EFFECTIVE
July 1, 2014

DENTAL OFFICE REFERENCE MANUAL

LIBERTY Dental Plan Corporation

Effective July 1, 2014

Dental Office Reference Manual

1-888-700-0643

LIBERTY Dental Plan Corporation

Address and Telephone Numbers

LIBERTY DENTAL PLAN CORP.

Customer Service
1-888-352-7924

Information Systems
support@libertydentalplan.com

Claims Questions
1-888-352-7924

Prior Authorizations and Retrospective Reviews should be sent to:
LIBERTY Dental Plan Corporation
Claims
P.O. Box 401086
Las Vegas, NV 89140

Dental claims should be sent to:
LIBERTY Dental Plan Corporation
Claims
P.O. Box 401086
Las Vegas, NV 89140

Dental claims for services performed in a HOSPITAL should be sent to:
LIBERTY Dental Plan Corporation
Claims
P.O. Box 401086
Las Vegas, NV 89140

IL Department of Healthcare and Family Services (HFS)

Dental Program Manager
607 East Adams
Springfield, IL 62701
1.217.557.5438

HFS Provider Hotline
1.800.842.1461

HFS Beneficiary Hotline
1.800.226.0768

TTY (Hearing Impaired) Hotline
1.877.204.1012

Department of Specialized Care for Children
2815 West Washington
Suite 300, Box 19481
Springfield, IL 62794-9481
1.800.322.3722

Fair Hearings (Appeals) HFS
Bureau of Administrative Hearings
401 South Clinton Street, 6th floor
Chicago, IL 60607
1.855.418.4421

Fraud Hotline
1.800.252.8903

TTY (Hearing Impaired) Fraud Hotline
1.800.447.6404

Questions About IL Managed Care Organizations:
Contact Provider Relations at 1-888-700-0643

LIBERTY Dental Plan

Statement of Beneficiary Rights and Responsibilities

The mission of LIBERTY Dental Plan is to expand access to high-quality, compassionate healthcare services within the allocated resources. LIBERTY Dental Plan is committed to ensuring that all Beneficiaries are treated in a manner that respects their rights and acknowledges its expectations of Beneficiaries' responsibilities. The following is a statement of Beneficiary rights and responsibilities.

1. All Beneficiaries have a right to receive pertinent written and up-to-date information about LIBERTY Dental Plan, the services LIBERTY Dental Plan provides, the participating dentists and dental offices, as well as Beneficiary rights and responsibilities.

2. All Beneficiaries have a right to privary and to be treated with respect and recognition of their dignity when receiving dental care, which is a private and personal service.

3. All Beneficiaries have the right to fully participate with caregivers in the decision making process surrounding their health care.

4. All Beneficiaries have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.

5. All Beneficiaries have the right to voice a complaint against LIBERTY Dental Plan, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Beneficiary's expectations.

6. All Beneficiaries have the right to appeal any decisions related to patient care and treatment.

7. All Beneficiaries have the right to make recommendations regarding LIBERTY Dental Plan's/Healthcare and Family Services' Beneficiary rights and responsibilities policies.

Likewise:

1. All Beneficiaries have the responsibility to provide, to the best of their abilities, accurate information that LIBERTY Dental Plan and its participating dentists need in order to provide the highest quality of healthcare services.

2. All Beneficiaries have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.

3. All Beneficiaries have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

Statement of Provider Rights and Responsibilities

Enrolled Participating Providers shall have the right to:

1. Communicate with patients, including Beneficiaries, regarding dental treatment options.

2. Recommend a course of treatment to a Beneficiary, even if the course of treatment is not a covered benefit, or approved by HFS/LIBERTY Dental Plan.

3. File an appeal or complaint pursuant to the procedures of HFS/LIBERTY Dental Plan.

4. Supply accurate, relevant, factual information to a Beneficiary in connection with a complaint filed by the Beneficiary.

5. Object to policies, procedures, or decisions made by HFS/LIBERTY Dental Plan.

Likewise:

1. If a recommended course of treatment is not covered, e.g., not approved by HFS/LIBERTY Dental Plan, the participating dentist, if intending to charge the Beneficiary for the non-covered services, must notify the Beneficiary. See Section 2.01 of the DORM.

2. A provider intending to terminate participation in the HFS dental program due to retirement, relocation or voluntary termination is requested to provide LIBERTY Dental Plan with written notification of termination at least 90 days prior to expected final date of participation. A list of existing Illinois HFS Dental Program patients currently in treatment and the treatment status should accompany the notification. All other HFS patients should be referred to the LIBERTY Dental Plan's toll-free referral number (1.888.286.2447) to find another dentisit in the area taking referrals when services are needed.

3. A provider may not bill both medical and dental codes for the same procedure.

4. A provider must notify LIBERTY Dental Plan of changes to address, phone, fax, tax ID, or other relevant information.

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

Table of Contents

1.00 Beneficiary Eligibility Verification Procedures and Services to Beneficiaries

1.01 Beneficiary Medical Card

HFS Beneficiaries are issued HFS medical cards when a case is approved, at the annual renewal, when a person is added to or deleted from the case, and when a replacement is requested.

HFS medical cards do not have beginning or end dates and do not guarantee eligibility. Providers are responsible for verifying that Beneficiaries are eligible at the time services are rendered and to determine if Beneficiaries have other health insurance.

LIBERTY Dental Plan recommends that each dental office make a photocopy of the Beneficiary's medical card each time treatment is provided.

In addition, LIBERTY Dental Plan recommends that each dental office make a photocopy of the Beneficiary's photo identification card (driver's license or state identification card) and maintain the copy in the dental health record. If the Beneficiary is a minor and does not have a photo identification card, LIBERTY Dental Plan recommends that the office make a photocopy of the parent's or guardian's photo identification card to maintain in the Beneficiary's dental record.

The Beneficiary's (or the parent's or guardian's) identification should be verified by photo identification at each visit to prevent fraudulent use of the Beneficiary's HFS medical card.

There will no longer be case specific messages printed on the cards. Providers must check the LIBERTY Dental Plan Provider Web Portal, Interactive Voice Response system or HFS MEDI system to confirm eligibility benefit limits, and restrictions before providing services.

For information on MEDI see: http://ww.myhfs.illinois.gov/ or call the MEDI help desk at 217-524-3814. There are on-line videos on how to get your user name and password and how to register.

See **Attachment B** for a copy of the medical card. For additional information concerning Beneficiary Eligibility Cards, please contact LIBERTY Dental Plan's Provider Relations Department at 1-888-700-0643

1.02 Handbook for Providers of Medical Services

The Department's *Handbook for Providers of Medical Services* is available for your review on the HFS Medical Provider Handbooks Web site. Please refer to Chapter 100 (General Policy and Procedures), for information necessary for providers to receive payment from the Department. If you do not have access to the Internet, please call 1.217.782.0538 or 1.217.524.7306 to request a copy of the handbook.

1.03 LIBERTY Dental Plan Eligibility Systems

Automated Phone System
Directions for using LIBERTY Dental Plan's AUTOMATED PHONE SYSTEM to verify eligibility:

1. Call LIBERTY Dental Plan Member Services at1-888-700-0643.
2. Press #:
   a. Eligibility and Benefits
   b. Claims
   c. Pre-estimates
   d. Specialty Referrals
   e. Request Materials

If the system is unable to verify the Beneficiary information you entered, you will be transferred to a Member Services Representative.

Access to eligibility information via the Internet

We also encourage you to log onto our website at **www.*Libertydentalplan.com*** where you can verify eligibility and do online claims submission

1.04 Transportation Benefits for Certain Beneficiaries

Beneficiaries who need assistance with transportation should contact LIBERTY Dental Plan's Customer Service Department directly at 1-800-226-0768.

The State of Illinois contracts with a transportation vendor to handle all transportation requests. LIBERTY Dental Plan provides the transportation vendor's toll-free phone number to Beneficiaries who inquire about transportation and are eligible for the State's transportation benefits.

Transportation benefits to the nearest available appropriate provider are available for most Beneficiaries. For those who are eligible, once a request is made, the Beneficiaries must allow 7 days before scheduling transportation, as the State requires this time to review and approve the request.

Please note: If a Beneficiary is seeing a specialist and he/she needs transportation, the Beneficiary must have a written referral from a general dentist. There are **no specific forms**. The general dentist may simply provide a notation of treatment required on office letterhead. This written referral is required by HFS' transportation vendor and HFS in order for the Beneficiary to receive transportation to go to the specialist.

1.05 Consent Process for DCFS Wards

There are two types of consent for DCFS wards related to dental care – one for ordinary and routine medical and dental care and one for medical/surgical treatment. Caregivers for DCFS wards do not have the authority to provide consent; such consent must be provided by the DCFS Guardianship Administrator or an authorized agent.

As a general rule, DCFS and private agency caseworkers are responsible for obtaining consents for children in their caseload. If you have not received a signed consent for providing care to a DCFS ward, please speak with the child's caseworker (or ask the foster parent to speak with the caseworker) to attain a signed consent form appropriate for the type of care being rendered. To receive a consent form for rendering medical/surgical treatment, be prepared to give detailed information regarding the procedure, including its risks and benefits.

If a DCFS ward arrives for dental care on a weekday (between 8:30 AM and 5:00 PM) and you do not have a consent form, please contact the DCFS Consent Unit at 1.800.828.2179 for assistance. The DCFS Consent Unit can facilitate your obtaining a consent form so that the appointment does not need to be rescheduled. If urgent treatment is required during weekends, holidays and after regular office hours, please call DCFS at 1.773.538.8800 or 1.217.782.6533 to obtain a consent form.

1.06 LIBERTY Dental Plan Customer Service Numbers

LIBERTY Dental Plan offers Customer Service for Providers at **1-888-352-7924**.

LIBERTY Dental Plan offers Customer Service for Beneficiaries at:

- FHN TANF – 888-442-6395
- Meridian TANF – 888-442-8878
- WellCare/Harmony TANF – 888-352-0215
- Community Care Alliance (CCAI) – 888-352-7813
- Meridian Health Plan – 888-352-7810

LIBERTY Dental Plan offers TTY service for hearing impaired Beneficiaries at **1-800-735-2929**

1.07 Dental Periodicity Schedule

The Dental Periodicity Schedule is included as a recommendation of the ages at which certain oral health services should be provided for children. See Attachment CC for the complete Illinois Dental Periodicity Schedule.

1.08 Managed Care Dental

By 2015, 50% of the eligible Beneficiaries will migrate out of the HFS Dental Program and into Managed Care Organizations (MCOs). In addition to medical benefits, the MCOs are responsible for managing the dental benefits for Beneficiaries covered by their plans. In many instances, the MCO subcontracts with a dental benefit administrator, like LIBERTY Dental Plan, to manage the dental portion of their plan.

Some, but not all, of the IL HFS MCOs have contracted with LIBERTY Dental Plan to manage their dental benefits. Please contact LIBERTY Dental Plan at 1-888-700-0643 to learn more about the Illinois Managed Care Plans subcontracting with LIBERTY Dental Plan for their dental benefit administration. For additional information about all of the MCOs go to: www2.illinois.gov/hfs/publicinvolvement/cc

2.00 Covered Benefits

Please refer to the following attachments for a complete list of covered

benefits:	**Coverage**	**Exhibit**
Children		**A**
Adult		**B**

This section identifies program benefits and clearly defines individual age and benefit limitations, exclusions and special documentation requirements.

HFS Beneficiaries should receive the same access to dental treatment as any other patient in the dental practice. **Enrolled Participating Providers are not allowed to charge Beneficiaries for missed appointments.** Pursuant to Section 140.12(i) of the Illinois Administrative Code, payment made must be accepted as payment in full for covered services. Private reimbursement arrangements may be made only for Non-Covered Services, with the prior knowledge and consent of the HFS-enrolled Beneficiary.

LIBERTY Dental Plan recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the Beneficiary's file for record retention and review. Beneficiary records must be kept for a minimum of 10 years, and records pertaining to the most recent 12 months must be available on-site.

All dental services performed must be recorded and signed by the rendering provider in the patient record. All records must be available as required by your Participating Provider Agreement.

For reimbursement, Enrolled Participating Providers should bill only per unique surface regardless of locations. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA procedure code D2140. Furthermore, LIBERTY Dental Plan will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

LIBERTY Dental Plan recommends that Providers submit claims with their "Usual and Customary" charges. LIBERTY Dental Plan reimburses Providers for covered services at their billed charges or the approved HFS fee, whichever is less.

The LIBERTY Dental Plan claim system only recognizes the current American Dental Association CDT code list for services submitted for payment. A complete copy of the current CDT book can be purchased from the American Dental Association at the following address and phone number:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1.800.947.4746

The guidelines in the benefit tables are all-inclusive for covered services and conform to generally accepted standards of dental practice.

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

- The approved procedure code to submit when billing,
- A brief description of the covered service,
- The age limits imposed on coverage,
- A description of documentation, in addition to a completed claim form, that must be submitted when a claim or request for prior authorization is submitted,
- An indicator of whether or not the service is subject to prior authorization, and
- Any other applicable benefit limitations.

2.01 Benefit Coverage for Medically Necessary Services for Children – EPSDT

Early and periodic screening, diagnostic and treatment (EPSDT) are required services under the Medicaid program for most individuals under age 21. EPSDT services include periodic screening, vision, dental and hearing services.

Per Section 1905(r)(3)(A) of the Social Security Act, children's dental services are to be provided at intervals which meet reasonable standards of practice, or at such intervals indicated as medically necessary. Additionally, the statute requires that dental services shall, at a minimum, include relief of pain and infections. Also, for other necessary healthcare diagnostic services, treatment, and other measures to correct or ameliorate defects, illness and conditions discovered by the screening services shall be covered under EPSDT.

For dental services that are deemed medically necessary above and beyond what is published in the benefit tables (Exhibit A and Exhibit B) and the dental periodicity schedule (Attachment CC), the dental provider should submit for prior authorization of the requested EPSDT services on the ADA Claim Form (Attachment D).

On the ADA claim form check EPSDT/Title XIX in type of Transaction (Box#1), list the recommended procedure code(s) (Box #29), and provide a description of the services (Box #30). A narrative/justification should be included in the "remarks field" (Box #35).

2.02 Benefit Coverage for Adults and Pregnant Women

Effective July 1, 2014, the State of Illinois reinstated comprehensive benefits for Adults – Age 21 and older. A detailed listing of the covered benefits is included in Exhibit B.

In addition to the codes covered for Adults – Age 21 and older, the following codes are covered for Pregnant Women.

- D0120 – Periodic Oral Examination
- D1110 – Prophylaxis – adult
- D4341 – Periodontal scaling and root planing – four or more teeth per quadrant
- D4342 – Periodontal scaling and root planing – 1 – 3 teeth, per quadrant
- D4355 – Full mouth debridement to enable comprehensive periodontal evaluation

These services are available during the term of pregnancy until the date of delivery.

Claims for pregnant women must be submitted with the word "Pregnant" in the Remarks field (Box 35) of the ADA claim form. If the word "Pregnant" is not included on the claim form, these additional covered services will deny.

2.03 Missed Appointments

LIBERTY Dental Plan offers the following suggestions to decrease the number of missed appointments.

- Contact the Beneficiary by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

- If the appointment is made through another state agency such as DCFS, DSCC or DHS, contact staff from that program to ensure the scheduled appointment is kept.

The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a provider from billing a HFS Dental Program Beneficiary for a missed appointment. In addition, your missed appointment policy for HFS-enrolled Beneficiaries cannot be stricter than that of your private or commercial patients.

If an HFS Beneficiary exceeds your office policy for missed appointments, you may choose to terminate the Beneficiary from your practice. Notify the Beneficiary of your decision and encourage him/her to contact LIBERTY Dental Plan at 1-888-700-0643 for a referral to a new dentist.

Providers with benefit questions should contact LIBERTY Dental Plan's Customer Service Department directly at: 1-800-700-0643

2.04 Payment for Non-Covered Services

Enrolled Participating Providers shall hold Beneficiaries, LIBERTY Dental Plan, and HFS harmless for the payment of Non-Covered Services except as provided in this paragraph. A Provider may bill a Beneficiary for Non-Covered Services if the Provider obtains an agreement (in writing) from the Beneficiary prior to rendering such service that indicates:

- The services to be provided;
- LIBERTY Dental Plan and HFS will not pay for or be liable for said services; and
- Beneficiary will be financially liable for such services.

A sample "Agreement to Pay for Non-Covered Services Form" is included as **Attachment R**.

2.05 Electronic Attachments

A. **LIBERTY Dental Plan Provider Web Portal** – LIBERTY Dental Plan accepts radiographs and other attachments electronically via the LIBERTY Dental Plan Provider Web Portal. This is a free service to providers and is accessible on the LIBERTY Dental Plan Provider Web site. The portal allows transmissions via secure internet lines for radiographs, periodontal charts, intraoral pictures, narratives, and EOB's.

B. **FastAttach™ -** LIBERTY Dental Plan accepts dental radiographs electronically via **FastAttach™** for authorization requests and claims

submissions. LIBERTY Dental Plan, in conjunction with National Electronic Attachment, Inc. (NEA), allows Enrolled Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives, and EOBs. **FastAttach™** is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments, and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouses or practice management systems.

For more information or to sign up for FastAttach go to the NEA Web site or call NEA at 1.800.782.5150.

C. **OrthoCAD™** LIBERTY Dental Plan accepts orthodontic models electronically via **OrthoCAD™** for authorization requests. LIBERTY Dental Plan allows Enrolled Participating Providers the opportunity to submit all orthodontic models electronically. This program allows transmissions via secure Internet lines for orthodontic models. **OrthoCAD™** is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged models and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouses or practice management systems.

To ensure your orthodontic authorizations are processed efficiently and timely, all orthodontia prior authorization submissions through email with OrthoCAD™ require an OrthoCAD™ submission form. If a request is received without the OrthoCAD™ submission form it will be returned to your office. A copy of the OrthoCAD™ submission form is included as **Attachment I.**

For more information or to sign up for **OrthoCAD™**, visit the OrthoCAD™ Web site or call **OrthoCAD™** at 1.800.577.8767.

