PROVIDER REFERENCE GUIDE
FLORIDA

www.libertydentalplan.com
03.30.17

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SECTION 1 –LIBERTY DENTAL PLAN INFORMATION

INTRODUCTION

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

The intent of this Provider Reference Guide is to aid each Participating Provider and their staff members in becoming familiar with the administration of LIBERTY.

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

OUR MISSION

To be the industry leader in providing quality, innovative and affordable dental benefits with the utmost focus on member satisfaction. Our continued expansion is an outgrowth of our commitment to exceptional service and expertise in our industry while providing a positive, rewarding, and enjoyable work environment

PROVIDER CONTACT AND INFORMATION GUIDE

LIBERTY Dental Plan

IMPORTANT PHONE NUMBERS AND GENERAL INFORMATION

LIBERTY PROVIDER SERVICE LINE

(888) 352-7924

Eligibility & Benefits:
Press Option 1

Claims: Press Option 2

Pre-Estimates: Press Option 3

Referrals & Specialty Pre-Authorizations:
Press Option 4

Request Materials:
Press Option 5

HOURS

Live representatives are available Monday – Friday,
5 a.m. – 8 p.m. EST

PROFESSIONAL RELATIONS DEPARTMENT

(888) 352-7924

Fax: (949) 313-0766

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

prinquiries@libertydentalplan.com

ELIGIBILITY & BENEFITS VERIFICATION

Provider Portal
(i-Transact)
www.libertydentalplan.com

or

TELEPHONE
(888) 352-7924
Press Option 1

PRE-APPROVAL, SUBMISSION & INQUIRIES

Provider Web Portal
(i-Transact)
www.libertydentalplan.com

TELEPHONE
(888) 352-7924
Press Option 4

Email
referrals@libertydentalplan.com

Regular Referrals By Mail

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

Emergency Referrals and Hotline
Phone (888) 352-7924
Fax (888) 334-6033

Hours
Monday- Friday
8 a.m. EST – 8 p.m. EST

CLAIMS INQUIRIES

Provider Portal
(i-Transact)
www.libertydentalplan.com

or

TELEPHONE
(888) 352-7924
Press Option 2

Fax
(888)700-1727

CLAIMS SUBMISSIONS

Provider Portal
(i-Transact)
www.libertydentalplan.com

EDI
Payor ID #: CX083

Email
Floridaclaims@libertydentalplan.com

TELEPHONE
(888) 352-7924
General Information
Press Option 6
Fax (888) 401-1129

Paper Claims By Mail
or
Corrected Claims By Mail

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

Corrected Claims By Fax
(888) 700-1727

PROVIDER WEB PORTAL (i-TRANSACT)

www.libertydentalplan.com

LIBERTY Dental Plan offers 24/7 real-time access to important information and tools through our secure online system

- Electronic Claims Submission
- Claims Inquiries
- Real-time Eligibility Verification
- Member Benefit Information
- Pre-approval Submission
- Pre- approval Status

Please visit:
www.libertydentalplan.com
to register as a new user and/or login.

Your "Access Code" can be found on your LIBERTY Welcome Letter. If you cannot locate your access code, or need help with the login process, please call (888) 352-7924 for assistance or email support@libertydentalplan.com.

APPEALS

Providers have the right to file an appeal regarding provider payment or contractual issues.

Appeals must be in writing and mailed to:
LIBERTY Dental Plan
Attn: Appeals
P.O. Box 26110
Santa Ana, CA 92799-6110

SECTION 2 – PROFESSIONAL RELATIONS

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

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

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

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

Our Professional Relations team is available to assist you Monday – Friday, from 5 a.m. – 5 p.m. PST 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 efficiency. Online tools are available for billing, eligibility, claim inquiries, referrals and other transactions related to the operation of your dental practice.

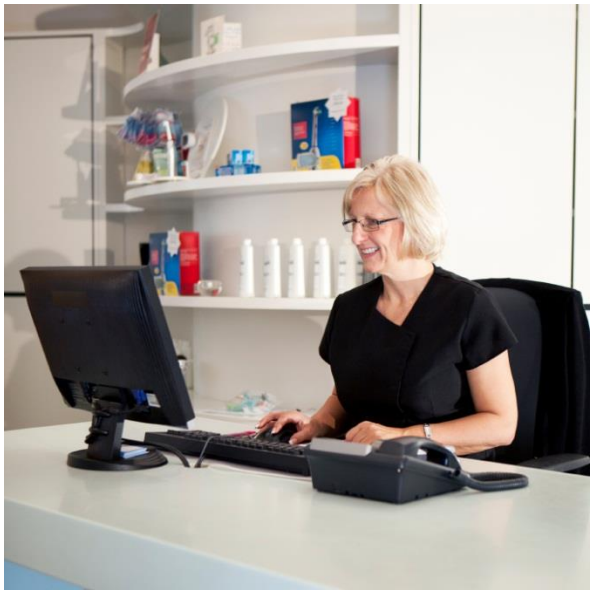
We offer 24/7 real-time access to important information and tools free of charge through our secure on-line Provider Portal. Registered users will be able to:

- 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 automatically the administrator. 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: Speak with a live Representative from 5 a.m. to 5 p.m. PST, Monday through Friday by contacting our Provider Service Line at (888) 352-7924, Option 1.

Monthly Eligibility Rosters (Capitation Programs Only)

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

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

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

In the event a member does not appear on the monthly Roster please contact LIBERTY Member Services Department at (888) 352-7924. Upon verification of eligibility LIBERTY will fax confirmation of eligibility to your office.

MEMBER IDENTIFICATION CARDS

Members will receive a plan ID card and should present their ID card at each appointment. 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.

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. 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 one of your choices to begin electronic claims submission. The EDI vendors accepted by LIBERTY are:

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

All electronic submissions should be submitted in compliance with state and federal laws, and LIBERTY'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
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 as follows:
    - Medicare Advantage Plans – per CMS guidelines, no later than 12 months or (365) days after the date of service.
    - Medicaid Plans – please refer to your Medicaid Provider Addendum.
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 under which the member is covered and all the information and documentation necessary to adjudicate the claim.

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

CLAIMS STATUS INQUIRY

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

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

Claims Status Explanations

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

CLAIMS RESUBMISSION

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

- Missing documentation
- Incorrect coding
- Processing errors

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

Offsets to Payments

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

PROMPT PAYMENT OF CLAIMS

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

Electronic clean claims must be paid in 20 days and paper claim paid in 40 days. Interest penalty for overdue claims is 12% per year.

DIRECT DEPOSIT OF FUNDS

LIBERTY's Electronic Fund Transfer (EFT) Form is located on our provider portal at www.libertydentalplan.com or in the Forms section at the back of this Reference Guide.

ENCOUNTER DATA REPORTING

All contracted LIBERTY providers must submit encounter data regardless of reimbursement methodology on a regular basis. The information can be submitted on a standard ADA claim form for all services provided to the member. The collected encounter data is submitted to the state on a regular basis for HEDIS reporting, Medicaid Management Information System (MMIS) and used to analyze data.

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 dental coverage through employer	Member coverage is always primary
Member has dental coverage as an active employee and through the spouse	Member coverage is primary
Member has two active insurance carriers, both provide dental coverage	The carrier with the earliest effective date is primary
Member has dental coverage through a group plan and COBRA coverage	Group plan is primary
Member has dental coverage through a group plan and individual or supplemental coverage through another carrier Note: Supplemental/Individual plans are purchased by the member for added coverage Examples: • Student Accident Plans • Supplemental Plans (Western Dental) • Prepaid Trust Plans • Individual Plan (AFLAC) • Reimbursement Plans • Discount/Reduced Fee Plan	Group plan is primary
Member has dental coverage as an active employee of one plan and as retired employee of another plan	The active coverage is primary

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

PATIENT IS THE DEPENDENT	PRIMARY
Dependent Child and the Birthday Rule	The plan of the parent whose birthday falls earlier in the calendar year (month and day only) holds the primary coverage for dependent children. If both parents have the same birthday, the plan that has covered either of the parents the longest is the primary plan. However, if the other plan follows the "gender rule" with male coverage always primary, LIBERTY will follow the rules of that plan. These rules may be superseded by a court order that establishes the responsible party for the child's coverage. When determining the primary carrier for dependents with dual coverage, verify that both parents are the biological parents before applying the birthday rule. Coverage through the biological parent is primary.
If coverage is through a biological parent and a step-parent residing in the same household	The biological parent's plan is primary
If parents are divorced or separated and there are two dental plans	The parent with custody to be the primary
If coverage is through both biological parents and stepparent, in absence of a court order, if the biological parents are legally separated or Divorced	1. The plan covering the parent with custody or with whom the child resides is primary. 2. The plan covering the stepparent residing in the same household is secondary. 3. The plan covering the other biological parent's coverage is third (tertiary). 4. The plan covering the other stepparent's coverage is fourth.

