event that is the subject of the complaint, or 180 days from when the member became aware of the subject of the complaint in accordance with local laws and regulations. The LIBERTY member grievance process encompasses investigation, review and resolution of member issues to LIBERTY and/or contracted providers. Members can submit a grievance via telephone, fax, e-mail, letter, or grievance form. 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. Providers must be aware of how to assist a member in filing a grievance and know how to provide a grievance form to a member upon request.

All member and provider complaints, grievances and disputes, and appeals are received and processed by LIBERTY. No aspect of this process is delegated to an outside entity.

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

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

As a contracted provider, you have agreed to cooperate with quality management processes such as the grievance resolution process. You may be contacted to provide copies of records (including, but not limited to, x-rays, progress notes, financial documents, etc.) and a narrative of your perception of the incident. In most cases the Quality Management Department's Grievance Analysts and Dental Consultants seek to provide additional explanation to the grieving member and relies on your records to do so. LIBERTY can only help you through the grievance process with your cooperation in supplying complete records. Grievances are resolved within 30 days unless an expedited issue is identified, in which cases, those issues are resolved within 72 hours or sooner as required.

All member quality of care grievances, benefit complaints, and appeals are received and processed by the Grievance and Appeals Committee. LIBERTY'S Grievance Analyst records and reviews all member issues involving 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 licensed dentist dental consultant. In order to identify systemic deficiencies, the Grievance Analyst completes the case investigation and then a grievance history review is performed.

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

PROVIDER DISPUTES

Definition: A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

Providers may register a complaint (or dispute) in writing to LIBERTY Dental Grievance Department regarding any aspect of business dealings with LIBERTY or on behalf of a member/patient. The complaint should include any supporting documentation that may help yield a satisfactory resolution, including any requested action or outcome to resolve the issue.

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 and Appeals Committee in accordance with LIBERTY's Provider Dispute Resolution Policy.

Each contracted provider dispute must contain, at a minimum, the following information: provider's name; provider's license number, 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: a clear identification of the disputed item, the date of service and 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 must be provided.

LIBERTY will acknowledge the receipt of a provider dispute within 15 days, and will respond with a final resolution in writing within sixty (60) days of receipt of all information necessary to make a fair and accurate decision.

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.

Sending a Contracted Provider Dispute 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

P.O. Box 15149

Tampa, FL 33684-5149

ATTN: Provider Dispute Resolution Mechanism Department**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.

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 thirty (30) working days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Disputes

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

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.

APPEALS

Both providers and members may appeal any resolutions or claims determination made by LIBERTY. The request for appeal must be in writing and received by LIBERTY within 180 days of receipt of the resolution. The Grievance Analyst will compile all the information used in the initial determination and any additional information received and forward it to the committee. LIBERTY will review any appeal with dental consultants having no prior involvement in the decision and no vested interest in the case.

An appeal is considered to be a type of complaint and is therefore handled with the same procedures as with the member grievance and provider dispute resolution processes described above.



SECTION 11 - FRAUD, WASTE AND ABUSE

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

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:

- Billing for services not furnished;
- 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 Fraud, Waste and Abuse

To report suspected fraud, waste or abuse, please contact LIBERTY'S Special Investigation Unit's toll-free hotline at (888) 704-9833 or by emailing hotline@libertydentalplan.com.

SECTION 12 - FLORIDA MEDICAID PROGRAM & GUIDELINES

LIBERTY Dental Plan follows the limitations and guidelines as stated in the Florida Medicaid Dental Services Coverage and Limitations Handbook.

The Dental Services Coverage and Limitations Handbook explains Medicaid covered services and limitations.

Children's Dental Services are for eligible children ages 0 – 20.

The following federal and state laws govern Florida Medicaid as stated in the Florida Medicaid Handbook:

- Title XIX of the Social Security Act.
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes.
- Chapter 59G, Florida Administrative Code

ORTHODONTIC SPECIALTY SERVICES

Prior Authorization is required for all orthodontic services. As stated in the FL Medicaid Handbook, orthodontic services are limited to those recipients with the most handicapping malocclusion.