3.00 Prior Authorization, Retrospective Review, and Documentation Requirements

Procedures Requiring Prior Authorization

Prior Authorization is a utilization tool that requires Providers to submit documentation associated with certain dental services for a Beneficiary. Providers are not paid if this documentation is not submitted to LIBERTY Dental Plan.

LIBERTY Dental Plan uses specific dental treatment criteria based on industry standards, as well as an evaluation process to determine if requested services are required. The criteria are included in this manual (see Section 13). Please review these criteria as well as the Benefits (Exhibit A and Exhibit B) covered to understand the decision-making process used to determine payment for services rendered.

Services that require prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for non-emergency services. Non- emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Beneficiary, the State of Illinois or any agents, and/or LIBERTY Dental Plan.

Prior authorizations will be honored for 90 days from the date they are issued. An approval does not guarantee payment. The Beneficiary must be eligible at the time the services are rendered. The Provider should verify eligibility at the time of service.

Requests for Prior Authorization are granted or denied based upon whether the item or service is medically necessary, whether a less expensive service would adequately meet the Beneficiary's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community.

LIBERTY Dental Plan Corporation must make a decision on a request for prior authorization within thirty (30) days from the date LIBERTY Dental Plan receives this request, provided all information is complete. If LIBERTY Dental Plan does not decide on this request and send the Provider written notice of its decision on the services requested on this statement within thirty (30) days, the request will automatically be approved. If LIBERTY Dental Plan denies the approval for some or all of the services requested, LIBERTY Dental Plan will send the Beneficiary a written notice of the reasons for the denial(s) and will tell the Beneficiary that he or she may appeal the decision.

Documentation Required

Requests for prior authorization should be sent with the appropriate documentation on a standard ADA approved claim form.

The tables of covered services, Exhibit A and Exhibit B, contain a column marked "Prior Authorization Required". A "Yes" in this column indicates that the service requires prior authorization to be considered for reimbursement. The "Documentation Required" column lists the information required for submission with the Prior Authorization request.

Examples of documentation requirements are:

- X-rays;
- Narrative of Medical Necessity;
- Photographs (digital); and
- Electronic Models (OrthoCAD)

Within fourteen (14) days of receipt of a prior authorization or a retrospective review request, that in the opinion of LIBERTY Dental Plan requires additional information, LIBERTY Dental Plan will notify the Provider submitting the request that additional information is necessary. This additional information\documentation must be received within 30 days or the authorization request is denied.

Retrospective Review

Services that normally require a Prior Authorization, but are performed in an emergency situation, are subject to a Retrospective Review. **These claims should be submitted to the same address used for submitting services for Prior Authorization, along with any required documentation.** Any claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

After the LIBERTY Dental Plan Consultant reviews the documentation, an authorization number is provided to the submitting office for tracking purposes and to maintain in the Beneficiary's record. For emergency services submitted for retrospective review, the claim is forwarded for processing. **The office will receive a Prior Authorization Determination document, but no further submission is necessary for payment.**

4.00 Dental Services in a Hospital Setting

LIBERTY Dental Plan does not require dentists to obtain prior approval for dental procedures performed in a hospital outpatient setting or an Ambulatory Surgical Treatment Center (ASTC). All dental procedures performed in these outpatient settings are subject to post payment review.

Patient Criteria

Specific criteria must be met in order to justify the medical necessity of performing a dental procedure in the outpatient setting. The criteria are:

- The Beneficiary requires general anesthesia or conscious sedation;
- The Beneficiary has a medical condition that places the Beneficiary at an increased surgical risk, such as, but not limited to: cardio-pulmonary disease, congenital anomalies, history of complications associated with anesthesia, such as hyperthermia or allergic reaction, or bleeding diathesis; or
- The Beneficiary cannot safely be managed in an office setting because of a behavioral, developmental or mental disorder.

Dental Billing Procedures

- Claims must include documentation to support the medical necessity for performing the procedure in the outpatient setting including a narrative specifying the medical necessity, supporting X-rays and any other explanation necessary to make a determination.
- Dentists must record a narrative of the dental procedure performed and the corresponding CDT dental codes in the Beneficiary's medical record at the outpatient setting. If the specific dental code is unknown, the code D9999 may be used.
- Claims must be submitted to LIBERTY Dental Plan for the covered professional services in the same format and manner as all standard dental procedures.
- Claims for services performed in a hospital must be sent to:

LIBERTY Dental Plan Corporation
Attn. Hospital Claims
PO Box 26110
Santa Ana, CA 92799-6110

Please contact our member services department at 1-888-700-0643 if you are planning to render dental services in a hospital setting. We will assist in the coordination of care for hospital cases.

Hospital/ASTC Billing Procedures

The hospital or ASTC will bill HFS for the all-inclusive rate for facility services using the assigned CDT/HCPCS dental code. The hospital must have this code in order to be paid for the facility services. The applicable dental codes will result in payment to hospital/ASTC for the Ambulatory Procedures Listing (APL) Group 1d – Surgical Procedures/Very Low Intensity. All facility bills for services performed in the outpatient setting should be forwarded to:

Department of Healthcare and Family Services
P.O. Box 19132
Springfield, Illinois 62794-9132

Participating Hospitals/ASTCs

Dentists must administer the services at a hospital or ASTC that is enrolled in the Illinois HFS Medical Benefits Program. Questions regarding hospital participation should be directed to the Bureau of Comprehensive Health Services toll-free at 1.877.782.5565.

5.00 Claim Submission Procedures

LIBERTY Dental Plan is 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 of treatment completion. Payments are denied for claims submitted more than 180 days from the date of service. Following are the ways to submit a claim:

- HIPAA Compliant "837D" file
- Electronic submission via clearinghouses
- Electronic claims via LIBERTY Dental Plan's Provider Portal
- Paper claims

5.01 Electronic Claim Submission Utilizing LIBERTY Dental Plan's Internet Web site

LIBERTY Dental Plan 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 CLEARINGHOUSE**

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

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

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

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

5.02 Electronic Authorization Submission Utilizing LIBERTY Dental Plan's Internet Website

Participating Providers may submit Pre-Authorizations directly to LIBERTY Dental Plan by following the steps above to log into the LIBERTY Dental Plan Web site. Once in the Claims/Pre- Authorizations screen, select "Dental Pre-Auth Entry".
The Dentist Web Portal also allows you to attach electronic files (such as X-rays in jpeg format, reports and charts) to the pre-authorization.

5.03 Electronic Claim Submission via Clearinghouse

Dentists may submit their claims to LIBERTY Dental Plan via an electronic claims clearinghouse. Contact your software vendor and to ensure LIBERTY Dental Plan is listed as a payer. Your software vendor will provide you with the information you need to ensure that submitted claims are forwarded to LIBERTY Dental Plan.

5.04 HIPAA Compliant 837D File

LIBERTY Dental Plan 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 support@libertydentalplan.com.

5.05 NPI Requirements for Submission of Electronic Claims

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

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.

5.06 Paper Claim Submission

Paper claims must be submitted on a 2006 or later ADA approved claim form. Please see **Attachment D** for a sample claim form and completion instructions. Forms are available through the American Dental Association at:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1.800.947.4746

Claims Submission Requirements

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

1. All claims must be submitted to LIBERTY for payment for services with the Member ID number, first and last name and pre- or post-treatment documentation, if required.:
2. Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. All health care providers, health plans and clearinghouses are required to use the National Provider Identifier number (NPI) as the ONLY provider identifier in electronic health care claims and other transactions.
    - If you do not have an NPI number, you must register for one at the following website: http://nppes.cms.hhs.gov
3. All claims must include the name of the program (such as Florida Medicaid) under which the member is covered and all the information and documentation necessary to adjudicate the claim.

Mail paper claims to the following address:

LIBERTY Dental Plan Corporation
Attn: Claims
P.O. Box 401086
Las Vegas, NV 89140

5.07 Claims Adjudication and Payment

LIBERTY Dental Plan adjudicates claims on a daily basis and releases payment cycles weekly.

The average weekly turnaround time between receipt of a clean claim and check release is generally within 30 days.

5.08 Direct Deposit

As a benefit to participating Providers, LIBERTY Dental Plan offers Electronic Funds Transfer (Direct Deposit) for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Form (**Attachment E**)
- Attach a voided check to the form. The authorization cannot be processed without voided check.
- Return the Direct Deposit Form and voided check to LIBERTY Dental Plan.

- Via Email – **prnational@libertydentalplan.com**
- Via Mail –

LIBERTY Dental Plan Corporation
Attn: Provider Relations
PO Box 26110
Santa Ana, CA 92799-6110

The Direct Deposit Form must be legible to prevent delays in processing. Providers should allow 15 days for the first direct deposit to occur. Once a payment has been made you will receive an email alert notifying your office that direct deposit has been processed. In order to access your Evidence of Payments you will need to create a Vendor account by logging on to www.libertydentalplan.com. Instructions on how to register will be provided to the dental office upon activation. Once registered, if you experience any problems with accessing your EOPs, please contact LIBERTY Dental Plan at 1- 888-352-7924.

Providers enrolled in the Direct Deposit process must notify LIBERTY Dental Plan of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Form **(Attachment E)**. Changes to bank accounts or banking information typically take 2-3 weeks. LIBERTY Dental Plan is not responsible for delays in funding if Providers do not properly notify LIBERTY Dental Plan in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on LIBERTY Dental Plan's On-Line Vendor Portal**.**

5.09 Coordination of Benefits (COB)

When LIBERTY Dental Plan is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds the HFS Dental Program fee schedule, LIBERTY Dental Plan considers the claim as paid in full and no further payment is made on the claim.

5.10 Filing Limits

The timely filing requirement for the Illinois Medicaid program administered by LIBERTY Dental Plan is 180 calendar days from the date of service. LIBERTY Dental Plan determines whether a claim has been filed timely by comparing the date of service to the date LIBERTY Dental Plan received the claim. If the span between these two dates exceeds 180 days, the claim is denied due to untimely filing.

5.11 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each dentist, LIBERTY Dental Plan performs an edit of all claims upon receipt. This edit validates Beneficiary eligibility, procedure codes, and provider identifying information. LIBERTY Dental Plan analyzes any claim conditions that would result in non-payment. When potential

problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact LIBERTY Dental Plan's Provider Relations Department at **1-888-700-0643** – select option "3" with any questions you may have regarding claim submission of your remittance.

5.11 Receipt and Audit of Claims

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Each Enrolled Participating Provider office receives an "explanation of benefit" report with it's remittance. This report includes Beneficiary information and an allowable fee by date of service for each service rendered during the period.

If a dentist wishes to appeal any reimbursement decision, he/she must submit the appeal in writing, along with any necessary additional documentation within 180 days to:

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

Provider appeals should be submitted on the LIBERTY Dental Plan Provider Appeal Form found in **Attachment F**.

LIBERTY Dental Plan must respond to all provider appeals, in writing, within 30 days.

5.12 Illinois Dental Schools – Supervising Dentists and Gold Card Status

The students and post-graduate residents at Illinois Dental Schools render services under the direct supervision of attending dentists. The attending dentist is responsible for ensuring services performed under his/her direct supervision are medically necessary and appropriate for each patient. All claims for services performed by students and post-graduate residents at Illinois Dental Schools are submitted under the license of either the attending dentist, the clinical department head or the Dean. Because of the close supervision required by dental students and residents, Illinois Dental Schools are granted Gold Card status by the HFS Dental Program. Providers with Gold Card status are not required to submit requests for authorization for those services requiring prior authorization.

6.00 Inquiries, Complaints and Appeals

LIBERTY Dental Plan of Illinois, LLC, is committed to providing high quality dental services to all Beneficiaries. As part of this commitment, LIBERTY Dental Plan supports a complaints and appeals protocol assuring that all Beneficiaries have the opportunity to exercise their rights to a fair and expeditious resolution to any and all inquiries, complaints and appeals.

Inquiry

An inquiry is any Beneficiary request for administrative services or information, or an expression of an opinion regarding services or benefits available under the HFS Dental Program.

If specific corrective action is requested by the Beneficiary or determined to be necessary by LIBERTY Dental Plan, then the inquiry is upgraded to complaint.

Complaints

Beneficiaries may submit complaints to LIBERTY Dental Plan telephonically or in writing on any HFS Dental Program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues.

LIBERTY Dental Plan must resolve and respond to all Beneficiary complaints within 30 days.

If the Beneficiary chooses to appeal the decision, a Customer Services Representative will assist by providing the information on how to initiate the appeals process.

The toll-free number to call to file a complaint is:

1-888-700-0643

The address to file a complaint is:

LIBERTY Dental Plan Corporation
Quality Management Department
P.O. Box 26110
Santa Ana, CA 92799-6110

Appeals

Beneficiary Appeals

Beneficiaries have the right to appeal any adverse decision LIBERTY Dental Plan has made to deny, or reduce dental services.

A Beneficiary may contact his/her caseworker for assistance in filing an appeal. In addition, DHS will help a Beneficiary file an appeal.

Appeals must be filed within 60 days following the date the denial letter was mailed by LIBERTY Dental Plan.

Beneficiaries request a hearing by calling the Fair Hearings Section at 1.855.418.4421 (TTY: 1.312.793.2697 or 1.800.526.0857) or by fax at 1.312.793.2005 or by writing to:

HFS, Bureau of Administrative Hearings
401 South Clinton Street, 6th floor
Chicago, IL 60607

Appeals are reviewed by HFS under its existing administrative appeal procedure, and matters are heard before an Administrative Hearing Officer. LIBERTY Dental Plan approves and allows payment for any services ordered rendered by HFS or any Court of Jurisdiction, provided the Beneficiary is eligible.

Dentist Appeal Procedures

Providers that disagree with determinations made for Prior Authorization requests may submit a written Notice of Appeal to LIBERTY Dental Plan specifying the nature and rationale of the disagreement. This notice *and* additional support information must be sent to LIBERTY Dental Plan at the address below within 60 days from the date of the original determination to be reconsidered:

LIBERTY Dental Plan Corporation
Provider Dispute Resolution Mechanism Department
P.O. Box 26110
Santa Ana, CA 92799-6110
1-888-700-0643

Provider appeals should be submitted on the form found in **Attachment F**. LIBERTY Dental Plan must respond to all provider appeals, in writing, within 30 days.

Peer Review

LIBERTY Dental Plan facilitates a Peer Review Committee composed of the LIBERTY Dental Plan Dental Director, HFS dental consultants, and participating dentists. The Committee evaluates the operational procedures and policies as they affect the administration of the HFS Dental Program. In addition, the Peer Review Committee periodically evaluates the quality of care provided by participating providers.

The Peer Review Committee's recommendations are communicated to providers in a helpful and proactive manner so that questionable practice patterns are eliminated. Thus, the Committee takes corrective action before abuses in the system affect the Beneficiary.

Quality Management and Improvement (QI/UM) Committee

The purpose of the QMI Committee is to monitor, review, elevate, and approve plans, policies, and programs to continuously achieve quality improvement in LIBERTY's entire organization. These efforts and activities are reviewed, discussed, evaluated at the QMI Committee periodically, and then forwarded to the Board of Directors.

7.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

LIBERTY Dental Plan has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification, and Security Standards of HIPAA.

The Provider and LIBERTY Dental Plan agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this DORM reflect the most current coding standards (CDT-2014) recognized by the ADA. Effective the date of this manual, LIBERTY Dental Plan will require providers to submit all claims with the proper CDT-2014 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form, version 2006 or later.

Note: Copies of LIBERTY Dental Plan's HIPAA policies are available upon request by contacting LIBERTY Dental Plan's I.T. Department by emailing support@libertydentalplan.com.

Please refer to Attachment J of this manual for LIBERTY Dental Plan's *HIPAA Transaction 837 Dental Claims & Encounter Companion Guide.*

8.00 Utilization Management Program

8.01 Introduction

The Illinois State Legislature annually appropriates or "budgets" the amount of dollars available for reimbursement to dentists for treating Illinois HFS Dental Program Beneficiaries. Any co-payments collected by the dentists are not subtracted from the HFS Dental Program fees; therefore, the legislatively appropriated dollars represent all the reimbursement available to the dentists. The fair and appropriate distribution of these limited funds is critical.

8.02 Evaluation

LIBERTY Dental Plan's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and
- Treatment cost effectiveness.

8.03 Results

With the objective of ensuring the fair and appropriate distribution of these budgeted HFS Dental Program dollars to dentists, LIBERTY Dental Plan's Utilization Management Program helps identify dentists whose patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than 5% of all dentists). LIBERTY Dental Plan is contractually obligated to report suspected fraud, abuse or misuse by Beneficiaries and Participating Dental Providers to the HFS Office of the Inspector General.

8.04 Fraud and Abuse

LIBERTY Dental Plan is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as:

Fraud: includes, but is not limited to, "knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit." Fraud also includes fraud or misrepresentation by a subscriber or enrollee with respect to coverage of individuals and fraud or deception in the use of the services or facilities of LIBERTY or knowingly permitting such fraud or deception by another.

Abuse: means the excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use so as to abuse one's position or authority. "Abuse" does not necessarily lead to an allegation of "fraud", but it could.

Provider Fraud: means the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls. Waste does not normally lead to an allegation of "fraud", but it could. .

8.05 Deficit Reduction Act of 2005: The False Claims Act

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. The DRA is a bill designed to reduce federal spending on entitlement programs over five years. The DRA requires that any entity that receives or makes annual Medicaid payments of a least $5 million establish written policies for its employees, management, contractors and agents regarding the False Claims Act (the "FCA").

The FCA allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the FCA, the person bringing suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may seek to exclude them from future participation in federal healthcare programs or impose additional obligations against the individual.

For more information about the False Claims Act go to the Tax Payers Against Fraud, The False Claims Web site.

LIBERTY Dental Plan is contractually obligated to report suspected fraud, waste, or abuse by Beneficiaries and Participating Dental Providers of the HFS Dental Program.