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

Scenarios of COBs:

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

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

Examples:

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

2. When LIBERTY is Primary Carrier

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

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

3. When LIBERTY is Secondary Carrier

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

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

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

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

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

Example #1**:**

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

After applying COB:

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

Example #2**:**

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

After applying COB:

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

SECTION 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;
- Work closely with specialty care provider to promote continuity of care;
- Maintain adherence to the LIBERTY QMI Program;
- Identify dependent children with special health care needs and notify LIBERTY of these needs;
- Notify LIBERTY of a member death;
- Arrange coverage by another provider when away from dental facility;
- Ensure that emergency dental services are available and accessible 24 hours a day, 7 days a week through primary care dentist;
- Maintain scheduled office hours;
- Maintain dental records for a period of ten years
- Provide updated credentialing information upon renewal dates;
- Provide requested information upon receipt of patient grievance/complaint within 10 days of receiving a notice letter;
- Provide encounter data on standard ADA claim, Plan form or computer generated form in a timely manner (for capitation plans);
- Notify LIBERTY of any changes regarding practice, including location name, telephone number, address, associate additions / terminations, change of ownership, plan terminations, etc.
- 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 5 days of request.

SPECIALTY CARE PROVIDERS RESPONSIBILITIES & RIGHTS

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

ANTI-DISCRIMINATION

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

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

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

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

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

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

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).

This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

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

How to Apply for an NPI

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

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

VOLUNTARY PROVIDER CONTRACT TERMINATION

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

STANDARDS OF ACCESSIBILITY

Providers are required to schedule appointments for eligible members in accordance with the standards listed below, when not otherwise specified by regulation or by client performance standards. LIBERTY monitors compliance and may seek corrective action for providers that are not meeting accessibility standards.

Type of Appointment	Access to Care Standards
Routine Office Visit	Within 30 days
Preventive	Within 30 days
Emergency	Within 24 hours
After-Hours Availability	24 hours a day, 7 days per week • Answering service that will contact provider on behalf of the member • Call forwarding system that automatically directs members call to the Provider • Answering system with explicit instructions on how to reach the provider and emergency instructions.
Office Wait Time	Not to exceed 30 minutes
Office Hours	Minimum of 3 days / 30 hours per week
Urgent Care	Within 24 hours
Follow-up Dental Services	30 days after initial assessment

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, 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 or close your office to new enrollment.

TREATMENT PLAN GUIDELINES

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

Alternate and/or Elective/non-covered Procedures and Treatment Plans: LIBERTY Dental members cannot be denied their plan benefits if they do not choose "alternative or elective/non-covered" procedures. All accepted or declined treatment plans must be signed and dated by the patient or his/her guardian and the treating dentist. Refer to the Members' benefit plans to determine covered, alternate and elective procedures. Note: Most plans allow for an upgrade to noble and high noble metal and for porcelain on molar teeth with an informed consent by the Member.

SECOND OPINIONS

Members may request a consultation with another network dentist for a second opinion to confirm the diagnosis and/or treatment plan. Dentist should refer these members to the Member Services Department at (888) 352-7924, Monday through Friday, 5 a.m. to 5 p.m. PST.

RECALL, FAILED OR CANCELLED APPOINTMENTS

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

CONTINUITY AND COORDINATION OF CARE

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

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

- An enrollment packet contains a list of Providers that shall be given to all members upon enrollment;
- A current list of Providers is maintained on LIBERTY'S web site at www.libertydentalplan.com;
- If a member has not selected Provider within 30 days of enrollment, a reminder postcard notifying the member of their "automatic assignment" shall be sent 10 days after assignment of his/her Provider (for capitation plans);
- Members who do not select a Provider shall be assigned one, based on the member's geographic location (for capitation plans);
- Dental chart documentation standards are included in this provider guide;
- Dental chart audits will verify compliance to documentation standards;
- Guidelines for adequate communications between the referring and receiving providers when members are referred for specialty dental care are included in this provider guide;
- During facility on-site audits, LIBERTY monitors compliance with continuity and coordination of care standards;
- When a referral to a specialist is authorized, the Provider is responsible for evaluating the need for follow-up care after specialty care services have been rendered and schedule the member for any appropriate follow-up care;
- When a specialty care referral is denied, the Provider is responsible for the evaluation for the need to perform the services directly, and schedule the member for appropriate treatment;
- The results of site audits shall be reported to the QM Committee, and corrective action shall be implemented when deficiencies are identified.

PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that health care providers or health care facility 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 Statues. 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 who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A member has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A member has the right to express grievances regarding any violation of his or her rights, as stated in 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 <u>responsibility</u> 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 Fen-Phen/Redux and bisphosphonates)
7. Allergies and sensitivity to medications or materials (including latex)
8. Adverse reaction to local anesthetics
9. History of diseases:

- Cardio-vascular disease, including heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.
- Pulmonary disorders including tuberculosis, asthma and emphysema
- Nervous disorders
- Diabetes, endocrine disorders, and thyroid abnormalities
- Liver or kidney disease, including hepatitis and kidney dialysis
- Sexually transmitted diseases
- Disorders of the immune system, including HIV status/AIDS
- Other viral diseases

- Musculoskeletal system, including prosthetic joints and when they were placed

10. Pregnancy

    - Document the name of the 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

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

INFECTION CONTROL

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

LANGUAGE ASSISTANCE PROGRAM (LAP)

To ensure that there are no language barriers in the comprehension of the patient's presented treatment plan, LIBERTY offers a Language Assistance Program that is available to both our contracted providers and eligible members. To obtain assistance, please contact LIBERTY's Member Services Department at 888-700-0643.

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. Full mouth periodontal probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.

D. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented.

E. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the 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.*

C. D0210 Intraoral – complete series (including bitewings)

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

Benefits for this procedure are determined within each plan design.

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

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

D. Decisions about the types of recall films should also be made by the dentist and based on current *ADA/FDA* radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the 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, the patient may not be charged any X-ray duplication fees.

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

NOTE: X-ray duplication fees may not be allowed. Refer to specific plan designs.

PREVENTION

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

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

- patient education in oral hygiene and dietary instruction
- periodic evaluations and prophylaxis procedures
- topical or systemic fluoride treatment
- sealants and/or preventive resin restorations

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

- oral and systemic health information
- oral hygiene and dietary instructions
- prophylaxis procedures on a regular basis
- occlusal evaluation
- correction of malocclusion and malposed teeth
- restoration and/or replacement of broken down, missing or deformed teeth

C. D1110 and D1120 – prophylaxis procedures

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

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

D. D1203 and D1204 – topical application of fluoride procedures

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

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

E. Other areas of prevention may include:

- smoking cessation programs
- discontinuing the use of smokeless tobacco
- good dietary and nutritional habits for general health
- elimination of mechanical and/or chemical factors that cause irritation
- space maintenance in children where indicated for prematurely lost posterior teeth

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

TREATMENT PLANNING

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

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

C. Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing would include relief of pain, discomfort and/or infection, treatment of extensive caries and pulpal inflammation including endodontic procedures, periodontal procedures, restorative procedures, replacement of missing teeth, prophylaxis and preventive care and establishing an appropriate recall schedule.

D. Informed Consent Process

1. Dentists must document that all recommended treatment options have been reviewed with the 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.

E. Poor Prognosis

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

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

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

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

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

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

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

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

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

K. Consultations, referrals and their results should be documented

REQUEST FOR PRE-ESTIMATE

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

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

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

PROGRESS NOTES

A. Progress notes constitute a legal record and must be detailed, legible and in ink

B. All entries must be signed or initialed and dated by the person providing treatment. Entries may be corrected, modified or lined out, but require the name of the person making any such changes and the date.

C. The names and amounts of all local anesthetics must be documented, including the amount of any vasoconstrictor present. If no local anesthetic is used for a procedure that normally requires it (i.e. scaling and root planing), the related rationale should be documented.

D. All prescriptions must be documented in the progress notes or copies kept in the chart, including the medication, strength, amount, directions and number of refills.

E. Copies of all lab prescriptions should be kept in the chart.

F. For paperless dental records, computer entries cannot be modified without identification of the person making the modification and the date of the change.

G. Upon request, dental providers are required to provide LIBERTY with a legible copy of a member's dental records (including but not limited to progress notes, radiographs, etc.) as part of a case review, member grievance, peer review or any other quality or utilization management process.

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.