PROMPT PAYMENT OF CLAIMS

Florida Medicaid Program claims will be paid pursuant to FL Statutes 641.3155.

SECTION 13 - FORMS

MEDICAID BEHAVIOR MANAGEMENT REPORT

GRIEVANCE FORM

MEDICAID ORTHODONTIC INITIAL ASSESSMENT FORM (IAF)

NON-COVERED TREATMENT FORM

ADA CLAIM FORM

MEDICAID BEHAVIOR MANAGEMENT REPORT – APPENDIX F

Date of Service: _____

Recipient Name: _____

Recently, this child was seen in our dental office. Because of the misbehavior of the child during the dental visit, he/she could not have been worked on without behavior management techniques. The child exhibited the following behavior during his/her dental treatment:

- Crying or Fearful Defiance Thrashing around
- Hitting or kicking Apprehensive Grabbing instruments
- Difficulty getting into chair Uncooperative (due to physical or mental impairment)
 Will not lean back
 Will not stay in chair

Verbal communications were insufficient in accomplishing our goals and behavior management techniques had to be employed with

(Child's First Name)

Techniques used to manage the behavior:

- Tell-show-do
- Positive reinforcement or abnormal amount of time consumed
- Required two or more personnel to assure safety of child and staff
- Papoose or Pedi-wrap

Other Comments:

PROVIDER NAME **DATE**



WRITTEN MEMBER GRIEVANCE FORM – FLORIDA

MEMBER INFORMATION

Member last name	Member first name	Today's date	
Member street address	City	State	ZIP code
Member phone number	Member identification number (see identification card)		
Employer or Group	Patient name	Relationship	

DENTAL OFFICE/PROVIDER INFORMATION

I am authorizing LIBERTY Dental Plan to request my information, including chart records and x-rays, if applicable, from the following office:

Office number	Dental office name	Date of last visit	
Dental office street address	City	State	ZIP Code
Dental office phone number	Name(s) of dental office staff involved (if known)		

Description of Grievance

Describe your grievance in detail. Please provide the dates, names and treatment that are the subject of your grievance. Attach additional pages, if necessary.

Description of Grievance

Describe your grievance in detail. Please provide the dates, names and treatment that are the subject of your grievance. Attach additional pages, if necessary.

What is your desired resolution to your concern(s)?

PLEASE SEND COMPLETED FORM TO:

LIBERTY Dental Plan

Attention: Quality Management Department
P.O. Box 26110
Santa Ana, CA 92799-6110

Or you may submit your grievance

- By fax to LIBERTY’s Quality Management Department fax at **(949) 270-0109**, or
- Verbally by calling LIBERTY Dental Plan’s Member Services Department at toll-free number: **(888) 703-6999**, or
- By using our website online grievance filing process by visiting www.libertydentalplan.com.

You will receive a letter acknowledging receipt of your grievance within five (5) calendar days of receipt by LIBERTY.

You will receive a written resolution to your grievance within thirty (30) calendar days of receipt by LIBERTY.

If you are not satisfied with LIBERTY's final decision, you may contact the Florida Department of Financial Services (FDFS) in writing within 365 days of receipt of the final decision letter. You also have the right to contact FDFS at any time to inform them of an unresolved grievance.

The Florida Department of Financial Services

Consumer Complaints Division

State Capitol Larson Building

200 East Gaines Street, Room 637

Tallahassee, Florida 32399-0300

Telephone 1-800-342-2762

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-703-6999.

Spanish (Español)

IMPORTANTE: ¿Puede leer esta noticia? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta noticia escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-888-703-6999.