To report suspected fraud, waste or abuse of the HFS Dental Program call:

The Illinois Office of Inspector General at
1.888.814.4646

9.00 Illinois Dental Provider Enrollment Process

LIBERTY Dental Plan credentials Providers for participation with the IL Medicaid program. Providers must be contracted with LIBERTY Dental Plan in order to submit claims for payment. Provider enrollment application forms are available on LIBERTY Dental Plan's Web site.

To assist Providers in the enrollment process, you may contact LIBERTY Dental Plan's Provider Relations team at **1-888-700-0643**.

9.01 Existing Providers

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

- Plan Contracting
- Escalated Claim Payment Issues
- Providing training and orientation to new and existing providers
- Opening, changing or closing a location
- Adding or terminating associates
- Credentialing Inquiries
- Change in Office /Facility Name or Ownership
- Tax Payer Identification Number (TIN) Change

10.00 The Patient Record

The following criteria and requirements for the dental patient record apply to both paper and electronic records. Patient records must be kept for a minimum of 10 years, and records pertaining to the most recent 12 months must be available on-site.

Organization

1. The record must have areas for documentation of the following information:

    a. Registration data including a complete health history.
    b. Medical alert predominatly displayed
    c. Initial examination date
    d. Radiographs
    e. Periodontal and Occlusal staus
    f. Treatment plan/Alternative treatment plan
    g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
    h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability for periodic update, without the loss of documentation of the previous status, of the following information:
    a. Health history
    b. Medical alert
    c. Examination/Recall data
    d. Periodontal status
    e. Treatment plan

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, or identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

Content – The patient record should be organized in such a fashion to contain the following:

1. Adequate documentation of registration information, which requires entry of these items:
    a. Patient's first and last name
    b. Date of birth
    c. Sex
    d. Address
    e. Telephone number
    f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that documents:
    a. Current medical treatment
    b. Significant past illnesses
    c. Current medications
    d. Drug allergies
    e. Hematologic disorders
    f. Cardiovascular disorders

g. Respiratory disorders
h. Endocrine disorders
i. Communicable diseases
j. Neurologic disorders
k. Signature and date by patient
l. Signature and date by reviewing dentist
m. History of alcohol and tobacco using including smokeless tobacco

3. An adequate update of health history at subsequent recall examinations, which documents a minimum of:

   a. Significant changes in health status
   b. Current medical treatment
   c. Current medications
   d. Dental problems/concerns
   e. Signature and date by reviewing dentist

4. A conspicuously placed medical alert that documents highly significant terms from health history. These items may include:

   a. Health problems, which contraindicate certain types of dental treatment.
   b. Health problems that require precautions or pre-medication prior to dental treatment.
   c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
   d. Drug sensitivities
   e. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination, which is signed and dated by the rendering provider, and describes:

   a. Blood pressure (Recommended)
   b. Head/neck examination
   c. Soft tissue examination
   d. Periodontal assessment
   e. Occlusal classifaction
   f. Dentition charting

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations, which is signed and dated by the rendering provider, and describes changes/new findings in these items:

   a. Blood pressure (Recommended)
   b. Head/neck examination
   c. Soft tissue examination
   d. Periodontal assessment
   e. Dentition charting

7. Radiographs, which are:

   a. Identified by patient name
   b. Dated
   c. Designated by patient's left and right side
   d. Mounted (if intraoral films)

8. An indication of the patient's clinical problems/diagnosis

9. Adequate documentation of the treatment plan (including any alternate treatment options) which is signed and dated by the rendering provider, that specifically describes all the services planned for the patient by entry of these items:

    a. Procedure
    b. Localization (area of mouth, tooth number, surface)

10. Adequate documentation of the periodontal status, if necessary, which is signed and dated by the rendering provider and requires charting of location and severity of these items:

    a. Periodontal pocket depth
    b. Furcation involvement
    c. Mobility
    d. Recession
    e. Adequacy of attached gingiva
    f. Missing teeth

11. Adequate documentation of the patient's oral hygiene status and preventive efforts, which documents:

    a. Gingival status
    b. Amount of plaque
    c. Amount of calculus
    d. Education provided to the patient
    e. Patient receptiveness/compliance
    f. Recall interval
    g. Date

12. Adequate documentation of medical and dental consultations within and outside the practice, which describes:

    a. Provider to whom consultation is directed
    b. Information/services requested
    c. Consultant's response

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13. Adequate documentation of treatment rendered which verifies the claims submitted, identifying:

    a. Date of service/procedure
    b. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation (tooth #, quadrant etc.)
    e. Signature of the Provider who rendered the service

14. Adequate documentation of the specialty care performed by another dentist that includes:

    a. Patient examination
    b. Treatment plan
    c. Treatment status

Compliance

1. The patient record has on explicitly defined format that is currently in use
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the record are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and commonly understood in the practice.

11.00 Quality Management Improvement Program

LIBERTY's Quality Management and Improvement (QMI) Program is designed to provide a structured and comprehensive review of the quality and appropriateness of care delivered by the entire network of dental providers. LIBERTY documents all quality improvement initiatives, processes and procedures in a formal QMI Plan. The QMI Plan identifies and fulfills the dental healthcare needs of members, improves member accessibility to dental services, improves member satisfaction with participating providers and improves member and provider satisfaction. Functions of the QMI program are overseen by the Dental Director who ensures that day to day quality assurance functions are carried out in compliance with dental program contracts and applicable requirements.

LIBERTY QMI Program is modeled after the National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to because these standards apply to best practices in the dental service delivery system. The Quality Improvement Program includes:

- Beneficiary Satisfaction Surveys
- Provider Satisfaction Surveys
- Complaint Monitoring and Trending
- Peer Review Process
- Utilization Management and Practice Patterns
- Quarterly Quality Indicator Tracking

A copy of LIBERTY Dental Plan's Quality Improvement Program is available upon request by emailing LIBERTY Dental Plan's Customer Service Department or calling 1-888-700-0643

In establishing criteria for quality dental care and making these characteristics of quality care the standard for review, two types of criteria are involved in developing standards. One type of criteria is **explicit** in nature and is delineated in the written form of Beneficiary treatment protocol and utilization guidelines. The second type of criteria is **implicit** in nature and based on health care procedures and practices which are "commonly understood" to be acceptable and consistent with the provision of good quality care:

- Comparing the care that has actually been rendered with the criteria.
- Making a peer judgment on quality based on the results of the comparison.

The QMI Program's activities focus on the following components of quality that are included in established definitions of high-quality dental care services:

- **Accessibility of care**: the ease and timeliness with which patients can obtain the care that they need when they need it
- **Appropriateness of care**: the degree to which the correct care is provided, given the current standard of the community
- **Continuity of care**: the degree to which the care needed by patients is coordinated among practitioners and is provided without unnecessary delay
- **Effectiveness of care**: the degree to which the dental care provided achieves the expected improvement in dental health consistent with the current standard of the community
- **Efficacy of care**: the degree to which a service has the potential to meet the need for which it is used
- **Efficiency of care**: the degree to which the care received has the desired effect with a minimum of effort, expense, or waste of time for the patient and the staff

- **Acceptability of care**: the degree to which patients are involved in the decision-making process in matters pertaining to their dental health and the degree to which they are satisfied with their care
- **Safety of the care environment**: the degree to which the environment is free from hazard and danger to the patient

LIBERTY is committed to continuous improvement in the service delivery and quality of clinical dental care provided to members with the primary goal of improving the dental health status of members and, where the Member's condition is not amenable to improvement, maintain the Member's current dental health status by implementing measures to prevent any further decline in condition or deterioration of dental health status. LIBERTY has established quality of care guidelines that include recommendations developed by organizations and specialty groups such as the American Academy of Pediatric Dentistry, the American Academy of Endodontists, the American Academy of Periodontology, the American Academy of Oral and Maxillofacial Surgeons and the American Dental Association. LIBERTY applies these guidelines equally to general practice dentists and specialists and uses them to evaluate care provided to members.

12.00 All Kids School-Based Dental Program

The HFS Dental Program allows out-of-office delivery of preventive dental services in a school setting to children ages 0–18. This program is called the All Kids School-Based Dental Program.

Recognizing the unique qualities of the All Kids School-Based Dental Program, specific protocols have been developed to assist All Kids School-Based Dental Program Providers.

** Exam, phophy and fluoride are covered through age 20 as long as the services are rendered in the school and the patient is currently enrolled as a student.

12.01 Participation Guidelines and Forms

Providers who wish to participate as an All Kids School-Based Dental Program Provider must meet the following requirements. Providers who do not adhere to the requirements for participation are not eligible for reimbursement.

1. **All Kids School-Based Dental Program Providers must be enrolled as a participating Provider in the HFS Dental Program.**

   The process for provider enrollment is outlined in Section 9.00.

2. **All Kids School-Based Dental Program Providers must be able to render the full scope of preventive school-based services for an out-of-office setting:**

   - D0120 - Periodic Oral Examination
   - D1120 - Prophylaxis – Child
   - D1208 - Topical Application of Fluoride (excluding prophylaxis)
   - D1206 - Topical Application of Fluoride Varnish
   - D1351 - Sealant – Per Tooth
   - D0601 – Caries Risk Assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
   - D0602 – Caries Risk Assessment and documentation, with a finding of medium risk (Equates to Oral Health Score 2)
   - D0603 – Caries Risk Assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)

3. **Effective August 1, 2014, All Kids School-Based Dental Providers must submit a Caries Risk Assessment (CRA) code with each school-based dental service claim in order for the services on the claim to pay. The CRA codes are as follows:**

   - D0601 – Caries Risk Assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
   - D0602 – Caries Risk Assessment and documentation, with a finding of medium risk (Equates to Oral Health Score 2)
   - D0603 – Caries Risk Assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)

4. **All Kids School-Based Dental Program Providers must register as an All Kids School-Based Dental Program Provider annually. (Attachment S)**

   Each entity (corporation, partnership, etc.) must register all Providers rendering services for the entity. If a Provider renders services for more than one entity, he/she must be registered under each entity separately.

5. **All Kids School-Based Dental Program Providers must create and maintain a Google Events Calendar. (Attachment T)**

   Each entity must create a Google Event Calendar and provide the user name and password to the LIBERTY Dental Plan Outreach Coordinator. The Google Event Calendar must be populated with at least the first 30 days of school-based events before the All Kids School-Based Dental Program registration is approved.

   The Google Event Calendar must be current and reflect any additions or changes made to the Provider's schedule.

6. **All Kids School-Based Dental Program Providers must complete an Illinois Department of Public Health (IDPH) Proof of School Exam Form for every child seen. (Attachment W)**

   A copy of this form can be found on the IDPH Web site.

   The completed IDPH Proof of School Exam Forms should be forwarded to the school staff member (secretary, principal, school nurse, counselor, etc.) coordinating the All Kids School-Based Dental Program services. The completed forms remain at the school.

   *** Office-based providers who complete a school exam on a Beneficiary must complete the school exam form free of charge, if requested by the parent or guardian, within six (6) months of the oral examination.*

7. **All Kids School-Based Dental Program Providers must complete a School Exam Follow-Up Form (to be sent home with the student) for every child seen. (Attachment V)**

   This form shall be completed by the Provider and given to school personnel to communicate with the Beneficiary's parent/guardian regarding the student's oral health and the need for follow-up care.

   The form must provide the Beneficiary's Caries Risk Assessment/Oral Health Score and the appropriate Referral Plan to provide restorative follow-up care to the Beneficiary (if follow-up care is required).

8. **All Kids School-Based Dental Program Providers must complete a Referral Plan for each location where services are provided. (Attachment U)**

   Each entity is responsible for selecting, implementing, and providing a referral plan for each location, and each child with urgent treatment needs.

9. **All Kids School-Based Dental Program Providers must complete and maintain a dental record for each Beneficiary receiving School-Based services. This record must include relevant components of the Patient Record, as outlined in Section 10.00. (Attachment Y)**

The All Kids School-Based Dental Provider is responsible for ensuring HIPAA compliant record retention. The location of record retention storage must be provided at the request of HFS.

The requirements of record retention are outlined in Section 2.00.

10. **All Kids School-Based Dental Program Providers must obtain a signed Consent Form from each Beneficiary prior to providing services. (Attachment X)**
The Consent Form must provide information regarding each of the school-based preventive services and must be signed and dated by the Beneficiary's parent/guardian.

An additional consent form must be utilized for those Providers who perform mobile restorative care to children in the All Kids School-Based Dental Program. A sample Consent Form for restorative treatment will not be provided by LIBERTY Dental Plan or HFS.

In accordance with HFS policy, signed Consent Forms are valid for 365 days from the date of parent/guardian signature.

12.02 All Kids School-Based Dental Program Site Visits

On behalf of HFS, the Illinois Department of Public Health (IDPH) performs periodic site visits to providers enrolled as an All Kids School-Based Dental Program Provider.

12.03 Place of Service (POS) Definition

School-Based services coded as a POS of school are limited to the eight (8) preventive codes.

- D0120- Periodic Oral Examination
- D1120- Prophylaxis – Child
- D1208- Topical Application of Fluoride (excluding prophylaxis)
- D1206- Topical Application of Fluoride Varnish
- D1351- Sealant – Per Tooth
- D0601 – Caries risk assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
- D0602 – Caries risk assessment and documentation, with a finding of moderate risk (Equates to Oral Health Score 2)
- D0603 – Caries risk assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)

12.04 Designating a POS on a Claim

When filing a claim for **preventive services** performed out-of-office, designate the place of service as follows:

- For paper claims, mark the 'other' box in the place of service field, #38 and, write "school" in the remarks field, #35.
- For electronic claims, in the place of service field, type 03 for school, or 15 for other.

When filing a claim for **restorative services** performed out-of-office, designate the place of service as follows:

- For paper claims, mark the **ECF or Other (If other Note Mobile in remark Box #35)** box in the place of service field, #**38** and, if applicable, put the name of the location where services were performed in the remarks field of #**35**.
- For electronic claims, in the places of service field, **choose the appropriate POS from the drop down menu**.

If claims for services, other than the eight (8) preventive services are submitted with a POS of school all services on the claim are denied.

13.00 FQHC Denture Billing

A Federally Qualified Health Center (FQHC) may bill up to three (3) additional encounters per plate for a Beneficiary receiving a complete or partial denture. Partial dentures are limited to children age 2 through 20 only. The HFS Dental Program has established Procedure Code D5899 – Unspecified Removable Prosthodontic Procedure – as a covered service for HFS Dental Program Beneficiaries receiving dentures in a FQHC facility. Including the first visit (exam and X- rays) and placement, this allows an FQHC to receive reimbursement for a total of six (6) encounters per full denture placement per patient. (See Exhibit C).

To receive consideration for additional reimbursement, a FQHC must submit prior authorization for a maximum of three (3) procedure codes D5899 along with authorization for the complete or partial denture. If the authorization is approved, the FQHC will also receive approval for the additional visits.

Appropriate Visits for Procedure Code D5899

1. Initial denture impressions
2. Final denture impressions
3. Vertical dimension of occlusion visits
4. Wax try in visits
5. Necessary adjustments post insertion
6. Repairs or relines during the six (6) month period following the insertion of the new prosthesis

In each case, a narrative of the service performed must be provided at the time procedure code D5899 is billed.

Providers should submit for payment for the complete denture (D5110, D5120, D5211, D5212) at the time prosthesis is delivered.

Exam and X-rays are considered the same encounter, as radiographic interpretation is included in the initial examination.

Example #1 – Beneficiary Receives Mandibular and Maxillary Complete Dentures

Appointment	Services Provided	Possible Procedure Codes Billed
First	Initial Exam and X-Rays	D0120/D0150, D0210/D0330
Second	Denture Impressions	D5899
Third	Denture Placement	D5110, D5120, D5211, D5212, D5213, D5214
Fourth	Denture Adjustment	D5899
Fifth	Denture Adjustment	D5899
Sixth	Denture Reline	D5899
Seventh	Denture Reline	D5899
Eight	Denture Adjustment	D5899

Example #2 – Beneficiary Receives Mandibular or Maxillary Dentures

Appointment	Services Provided	Possible Procedure Codes Billed
First	Initial Exam and X-Rays	D0120/D0150, D0210/D0330
Second	Denture Impressions	D5899
Third	VDO	D5899
Fourth	Wax try in	D5899
Fifth	Denture Placement	D5110, D5120, D5211, D5212, D5213, D5214

Example #3 – Beneficiary Receives Mandibular or Maxillary Dentures

Appointment	Services Provided	Possible Procedure Codes Billed
First	Initial Exam and X-rays	D0120/D0150, D0210/D0330
Second	Denture Impressions	D5899
Third	Wax try in	D5899
Fourth	Denture Placement	D5110, D5120, D5211, D5212, D5213, D5214
Fifth	Denture Adjustment	D5899

14.00 Clinical Criteria – Children and Adults

The criteria outlined in LIBERTY Dental Plan's Dental Office Reference Manual are based around procedure codes as defined in the **American Dental Association's Code Manuals, and other trusted clinical-based and evidence based sources**. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State requirements as well. They are designed as *guidelines* for authorization and payment decisions and *are not intended to be all-inclusive or absolute*. Additional narrative information is appreciated when there may be a special situation.

LIBERTY Dental Plan hopes that the enclosed criteria will provide a better understanding of the decision- making process for reviews. LIBERTY Dental Plan also recognizes that "local community standards of care" may vary from region to region and LIBERTY Dental Plan will continue its goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. LIBERTY Dental Plan shares your commitment and belief to provide quality care to Beneficiaries and appreciates your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential you review the Benefits Covered Section before providing any treatment.

14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex.

Treatment rendered under emergency conditions, when authorization is not possible, requires that appropriate radiographs be submitted with the claim for review for payment.

Narrative demonstrating medical necessity may be needed.

Criteria

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.

14.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation decay.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.

- Crowns are being planned to alter vertical dimension.

14.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for procedures requiring authorization:

- Sufficient and appropriate radiographs such as a pre-operative radiograph of the tooth to be treated such as bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.

- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs such as a pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- The canal obturation should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Payment for root canal therapy will **not** be made if any of the following criteria are met:

- Gross periapical or periodontal pathosis is demonstrated radiographically (decay subcrestal or to the furcation, deeming the tooth non-restorable).

- The general oral condition does not justify root canal therapy due to loss of arch integrity.

- Tooth does not demonstrate 50% bone support.

- Root canal therapy is in anticipation of placement of an overdenture.

- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- In cases where the root canal filling does not meet LIBERTY Dental Plan's treatment standards, LIBERTY Dental Plan can require the procedure to be

redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after LIBERTY Dental Plan reviews the circumstances.

14.04 Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required, the following criteria apply:

Documentation needed for authorization of procedure:

- Appropriate radiographs should be submitted for authorization review, such as bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs to be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- The permanent tooth must be at least 50% supported in bone.

- Stainless steel crowns on permanent teeth are expected to last, at a minimum, five years.

Authorization and treatment using stainless steel crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.

14.05 Criteria for Operating Room (OR) Cases

Criteria

- Young children and\or patients with special needs requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Beneficiary convenience.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, developmental or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.06 Criteria for Removable Prosthodontics

Documentation needed for authorization of procedure:

- Appropriate radiographs must be submitted for authorization review, such as bitewings, periapicals or panorex.

- Treatment rendered without necessary authorization will still require appropriate radiographs to be submitted with the claim for review for payment.

- Within the first six months following insertion of a new prosthesis, any necessary adjustments, relines, and/or rebases are considered part of the insertion process and are the responsibility of the provider.

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.

- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

- Abutments must be at least 50% supported in bone.

- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures); it must be at least five years old and unserviceable to qualify for replacement.

- Dentures are only appropriate for patients who can reasonably be expected to coordinate use of prosthesis (i.e. not for those who are comatose or severely handicapped).

- Fabrication of a removable prosthetic includes multiple steps (appointments). These multiple steps (impressions, try-in appointments, delivery, etc.) are inclusive in the fee for the removable prosthetic and as such are not eligible for additional compensation

Authorizations for Removable prosthesis will **not** meet criteria:

- If there is a pre-existing prosthesis which is not at least five years old and unserviceable.

- If poor oral health and hygiene, poor periodontal health, and an unfavorable prognosis are not present.

- If there are untreated cavities or active periodontal disease in the abutment teeth.

- If abutment teeth are less than 50% supported in bone.

- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).

- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional criteria.
- If there is a pre-existing prosthesis, it must be at least five years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are allowed when there are extenuating circumstances, and/or medical necessity.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

14.07 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

14.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation are reviewed on a case by case basis. Acceptable conditions include, but are not limited to, one or more of the following• Documented local anesthesia toxicity.

- Severe cognitive impairment or developmental disability.
- Severe physical disability.
- Uncontrolled management problem.
- Extensive or complicated surgical procedures.
- Failure of local anesthesia.
- Documented medical complications.
- Acute infections.

14.09 Criteria for Periodontal Treatment

All procedures require authorization.
Documentation needed for authorization of any periodontal procedures:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.

A narrative of medical necessity may be required if the submitted documentation does not support the need for the requested treatment.

Periodontal scaling and root planing – (D4341/4342), per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria

- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:
  1) Radiographic evidence of root surface calculus.
  2) Radiographic evidence of noticeable loss of bone support
- Other periodontal procedures will be reviewed for medical necessity and appropriateness of care according to the ADA definitions of code terminology.

14.10 Criteria for Medical Immobilization Including Papoose Boards

Written informed consent from a legal guardian must be obtained and documented in the patient record prior to medical immobilization.

The patient's record must include:

- Written consent;
- Type of immobilization used;
- Indication for immobilization;
- Duration of application.
- Indication of whether a lesser means of restraint will be possible at the next visit.

Indications

- Patient who requires immediate diagnosis and/or treatment and cannot cooperate due to lack of maturity;
- Patient who requires immediate diagnosis and/or treatment and cannot cooperate due to a mental or physical disability;
- When the safety of the patient and/or practitioner would be at risk without the protective use of immobilization.

Contraindications

Use of this method must not be used:

- With cooperative patients;
- On patients who, due to their medical or systemic condition cannot be immobilized safely;
- As punishment; or
- For the convenience of the dentist and/or dental staff.
- Without a prior attempt to manage the patient without the use of immobilization.

Goals of Behavior Management

- Establish communication
- Alleviate fear and anxiety;
- Deliver quality dental care
- Build a trusting relationship between the dentist and the child and parent; and
- Promote the child's positive attitude towards oral/dental health.

1. Routine use of restraining devices to immobilize young children in order to complete their routine dental care is not acceptable practice and violates the standard of care.

2. Dentists without formal training in medical immobilization must not restrain children during treatment.
3. General dentists without training in immobilization should consider referring to dental specialties those patients who they consider to be candidates for immobilization.

4. Dental auxiliaries must only use medical immobilization devices to immobilize children with direct supervision of a general dentist.

14.11 Criteria for Orthodontic Services

Documentation

LIBERTY Dental Plan accepts a complete series of intra-oral photos along with all other required documentation, including panoramic and cephalometric films, tracings, score sheets, and narratives. Plaster study models are optional. However, if your office is unable to submit intra-oral photos, plaster models are still accepted.

The photos must be of good clinical quality and should include:

Facial photographs (right and left profiles in addition to a straight-on facial view)

- Frontal view, in occlusion, straight-on view
- Frontal view, in occlusion, from a low angle
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Maxillary Occlusal view
- Mandibular Occlusal view

In addition to the photos, requests for orthodontic treatment must include overjet and any other pertinent measurements.

If your office currently submits digital models through OrthoCAD, these are also accepted.

Authorization for orthodontic services also requires a claim form listing the requested services, the Orthodontic Criteria Index Form (Attachment G), and any other documentation that supports medical necessity of the proposed orthodontic treatment.

Criteria

- All comprehensive orthodontic services require prior authorization by one of LIBERTY Dental Plan's Dental Consultants.
- An orthodontic patient should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.
- HFS Dental Program Beneficiaries are evaluated for orthodontic coverage using medical necessity/handicapping criteria as the first level review (**Attachment G**). If the requested orthodontic treatment meets one of the listed criteria, LIBERTY Dental Plan approves the request as meeting medically necessary handicapping criteria.
- If the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form, LIBERTY Dental Plan will proceed with evaluating the request by applying the Salzmann Malocclusion Severity Assessment (**Attachment H**). A patient must score a 42 or higher to qualify for orthodontic services using the Salzmann Malocclusion Severity Assessment, if the request does not meet any of the listed criteria on the Orthodontic Criteria Index Form.

Attachment A- General Definitions

The following definitions apply to this Dental Office Reference Manual:

A. **"Covered Service"** is a dental service or supply that satisfies all of the following criteria:

- Provided by an Enrolled Participating Provider to a Beneficiary or by a licensed volunteer dentist through a not-for-profit clinic to a Beneficiary;
- Authorized by LIBERTY Dental Plan in accordance with the Provider's Certificate of Coverage; and
- Submitted to LIBERTY Dental Plan according to LIBERTY Dental Plan's filing requirements.

B. **"LIBERTY Dental Plan"** shall refer to LIBERTY Dental Plan of Illinois, LLC.

C. **"Enrolled Participating Provider"** is a dental professional or facility or other entity that has entered into a written agreement with HFS through LIBERTY Dental Plan to provide dental services. Any dentist providing services to Beneficiaries of a HFS Medical Benefits Program is required to be enrolled with the Department (89 IL Admin Code 140.23). The provider of service must bill as the treating dentist. The provider of service may elect to be his/her own payee or identify an alternate payee.

D. **"HFS Dental Program"** means dental program administered by HFS for HFS Beneficiaries. When referring to HFS Beneficiaries under age 21, the HFS Dental Program is also referred to as the All Kids Dental Program.

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

F. **"EPSDT" (Early Periodic Screening Diagnosis and Treatment) Services"** means benefits required by Federal Law that provide comprehensive and preventative health care services, including dental services, for children under age 21 who are enrolled in Medicaid. EPSDT Services can include necessary health care and diagnostic services, treatment, and other medically necessary measures.

G. "**Beneficiary"** means any individual who is enrolled in the Illinois Medicaid or HFS Dental Program.

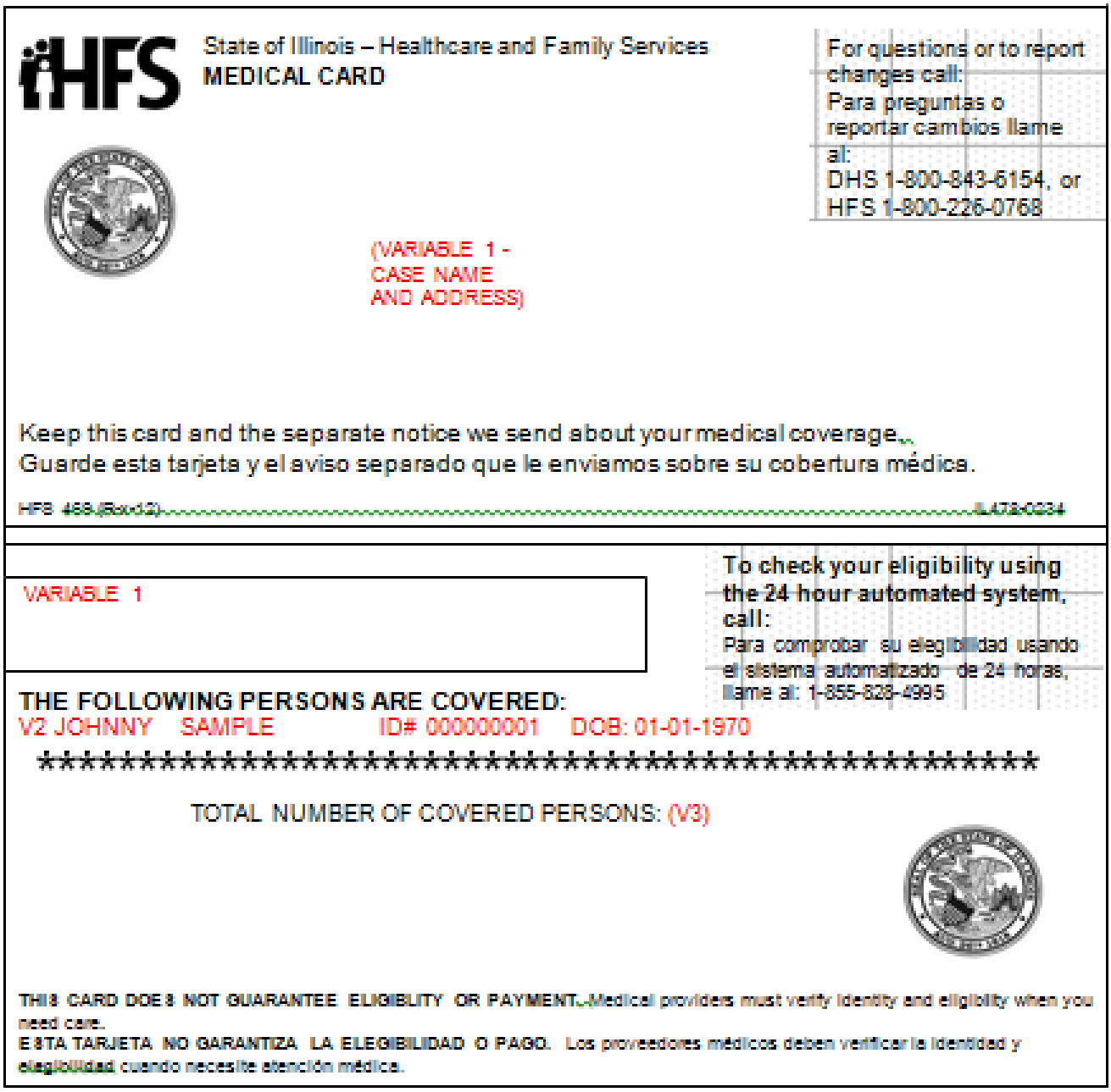
H. **"HFS"** means Illinois Department of Healthcare and Family Services.

I. **"DHS"** means Illinois Department of Human Services.

J. **"DCFS"** means Illinois Department of Children and Family Services.

K. **"DPH"** means Illinois Department of Public Health.

Attachment B - Healthcare and Family Services Medical Card (Front)



HFS State of Illinois – Healthcare and Family Services
MEDICAL CARD

For questions or to report changes call:
Para preguntas o reportar cambios llame al:
DHS 1-800-843-6154, or
HFS 1-800-226-0768

(VARIABLE 1 -
CASE NAME
AND ADDRESS)

Keep this card and the separate notice we send about your medical coverage.
Guarde esta tarjeta y el aviso separado que le enviamos sobre su cobertura médica.

HFS 468 (Rev-12) IL478-0234

VARIABLE 1

To check your eligibility using the 24 hour automated system, call:
Para comprobar su elegibilidad usando el sistema automatizado de 24 horas, llame al: 1-855-828-4995

THE FOLLOWING PERSONS ARE COVERED:
V2 JOHNNY SAMPLE ID# 000000001 DOB: 01-01-1970

****

TOTAL NUMBER OF COVERED PERSONS: (V3)

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT. Medical providers must verify identity and eligibility when you need care.
ESTA TARJETA NO GARANTIZA LA ELEGIBILIDAD O PAGO. Los proveedores médicos deben verificar la identidad y elegibilidad cuando necesite atención médica.

Attachment C - The Dental Home Concept

Are you building a Dental Home for your patients?

Effective July 1, 2006, the State of Illinois' dental coverage for children expanded under the provisions of the All Kids Program. What was previously known as Medicaid and KidCare was renamed the All Kids Program.

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

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

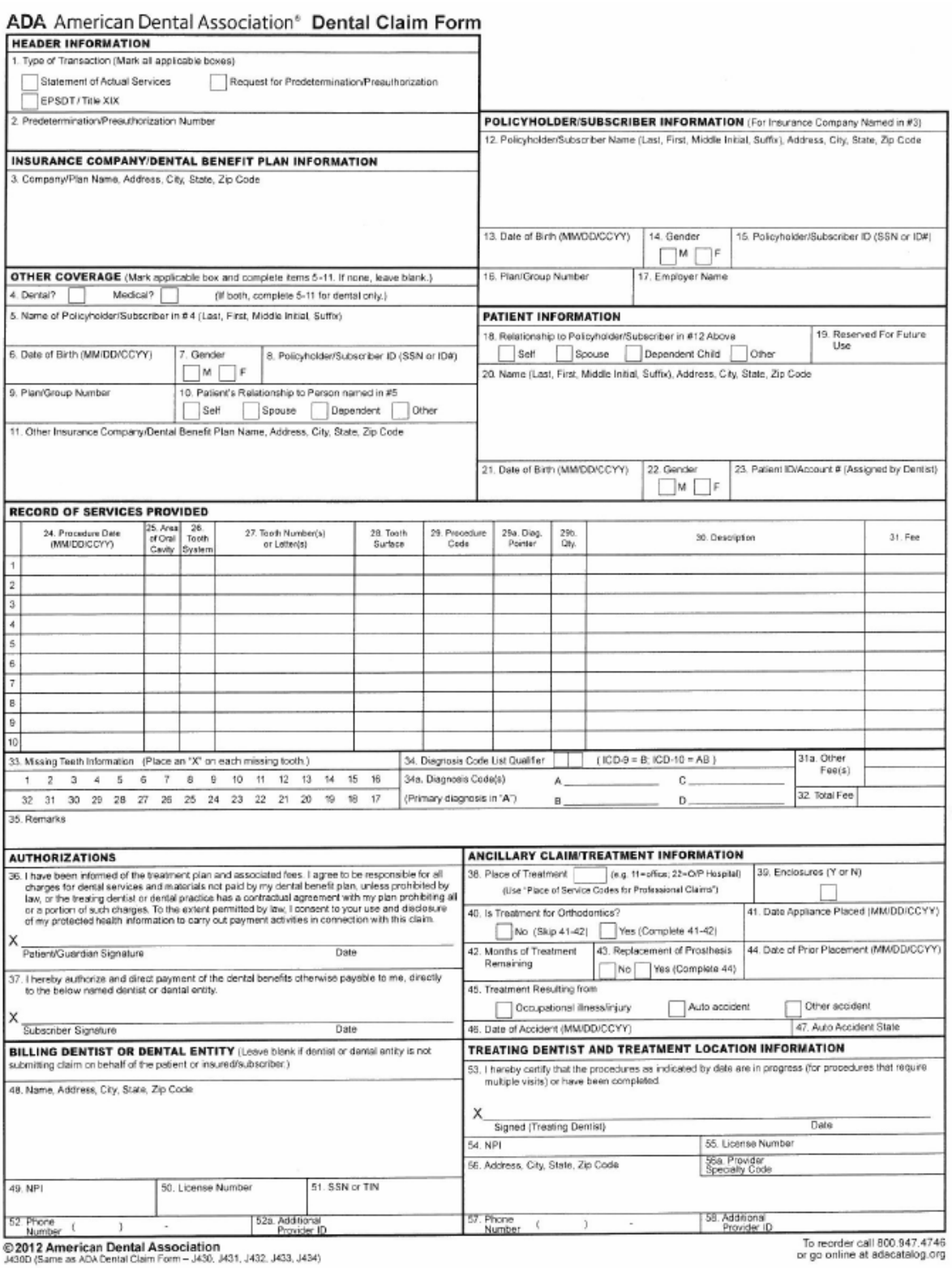
The American Academy of Pediatric Dentistry (AAPD) defines dental home as "inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals, and dental professionals." It constitutes the ongoing relationship between the dentist who is the Primary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

Provider support is essential to effectively employ the Dental Home concept with All Kids/HFS Dental Program Beneficiaries. With assistance and support from dental professionals, a system for improving the overall health of children in the All Kids Program can be achieved.

For additional information regarding the All Kids Program, visit the All Kids Web site.

For additional information regarding the Dental Home Concept, visit the American Academy of Pediatrics Healthy Smile Healthy Children Web site.