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

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

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

    Note regarding inappropriate unbundling/coding for endodontic irrigation:

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

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

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

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

LIBERTY 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 narratives 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

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

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

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

    - Untreated or advanced periodontal disease

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

ORAL SURGERY

A. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the 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. Bone grafting (D7953) for ridge preservation may be indicated in preparation for implant placement or where alveolar contour is critical to planned prosthetic reconstruction.

H. Documentation of a surgical procedure should include: recording the tooth number, tissue removed and a description of the surgical method used; a record of unanticipated complications such as: failure to remove planned tissue/root tips; displacement of tissue to abnormal sites; unusual blood loss; presence of lacerations and other surgical or non-surgical defects.

THIRD MOLAR EXTRACTIONS AND BENEFIT DETERMINATION

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

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

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

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

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

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

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

I. All suspicious lesions should be biopsied and examined microscopically.

J. D9220 – deep sedation / general anesthesia

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

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

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

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

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

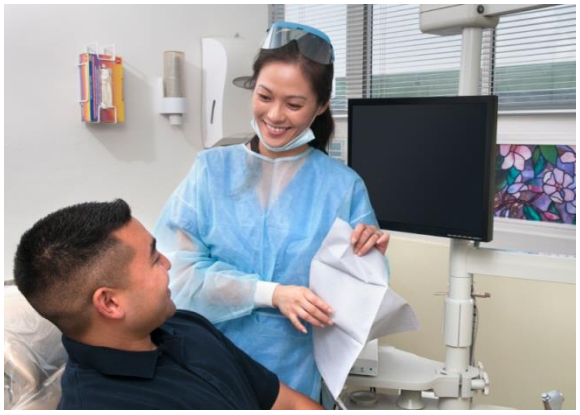
This oral surgery procedure should be reported when the bone graft "is placed in an extraction site at the time of the extraction . . ." to preserve ridge integrity. (See above for indications.) (CDT 2011-2012, p. 159)

L. D4263 bone replacement graft – first site in quadrant

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

PERIODONTICS

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



Comprehensive oral evaluations should include the quality and quantity of gingival tissues. Additional components of the evaluation would include documenting: six-point periodontal probing for each tooth, the location of bleeding, exudate, plaque and calculus, significant areas of

recession, mucogingival problems, mobility, open or improper contacts, furcation involvement, and occlusal contacts or interferences. Following the completion of a comprehensive evaluation, a diagnosis and treatment plan should be completed.

Periodontal treatment sequencing:

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

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

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

Note, this procedure:

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

B. D4341/D4342 - Scaling and root planing

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

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

Definitive vs. Pre-Surgical scaling and root planing:

1. For early stages of periodontal disease, this procedure is used as definitive treatment and the 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 usually not appropriate to perform D1110 and D4341 on the same date of service. LIBERTY'S licensed dental consultants may review documented rationale for any such situations on a case-by-case basis.

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

Soft Tissue Management Programs (STMP)

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

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

Gross debridement and scaling/root planing.

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

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

Irrigation, periodontal/D4999 - by report

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

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

Notes on appropriate coding:

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

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

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

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

Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients as an adjunct to procedures D4341/D4342 (scaling and root planing) AFTER the following steps [1]:

1. A clinician has completed D4341/D4342 and allowed a minimum 4-week healing period. Then, the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing.

2. Re-evaluation confirms that several teeth were non-responsive to scaling and root planing, with localized residual pocket depths of 5 mm's or deeper plus inflammation.

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

1. In such cases, benefits may be approved for two teeth per quadrant in any twelve month period

2. Other procedures, such as systemic antibiotics[2] or surgery, should be considered when multiple teeth with 5 mm pockets or deeper exist in the same quadrant.

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

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

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

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

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

[1] (American Academy of Periodontology Statement on Local Delivery of Sustained or Controlled Release Antimicrobials as Adjunctive Therapy in the Treatment of Periodontitis, May, 2006)
[2] (American Academy of Periodontology Position Paper, Systemic Antibiotics in Periodontics, November, 2004)

C. Periodontal surgical procedures

- The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures.
- Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.
- Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens.
- 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:
    1. pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)
    2. patients are smokers or diabetics who's disease is not being adequately managed
- Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
- Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
- Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.

D4249 Clinical crown lengthening – hard tissue

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

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

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

Lasers

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

LASER-MEDIATED SULCULAR AND/OR POCKET DEBRIDEMENT

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

American Academy of Periodontology, April 2011

RESTORATIVE

Diagnosis and Treatment Planning

It is appropriate to restore teeth with radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or for post-endodontic purposes. Sequencing of treatment must be appropriate to the needs of the 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 should be good (estimated at 5 years or more).

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

B. Restorative procedures in operative dentistry include amalgam, composites, inlays, onlays, crowns, as well as the use of various temporary materials.

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. Referrals are required and must be approved prior to member receiving an orthodontic consultation. Prior authorization is required for all orthodontic services.

The Medicaid Orthodontic Initial Assessment Form (IAF) must be completed by the orthodontic provider at the approved initial evaluation form and submitted with the completed pre authorization request form to LIBERTY.

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 <u>not</u> involving or undermining the cusps of <u>posterior teeth</u> is generally amalgam or composite.

   ii. The procedures of choice for treating caries or the replacement of an existing restoration <u>not</u> involving or undermining the incisal edges of an <u>anterior tooth</u> 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 be veneers or crowns, either porcelain fused to metal or porcelain/ceramic substrate.

ix. An onlay should be considered when there is sufficient tooth structure, but cusp support is needed. An inlay is usually not a restoration of choice.

x. An inlay is usually not a restoration of choice.

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

Amalgam free dental offices

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

D1351 sealant – per tooth

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

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

D2330, D2391 or D2392 - Resin-based composites

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

D9910/D9911 - Desensitizing

Appropriate reporting of these procedures is clearly detailed below.

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

D9910 – application of desensitizing medicament

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

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

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

CROWNS AND FIXED BRIDGES

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

Upgrades

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

Typical upgrades may include:

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

Single Crowns

A. When bicuspid and anterior crowns are covered, the benefit is usually a porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.

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

C. Porcelain/ceramic substrate crowns and porcelain fused to metal crowns on molars may be more susceptible to fracture than full metal crowns.

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

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

F. Crown procedures should always be reported and documented using valid procedure codes as found in the *American Dental Association's Current Dental Terminology (CDT).*

Brand name dental materials/alternatives

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

CDT includes the Code on Dental Procedures and Nomenclature.

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

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

Benefit determination protocols utilized by LIBERTY licensed Dental Consultants:

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

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

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

Post and core procedures include buildups

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

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

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

Outcomes

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

Fixed Bridges

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

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

B. Fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced in x-rays, or when a proposed abutment tooth or teeth have poor crown/root ratios.

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

D. Bridge abutments would generally be full coverage crowns.

E. A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.

F. Third molars should generally not be replaced, particularly if the replacement would not be functional.

G. Outcomes

   i. Margins, contours and contacts should be clinically acceptable

   ii. Prognosis should be good for long term longevity

REMOVABLE PROSTHODONTICS

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

A. Partial Dentures

1. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars.

2. Partial dentures may be covered when posterior teeth require replacement on both sides of the same arch.

3. Full or partial dentures may not be covered for replacement if an existing appliance can be made satisfactory by relining or repair.

4. Full or partial dentures may not be covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.

5. Unilateral removable partial dentures are rarely appropriate, as they may be readily swallowed or inhaled into a patient's lungs.

6. Abutment teeth should be restored prior to the fabrication of a removable appliance and may be covered if such teeth meet the same stand-alone benefit requirements of a single crown.

7. Partials should be designed to minimize any harm to the remaining natural teeth.

8. Materials used for removable partial dentures should be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.

9. Appliances should be designed to minimize any harm to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.

10. Flexible partial dentures (D5225/D5226) include the following brands: *Valplast, Thermoflex, Flexite*, etc.

11. *Combo Partials* – because these appliances may include cast metals, they would be appropriately reported as D5213/D5214.

B. Complete Dentures

1. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations.

2. Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.

C. Interim Complete Dentures

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

D. Immediate Complete Dentures

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

E. Repairs and Relines

1. Repair of a partial or complete denture is covered if it results in a serviceable appliance, subject to limitations.

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

IMPLANTS

A. General Guidelines

1. A thorough history and clinical examination leading to the evaluation of the patient's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.