APPENDIX A

MEDICAID ORTHODONTIC INITIAL ASSESSMENT FORM (IAF)

You will need this scoresheet and a disposable ruler (or a Boley Gauge)

Name: _____ I. D. Number: _____

Conditions:	HLD Score
1. Cleft palate deformities (Indicate an "X" if present and score no further)	_____
2. Deep impinging overbite. When lower incisors are destroying the soft tissue (Indicate an "X" if present and score no further)	_____
3. Crossbite of individual anterior teeth. When destruction of soft tissue is present (Indicate an "X" if present and score no further)	_____
4. Severe traumatic deviations. (Attach description of condition. For example, loss of a premaxilla segment by burns or accident, the result of osteomyelitis or other gross pathology) (Indicate an "X" if present and score no further)	_____
5A. Overjet greater than 9 mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties. (Indicate an "X" if present and score no further)	
5B. Overjet in mm	
6. Overbite in mm	_____
7. Mandibular protrusion in mm	_____ x 5= _____
8. Open bite in mm	_____ x 4= _____
IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT SCORE BOTH CONDITIONS.	
9. Ectopic eruption (Count each tooth, excluding third molars).	_____ x 3= _____
10. Anterior crowding (Score one point for MAXILLA and one point for MANDIBLE, two points for maximum anterior crowding).	_____ x 5= _____
11. Labio-Lingual spread in mm	_____
12. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar)	Score 4 _____
	Total Score _____

Dental Services Coverage and Limitations Handbook

Patient name: _____ Medicaid I.D. # _____

Please describe these and any other problems:

Please describe tentative treatment plan:

Use additional sheets as required.

Date Provider's signature

For Medicaid use

___ Patient does not meet Medicaid criteria for "most severely handicapped"

___ Patient not eligible

___ Send additional materials, as per handbook

Consultant Date

Appendix A, continued

How to Score the Initial Assessment Form

Cleft Palate – Submit a cleft palate case in the mixed dentition only if you can justify in a narrative why there should be treatment before the client is in full dentition.

Severe Traumatic Deviation – Refers to facial accidents only. Points cannot be awarded for congenital deformity. It does not include traumatic occlusions for crossbites.

Overjet in Millimeters – Score the case exactly as measured, then subtract 2mm (considered the norm) and enter the difference as the score.

Overbite in Millimeters – Score the case exactly as measured, then subtract 3mm (considered the norm) and enter the difference as the score. This would be double counting.

Mandibular Protrusion in Millimeters – Score the case by measurement in mm by the distance from the labial surface of the mandibular incisors to the labial surface of the maxillary incisor. Do not score both overbite and open bite.

Open Bite in Millimeters – Score the case exactly as measured. Measurement should be recorded from the “line of occlusion” of the permanent teeth-not from ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.

Ectopic Eruption – An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge. Do **not** include (score) teeth from an arch if that arch is to be counted in the following category of “Anterior crowding.” For each arch, you may score either the ectopic eruption **or** anterior crowding but **not** both.

Anterior Crowding – Anterior teeth that require extractions as a prerequisite to gain adequate room to treat the case. If the arch expansion is to be implemented as an alternative to extraction, provide an estimated number of appointments required to attain adequate stabilization. Arch length insufficiency must exceed 3.5 mm to score for crowding on any arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as “crowded.”

Labio-Lingual Spread in millimeters –The measurement of the lower incisors in millimeters in the deviation from the normal arch of the lower teeth.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case **must** be considered **dysfunctional** and have a minimum of **26** points on the IAF to qualify for any orthodontic care other than crossbite correction.

The intent of the program is to provide orthodontic care to recipients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

If attaining a qualifying score of 26 points is uncertain, provide a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Directions For Using The Handicapping Labio-Lingual Deviation (HLD) Index

Instructions for HLD Index Measurements

Procedure:

1. Position the patient's teeth in centric occlusion.
2. Record all measurements in the order given and round off to the nearest millimeter (mm).
3. Enter score "0" if condition is absent.
4. The use of a recorder is recommended.