Attachment D – Dental Claim Form and Instructions



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

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

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

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

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

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

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

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

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

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

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

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A ____ C ____
(Primary diagnosis in "A") B ____ D ____

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

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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 COT 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 COT 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 COT 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"

Attachment E - Direct Deposit Authorization

FACILITY INFORMATION

Facility Name: _____ Facility ID: _____ Tax ID: _____
Facility Address: _____
Email Address: _____

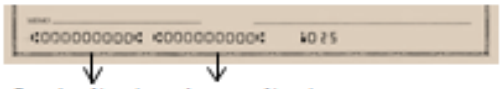
ACCOUNT INFORMATION

☐ Add ☐ Change (Existing)

Account Legal Name: _____ Account Number: _____

Account Type *(check one)*: ☐ Checking ☐ Savings Bank Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Financial Institution: _____



Routing Number Account Number

One of the following must be attached (select one):
☐ 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 Direct Deposit 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 Direct Deposit 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 Direct Deposit authorization.

Authorized Signature: _____ Date: _____
Print Name: _____ Title: _____

LIBERTY DENTAL PLAN USE ONLY

Vendor Name:

Vendor ID:

Rev. 04/2014

Instructions for Completing the Direct Deposit Form

Please allow 30 days after your form is submitted to receive your first direct deposit payment. Forms that are not fully or accurately completed will result in delays in processing the direct deposit arrangement.

General Instructions

1. Complete all portions of the form according to the type of enrollment and sign where required
    - Adding an account – complete the Provider Informatiom, Account Information (check “Add” box), and Authorization sections
    - Changing existing account (changing type of account, financial institution, account/routing numbers) – complete the Provider Information, Account Information (check “Change” box), and Authorization sections
    - Deleting an account – complete the Provider Information and Cancellation sections
2. Attach a voided check from the listed account. Please note that this Direct Deposit Form will not be processed unless attached.

Attachment F - Provider Dispute Resolution Form

Provider Dispute Resolution Form

Please Return To:

LIBERTY Dental Plan
ATTN: Provider Dispute Resolution Mechanism Department
P.O. Box 26110
Santa Ana, CA 92799-6110
888-703-6999

Appeals must be submitted with all pertinent records and a narrative that clearly describes what actions you are requesting, and why you think the original determination was incorrect.

Date :			
Dental Office Name:		Dentist Name:	
Provider Number:	Location:		
Disputed Claims Number(s)		Date(s):	
Describe 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 or if the contracted provider dispute is not about a claim, a clear explanation of the issue(s) and the provider's position on the issue:			
Details:			

First Review ____ IL HFS Dental Program
Second Review ____

Models ____
Ortho cad ____
Ceph Film ____
X-Rays ____
Photos ____
Narrative ____

Attachment G - Orthodontic Criteria Scoring Form – Comprehensive D8080

Patient Name: _____ DOB: _____

ABBREVIATIONS	CRITERIA for Permanent Dentition	YES	NO
DO	Deep impinging overbite that shows palatal impingement causing tissue trauma with the majority of lower incisors.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisor have not fully erupted and not correctable by habit therapy.)		
AP	Demonstrates a large anterior - posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III).		
AX	Anterior crossbite. (Involves more than two teeth and in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited ortho treatment)		
PX	Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar and not correctable by limited ortho treatment).		
PO	Significant posterior openbites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy)		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
CR	Crowding of 7-8 mm in either the maxillary or mandibular arch.		
OJ	Overjet in excess of 9mm.		
CDD	Dentition exhibits a profound impact from a congenital or developmental disorder.		
FAS	Significant facial asymmetry requiring a combination orthodontic and orthognathic surgery for correction.		

☐ Approve

☐ When all are answered "NO", please refer to Salzmann

_____

First Review _____ IL HFS Dental Program
Second Review _____

Models
Ortho cad _____
Ceph Film _____
X-Rays _____
Photos _____
Narrative _____

Attachment H - Malocclusion Severity Assessment

By J.A. Salzmann, DDS, F.A.P.H.A.

Beneficiary Name: _____ Date of Birth: _____
Case Name: _____ Dentist's Name: _____
Examiner: _____ Date: _____

RECORDS RECEIVED:

Models	CEPH	PANO	Intra-Oral X-Rays	Photos Fees	Photos Intra

QUALITY:

Models	CEPH	PANO	Intra-Oral X-Rays	Photos Fees	Photos Intra

A. Intra-Arch Deviation

Score Teeth Affected Only		Missing	Crowded	Rotated	Spacing Open	Spacing Closed	No.	P. V.	Score
Maxilla	Ant							X2	
	Post							X1	
Mandible	Ant							X1	
	Post			0				X1	

Ant = anterior teeth (4 incisors) Total: _____
Post = posterior teeth (Include canine, premolars and first molar) No. = number of teeth affected
P.V. = point value

B. Inter-Arch Deviation

ANTERIOR SEGMENT:

Score Maxillary Teeth Affected Only Except Overbite*	Overjet	Overbite	Crossbite	Openbite	No.	P.V.	Score

*Score maxillary or mandibular incisors Total: _____

ANTERIOR SEGMENT:

Score Affected Teeth Only	Mandibular to Maxillary Teeth				Score Affected Maxillary Teeth Only				No.	P.V.	Score
Canine	Distal		Mesial		Crossbite		Openbite				
	Right	Left	Right	Left	Right	Left	Right	Left			
1st Premolar											
2nd Premolar											
1st Molar											

Total Score: _____

Add 8 points when intra-and intra-arch maxillary incisors score if 6 or more to denote esthetic handicap

Grand Total: _____

C. Dentofacial Deviations

The following deviations are scored as handicapping when associated with malocclusion: Score 8 points for each deviation.

1. Facial and oral clefts		
2. Lower lip palatal to maxillary incisor teeth		
3. Occlusal interference		
Possible Surgical Indication	4. Functional jaw	
Yes No	5. Facial asymmetry	
5. Speech impairment		
6. Total Score		

TOTAL Salzmann Index: _____

Malocclusion Severity Assessment
By J.A. Salzmann, DDS, F.A.P.H.A.

Summary of instructions

Score: 2 points for each maxillary anterior tooth affected.
1 point for each mandibular incisor and all posterior teeth affected.

1. Missing teeth. Count the teeth; remaining roots of teeth are scored as a missing tooth.
2. Crowding. Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.
3. Rotation. Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.
4. Spacing. Score teeth, not spacing. Score the points when:
    a. Open spacing. One or both interproximal tooth surfaces and adjacent papillae are visible in an anterior tooth; both interproximal surfaces and papillae are visible in a posterior tooth.
    b. Closed spacing. Space is not sufficient to permit eruption of a tooth that is partially eruption.
5. Overjet. Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.
6. Overbite. Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.
7. Cross-bite. Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact.
8. Open-bite. Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.
9. Mesiodistal deviations. Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

Instruction for using the "Handicapping Malocclusion

Assessment Record" Introduction

This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An

additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

A. Intra-Arch Deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record". The scoring can be entered later.

1. Anterior segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.
    a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
    b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
    c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
    d. Spacing
        (1) Open spacing refers to tooth separation that exposes to view the interdental papillac on the alveolar crest. Score the number of papillae visible (not teeth).
        (2) Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.
2. Posterior segment: A value of 1 point is scored of each tooth affected.
    a. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
    b. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
    c. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.
    d. Spacing
        (1) Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
        (2) Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

B. Inter-arch Deviations

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.
   a. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.
   b. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.
   c. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.
   d. Open-bite refers to vertical inter-arch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

C. Dentofacial Deviations

The following deviations are scored as handicapping when associated with a malocclusion: Score eight (8) points for each deviation.

1. Facial and oral clefts.
2. Lower lip positioned completely palatal to the maxillary incisor teeth.
3. Occlusal interference that cannot be corrected by a less intrusive therapy.
4. Functional jaw limitations.
5. Facial asymmetry to the extent that surgical intervention is indicated.
6. Speech impairment documented by a licensed or certified therapist whose cause is related to the improper placement of the dental units.

Attachment I – OrthoCad Submission Form

OrthoCAD Submission Form

Date: _____

Patient Information		
Name (First & Last)	Date of Birth:	SS or ID#
Address:	City, State, Zip	Area code & Phone number:
Group Name:	Plan Type:	
Provider Information		
Dentist Name:	Provider NPI #	Location ID #
Address:	City, State, Zip	Area code & Phone number:
Treatment Requested		

Code:	Description of request:

Attachment J- HIPPA Companion Guide

Liberty Dental Plan Corporation

HIPAA Transaction 837 Dental Claims & Encounter Companion Guide (Inbound)

Refers to the Implementation Guides Based on X12 version 005010X224A2

Companion Guide Version Number: 1.0

July 22, 2011

Implementation Checklist

Trading Partner Testing Check List

The following tasks should be completed to insure a smooth implementation of the EDI process.

TASK	Responsibility	Date
☐ Establish ISA and GS information	LDP & TP	
☐ Determine Communication Mode	LDP & TP	
☐ Execute Trading Partner Agreement	LDP & TP	
☐ Confirm Business rules	LDP & TP	
☐ If required, set-up encryption process	LDP & TP	
☐ Establish schedule for testing	LDP & TP	
☐ Complete testing	LDP & TP	
☐ Production cut-over	LDP & TP	

ISA, GS, GE and IEA Information

This section describes Liberty Dental Plan use of the interchange (ISA) and functional group (GS) control segments.

837 Inbound Transaction (Liberty Dental Plan is the Receiver)

Interchange and Functional Group Headers

X12 Data Element	Description	Values Used	Comments
ISA01	Authorization Qualifier	00	
ISA02	Authorization Information		
ISA03	Security Qualifier	00	
ISA04	Security Information		
ISA05	Sender Qualifier	30 or ZZ	
ISA06	Sender ID	Trading Partner's Sender ID	Tax ID is preferred
ISA07	Receiver Qualifier	30 or ZZ	
ISA08	Receiver ID	330979956	Liberty Dental Plan Tax ID
ISA09	Interchange Date	YYMMDD	
ISA10	Interchange Time	HHMM	
ISA11	Repetition Separator	^	
ISA12	Interchange Control Version Number	00501	
ISA13	Interchange Control Number		Must be unique 9 digit number.
ISA14	Acknowledgement Requested	0 1	None requested Requested
ISA15	Usage Indicator	T P	Test File Production File
ISA16	Component Element Separator	:	
GS01	Functional ID Code	HC	
GS02	Sender's Code	Trading Partner's Sender Code	Tax ID is preferred
GS03	Receiver's Code	330979956	
GS04	Date	CCYYMMDD	
GS05	Time	HHMM	
GS06	Group Control Number		Set by sender
GS07	Resp. Agency Code	X	
GS08	Version Release Industry ID Code	005010X224A2	

Functional Group and Interchange Trailers

X12 Data Element	Description	Values Used	Comments
GE01	Number of Transaction Sets Included		Count of transaction sets
GE02	Group Control Number		Same as GS06
IEA01	Number of Functional Groups		Count of functional groups in interchange
IEA02	Interchange Control Number		Same as ISA13

Transaction Specification

Transaction Set Header

Loop ID	Segment ID	Reference Designator	Values	Descriptions
	ST	ST01	837	
		ST02		Unique within transaction set functional group
		ST03	005010X224A2	

Beginning Hierarchical Transaction

Loop ID	Segment ID	Reference Designator	Values	Descriptions
	BHT	BHT01	0019	
		BHT02	00 18	Original Resubmission
		BHT03		Batch Number
		BHT04	CCYYMMDD	
		BHT05	HHMM	
		BHT06	CH RP	Payable Claims Encounters Submissions

Submitter Name

Loop ID	Segment ID	Reference Designator	Values	Descriptions
1000A	NM1	NM101	41	
1000A	NM1	NM102	2	Non-Person
1000A	NM1	NM103		Submitter Organizational Name
1000A	NM1	NM108	46	
1000A	NM1	NM109		Submitter ID (Tax ID is preferred)
1000A	PER	PER01	IC	
1000A	PER	PER02		Submitter Contact Name
1000A	PER	PER03	TE	
1000A	PER	PER04		Submitter Contact Phone No.

Receiver Name

Loop ID	Segment ID	Reference Designator	Values	Descriptions
1000B	NM1	NM101	40	
1000B	NM1	NM102	2	
1000B	NM1	NM103	Liberty Dental Plan	Receiver Name
1000B	NM1	NM108	46	
1000B	NM1	NM109	330979956	Tax ID is preferred

Hierarchy

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2000A	HL	HL01	1	(sequential number)
2000A	HL	HL03	20	
2000A	HL	HL04	1	

Billing Provider Name

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010AA	NM1	NM101	85	
2010AA	NM1	NM102	1 2	Person Non-Person
2010AA	NM1	NM103		Last Name or Organizational Name
2010AA	NM1	NM104		First Name (only if person)
2010AA	NM1	NM105		Middle Name (only if person)
2010AA	NM1	NM108	XX	Provider Identification Qualifier
2010AA	NM1	NM109		Billing Provider NPI
2010AA	N3	N301		**Physical Rendering Address**
2010AA	N4	N401		**Physical Rendering City**
2010AA	N4	N402		**Physical Rendering State**
2010AA	N4	N403		**Physical Rendering Zip**
2010AA	REF	REF01	EI	
2010AA	REF	REF02		EIN number

Hierarchy

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2000B	HL	HL01		Hierarchical ID number (sequential number)
2000B	HL	HL02		Hierarchical parent
2000B	HL	HL03	22	
2000B	HL	HL04	0 1	No subordinate HL segment Additional subordinate HL segment (dependent)

Subscriber Information

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2000B	SBR	SBR01	P S T	Primary Secondary Tertiary
2000B	SBR	SBR02	18	
2000B	SBR	SBR03		Liberty Group Number (optional)
2000B	SBR	SBR04		Liberty Group Name (optional)
2000B	SBR	SBR09	12 14 CI HM MB	PPO EPO Commercial HMO Medicare

Subscriber Name

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010BA	NM1	NM101	IL	
2010BA	NM1	NM102	1	
2010BA	NM1	NM103		Last Name
2010BA	NM1	NM104		First Name
2010BA	NM1	NM108	MI	
2010BA	NM1	NM109		Liberty Subscriber Member Number

Subscriber Address (if subscriber is patient)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010BA	N3	N301		Address Information
2010BA	N4	N401		City
2010BA	N4	N401		State
2010BA	N4	N401		Zip

Subscriber DOB (if subscriber is patient)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010BA	DMG	DMG01	D8	
2010BA	DMG	DMG02	CCYYMMDD	Date of Birth
2010BA	DMG	DMG03		Gender

Payer Name

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010BB	NM1	NM101	PR	
2010BB	NM1	NM102	2	
2010BB	NM1	NM103	Liberty Dental Plan	Organizational Name
2010BB	NM1	NM108	PI	
2010BB	NM1	NM109	330979956	

Hierarchy

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2000B	HL	HL01		Hierarchical ID number (sequential number)
2000B	HL	HL02		Hierarchical parent
2000B	HL	HL03	23	
2000B	HL	HL04	0	

Patient Information (if patient is not subscriber)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2000C	PAT	PAT01	01 19	Spouse Child

Patient Name (if patient is not subscriber)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010CA	NM1	NM101	QC	
2010CA	NM1	NM102	1	
2010CA	NM1	NM103		Last Name
2010CA	NM1	NM104		First Name
2010CA	NM1	NM108	MI	Qualifier
2010CA	NM1	NM109		Liberty Patient Member Number

Patient Address (if patient is not subscriber)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010CA	N3	N301		Address Information
2010CA	N4	N401		City
2010CA	N4	N401		State
2010CA	N4	N401		Zip

Patient DOB (if patient is not subscriber)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2010CA	DMG	DMG01	D8	
2010CA	DMG	DMG02	CCYYMMDD	Date of Birth
2010CA	DMG	DMG03		Gender

Claim Information

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2300	CLM	CLM01		Patient Account Number or Claim number
2300	CLM	CLM02		Total Claim Charges (0 for encounters)
2300	CLM	CLM05	11:B:1	
2300	CLM	CLM06	Y	
2300	CLM	CLM07	A	
2300	CLM	CLM08	Y	
2300	CLM	CLM09	Y	

Claim Date of Service (or may be listed on individual line items)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2300	DTP	DTP01	472	
2300	DTP	DTP02	D8	
2300	DTP	DTP03	CCYYMMDD	Date of Service

Rendering Provider Name

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2310B	NM1	NM101	82	
2310B	NM1	NM102	1 2	Person Non-Person
2310B	NM1	NM103		Last Name or Organizational Name
2310B	NM1	NM104		First Name (only if person)
2310B	NM1	NM105		Middle Name (only if person)
2310B	NM1	NM108	XX	Provider Identification Qualifier
2310B	NM1	NM109		Rendering Provider NPI
2310B	PRV	PRV01	PE	
2310B	PRV	PRV02	PXC	
2310B	PRV	PRV03		Provider Taxonomy Specialty Code

Other Subscriber Information (if COB)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2320	SBR	SBR01		Payer Responsibility Sequence
2320	SBR	SBR02		Relationship Code
2320	SBR	SBR03		Group Number (optional)
2320	SBR	SBR09	12 14 CI HM MB	PPO EPO Commercial HMO Medicare

COB Paid Amount (if COB)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2320	AMT	AMT01	D	
2320	AMT	AMT02		COB Paid Amount

Other Insured Information (if COB)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2320	DMG	DMG01	D8	
2320	DMG	DMG02	CCYYMMDD	Date of Birth
2320	DMG	DMG03		Gender
2320	OI	OI3		COB Indicator
2320	OI	OI6		Release of Information Indicator

Other Insured Name (if COB)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2330A	NM1	NM101	IL	
2330A	NM1	NM102	1	
2330A	NM1	NM103		Last Name
2330A	NM1	NM104		First Name
2330A	NM1	NM108	MI	
2330A	NM1	NM109		COB Member Number or Plan Policy Number

Other Insured Payer (if COB)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2330B	NM1	NM101	PR	
2330B	NM1	NM102	2	
2330B	NM1	NM103		COB Organizational Name
2330B	NM1	NM108	PI	
2330B	NM1	NM109		COB Payer TIN

COB Adjudication Date (if COB)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2330	DTP	DTP01	573	
2330	DTP	DTP02	D8	
2330	DTP	DTP03	CCYYMMDD	COB Adjudication Date
2330	REF	REF01	F8	
2330	REF	REF02		Patient Account Number or Claim number

Line Counter (repeat as necessary)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2400	LX	LX01		Claim Line Number

Dental Services (repeat as necessary)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2400	SV3	SV301	AD:	AD: then service code
2400	SV3	SV302		Line Item Charge Amount
2400	SV3	SV304		Quadrant/Oral Cavity
2400	SV3	SV306		Quantity
2400	TOO	TOO01	JP	
2400	TOO	TOO02		Tooth Number One tooth number per detail line (DTL) **Required, if segment is present.**
2400	TOO	TOO03		Tooth Surfaces (if necessary)

Service Line Date of Service (if different than Claim Date of Service)

Loop ID	Segment ID	Reference Designator	Values	Descriptions
2400	DTP	DTP01	472	
2400	DTP	DTP02	D8	
2400	DTP	DTP03	CCYYMMDD	Date of Service

Attachment K- Patient Recall System Recommendations

Recall System Requirements

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

Office Compliance Verification Procedures

In conjunction with its office claim audits described in section 5, LIBERTY Dental Plan will measure compliance with the requirement to maintain a patient recall system.