2. A conservative treatment plan should be considered prior to providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:

- Adverse systemic factors such as diabetes and smoking
- Poor oral hygiene and tissue management by the patient

- Inadequate osseo-integration (movable) of the dental implant(s)
- Excessive para-function or occlusal loading
- Poor positioning of the dental implant(s)
- Excessive loss of bone around the implant prior to its restoration
- Mobility of the implant(s) prior to placement of the prosthesis
- Inadequate number of implants or poor bone quality for long span prostheses
- Need to restore the appearance of gingival tissues in high esthetic areas
- When the patient is under 16 years of age, unless unusual conditions prevail

B. Restoration

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

C. Outcomes

1. The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.
2. The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the patient.
3. The appearance and shape of the fixed prosthesis must exhibit contours that are in functional harmony with the remaining hard and soft tissues of the mouth.
4. They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.
5. Fixed implant prostheses must incorporate a strategy for removal of the appliance without damage to the implant, or adjacent dentition, so that the implant can be utilized in cases where there is further loss of teeth, or where repair of the appliance is necessary.
6. Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.

7. It is a contra-indication to have a fixed dental prosthesis abutted by both dental implant(s) and natural teeth (tooth) without incorporating a design to alleviate the stress from an osseo-integrated (non-movable) abutment to a natural tooth.

8. It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with a restoration.

9. It is the responsibility of the restoring dentist to instruct the patient in the proper care and maintenance of the implant system and to evaluate the patient's care initially following the final placement of the prosthetic restoration.

10. Fixed partial prostheses, as well as a single unit crowns, are expected to have a minimum prognosis for 5-years of service.

SECTION 9 - SPECIALTY CARE REFERRAL GUIDELINES (DHMO PROGRAMS ONLY)

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

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

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

NON-EMERGENCY REFERRAL SUBMISSION & INQUIRIES

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

Provider Portal: www.libertydentalplan.com

Telephone: (888) 352-7924, Press Option 2

Mail:

LIBERTY Dental Plan
P.O. Box 15149
Tampa, FL 33684
Attn: Referral Department

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

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

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

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

EMERGENCY REFERRAL

If emergency specialty care is needed, the Referral Unit can issue an emergency authorization number to the General Dentist by calling the Emergency Referral Hotline at (888) 359-1087.

ENDODONTICS

Referral Guidelines for the General Dentist

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

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

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

Inform the member that:

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

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

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

Referral Guidelines for the Endodontist:

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

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

If an emergency endodontic service is needed, but has not been listed on the original authorization form, the Endodontist should contact the Plan's Referrals Unit at 888-401-1128 for an emergency authorization number.

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

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

Endodontic Referral Guidelines					
Endodontic Referrals General Dentist Specialty Care Guidelines (Subject to plan Benefits)		**Procedures Usually Approved For Referral**	**Referral Criteria** (teeth must have a good prognosis & be restorable)	**Emergency Referral Criteria**	**Qualifies for Emergency Referrals**
D0220	Intraoral - periapical first film	No	N/A	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	If no diagnostic PA x-ray is available
D3310	Root canal - anterior (excluding final restoration)	No	When excessive root curvature or calcification evident on x-rays precludes General Dentist from treating		Extraordinary circumstances considered on a case-by-case basis
D3320	Root canal - bicuspid (excluding final restoration)	No			Extraordinary circumstances considered on a case-by-case basis
D3321	Pulpal Debridement	No	This procedure would only be covered for General Dentists who then refer to an Endodontist to continue treatment		No
D3330	Root canal - molar (excluding final restoration)	Yes	Attending General Dentist documents procedure to be "outside the scope" of his or her skills		Yes
D3331	Treatment of root canal obstruction; non-surgical access	No	Endodontist's claims for this procedure evaluated on a case-by-case		No
D3332	Incomplete endodontic therapy; inoperable, non-restorable or fractured tooth	No	N/A		No
D3333	Internal root repair of perforation defects	B/R	Case-By-Case	Swelling, bleeding and/or pain and	Yes
D3346	Retreatment of previous root canal therapy - anterior	Yes			Yes

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

Endodontic Referral Guidelines					
Endodontic Referrals General Dentist Specialty Care Guidelines (Subject to plan Benefits)		**Procedures Usually Approved For Referral**	**Referral Criteria** (teeth must have a good prognosis & be restorable)	**Emergency Referral Criteria**	**Qualifies for Emergency Referrals**
D0220	Intraoral - periapical first film	No	N/A	Swelling, bleeding and/or pain and the General Dentist has attempted palliative treatment	If no diagnostic PA x-ray is available
D3310	Root canal - anterior (excluding final restoration)	No	When excessive root curvature or calcification evident on x-rays precludes General Dentist from treating		Extraordinary circumstances considered on a case-by-case basis
D3320	Root canal - bicuspid (excluding final restoration)	No			Extraordinary circumstances considered on a case-by-case basis
D3321	Pulpal Debridement	No	This procedure would only be covered for General Dentists who then refer to an Endodontist to continue treatment		No
D3330	Root canal - molar (excluding final restoration)	Yes	Attending General Dentist documents procedure to be "outside the scope" of his or her skills		Yes
D3331	Treatment of root canal obstruction; non-surgical access	No	Endodontist's claims for this procedure evaluated on a case-by-case		No
D3332	Incomplete endodontic therapy; inoperable, non-restorable or fractured tooth	No	N/A		No
D3333	Internal root repair of perforation defects	B/R	Case-By-Case	Swelling, bleeding and/or pain and	Yes
D3346	Retreatment of previous root canal therapy - anterior	Yes			Yes

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

ORAL SURGERY

Referral Guidelines for the General Dentist:

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

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

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

Inform the member that:

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

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

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

Referral Guidelines for the Oral Surgeon:

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

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

If an emergency oral surgery service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Oral Surgeon should contact the Plan's Membership Services Referrals Unit department at 800-268-9012 for an emergency authorization number.

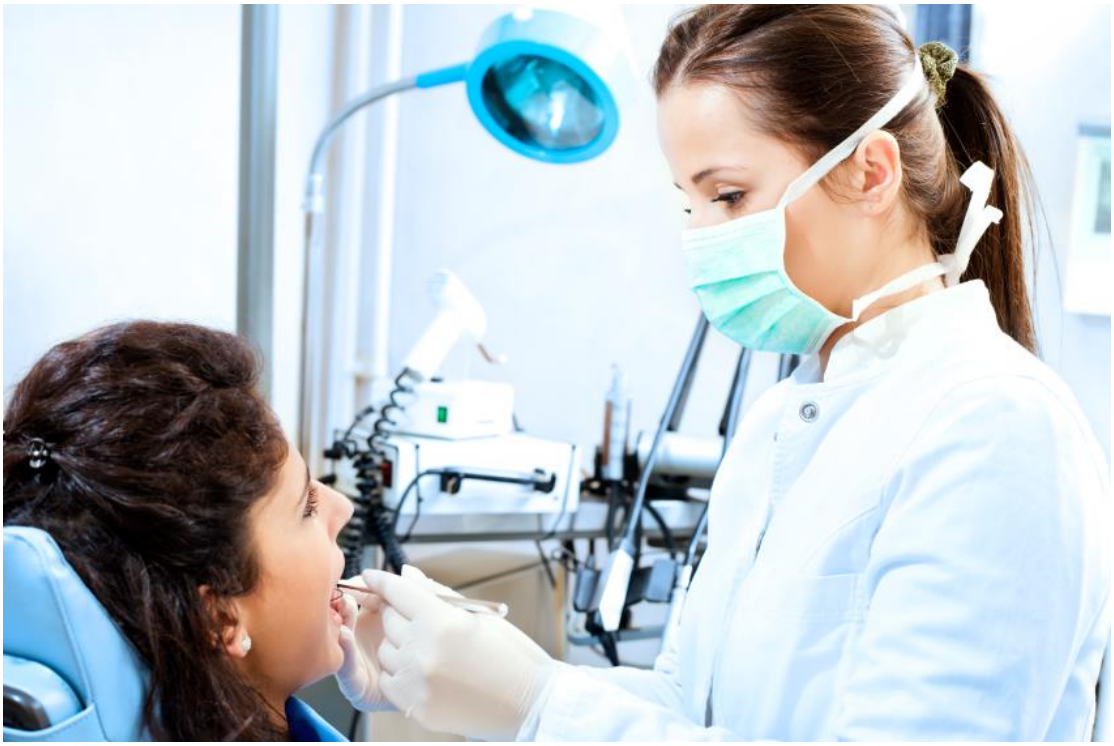
After completion of treatment, submit your claim for payment. To avoid delays in claim payment, please attach a copy of the member's LIBERTY Specialty Care Authorization or the Plan's authorization form. If emergency care was provided after obtaining a Plan emergency authorization number, print that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

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

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

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

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



ORTHODONTICS

Referral Guidelines for the General Dentist:

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

Complete a LIBERTY Specialty Care Authorization and provide the:

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

Inform the member that:

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

Referral Guidelines for the Orthodontist:

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

Contact the Plan's Membership Service department at (888) 700-0643 to obtain member's copayments and plan-specific benefits, limitations and exclusions for:

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

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

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

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

Orthodontic Referral Guidelines			
Orthodontic Referrals General Dentist Specialty Care Guidelines (subject to Plan Benefits)		**Generally Approved For Referral**	**Referral Criteria**
D8010	Limited orthodontic treatment of the primary dentition	Yes	General Dentist feels orthodontic treatment may be appropriate for patient
D8020	Limited orthodontic treatment of the transitional dentition	Yes	
D8030	Limited orthodontic treatment of the adolescent dentition	Yes	
D8040	Limited orthodontic treatment of the adult dentition	Yes	
D8050	Interceptive orthodontic treatment of the primary dentition	Yes	
D8060	Interceptive orthodontic treatment of the transitional dentition	Yes	
D8070	Comprehensive orthodontic treatment of the transitional dentition	Yes	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Yes	
D8090	Comprehensive orthodontic treatment of the adult dentition	Yes	
D8210	Removable appliance therapy	Yes	
D8220	Fixed appliance therapy	Yes	
D8660	Pre-orthodontic treatment visit	Yes	
D8670	Periodic orthodontic treatment visit (as part of contract)	Yes	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) - to age 18	Yes	
D8690	Orthodontic treatment (alternative billing to a contract fee)	Yes	
D8691	Repair of orthodontic appliance	Yes	
D8692	Replacement of lost or broken retainer	Yes	
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	Yes	
D0210	Intraoral - complete series	Yes	
D0330	Panoramic Film	Yes	N/A
D0340	Cephalometric Film	Yes	N/A
D0350	Oral / facial photographic images	Yes	N/A
D0470	Diagnostic casts	Yes	N/A

PEDIATRIC DENTISTRY

Referral Guidelines for the General Dentist:

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

Complete a Specialty Care Authorization and provide the:

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

Inform the member that:

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

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

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

Referral Guidelines for the Pediatric Dentist:

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

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

If an emergency pediatric service is needed, but has not been listed by the General Dentist on the LIBERTY Specialty Care Authorization, the Pediatric Dentist should contact the Plan's **Referrals Unit** at (888) 359-1087 for an emergency authorization number.

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

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

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

PERIODONTICS

Referral Guidelines for the General Dentist:

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

Complete a LIBERTY Specialty Care Authorization and provide the:

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

Inform the member that:

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

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

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

Referral Guidelines for the Periodontist:

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

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

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

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

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

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

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

Periodontics

Referral Coverage Based on Diagnosis

Gingivitis associates with dental plaque

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

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

Slight Chronic/Aggressive Periodontitis (localized or generalized)

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

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

Slight Chronic/Aggressive Periodontitis (localized or generalized)

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

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

Moderate Chronic/Aggressive Periodontitis, (localized or generalized)

- Pocket depths of 4-6mm with the possibility of localized greater pocket depths with 3 to 4 mm's of clinical attachment loss;
- Generalized bleeding upon probing;
- Possible Class 1 to Class 2 (1-2mm) tooth mobility;

- Class I furcation involvement with the possibility of some early Class II (i.e., can probe between the roots); and
- Radiographic evidence of moderate (20%-40%) bone loss, which is usually horizontal in nature.
- Referral to a Periodontist covered for a problem-focused examination and possible periodontal surgery.
- Moderate Chronic/Aggressive Periodontitis is eligible for direct specialty referral.

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

Severe Chronic/Aggressive Periodontitis (localized or generalized)

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

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

Refractory Chronic/Aggressive Periodontitis

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

PROSTHODONTIST

Referrals for this type of specialist are not covered under LIBERTY Dental Capitation, DHMO-EPO and Discount Programs.

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 all 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.

COMMITTEES

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

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

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

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

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

Dentists are recredentialed on a three-year cycle and as needed. Sixty days before the provider's assigned 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 **Network Management Sub-Committee** is responsible for monitoring the number and distribution of primary care and specialty care dentists to ensure an adequate network of providers. Quarterly, this sub-committee reports on the geographic distribution and members to dentist ratio as well as the analysis of data regarding appointment availability, wait times and grievances/appeals to determine shortcomings in the network and submits the finding to the QMI Committee for review.

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

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

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

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

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

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

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

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

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

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

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

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

PROGRAM STANDARDS AND GUIDELINES

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

Emergency Services:

Emergency Appointments (acute pain/swelling/bleeding)

- 24 hours a day, 7 days per week

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

- Not to Exceed 30 business days

Preventative Care (prophylaxis or periodontal care)

- Not to exceed 30 business days

Lobby waiting time (for scheduled appointment)

- Not to exceed 30 minutes

Surveys:

Provider Access Surveys:

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

Member Satisfaction Surveys:

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

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

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

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

Provider QMI Program Responsibilities

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

CREDENTIALING / RECREDENTIALING

Prior to acceptance in the LIBERTY Dental provider network, dentists must submit a copy of the following information which will be verified:

Current State dental license for each participating dentist;

Current DEA license, (does not apply to Orthodontists);

Current evidence of malpractice insurance for at least one million ($1,000,000) per incident and three million ($3,000,000) annual aggregate for each participating dentist;

Current certificate of a recognized training residency program with completion, (for specialists);

Current permit of general anesthesia or conscious oral sedation, if administered, for the appropriate dentist;

Immediate notification of any professional liability claims, suits, or disciplinary actions;

Verification is made by referencing the State Dental Board and National Practitioner Data Bank.

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

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. The Provider Reference Guide obligates all providers to abide by LIBERTY'S QMI Program Policies and Procedures. The Reference Guide is considered an addendum to the Provider Agreement. To resolve any issues for the new provider, and following orientation, a representative will make a follow-up service call within 60 days either in person or by telephone.

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

RECORDS REVIEW

LIBERTY 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.

GRIEVANCES, PROVIDER CLAIM DISPUTES & APPEALS

GRIEVANCES

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

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.

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 CLAIM 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.

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 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
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 provider and members may appeal any resolutions 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 to the committee. LIBERTY personnel determining a member's appeal must have no prior involvement in the decision and no vested interest in the case.

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

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.

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.

BEHAVIORAL MANAGEMENT

Narratives explaining Medicaid necessity 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

CHILD MEDICAID BENEFITS AND LIMITATIONS

The following is a complete list of the dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered. This Plan does not allow alternate benefits. Members must visit a contracted provider to utilize covered benefits.

If elected, Member is responsible for non-covered services

Code	Description	Limitations	Auth Required	Documentation – X-rays required
Diagnostic Services				
D0120	Periodic oral evaluation	1 D0120 or D0145 per 6 month period	N	
D0140	Limited oral evaluation		N	
D0145	Oral evaluation under age 3	1 D0120 or D0145 per 6 month period	N	
D0150	Comprehensive oral evaluation	1 per 36 month period per provider	N	
D0190	Screening of a patient	1 per calendar year	N	Only payable in a school based or mobile setting; Not payable same day as D0120-D0180 or any other evaluation code.
D0191	Assessment of a patient	1 per calendar year	N	Only payable in a school based or mobile setting; Not payable same day as D0120-D0180 or any other evaluation code.
D0210	Intraoral, complete series of radiographic images	1 complete series x-rays or panoramic image per 36 months	N	Requires a minimum of 12 periapical radiographs
D0220	Intraoral, periapical, first radiographic image		N	
D0230	Intraoral, periapical, each add 'l radiographic image	Payable up to 5 units per date of service	N	
D0240	Intraoral, occlusal radiographic image	Payable up to 2 units per date of service	N	
D0250	Extra-oral 2D projection radiographic image, stationary radiation source		N	
D0251	Extra-oral posterior dental radiographic image		N	
D0270	Bitewing, single radiographic image	1 series per 6 month period	N	
D0272	Bitewings, two radiographic images		N	
D0274	Bitewings, four radiographic images		N	
D0290	Posterior-anterior, lateral skull & facial bone survey		N	
D0330	Panoramic radiographic image	1 complete series x-rays or panoramic image per 36 month period	N	
D0340	2D cephalometric radiographic image, measurement and analysis	In conjunction with orthodontic coverage	N	