Conditions:

1. Cleft palate deformities---automatic qualification; however, if the deformity cannot be demonstrated on the study model, the condition must be diagnosed by properly credentialed experts and that diagnosis must be supported by documentation. If present, enter an "X" and score no further.
2. Deep impinging overbite---tissue destruction of the palate must be clearly visible in mouth. On study models, the lower teeth must be clearly touching the palate and there must be clear evidence of damage visible on the submitted models; touching or slight indentations do not qualify. If present, enter an "X" and score no further.
3. Crossbite of individual anterior teeth---destruction of soft tissue must be clearly visible in the mouth and reproducible and visible on the study models. A minimum of 1.5mm of tissue recession must be evident to qualify as soft tissue destruction in anterior crossbite cases. If present, enter an "X" and score no further.
4. Severe traumatic deviations---these might include, for example, loss of premaxillary segment by burns or accident, the result of osteomyelitis, or other gross pathology. Traumatic deviation does not mean loss of anterior teeth due to gross destruction or evulsion. If present, enter an "X" and score no further.
5. Overjet---this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plane. Do not use the upper lateral incisors or cuspids. The measurement may apply to only one tooth if it is severely protrusive. Reverse overjet may be measured in the same manner. Do not record overjet and mandibular protrusion (reverse overjet) on the same patient. If the overjet is greater than 9mm or reverse overjet is greater than 3.5mm, enter an "X" and score no further. Otherwise, enter the measurement in mm x 1.
6. Overbite---a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do not use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor- from the incisal edge to the pencil mark. Do not record overbite and open bite on the same patient. Enter the measurement in mm x 1.
7. Mandibular (dental) protrusion or reverse overjet---measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Mandibular incisors in crossbite do not count as mandibular (dental) protrusion or reverse overjet. Skeletal mandibular protrusion must be present. Do not use the upper lateral incisors or cuspids for this measurement. Do not record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the scoresheet and multiplied by five (5).

Directions For Using The Handicapping Labio-Lingual Deviation (HLD) Index, continued

8. Open bite---measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do not use the upper lateral incisors or cuspids for this measurement. In some situations, one has to make an approximation by measuring perpendicular to the occlusal plane as illustrated in Fig. 1. Do not record overbite and open bite on the same patient. The measurement in millimeters is entered on the scoresheet and multiplied by four (4).
9. Ectopic eruption---count each tooth excluding third molars. Enter the number of teeth on the scoresheet and multiply by three (3). If condition No. 10, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). **Do not score both conditions.**
10. Anterior crowding---anterior arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter five (5) points for maxillary arch with anterior crowding and (5) points for mandibular arch with anterior crowding. If condition. No.9, ectopic eruption is also present in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). **Do not score both conditions.**
11. Labiolingual spread---use a disposable ruler (or a Boley gauge) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch line. Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth. In the event that multiple anterior crowding is observed, all deviations should be measured for labiolingual spread but only the most severe individual measurement should be entered on the scoresheet. Enter the measurement in millimeters on the scoresheet.
12. Posterior unilateral crossbite---this condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the two maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the scoresheet.

LIBERTY Dental Plan Non-Covered Treatment Form

Non-Covered Services – Member Commitment Form of Responsibility	
Office Name/LIBERTY Facility ID #	Provider Name
Office Phone Number	Date Presented

Below are Non-covered services offered to patient/guardian based on their requests.

CDT Code	Procedure(s)*	Tooth/Arch	Fee*

Print:
Member ID: _____ Member Name: _____

Print:
Signed by Name: (Member, Parent or Guardian): _____

I understand AND agree to what was presented to me. Answer YES or NO to Each Statement Below:	YES	NO	Initial
My dentist advised me that the services I am electing are not a covered benefit through Medicaid, and I am electing to have these services, and understand they are my financial responsibility.			
I understand I have to pay the dentist's usual fee for all elected and non-covered services , and that LIBERTY will not pay any portion of the cost.			

**I agree to pay for these dental services. If I fail to make each payment, I may be subject to collection action.*

Patient Signature (Parent or Guardian)
Date

This signed form is required to be kept as part of the member's dental chart.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services Request for Predetermination/Preauthorization

EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Person named in #5
 Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender M F 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
 Self Spouse Dependent Child Other 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender M F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____

(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s) 32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
 Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
 Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims")

40. Is Treatment for Orthodontics?
 No (Skip 41-42) Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining 43. Replacement of Prosthesis
 No Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
 Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number () - 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
 Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56a. Provider Specialty Code

57. Phone Number () - 58. Additional Provider ID

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"