Participating dentists are expected to meet minimum standards with regard to appointment availability. Emergent situations (those involving pain, infection, swelling and/or traumatic injury) need to be appointed within 24 hours. Urgent care should be available within 72 hours. Initial and Recall routine treatment should be scheduled within 30 days of initial contact with the dentist's office. Follow-up appointments should be scheduled within 45 days of the present treatment date. Providers should see a Beneficiary within 30 minutes of arriving at the office for a scheduled appointment.

Attachment L - Office Claim Audit

A. Purpose

LIBERTY Dental Plan utilizes a proprietary paperless process to collect procedure information and determine the value of services rendered by each participating office.

LIBERTY Dental Plan has designed a program to detect fraudulent claim submission.

B. Random Chart Audits

On a periodic basis, LIBERTY Dental Plan takes a sample of claims submitted by selected office locations. LIBERTY Dental Plan provides this listing of Beneficiaries and dates of service to the office location. For each Beneficiary and date of service, the office must supply complete dental records to support the services billed. These records will be reviewed to ensure compliance with the Beneficiary record protocols, as well as to detect possible billing irregularities.

Each office may either make copies of the records requested or arrange for a LIBERTY Dental Plan representative to review the original records at the office location itself.

LIBERTY Dental Plan claim audits will be scheduled on a random basis. LIBERTY Dental Plan shall make every effort to schedule these reviews at times that are convenient for the office and will make every effort to complete the review in as short a duration as is practical.

Participating providers agree to cooperate with claims audits, chart audits and to make the complete chart copies available upon reasonable request.

Attachment M - Radiology Guidelines

Note: Please refer to benefit tables for benefit limitations.

LIBERTY Dental Plan utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and may be updated from time to time. LIBERTY abides by any updated radiological recommendations as per the FDA. LIBERTY expects participating providers to render radiological services in accordance with the most current FDA radiology recommendations.

A. Radiographic Examination of the New Patient

Child – Primary Dentition

The Panel recommends Posterior Bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal examination with Posterior Bitewings OR a Panoramic X-ray and Posterior Bitewings, for a new patient with a transitional dentition.

Adolescent – Permanent Dentition Prior to the eruption of the third molars

The Panel recommends and individualized radiographic examination consisting of selected periapicals with posterior Bitewings for a new adolescent patient.

Adult – Dentulous

The Panel recommends and individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

Adult – Edentulous

The Panel recommends a Full-Mouth Intraoral Radiographic Survey or a Panoramic X- ray for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high – risk factors for caries

a. Child – Primary and Transitional Dentition

The Panel recommends that Posterior Bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

b. Adolescent

The Panel recommends that Posterior Bitewings be performed at a 6-12 month interval for adolescents
with clinical caries or who are at increased risk for the development of caries.

c. Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at a 6-12 month interval for adults with clinical caries or who are at increased risk for the development of caries.

d. Adult – Edentulous

The Panel found that an examination for occult disease in this group can not be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no X-rays be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high risk factors for caries

a. Child – Primary Dentition

The Panel recommends that Posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts who show no clinical caries and are not at increased risk for the development of caries.

b. Adolescent

The Panel recommends that Posterior Bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

c. Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition, Adolescent and Dentulous Adult.

The Panel recommends an individualized radiographic survey consisted of selected Periapicals and/or Bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

Child – Transitional Dentition

The Panel recommended and individualized Periapical/Occlusal series OR a Panoramic X-ray to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

Adolescent

The Panel recommended that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth or a panoramic radiograph.

Adult

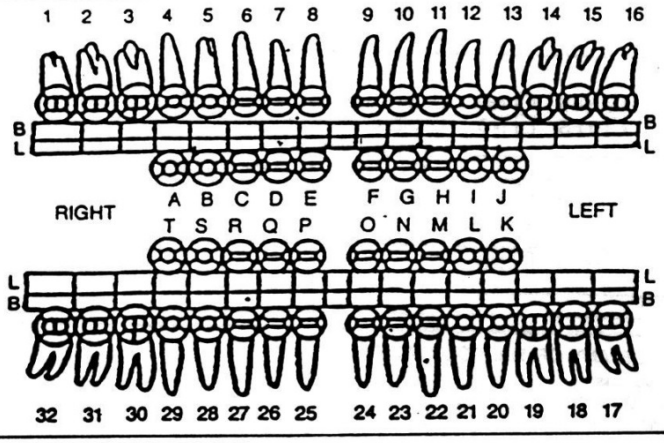
The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

Attachment N - Initial Clinical Exam – Sample

ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____ Last First Middle



GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

Note: The above form is intended to be a sample. LIBERTY Dental Plan is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

Attachment O- Recall Examination - Sample

Patient's Name _____

Changes In Health Status/Medical History _____

	Ok		Ok	Clinical Findings/Comments
Lymph Nodes		TMJ		
Pharynx		Tongue		
Tonsils		Vestibules		
Soft Palate		Buccal Mucosa		
Hard Palate		Gingiva		
Floor Of Mouth		Prosthesis		
Lips		Perio Exam		
Skin		Oral Hygiene		

Radiographs	B/P	RDH/DDS

R **Work Necessary** **L**

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

Comments: _____

Recall Examination

Patient's Name _____

Changes In Health Status/Medical History _____

	Ok		Ok	Clinical Findings/Comments
Lymph Nodes		TMJ		
Pharynx		Tongue		
Tonsils		Vestibules		
Soft Palate		Buccal Mucosa		
Hard Palate		Gingiva		
Floor Of Mouth		Prosthesis		
Lips		Perio Exam		
Skin		Oral Hygiene		

Radiographs	B/P	RDH/DDS

R **Work Necessary** **L**

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

Comments: _____

Note: The above form is intended to be a sample. LIBERTY Dental Plan is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

Attachment P - Authorization for Dental Treatment – Sample

I hereby authorize Dr. _____ and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgment, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

Note: The above form is intended to be a sample. LIBERTY Dental Plan is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines and consult your professional liability carrier for recommendations.

Attachment Q - Medical and Dental History – Sample Form

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

Why are you here today? _____

Are you having pain or discomfort at this time? ☐ Yes ☐ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you now taking any medication, drugs, or pills? ☐ Yes ☐ No

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? ☐ Yes ☐ No

If yes, please list: _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you use more than two pillows to sleep? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No

Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? ☐ Yes ☐ No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ☐ Yes ☐ No

Do you have or have you had any disease, or condition not listed? ☐ Yes ☐ No

If yes, please list: _____

Indicate which of the following your have had, or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	☐ Yes	☐ No	Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Hepatitis A (infectious)	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Hepatitis B (serum)	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Arteriosclerosis (hardening of arteries)	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	AIDS	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cortisone Medication	☐ Yes	☐ No	Cold sores/Fever blisters/ Herpes	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Cosmetic Surgery	☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature : _____ Date : _____

Dentist's Signature : _____ Date : _____

Review Date	Changes in Health Status	Patient's signature	Dentist's signature

Note: The above form is intended to be a sample. LIBERTY Dental Plan is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines and consult your professional liability carrier for recommendations.

Attachment R – Agreement to Pay Non-Covered Services – Sample

Patient Name: _____

Recipient (Medicaid) ID: _____

Guarantor Name: _____

Relationship to Patient: _____

Not all dental services are covered by the HFS/All Kids Dental Program. Some services are covered, but only within specific time frames (twice a year, once per year, once every 5 years, etc.) The following service(s) are recommended for the above named patient, but are not covered services:

Non-Covered Services

Code	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that the above services are not covered by the HFS/All Kids Dental program, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

_____ _____
Guarantor Signature Date

Guarantor Address:

_____
Street, Apt #

_____
City, State, Zip

Guarantor Phone

Home: _____

Cell: _____

Work _____

Attachment S- Illinois All Kids School-Based Dental Program – Provider Registration

Provider Registration

LIBERTY Dental Plan Corporation
1100 South Fifth Street,
Springfield, IL 62703
Attn: Illinois Outreach Coordinator
Fax (217) 522-8851

****Incomplete Applications Will Delay the Approval Process****

Providers must complete and submit the following documents in order to participate in the Illinois **All Kids School-Based Dental Program:**

____1. A **completed** All Kids School-Based Dental Program Provider Registration Application (page 88) and the Certification, Statements, and Signature form (page 89).
____2. A copy of the **Referral Plan,** with one of the required options chosen, for every community serviced in the All Kids School-Based Dental Program.
____3. Attend annual mandatory school provider training teleconference.

The following items are **required** on an on-going basis upon completion of school-based exams:

____1. A **completed** IDPH Proof of School Dental Examination Form.
____2. A **completed** School Exam Follow-Up Care Form (including the Referral Plan information) to be sent home with the student.
____3. A **completed** Dental Record for every All Kids Dental Program Beneficiary who received School-Based services.
____4. **The Google Events Calendar which must be current at all times.**

____5. Submission of a Caries Risk Assessment Code (CRA) on the claim form for every child receiving services in the school-based setting. **If a CRA code is not submitted on the claim, the entire claim (all services) will deny.**

Please remember:
Providers cannot be paid for School-Based services rendered to Beneficiaries until final approval from LIBERTY Dental Plan is received. This process will take approximately 2-4 weeks.

Audits may be conducted to prove best efforts have been made by the School-Based Provider to ensure that Beneficiaries are receiving necessary follow-up.

Site visits will be conducted by the Illinois Department of Public Health on behalf of the Department of Healthcare and Family Services.

Illinois All Kids School-Based Dental Program

Provider Registration Application

School-Based Provider Entity Name			Phone #:
Billing Location Contact Name	Email Address:		Fax #:
Billing Location Address	City	State	Zip Code

Office Information

Participating School Providers	Individual NPI	Billing Tax I.D.	Dentist Signature

Illinois All Kids School-Based Dental Program
Certification, Statements, and Signature

I hereby acknowledge that the information provided in this application is material to the determination by LIBERTY Dental Plan whether or not to execute my request. I hereby represent and warrant that all information provided herein is true to the best of my knowledge, and I agree to notify LIBERTY Dental Plan in the event an error is discovered or when new events occur which alter the validity of any response herein. I also agree to supply all necessary Beneficiary information required to HFS in a timely manner upon completion of each event.

I certify that:

- All services are provided by and under the supervision of a licensed dentist.
- The above information is complete, correct and true to the best of my knowledge.

Signed by: _____Date: _____

Entity's Owner or Owner's Designee

Please print name: _____

All applications are subject to review and approval by LIBERTY Dental Plan.

Information contained will be held in strict confidence, and available for review by only duly authorized employees of LIBERTY Dental Plan of IL, LLC, the Department of Healthcare and Family Services, or the
Illinois Department of Public Health. Any corrections, additions, or clarification to these files must be submitted in writing to the LIBERTY Dental Plan Outreach Coordinator. The practitioner has the right, upon request, to be informed of the status of their application via phone, fax, or email.

Attachment T- Illinois All Kids School-Based Dental Program Google Events Calendar

The Google Events Calendar is required by each All Kids School-Based Dental Program Provider/entity. The calendar is a real-time communication to relay the scheduled school-based events. The schedule must be current at all times. Events should be placed on the calendar at least three weeks in advance of each event.

Please Remember:

Submission of the Provider/entity school-based schedules will not be accepted in any other format.

A minimum of the first 30 days schedule must be completed before the All Kids School-Based Dental
Program registration can be approved.

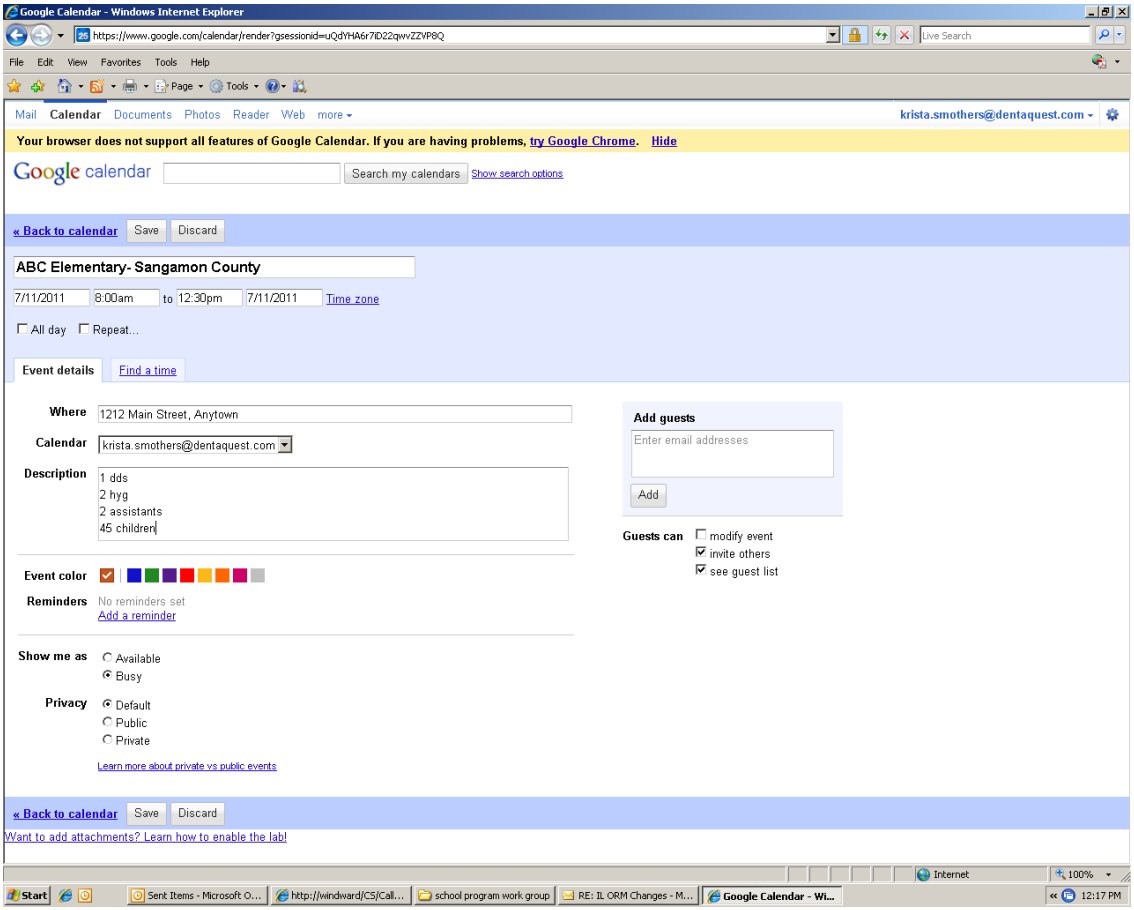
Instructions for Creating Google Calendar Account

1. Go to https://accounts.google.com in a Web browser
2. Click 'Create an Account'
3. Enter required information
   - First name (this could be business name or manager of school program)
   - Last name (this could be business name or manager of school program)
   - Create password
   - Confirm password
   - Birthday (use dummy birthday of 9/9/1970)
   - Gender

Instructions for Using Google Calendar

1. Go to https://accounts.google.com in a Web browser
2. Click 'Sign in Now" button (on right)
3. Enter user name and password
4. Calendar will appear
5. Find date of scheduled school visit- double click on time Provider will be arriving
6. Box will appear-- enter school visit information
   - 'Title'- enter school name and county
   - 'Where'- enter school address including name of town
   - 'Description'- enter name of dentist/number of clinical staff to be present/ number of students to be seen
   - Leave other options as default
7. Click 'Save' (lower left)

Illinois All Kids School-Based Dental Program
Google Events Calendar



Attachment U – School Based Provider Referral Plan

All Kids School-Based Dental Program

Provider Referral Plan

School-based dental Providers must develop a referral plan for follow-up care in the communities in which school-based services are rendered.

Please select the appropriate referral plan for each community in which school-based services are rendered.

Community_____ _____20_____ _____ school year

_____ Children who receive services in the school-based dental program with a Caries Risk Assessment of D0602 or D0603 (corresponding to an oral health score of 2 or 3) will be referred back to the school-based Provider's office to provide necessary follow up care and establish a Dental Home.

Office: _____
Name: _____
Address:
Telephone number: _____

_____ Children who receive services in the school-based dental program with a Caries Risk Assessment of D0602 or D0603 (corresponding to an oral health score of 2 or 3) will be provided necessary follow-up by the school-based Provider through the use of mobile restorative equipment. A yearly visit to the school by this Provider/entity will be scheduled to establish a continuation of care and case management as a mobile Dental Home.