Code	Description	Limitations	Auth Required	Documentation – X-rays required
D0350	2D oral/facial photographic image, intra-orally/extra-orally	1 unit per day, only when diagnostic-quality radiographic images cannot be taken	N	
D0470	Diagnostic casts	In conjunction with orthodontic coverage	N	
Preventive Services				
D1110	Prophylaxis, adult	1 per 6 month period	N	
D1120	Prophylaxis, child		N	
D1206	Topical application of fluoride varnish	1 per 3 month period age 0-3	N	
D1208	Topical application of fluoride, excluding varnish	1 per 6 month period age 4 and above	N	
D1330	Oral hygiene instruction	1 per 6 month period	N	Includes nutritional counseling
D1351	Sealant, per tooth	1 per tooth per 36 month period limited to 1st & 2nd molar only	N	Surface must be caries free with no restoration or previous sealant present
D1510	Space maintainer, fixed, unilateral	Space to be maintained more than 6 months	N	Narrative required w/ submission of claim. May be reimbursed for necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth
D1515	Space maintainer, fixed, bilateral	Space to be maintained more than 6 months		
D1550	Re-cement or re-bond space maintainer			
Restorative Services				
D2140	Amalgam, one surface, primary or permanent	1 per surface per tooth per 36 month period (includes D2140-D2335 and D2391-D2394)	N	
D2150	Amalgam, two surfaces, primary or permanent			
D2160	Amalgam, three surfaces, primary or permanent			
D2161	Amalgam, four or more surfaces, primary or permanent			
D2330	Resin-based composite, one surface, anterior	1 per surface per tooth per 36 month period (includes D2140-D2335 and D2391-D2394)	N	
D2331	Resin-based composite, two surfaces, anterior			
D2332	Resin-based composite, three surfaces, anterior			
D2335	Resin-based composite, four or more surfaces, involving incisal angle			
D2390	Resin-based composite crown, anterior	1 per tooth per 36 month period	See Documentation	Children 6 and older require pre-authorization, except when pulpotomy (D3220) or pulpal therapy (D3230) has been rendered on the same day
D2391	Resin-based composite, one	1 per surface per tooth	N	

Code	Description	Limitations	Auth Required	Documentation – X-rays required
	surface, posterior	per 36 month period (includes D2140-D2335 and D2391-D2394)		
D2392	Resin-based composite, two surfaces, posterior			
D2393	Resin-based composite, three surfaces, posterior			
D2394	Resin-based composite, four or more surfaces, posterior			
D2710	Crown, resin-based composite (indirect)	Crowns are covered only if the tooth is endodontically treated, and cannot be restored with an amalgam or resin restoration	Y	Pre-authorization, x-rays, and narrative required
D2721	Crown, resin with predominantly base metal			
D2740	Crown, porcelain/ceramic substrate			
D2751	Crown, porcelain fused to predominantly base metal			
D2920	Re-cement or re-bond crown	Not payable within 6 month period of initial placement	N	
D2930	Prefabricated stainless steel crown, primary tooth		See Documentation	Pre-Authorization is required for members age 6 and over, except when pulpotomy (D3220) or pulpal therapy (D3230 or D3240) has been rendered on the same day
D2931	Prefabricated stainless steel crown, permanent tooth			
D2932	Prefabricated resin crown		See Documentation	
D2933	Prefabricated stainless steel crown with resin window			
D2940	Protective restoration	Not payable in conjunction with other restorative procedures on the same tooth	N	
D2950	Core buildup, including any pins when required		N	Considered inclusive with crown. Separate fee may be allowed when submitted with supporting documentation
D2951	Pin retention, per tooth, in addition to restoration		N	
D2954	Prefabricated post and core in addition to crown		N	
Endodontic Services				
D3110	Pulp cap, direct (excluding final restoration)		N	Pre-op x-rays required. Subject to Pre-Payment review
D3120	Pulp cap, indirect (excluding final restoration)			
D3220	Therapeutic pulpotomy (excluding final restoration)			
D3221	Pulpal debridement, primary and permanent teeth	Not payable in conjunction with D3310, D3320, D3330 on same tooth by same provider	N	Pre-op x-rays required. Subject to Pre-Payment review

Code	Description	Limitations	Auth Required	Documentation – X-rays required
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root		N	Pre and Post-operative x-rays required. Subject to pre-payment review
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)		N	X-rays required. Subject to Pre-Payment review
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)		N	Requires good restorative and periodontal prognosis. Pre and Post-operative x-rays required. Subject to Pre-Payment review
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)			
D3330	Endodontic therapy, molar (excluding final restoration)			
D3331	Treatment of root canal obstruction; non-surgical access		N	Requires good restorative and periodontal prognosis. Pre and Post-operative x-rays required. Subject to Pre-Payment review
D3333	Internal root repair of perforation defects			
D3351	Apexification/recalcification, initial visit	not on same day as D3352 or D3353		
D3352	Apexification/recalcification, interim medication replacement	not on same day as D3351 or D3353		
D3353	Apexification/recalcification, final visit	not on same day as D3351 or D3352		
D3410	Apicoectomy, anterior		N	Requires good restorative and periodontal prognosis. Pre and Post-operative x-rays required Subject to Pre-Payment review
D3430	Retrograde filling, per root			
Periodontal Services				
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	1 per quad per 36 month period. Maximum 2 quads per date of service.	Y	Pre-authorization and x-rays required
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant			
D4240	Gingival flap procedure, four or more teeth per quadrant	1 per quad per 36 month period. Maximum 2 quads per date of service. Not payable within 36 months of D4260 or D4261.	Y	Pre-authorization and x-rays required
D4241	Gingival flap procedure, one to three teeth per quadrant			
D4260	Osseous surgery, four or more teeth per quadrant	1 per quad per 36 month period. Maximum 2 quads per date of service.		
D4261	Osseous surgery, one to teeth per quadrant			
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	1 per quad per 36 month period. Maximum 2 quads per	Y	Pre-authorization and x-rays required

Code	Description	Limitations	Auth Required	Documentation – X-rays required
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	date of service. Not payable within 36 months of D4240, D4241, D4260 or D4261.		
D4355	Full mouth debridement	1 per 24 month period Not payable on same day as D1110 or D1120	N	Narrative required w/ submission of claim. Subject to pre-payment review
Removable Prosthodontic Services				
D5110	Complete denture, maxillary	1 per arch per lifetime-with exception	N	For replacement dentures: submit prior placement date of original denture and narrative of medical necessity required. Replacement of a lost denture is not covered.
D5120	Complete denture, mandibular			
D5211	Maxillary partial denture, resin base	1 per arch per lifetime-with exception. Replacement of a lost denture is not covered.	Y	Pre-authorization and x-rays required
D5212	Mandibular partial denture, resin base			
D5213	Maxillary partial denture, cast metal, resin base			
D5214	Mandibular partial denture, cast metal, resin base			
D5410	Adjust complete denture, maxillary	1 per arch per 12 month period	N	Narrative required w/ claim submission. No additional payment is allowed within 6 months of delivery date
D5411	Adjust complete denture, mandibular			
D5421	Adjust partial denture, maxillary			
D5422	Adjust partial denture, mandibular			
D5510	Repair broken complete denture base		N	Narrative required w/ claim submission. No additional payment is allowed within 6 months of delivery date
D5520	Replace missing or broken teeth, complete denture			
D5610	Repair resin denture base			
D5620	Repair cast framework			
D5630	Repair or replace broken clasp, per tooth			
D5640	Replace broken teeth, per tooth			
D5650	Add tooth to existing partial denture			
D5660	Add clasp to existing partial denture, per tooth			
D5730	Reline complete maxillary denture, chairside	1 per arch per 12 month period	N	Narrative required w/ claim submission. No additional payment is allowed within 6 months of delivery date
D5731	Reline complete mandibular denture, chairside			
D5740	Reline maxillary partial denture, chairside			

Code	Description	Limitations	Auth Required	Documentation – X-rays required
D5741	Reline mandibular partial denture, chairside			
D5750	Reline complete maxillary denture, laboratory			
D5751	Reline complete mandibular denture, laboratory			
D5760	Reline maxillary partial denture, laboratory			
D5761	Reline mandibular partial denture, laboratory			
D5820	Interim partial denture, maxillary	1 per lifetime	Y	Pre-authorization with x-rays and narrative required
Fixed Prosthodontic Services				
D6985	Pediatric partial denture, fixed	1 per lifetime	Y	Pre-authorization with x-rays and narrative of medical necessity required
Oral & Maxillofacial Services				
Pre-Authorization, x-rays and narrative required for extractions of 3rd molars				
D7111	Extraction, coronal remnants, deciduous tooth	Prophylactic extractions of asymptomatic impacted or erupted teeth is not a covered benefit	Y	Third Molar Extractions require Pre-Treatment Approval. All other non-third molar extractions require pre-treatment radiographs with submission of claim
D7140	Extraction, erupted tooth or exposed root			
D7210	Surgical removal of erupted tooth			
D7220	Removal of impacted tooth, soft tissue			
D7230	Removal of impacted tooth, partially bony			
D7240	Removal of impacted tooth, completely bony			
D7241	Removal impacted tooth, complete bony, complication			
D7250	Surgical removal residual tooth roots, cutting procedure			
D7260	Oroantral fistula closure	Covered only when medically necessary	N	X-rays and Narrative required with claim. Subject to pre-payment review.
D7261	Primary closure of a sinus perforation			
D7270	Tooth reimplantation and/or stabilization, accident		N	X-rays and Narrative required w/ submission of claim
D7280	Surgical access of an unerupted tooth		Y	Pre-authorization and narrative of medical necessity required
D7283	Placement, device to facilitate eruption, impaction			
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	1 per lifetime per quadrant	Y	Pre-authorization required. D7310 is only payable in preparation of full dentures. Pre-op x-rays and/or narrative required
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant			
D7472	Removal of torus palatinus	1 per lifetime per area/quadrant	Y	Pre-authorization, narrative and restorative/prosthodontic treatment plan required
D7473	Removal of torus mandibularis	1 per lifetime per	Y	Pre-authorization, narrative and