_____ Children who receive services in the school-based dental program with a Caries Risk Assessment of D0602 or D0603 (corresponding to an oral health score of 2 or 3) will be provided case management to follow-up care and provide referrals to the parent/guardian for necessary treatment.
The case manager will locate a dental Provider who is willing to accept each child into their practice to perform required follow-up care and provide a Dental Home. Additionally, case management will include education to the parent/guardian regarding transportation benefits, when necessary.

Name of Case Manager: _____
Telephone number: _____

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

Illinois All Kids School-Based Dental Program
Caries Risk Assessment/Oral Health Score Rating Guidelines

Dentists practicing in the All Kids School-Based Dental Program should refer to the following guidelines when selecting the Caries Risk Assessment (CRA)/Oral Health Score for each child examined. The CRA code must be submitted on the claim form for each child receiving services in the school-based setting. If the CRA code is not submitted on the claim, no other school-based services will pay. The Oral Health Score will be placed on
the All Kids School-Based Dental Program School Exam Follow-Up Care Form (Attachment V).

Caries Risk Assessment Code	Oral Health Score	Criteria	ASTDD Indicator: Urgency of Need for Dental Care *
D0601	1	No visual signs of decay, no cavitated lesions, no signs of shadowing or carious interproximal enamel at the marginal ridges.	Children with no untreated decay or other dental problems requiring early attention are considered to have no obvious problem, which means that they should receive routine dental checkups.
D0602	2	Four or less cavitated, occlusal, or incipient caries. Caries not close proximity to pulpal tissue.	If someone needs to see a dentist because of untreated decay but they do not have pain or an infection they are classified as needing early dental care. For our purposes, early treatment means that they should see a dentist within the next several weeks or before their next regularly scheduled dental appointment. An individual with a broken or missing filling, but no other untreated decay, would be classified as needing early dental care.
D0603	3	Five or more carious lesions, gross caries, root tips, any carious tooth likely to involve pulpal treatment, dental abscess, presence of soft tissue oral pathology, foreign object in mouth causing dental pain, or presence of dental pain associated with dental disease reported by the patient.	Urgent need for dental care is used for those who need dental care within 24 to 48 hours because of signs or symptoms that include pain, infection, or swelling. In children, the most common reason for being classified as needing urgent care is an abscess.

* Basic Screening Surveys, Association of State and Territorial Dental Directors:
http://www.astdd.org/docs/BSSChildren'sManual20081revised2.9.2010.pdf

Attachment V- School Based Exam Follow-Up Care Form (Including Spanish Translation)

All Kids School-Based Dental Program

Space for Logo

Date: ____/____/_____

Dear Parent or guardian of _____,
(student's name)

A dentist, Dr. _____, saw your child today.

Today your child was given:

___ **Dental Exam**
___ **Cleaning**
___ **Fluoride**
___ **Dental sealants**

Space for Referral Plan

*If you see a dentist regularly please continue with them for your child's oral health care and X-rays.

This is what the dentist saw today. Dental X-rays were not taken. The picture shows where decay is. The other box shows more about your child's teeth and gums.

___**1 – *No visual signs of decay*—**See your dentist twice a year. Keep brushing and flossing every day. Please remember: This school oral health visit does not take the place of regular dental visits.
___**2 – *Cavity/cavities*—**Your child needs a check-up for fillings or crowns, and X-rays. Go to a dentist **soon**.
___**3 – *Dental disease*—**Go to dentist **now**! Your child may have a toothache.

Your child has a possible cavity or cavities:

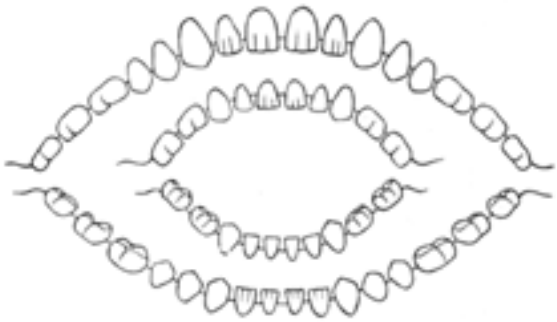
_____ No _____ Yes

Oral Hygiene (How **clean** the teeth are):

_____ Good _____ Fair _____ Poor

Periodontal Status (Health of gums):

_____ Good _____ Fair _____ Poor



Thank you for helping your child have healthy teeth and gums! Oral health is an important part of overall health. If you have any questions about your child's visit today, or would like to get dental records, please call _____ at (_____) _____– _____ .

Address_____ License Number _____

Sincerely,

_____
(Dentist's signature)

_____
Phone number

Notes:

Attachment V (Spanish)

All Kids School-Based Dental Program
School Exam Follow-Up Care Form

Space for Logo

Fecha: ____/____/_____

Estimado padre, madre o tutor de _____
(Nombre del alumno)

Hoy, un dentista, el Dr. _____, examinó a su hijo(a).

Hoy, su hijo(a) recibió:

___ **Un examen dental**
___ **Una limpieza**
___**Aplicación de fluoruro**
___**Aplicación de selladores dentales**
(en los siguientes dientes)
_____

SPACE FOR REFERRAL PLAN

* Si visita a un dentista regularmente, sírvase continuar con su dentista para recibir el cuidado de salud dental y obtener radiografías.

Esto es lo que vio el dentista hoy. No se tomaron radiografías. La ilustración muestra dónde hay caries. El otro cuadro muestra más información sobre los dientes y encías de su hijo(a).

___**1** - ***No No hay señales visibles de caries***—Vaya al dentista dos veces al año. Siga cepillándose y usando hilo dental todos los días. Recuerde: Esta consulta de salud bucodental en la escuela no sustituye el cuidado regular con un dentista.
___**2** - ***Una o más caries***—Su hijo(a) necesita ser examinado para obtener empastes o coronas. Vaya al dentista **pronto.**
___**3** - ***Enfermedad dental***—¡Vaya al dentista **ahora**! **Su hijo(a) podría tener dolor de dientes.**

Su hijo(a) posiblemente tiene una o más caries.

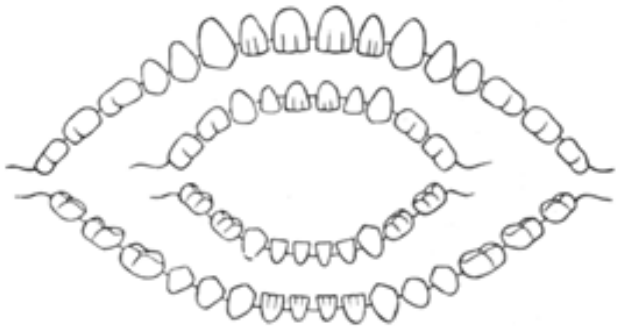
_____ No _____ Si

Higiene dental (cuán **limpios** están los dientes):

_____ Buena _____ Regular _____ Mala

Estado periodontal (salud de las encías):

_____ Buena _____ Regular _____ Mala



¡Gracias por ayudar a que su hijo(a) tenga dientes y encías sanos! La salud bucodental es parte importante de la salud general. Si tiene alguna pregunta sobre la consulta de su hijo(a) el día de hoy, o para obtener registros de historia dental, no dude en llamar a
_____ al (_____) _____– _____ .

Dirección _____Número de licencia_____.

Notas:

Atentamente,

_____
(Firma del dentista)

Illinois All Kids School-Based Dental Program
Referral Plan Language for the
School Exam Follow-Up Care Form

The box titled “Space for Referral Plan” on the School Exam Follow-Up Care Form provides a space for the School-Based Provider to indicate which type of Referral Plan will be used for each location.

Based on the Referral Plan chosen, use the following language:

Option 1: Please call to schedule an appointment with my office for follow-up care.

Name
Address
Phone Number

Option 2: [Insert your entity name] will be returning to this location on [insert date] to provide follow- up treatment. Please call [insert phone number] to schedule an appointment.

Option 3: The case manager for [Insert your entity name] will be contacting your for follow-up care
information. If you don’t receive a call from us, please contact us at [insert phone number here].

Opción 1: Por favor, llame a mi oficina para programar una cita de cuidado de seguimiento.

Nombre
Dirección
Número de teléfono

Opción 2: [Inserte el nombre de su entidad] volverá a este local el [inserte fecha] para proveer tratamiento de seguimiento. Sírvase llamar al [inserte número de teléfono] para programar una cita.

Opción 3: El coordinador de caso de [Inserte el nombre de su entidad] se comunicará con usted para informarle del cuidado de seguimiento. Si no recibe una llamada nuestra, por favor comuníquese con nosotros al [inserte número de teléfono aquí].

Attachment W – Proof of School Dental Examination Form

Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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Attachment X –Sample Consent Form

All Kids School-Based Dental Program

Dental Exam Must be returned tomorrow

Please print in ink:

Name of School: _____

Teacher: _____Grade:_____

County: _____

Dear Parent or Guardian,

(Name of entity) has arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants. Sealants are a protective coating on the chewing surfaces of the back teeth. Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child to receive these services, **you must provide all the information requested below and sign in the area indicated.**

Your child's name: _____Birth date: _____/_____/_____

Address: _____City/Zip: _____

Phone number: (_____) _____-_____ Male ___ Female ___ Race/Ethnicity: _____

Does your child qualify for free/reduced meals? YES NO

Is your child enrolled in the All Kids Program? YES NO

If yes, include your child's recipient ID number: _____

Is your child covered by private dental insurance? YES NO

Name of insurance company: _____

Insurance telephone number: (_____) _____-_____Group number: _____

Employer Name: _____

Name of insured: _____Date of birth: _____/_____/_____

Social security number of insured person: _____

Has your child had any history of, or conditions related to, any of the following:

___Latex allergy ___Chronic Sinusitis ___Seizures ___Asthma ___Fainting
___Hearing impairment ___Bleeding disorder ___Cancer ___Anemia
___Heart condition ___Tobacco/drug use ___Epilepsy ___Pregnancy

Is your child taking any prescription and/or over the counter medications at this time? YES NO

If yes, please list:

Does your child have any speech difficulties? YES NO

Has your child ever suffered injuries to the m outh, head, or teeth? YES NO

What type of water does your child drink? ___City water ___Well water ___Bottled water

IMPORTANT: Parent/guardian signature required

I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse, school representative and dental provider to access the child's dental record.

Signature: _____Date: _____

In signing this form you give permission to treat your child and also verify that you have read the a dditional form regarding HIPAA.

This will also give permission for IDPH Quality Assurance Audits to be performed and providers to return to your school to recheck your child's sealants.

Dentist's Initials _____

Attachment Y - All Kids School-Based Dental Program Sample Dental Record

To Be Completed by Dentist

Treatment Received Today:

Exam _____
Fluoride treatment (gel) _____
Prophylaxis (including scaling, if needed) _____ Fluoride treatment (varnish)
Dental sealants (teeth #'s) _____

Current Dental Status Of Patient

Prior Treatment:	**Restorations**	**Sealants**
	_____	_____
	_____	_____
	_____	_____

Treatment Needed:	**Restorative**	**Sealants**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Oral Hygiene Status: ___Good ___Fair ___Poor

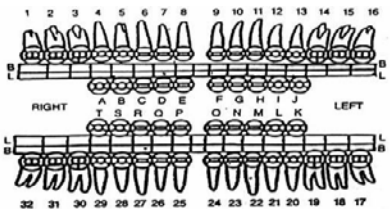
Periodontal Status: ___Good ___Fair ___Poor

Oral Health Assessment Rating:

1. Preventive Care (services rendered today) - There is no visual evidence of caries activity or periodontal pathology.
2. Restorative Care- Amalgams, composites, crowns, etc.
3. Urgent Treatment- Abscess, nerve exposure advanced disease state, signs or symptoms that include pain, infection or swelling.

Oral Health Assessment Score: _____

Notes: _____



Dentist's Signature: _____ Treatment Date: _____

ATTACHMENT Z- IL-CHILD Medicaid FFS
LIBERTY Dental Corporation

Code	Description of Services	Fee
	DIAGNOSTIC	
D0120	Periodic Oral Evaluation, Established Patient	$28.00
D0140	Limited Oral Evaluation, Problem Focused	$16.20
D0150	Comprehensive Oral Evaluation	$21.05
D0210	Full Mouth X-Ray	$30.10
D0220	Periapical, First Image	$5.60
D0230	Periapical, Each Additional Image	$3.80
D0270	Bitewings, Single Image	$5.60
D0272	Bitewings, Two Images	$9.40
D0274	Bitewings, Four Images	$16.90
D0277	Vertical bitewings, 7 to 8 radiographic images	$16.90
D0330	Panoramic radiographic image	$22.60
	PREVENTATIVE	
D1110	Prophylaxis, Adult	$25.40
D1120	Prophylaxis, Child	$41.00
D1206	Topical application of fluoride varnish	$26.00
D1208	Topical application of fluoride	$26.00
D1351	Sealant, per tooth	$36.00
D1510	Space maintainer, fixed, unilateral	$70.60
D1515	Space maintainer, fixed, bilateral	$103.50
D1520	Space maintainer, removable, unilateral	$70.60
D1525	Space maintainer, removable, bilateral	$74.70
D1550	Recementation of space maintainer	$10.70
	RESTORATIVE	
D2140	Amalgam, 1 Surface, Primary or Permanent	$30.85
D2150	Amalgam, 2 Surfaces, Primary or Permanent	$48.15
D2160	Amalgam, 3 Surfaces, Primary or Permanent	$58.05
D2161	Amalgam, 4 or More Surfaces, Primary or Permanent	$58.05
D2330	Resin-Based Composite, 1 Surface, Anterior	$34.60
D2331	Resin-Based Composite, 2 Surfaces, Anterior	$51.90
Code	Description of Services	Fee
D2332	Resin-Based Composite, 3 Surfaces, Anterior	$61.80
D2335	Resin-Based Composite, 4+ Surfaces or Involving Incisal Angle (Anterior)	$61.80
D2391	Resin-Based Composite, 1 Surface, Posterior	$30.85
D2392	Resin-Based Composite, 2 Surfaces, Posterior	$48.15
D2393	Resin-Based Composite, 3 Surfaces, Posterior	$58.05
D2394	Resin-Based Composite, 4+ Surfaces, Posterior	$58.05
D2740	Crown, porcelain/ceramic	$235.20
D2750	Crown, porcelain fused to high noble metal	$235.20
D2751	Crown, porcelain fused to predominantly base metal	$235.20
D2752	Crown, porcelain fused to noble metal	$235.20
D2790	Crown, full cast high noble metal	$145.85
D2791	Crown, full cast predominantly base metal	$145.85
D2792	Crown, full cast noble metal	$145.85
D2910	Recement inlay, onlay, partial coverage restoration	$11.30

D2915	Recement cast or prefabricated post & core	$23.50
D2920	Recement crown	$23.50
D2930	Prefabricated stainless steel crown, primary tooth	$73.40
D2931	Prefabricated stainless steel crown, permanent tooth	$73.40
D2932	Prefabricated resin crown	$56.45
D2933	Prefabricated stainless steel crown, resin window	$56.45
D2934	Prefabricated esthetic coated SS crown, primary	$73.40
D2940	Protective restoration (temporary)	$11.30
D2950	Core build-up, including any pins	$58.05
D2951	Pin retention, per tooth, in addition to restoration	$9.40
D2954	Prefabricated post & core in addition to crown	$32.90
	ENDODONTICS	
D3220	Therapeutic pulpotomy (excluding final restoration)	$52.70
D3222	Partial pulpotomy for apexogenesis	$60.35
D3230	Pulpal therapy (resorbable filling), anterior primary	$52.70
D3310	Root canal - anterior (excluding final restoration)	$136.40
D3320	Bicuspid (excluding final restoration)	$155.25
D3330	Molar (excluding final restoration)	$202.30
D3351	Apexification/recalcification/pulp reg. – initial visit	$28.20
D3352	Apexification/recalcification/pulp reg. – interim med.	$14.10
D3353	Apexification/recalcification – final visit	$14.10
D3410	Apicoectomy/periradicular surgery – anterior	$112.90
	PERIODONTICS	
D4210	Gingivectomy or Gingivoplasty, 4+ teeth per quad	$131.70
D4211	Gingivectomy or Gingivoplasty, 1-3 teeth per quad	$65.85
D4240	Gingival flap procedure, 4+ teeth per quadrant	$229.60
D4241	Gingival flap procedure, 1-3 teeth per quadrant	$114.80
D4260	Osseous surgery, 4+ teeth per quadrant	$277.60
D4261	Osseous surgery, 1-3 teeth per quadrant	$138.80
D4263	Bone replacement graft, 1st site in quadrant	$141.15
D4264	Bone replacement graft, each add 'l site, quadrant	$70.60
D4270	Pedicle soft tissue graft procedure	$141.15
D4273	Subepithelial connective tissue graft, per tooth	$141.15
D4274	Distal/proximal wedge procedure	$70.60
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous position	$141.15
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth	$141.15
Code	Description of Services	Fee
D4320	Provisional splinting - intracoronal	$188.20
D4321	Provisional splinting - extracoronal	$56.50
D4341	Periodontal scaling & root planing, 4+ teeth per quad	$122.00
D4342	Periodontal scaling & root planing, 1-3 teeth per quad	$77.00
D4355	Full mouth debridement	$62.00
D4910	Periodontal maintenance	$67.00
	PROSTHODONTICS, REMOVED	
D5110	Complete Denture, Maxillary	$376.35
D5120	Complete Denture, Mandibular	$376.35
D5130	Immediate Denture, Maxillary	$376.35
D5140	Immediate Denture, Mandibular	$376.35
D5211	Maxillary Partial Denture, Resin Base	$357.55
D5212	Mandibular Partial Denture, Resin Base	$357.55
D5213	Maxillary partial denture, cast metal/resin base	$366.95