Code	Description	Limitations	Auth Required	Documentation – X-rays required
		area/quadrant		restorative/prosthodontic treatment plan required
D7510	Incision & drainage of abscess, intraoral soft tissue		N	Not payable on same day as extraction
D7520	Incision & drainage of abscess, extraoral soft tissue		N	
D7880	Occlusal orthotic device, by report		Y	Pre-authorization required.
D7881	Occlusal orthotic device adjustment	1 per 12 month period	N	
D7970	Excision of hyperplastic tissue, per arch		N	Not allowed in conjunction with D7310 or D7320
Orthodontic Services				
Prior Authorization including Medicaid Orthodontic Initial Assessment Form (AIF), study models, cephalometric and panoramic image is required for all orthodontic services. A maximum of five (5) broken brackets will be considered covered as part of the orthodontic coverage with no additional payment to the provider. If the member exceeds five (5) broken brackets during the treatment period the provider may pass on additional costs to the member. The member must be eligible on each date of service. If the member becomes ineligible during active orthodontic treatment, the member is responsible to pay any remaining balance.				
D8070	Comprehensive orthodontic treatment of the transitional dentition	1 per lifetime	Y	Medicaid Orthodontic Initial Assessment Form - (IAF), study models, cephalometric and panoramic images must be submitted with Pre-authorization
D8080	Comprehensive orthodontic treatment of the adolescent dentition			
D8090	Comprehensive orthodontic treatment of the adult dentition			
D8210	Removable appliance therapy		Y	Pre-authorization required
D8220	Fixed appliance therapy			
D8660	Pre-orthodontic treatment examination to monitor growth and development		Y	Includes diagnostic casts, photographs, panoramic image, cephalometric image and tracing
D8670	Periodic orthodontic treatment visit		Y	Limited to a maximum of 24 monthly visits or 36 months following the banding date whichever occurs first. An extension beyond this may be approved for severe cases such as surgical orthognathic or cleft cases
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	1 per lifetime	Y	
D8692	Replacement of lost or broken retainer		Y	
Adjunctive General Services				
D9110	Palliative (emergency) treatment, minor procedure		N	Narrative required with claim submission. No additional payment allowed if submitted w/ procedures other than x-rays and/or limited exam on the same

Code	Description	Limitations	Auth Required	Documentation – X-rays required
				date of service, for purpose of relief of pain
D9223	Deep sedation/general anesthesia, each 15 minute increment	A total of 3 occurrences of either D9223 and/or D9243 per 366 days. Limited to 5 units per date of service and a total of 15 units in 366 days.	Y	Pre-authorization, narrative and case guidelines and qualifications required. Not payable in conjunction with nitrous oxide (D9230) or Behavior Management (D9920)
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	3 per 366 days	N	Not payable in conjunction with sedation codes D9223, D9243 or Behavior Management (D9920)
D9243	Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment	A total of 3 occurrences of either D9223 and/or D9243 per 366 days. Limited to 5 units per date of service and a total of 15 units in 366 days.	Y	Pre-authorization, narrative and case guidelines and qualifications required
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	3 per 366 days	N	Not payable in conjunction with Behavior Management (D9920)
D9310	Consultation, other than requesting dentist		N	Narrative required w/ submission of claim. Not payable on same day as treatment
D9420	Hospital or ambulatory surgical center call		Y	Pre-authorization and narrative required
D9920	Behavior management, by report	3 per 366 days Not payable in conjunction with sedation (D9223, D9243, D9248) or nitrous oxide analgesia (D9230).	N	Defined as "extraordinary means used to control a patient management problem and without this management, treatment could not be rendered." Medicaid Behavior Management Report or Narrative is required for consideration of claim payment

ADULT MEDICAID BENEFITS AND LIMITATIONS

The following is a complete list of the dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered. This Plan does not allow alternate benefits. Members must visit a contracted provider to utilize covered benefits.

If elected, Member is responsible for non-covered services

Code	Description	Limitations	Auth Required	Documentation – X-rays required
Diagnostic Services				
D0120	Periodic oral evaluation	1 per 12 month period	N	
D0140	Limited oral evaluation		N	
D0150	Comprehensive oral evaluation	1 per 36 month period per provider	N	
D0210	Intraoral, complete series of radiographic images	1 per 12 month period	N	Requires a minimum of 12 periapical radiographs
D0220	Intraoral, periapical, first radiographic image		N	
D0230	Intraoral, periapical, each add 'l radiographic image	Payable up to 5 units per date of service	N	
D0240	Intraoral, occlusal radiographic image	Payable up to 2 units per date of service	N	
D0272	Bitewings, two radiographic images	1 per 12 month period	N	
D0290	Posterior-anterior, lateral skull & facial bone survey		N	
D0330	Panoramic radiographic image	1 per 36 month period	N	
Preventive Services				
D1110	Prophylaxis, adult	2 per 12 month period	N	
D1330	Oral hygiene instructions	1 per 12 month period	N	Includes nutritional counseling
Removable Prosthodontic Services				
D5110	Complete denture, maxillary	1 per arch per lifetime-with exception Replacement of a lost denture is not covered.	Y	For replacement dentures: submit prior placement date of original denture and narrative of medical necessity required. Replacement of a lost denture is not covered.
D5120	Complete denture, mandibular		Y	
D5211	Maxillary partial denture, resin base		Y	Pre-authorization and x-rays required
D5212	Mandibular partial denture, resin base		Y	
D5213	Maxillary partial denture, cast metal, resin base		Y	
D5214	Mandibular partial denture, cast metal, resin base		Y	
D5410	Adjust complete denture, maxillary	1 per arch per 12 month period	N	Narrative required w/ claim submission. No additional payment is allowed within 6 months of delivery date
D5411	Adjust complete denture, mandibular		N	
D5421	Adjust partial denture, maxillary		N	
D5422	Adjust partial denture, mandibular		N	
D5510	Repair broken complete denture base		N	Narrative required w/ claim submission. No additional payment is allowed
D5520	Replace missing or broken teeth,		N	

Code	Description	Limitations	Auth Required	Documentation – X-rays required
	complete denture			within 6 months of delivery date
D5610	Repair resin denture base		N	
D5620	Repair cast framework		N	
D5630	Repair or replace broken clasp, per tooth		N	
D5640	Replace broken teeth, per tooth		N	
D5650	Add tooth to existing partial denture		N	
D5660	Add clasp to existing partial denture, per tooth		N	
D5730	Reline complete maxillary denture, chairside	1 per arch per 12 month period	N	Narrative required w/ claim submission. No additional payment is allowed within 6 months of delivery date
D5731	Reline complete mandibular denture, chairside		N	
D5740	Reline maxillary partial denture, chairside		N	
D5741	Reline mandibular partial denture, chairside		N	
D5750	Reline complete maxillary denture, laboratory		N	
D5751	Reline complete mandibular denture, laboratory		N	
D5760	Reline maxillary partial denture, laboratory		N	
D5761	Reline mandibular partial denture, laboratory		N	
Oral Surgery Services				
Pre-authorization, x-rays, narrative required for extractions of third molars				
D7140	Extraction, erupted tooth or exposed root	Prophylactic extractions of asymptomatic impacted or erupted teeth is not a covered benefit	Yes, for 3rd molar extractions	Third Molar Extractions require Pre-Treatment Approval. All other non-third molar exactions require pre-treatment radiographs with submission of claim
D7210	Surgical removal of erupted tooth			
D7220	Removal of impacted tooth, soft tissue			
D7230	Removal of impacted tooth, partially bony			
D7240	Removal of impacted tooth, completely bony			
D7241	Removal impacted tooth, complete bony, complication			
D7250	Surgical removal residual tooth roots, cutting procedure			
D7260	Oroantral fistula closure	Covered only when medically necessary or denture related	Y	X-rays and Narrative required with claim. Subject to pre-payment review.
D7261	Primary closure of a sinus perforation		Y	
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	1 per lifetime per quadrant	Y	Pre-authorization required. D7310 is only payable in preparation of full dentures. Pre-op x-rays and/or narrative required
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant		Y	
D7472	Removal of torus palatinus	1 per lifetime per area/quadrant	Y	Pre-authorization, narrative and restorative/prosthodontic treatment plan required
D7473	Removal of torus mandibularis	1 per lifetime per area/quadrant	Y	Pre-authorization, narrative and restorative/prosthodontic

Code	Description	Limitations	Auth Required	Documentation – X-rays required
				treatment plan required
D7510	Incision & drainage of abscess, intraoral soft tissue		N	Not payable on same day as extraction
D7520	Incision & drainage of abscess, extraoral soft tissue		N	
D7970	Excision of hyperplastic tissue, per arch		N	Not allowed in conjunction with D7310 or D7320

Code	Description	Limitations	Auth Required	Documentation – X-rays required
Adjunctive General Services				
D9223	Deep sedation/general anesthesia, each 15 minute increment	A total of 3 occurrences of either D9223 and/or D9243 per 366 days. Limited to 5 units per date of service and a total of 15 units in 366 days.	Y	Pre-authorization, narrative and case guidelines and qualifications required. Not payable in conjunction with nitrous oxide (D9230)
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	3 per 366 days	N	Not payable in conjunction with sedation codes D9223 and D9243
D9243	Intravenous moderate (conscious) sedation/analgesia, each 15 minute increment	A total of 3 occurrences of either D9223 and/or D9243 per 366 days. Limited to 5 units per date of service and a total of 15 units in 366 days.	Y	Pre-authorization, narrative and case guidelines and qualifications required
D9248	Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation	3 per 366 days	N	
D9420	Hospital or ambulatory surgical center call		Y	Pre-authorization and narrative required
D9430	Office visit, observation, regular hours, no other services		N	

SECTION 13 - FORMS

MEDICAID BEHAVIOR MANAGEMENT REPORT

ADA CLAIM FORM

GRIEVANCE FORM

MEDICAID ORTHODONTIC INITIAL ASSESSMENT FORM (IAF)

ELECTRONIC FUND TRANSFER (EFT)

SPECIALTY CARE REFERRAL 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**

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) (Primary diagnosis in "A") A _____ C _____ 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

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

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

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"

LIBERTY DENTAL PLAN

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 _____

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.

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

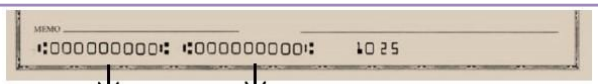
FACILITY INFORMATION

Type of Authorization: ☐ Add ☐ Update ☐ Cancel

Facility Name:	**Facility ID:**	**Tax ID:**
Facility Address:		
Email Address:		
UPDATED EMAIL ADDRESS:		

ACCOUNT INFORMATION

Account Legal Name:	**Account Number:**
Account Type: ☐ **Checking** ☐ **Savings**	Bank Routing Number:
Name of Financial Institution:	



Routing Number Account Number

One of the following must be attached:

☐ Voided Check

☐ Confirmation letter from your bank with required account information

AUTHORIZATION

Please note that all references to "me," "my" or "I" below refer to the dental office contracted with LIBERTY Dental Plan and to which payments shall be directly deposited by LIBERTY Dental Plan under this authorization form.

By signing below, I hereby authorize LIBERTY Dental Plan to deposit any amounts due to me, less any mandatory or authorized withholdings or deductions, into the account indicated on this form. I understand that my payment statements will be available online and that paper statements will no longer be provided to me.

If at any time the amount so deposited exceeds the amount actually due and payable to me, I hereby authorize LIBERTY Dental Plan to either: (i) withhold a sum equal to the overpayment from future amounts due to me; or (ii) recover such overpayment from the above-indicated account. I understand that it is my responsibility to verify that payments have been credited to my account and I agree that LIBERTY Dental Plan assumes no liability for overdrafts for any reason whatsoever. I further understand that in the event my financial institution is not able to deposit any electronic transfer into my account due to any action or inaction by me, LIBERTY Dental Plan cannot issue the funds to me until the funds are returned to LIBERTY Dental Plan by the financial institution.

I certify that the account is drawn in my name and that I have sole control of the account. I certify that the account is drawn in the legal business name of the dental office and that such dental office has sole control of the account. Either way, I certify that all arrangements between my financial institution(s) and me are in accordance with all applicable federal and state laws and regulations.

This authorization will remain in effect until I have submitted a new Electronic Fund Transfer Form to LIBERTY Dental Plan or until either Dental Plan or I have provided the other with written notice to terminate this authorization or direct deposit arrangement. I understand that I can change my account information or financial institution arrangement by completing a new Electronic Fund Transfer Form available from LIBERTY Dental Plan. I agree to immediately notify LIBERTY Dental Plan before I close any account listed above while this authorization is in effect.

☐ I certify that 100% of the net deposit will not be sent to a financial institution outside the jurisdiction of the United States.

Authorized Signature:	Date:
Print Name:	Title:

CANCELLATION

I hereby cancel my Electronic Fund Transfer Authorization.	
Authorized Signature:	Date:
Print Name:	Title:

LIBERTY DENTAL PLAN USE ONLY

Vendor Name:	Vendor ID:

Electronic Fund Transfer (EFT) Form

(Please Print Clearly)

Instructions for Completing the Electronic Fund Transfer (EFT) Form

Please allow 30 days after submission of form to receive your first Electronic Fund Transfer (EFT) deposit. Forms that are illegible or not fully or accurately completed will result in delays in processing the EFT deposit arrangement.

General Instructions
Complete all portions of the form according to the type of enrollment and sign where required.

Facility Information – Clearly print and complete all parts of this section for any addition, update or cancellation to account. Enter your current email address for verification purposes in the "Email Address" section.

Update to Email Address – Clearly print the email address you wish to update the account to in the "Updated Email Address" section. (A **voided check or bank letter will not be required** for submission if this is the only change to the account information.)

Account Information - Attach a voided check or Confirmation Letter from your bank for the account listed. Please note that this EFT Form will not be processed unless the voided check or bank letter is attached.

Authorization – An authorized signature is required for any addition, change or update to an account. The signer's name must be clearly printed under the signature, title provided, and form dated. Omission will result in delays in processing this EFT form. The certification box above the signature must be checked when adding or changing bank account information.

Cancellation - An authorized signature is required for cancellation of the EFT deposit arrangement. The signer's name must be clearly printed under the signature, title provided, and form dated. Omissions will result in delays in processing of the EFT form.

Please return the completed EFT form along with all required documents by

email or regular mail. Email submissions to:

prinquiries@libertydentalplan.com

Mail submissions to:

Attn. Professional Relations
LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799

LIBERTY Dental Plan Specialty Care Referral Request

P.O. Box 15149
Tampa, FL 33684-5149
Phone: 888-352-7924 Fax: 888-700-1727

Eligibility Verified: Yes No
Verifiers Initials:
Date & Time:

☐ Specialty Referral (Mail to LDP with x-ray & documents) ☐ Emergency Referral (Call 888-352-7924)

Provider		**Referring Specialist**	
Name:		Specialist Name:	
Phone:	ID#:	Phone:	ID#:
Address:		Address:	
City, State, Zip:		City, State, Zip:	

Member		
Member Name:	ID #:	Eligibility Verified: ☐ Yes ☐ No
Patient Name:	DOB:	Verifiers Initials:
Address:	Phone:	Date & Time:
City, State, Zip:		

Treatment Request

CDT Code	Procedure Code Description	Tooth #	Surface

PLEASE CHECK ALL THAT APPLY IN EACH SPECIALTY CATEGORY:

Endodontics (must submit PA & BWX)	☐ Prognosis (circle one): good / poor ☐ Reason for Referral Additional Information _____
Oral Surgery (must submit PA or Pano)	☐ Reason for Referral _____ Additional Information _____ *In absence of Pathology extractions of impacted teeth and roots are not a benefit
Pediatric Dentistry	☐ Reason for Referral (Please document behavioral problems occurring at initial exam): Date(s) _____ ☐ Age of Child _____ Additional Information _____
Periodontics	Referral limited to D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician (circle one) Case Type I, II, III, IV Dates of Root Planing UR _____ UL _____ LR _____ LL _____ Additional Information _____
Orthodontics	Notes:

I hereby certify that the above noted treatment request has met the criteria for specialty referral and acknowledge that the final claim for payment is subject to clinical review.

Dentist Signature: _____ Date: _____

Dental plan use only ☐ Approve ☐ Deny ☐ Pend Dental Consultant Signature _____

Comments _____