D5214	Mandibular partial denture, cast metal/resin base	$366.95
D5510	Repair Broken Complete Denture Base	$61.15
D5520	Replace Missing Or Broken Teeth, Complete Denture	$38.10
D5610	Repair Resin Denture Base, Partial Denture	$51.75
D5620	Repair cast framework	$79.05
D5630	Repair or replace broken clasp	$71.50
D5640	Replace Broken Teeth, Partial Denture	$37.65
D5650	Add Tooth To Existing Partial Denture	$42.35
D5730	Reline Complete Maxillary Denture (Chairside)	$70.60
D5731	Reline Complete Mandibular Denture (Chairside)	$70.60
D5740	Reline Maxillary Partial Denture (Chairside)	$70.60
D5741	Reline Mandibular Partial Denture (Chairside)	$70.60
D5750	Reline Complete Maxillary Denture (Laboratory)	$117.60
D5751	Reline Complete Mandibular Denture (Laboratory)	$117.60
D5760	Reline Maxillary Partial Denture (Laboratory)	$117.60
D5761	Reline Mandibular Partial Denture (Laboratory)	$117.60
D5911	Facial moulage (sectional)	$361.25
D5912	Facial moulage (complete)	$453.90
D5913	Nasal prosthesis	$1,020.00
D5914	Auricular prosthesis	$1,020.00
D5915	Orbital prosthesis	$510.00
D5916	Ocular prosthesis	$1,020.00
D5919	Facial prosthesis	$1,020.00
D5922	Nasal septal prosthesis	$510.00
D5923	Ocular prosthesis, interim	$510.00
D5924	Cranial prosthesis	$1,190.00
D5925	Facial augmentation implant prosthesis	$255.00
D5926	Cranial prosthesis	$255.00
D5927	Auricular prosthesis, replacement	$255.00
D5928	Orbital prosthesis, replacement	$255.00
D5929	Facial prosthesis, replacement	$255.00
D5931	Obturator prosthesis, surgical	$850.00
D5932	Obturator prosthesis, definitive	$1,275.00
D5933	Obturator prosthesis, modification	$191.25
D5934	Mandibular resection prosthesis with guide flange	$1,445.00
D5935	Mandibular resection prosthesis without guide flange	$1,190.00
Code	Description of Services	Fee
D5936	Obturator prosthesis, interim	$765.00
D5937	Trismus appliance (not for TMD treatment)	$106.25
D5951	Feeding aid	$170.00
D5952	Speech aid prosthesis, pediatric	$680.00
D5953	Speech aid prosthesis, adult	$1,232.50
D5954	Palatal augmentation prosthesis	$170.00
D5955	Palatal lift prosthesis, definitive	$1,190.00
D5958	Palatal lift prosthesis, interim	$680.00
D5959	Palatal lift prosthesis, modification	$187.00
D5960	Speech aid prosthesis, modification	$187.00
D5982	Surgical stent	$106.25
D5983	Radiation carrier	$68.00
D5984	Radiation shield	$170.00
D5985	Radiation cone locator	$170.00

D5986	Fluoride gel carrier	$68.00
D5987	Commissure splint	$106.25
D5988	Surgical splint	$174.25
D5999	Unspecified maxillofacial prosthesis, by report	By Report
	PROSTHODONTICS, FIXED	
D6210	Pontic, cast high noble metal	$178.80
D6211	Pontic, cast predominantly base metal	$178.80
D6212	Pontic, cast noble metal	$178.80
D6240	Pontic, porcelain fused to high noble metal	$178.80
D6241	Pontic, porcelain fused to predominantly base metal	$178.80
D6242	Pontic, porcelain fused to noble metal	$178.80
D6251	Pontic, resin with predominantly base metal	$103.50
D6721	Crown, resin with predominantly base metal	$136.40
D6750	Crown, porcelain fused to high noble metal	$159.95
D6751	Crown, porcelain fused to predominantly base metal	$159.95
D6752	Crown, porcelain fused to noble metal	$159.95
D6790	Crown, full cast high noble metal	$159.95
D6791	Crown, full cast predominantly base metal	$159.95
D6792	Crown, full cast noble metal	$159.95
D6930	Recement fixed partial denture	$32.90
D6972	Prefabricated post and core + retainer	$26.35
D6999	Unspecified fixed prosthodontic procedure, by report	By Report
	ORAL AND MAXILLOFACIAL SURGERY	
D7140	Extraction, Erupted Tooth/Exposed Root	$39.12
D7210	Surgical Removal Of Erupted Tooth	$57.40
D7220	Removal Of Impacted Tooth, Soft Tissue	$66.80
D7230	Removal Of Impacted Tooth, Partially Bony	$86.60
D7240	Removal Of Impacted Tooth, Complete Bony	$100.70
D7250	Surgical Removal Of Residual Tooth Roots	$57.40
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$217.00
D7280	Surgical access of an unerupted tooth	$50.80
D7283	Placement, device to facilitate eruption, impaction	$45.00
D7310	Alveoloplasty with extractions, 4+ teeth, quadrant	$64.00
D7311	Alveoloplasty with extractions, 1-3 teeth, quadrant	$64.00
D7320	Alveoloplasty, w/o extractions, 4+ teeth, quadrant	$64.00
D7321	Alveoloplasty, w/o extractions, 1-3 teeth, quadrant	$64.00
Code	Description of Services	Fee
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25	$94.30
D7451	Removal, benign odontogenic cyst/tumor, over 1.25	$199.60
D7460	Removal, benign nonodontogenic cyst/tumor, to 1.25	$94.30
D7461	Removal, benign nonodontogenic cyst/tumor, 1.25+	$199.60
D7510	Incision & drainage of abscess, intraoral soft tissue	$36.70
D7511	Incision/drainage, abscess, intraoral soft, complicated	$36.70
D7610	Maxilla - open reduction (teeth immobilized, if present)	$657.95
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$471.50
D7630	Mandible - open reduction (teeth immobilized, if present)	$824.65
D7640	Mandible - closed reduction (teeth immobilized, if present)	$706.95
D7710	Maxilla - open reduction	$1,059.35
D7720	Maxilla - closed reduction	$706.35
D7730	Mandible - open reduction	$1,059.35
D7740	Mandible - closed J reduction	$706.20

D7810	Open reduction of dislocation	$438.60
D7820	Closed reduction of dislocation	$177.65
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$77.15
D7963	Frenuloplasty	$77.15
D7999	Unspecified oral surgery procedure, by report	By Report
	ORTHODONTICS	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$900.00
D8660	Pre-orthodontic treatment visit	$100.00
D8670	Periodic orthodontic treatment visit (as part of contract)	$240.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$150.00
D8999	Unspecified orthodontic procedure, by report	$47.05
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment, minor procedure	$55.00
D9220	Deep sedation/general anesthesia, 1st 30 minutes	$76.70
D9221	Deep sedation/general anesthesia, each add 'l 15 minutes	$38.35
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$26.00
D9241	Intravenous conscious sedation/analgesia, 1st 30 minutes	$76.70
D9242	IV conscious sedation/analgesia, each add 'l 15 minutes	$38.35
D9248	Non-intravenous conscious sedation	$48.00
D9310	Consultation, Diagnostic Service Provided by Dentist or Physician Other Than Requesting	$17.10
D9610	Therapeutic parenteral drug, single admin	By Report
D9630	Other drugs and/or medicaments, by report	$23.50
D9999	Unspecified adjunctive procedure, by report	By Report

ATTACHMENT Z - IL-ADULT Medicaid FFS
LIBERTY Dental Corporation

Code	Description of	Fee
	DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	$16.20
D0140	Limited oral evaluation - problem focused	$16.20
D0150	Comprehensive oral evaluation - new or established patient	$21.05
D0210	Intraoral - complete series of radiographic images	$30.10
D0220	Intraoral - periapical first radiographic image	$5.60
D0230	Intraoral - periapical each additional radiographic image	$3.80
D0270	Bitewing - single radiographic image	$5.60
D0272	Bitewings - two radiographic images	$9.40
D0274	Bitewings - four radiographic images	$16.90
D0277	Vertical bitewings - 7 to 8 radiographic images	$16.90
D0330	Panoramic radiographic image	$22.60
	PREVENTIVE	
D1110	Prophylaxis – adult	$25.40
	RESTORATIVE	
D2140	Amalgam - one surface, primary or permanent	$30.85
D2150	Amalgam - two surfaces, primary or permanent	$48.15
D2160	Amalgam - three surfaces, primary or permanent	$58.05
D2161	Amalgam - four or more surfaces, primary or permanent	$58.05
D2330	Resin-based composite - one surface, anterior	$34.60
D2331	Resin-based composite - two surfaces, anterior	$51.90
D2332	Resin-based composite - three surfaces, anterior	$61.80
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$61.80
D2391	Resin-based composite - one surface, posterior	$30.85
D2392	Resin-based composite - two surfaces, posterior	$48.15
D2393	Resin-based composite - three surfaces, posterior	$58.05
D2394	Resin-based composite - four or more surfaces, posterior	$58.05
Code	Description of Services	Fee
D2740	Crown - porcelain/ceramic substrate	$235.20
D2750	Crown - porcelain fused to high noble metal	$235.20
D2751	Crown - porcelain fused to predominantly base metal	$235.20
D2752	Crown - porcelain fused to noble metal	$235.20
D2790	Crown - full cast high noble metal	$145.85
D2791	Crown - full cast predominantly base metal	$145.85
D2792	Crown - full cast noble metal	$145.85
D2910	Recement inlay, onlay, or partial coverage restoration	$11.30
D2915	Recement cast or prefabricated post and core	$23.50
D2920	Recement crown	$23.50
D2931	Prefabricated stainless steel crown - permanent tooth	$73.40
D2932	Prefabricated resin crown	$56.45
D2940	Protective restoration	$11.30
D2950	Core buildup, including any pins when required	$58.05
D2951	Pin retention - per tooth, in addition to restoration	$9.40

D2954	Prefabricated post and core in addition to crown	$32.90
	ENDODONTICS	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$136.40
	PERIODONTICS	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$122.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$77.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$62.00
	PROSTHODONTICS, REMOVED	
D5110	Complete denture - maxillary	$376.35
D5120	Complete denture - mandibular	$376.35
D5130	Immediate denture - maxillary	$376.35
D5140	Immediate denture - mandibular	$376.35
D5510	Repair broken complete denture base	$61.15
D5520	Replace missing or broken teeth - complete denture (each tooth)	$38.10
D5610	Repair resin denture base	$51.75
D5620	Repair cast framework	$79.05
D5630	Repair or replace broken clasp	$71.50
D5640	Replace broken teeth - per tooth	$37.65
D5650	Add tooth to existing partial denture	$42.35
D5730	Reline complete maxillary denture (chairside)	$70.60
D5731	Reline complete mandibular denture (chairside)	$70.60
D5740	Reline maxillary partial denture (chairside)	$70.60
D5741	Reline mandibular partial denture (chairside)	$70.60
D5750	Reline complete maxillary denture (laboratory)	$117.60
D5751	Reline complete mandibular denture (laboratory)	$117.60
D5760	Reline maxillary partial denture (laboratory)	$117.60
D5761	Reline mandibular partial denture (laboratory)	$117.60
D5911	Facial moulage (sectional)	$361.25
D5912	Facial moulage (complete)	$453.90
D5913	Nasal prosthesis	$1,020.00
D5914	Auricular prosthesis	$1,020.00
D5915	Orbital prosthesis	$510.00
D5916	Ocular prosthesis	$1,020.00
D5919	Facial prosthesis	$1,020.00
Code	Description of Services	Fee
D5922	Nasal septal prosthesis	$510.00
D5923	Ocular prosthesis, interim	$510.00
D5924	Cranial prosthesis	$1,190.00
D5925	Facial augment implant prosthesis	$255.00
D5926	Cranial prosthesis	$255.00
D5927	Auricular prosthesis, replacement	$255.00
D5928	Orbital prosthesis, replacement	$255.00
D5929	Facial prosthesis, replacement	$255.00
D5931	Obturator prosthesis, surgical	$850.00
D5932	Obturator prosthesis, definitive	$1,275.0
D5933	Obturator prosthesis, modification	$191.25
D5934	Mandibular resection prosthesis with guide flange	$1,445.0
D5935	Mandibular resection prosthesis without guide flange	$1,190.0
D5936	Obturator prosthesis, interim	$765.00
D5937	Trismus appliance (not for TMD treatment)	$106.25

D5951	Feeding aid	$170.00
D5953	Speech aid prosthesis, adult	$1,232.5
D5954	Palatal augmentation prosthesis	$170.00
D5955	Palatal lift prosthesis, definitive	$1,190.0
D5958	Palatal lift prosthesis, interim	$680.00
D5959	Palatal lift prosthesis, modification	$187.00
D5960	Speech aid prosthesis, modification	$187.00
D5982	Surgical stent	$106.25
D5983	Radiation carrier	$68.00
D5984	Radiation shield	$170.00
D5985	Radiation cone locator	$170.00
D5986	Fluoride gel carrier	$68.00
D5987	Commissure splint	$106.25
D5988	Surgical splint	$174.25
D5999	Unspecified maxillofacial prosthesis, by report	By
	PROSTHODONTICS, FIXED	
D6930	Recement fixed partial denture	$32.90
D6999	Unspecified fixed prosthodontic procedure, by report	By Report
	ORAL AND MAXILLOFACIAL SURGERY	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$39.12
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevetion of mucoperiosteal flap if indicated	$57.40
D7220	Removal of impacted tooth - soft tissue	$66.80
D7230	Removal of impacted tooth - partially bony	$86.60
D7240	Removal of impacted tooth - completely bony	$100.70
D7250	Surgical removal of residual tooth roots (cutting procedure)	$57.40
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$94.30
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$199.60
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$94.30
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25	$199.60
D7510	Incision and drainage of abscess - intraoral soft tissue	$36.70
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$36.70
D7610	Maxilla - open reduction (teeth immobilized, if present)	$657.95
Code	Description of Services	Fee
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$471.50
D7630	Mandible - open reduction (teeth immobilized, if present)	$824.65
D7640	Mandible - closed reduction (teeth immobilized, if present)	$706.95
D7710	Maxilla - open reduction	$1,059.35
D7720	Maxilla - closed reduction	$706.35
D7730	Mandible - open reduction	$1,059.35
D7740	Mandible - closed J reduction	$706.20
D7810	Open reduction of dislocation	$438.60
D7820	Closed reduction of dislocation	$177.65
D7999	Unspecified oral surgery procedure, by report	By Report
	ADJUNCTIVE GENERAL SERVICES	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$55.00
D9220	Deep sedation/general anesthesia - first 30 minutes	$76.70

D9221	Deep sedation/general anesthesia - each additional 15 minutes	$38.35
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$26.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$76.70
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$38.35
D9248	Non-intravenous conscious sedation	$48.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$17.10
D9610	Therapeutic parenteral drug, single administration	By Report
D9630	Other drugs and/or medicaments, by report	$23.50
D9999	Unspecified adjunctive procedure, by report	By Report

Attachment AA - Dental Visit Co-Payments

HFS Dental Program/All Kids Program
Dental Visit Co-Payments

	All Kids Previously called Kid Care			Expanded Coverage Under All Kids/HFS Dental Program
Dental Visit Types	**All Kids Assist**	**All Kids Share**	**All Kids Premium Level 1**	**All Kids Premium Level 2**
Preventive	N/A	N/A	N/A	N/A
Diagnostic	N/A	N/A	N/A	N/A
Restorative	N/A	$3.90	$5	$10
Endodontics	N/A	$3.90	$5	$10
Peridontics	N/A	$3.90	$5	$10
Prosthodontics	N/A	$3.90	$5	$10
Oral and Maxillofacial Surgery	N/A	$3.90	$5	$10
Orthodontics	N/A	$3.90	$5	$10
Adjunctive Services	N/A	$3.90	$5	$10

Attachment BB - Dental Periodicity Schedule

Illinois Department of Healthcare and Family Services

Dental Periodicity Schedule

(Effective July 1, 2014)

The Illinois Department of HealthCare and Family Services (HFS) has based the Dental Health Periodicity Schedule on the American Academy of Pediatric Dentistry Periodicity Schedule oral health recommendations and consultation with the medical and dental communities. This schedule is designed for the care of children who have no contributing medical conditions and should be modified for children with special health care needs or in the event of trauma or disease results in variations from the norm.

As part of the well child visit, the Primary Care Provider (PCP) (medical home) performs an oral health screening, HFS recommends following the American Academy of Pediatrics guidelines, and as detailed in the guidance provided by the HFS Handbook for Providers of Healthy Kids Services in accordance with Bright Futures. An oral screening is part of the well child physical examination but does not replace referral to a dentist. Children should receive an oral health risk screening from their PCP by six months of age that includes: (1) assessing the child's risk factors for developing oral disease; providing education on the importance of oral health; and evaluating and optimizing fluoride exposure. Anticipatory guidance related to oral health provided to the parent, guardian and child should be age appropriate and follow the Bright Futures in Practice: ORAL HEALTH Pocket Guide.

At age one, or earlier as needed, PCP's should refer children to a dentist for routine and periodic preventive dental care. For children under age one, the PCP should perform the oral health screening to identify children who require evaluation by a dentist, and to provide evidence based/informed preventive oral health services, including anticipatory guidance.

A dentist will perform a thorough exam that will include X-rays. The dental hygienist will perform prophylaxis, fluoride, and oral health education.

Illinois Department of HealthCare and Family Services
Dental Periodicity Schedule
Birth to Age 21

SERVICE	Birth – 12 Months	12-24 Months	24 Months to 3 years	3-6 Years	6-12 Years	12 Years & Older
Anticipatory Guidance/Counseling[1]	•	•	•	•	●	●
Oral Health Screening by PCP (at physical exam)	•	•	•	•	●	●
Clinical Oral Examination[2]			•	•	●	●
Assess oral growth and development[3]	•	•	•	•	●	●
Caries-risk assessment 3	•	•	•	•	●	●
Fluoride Supplementation/ Topical Fluoride Varnish	•	•	•	•	●	●
Referral to a Dental Home by the PCP[4]		•	•	•	●	●
Radiographic Assessment			•	•	●	●
Pit & Fissure Sealants[5]				●	●	●
Fluoride Supplementation/ Topical Fluoride Varnish	●	●	●	●	●	●
Assessment and possible removal of 3rd molars						●

Note: While some services are not noted in a certain age category (e.g., birth to 12 months), those services are available, as medically necessary, to those children.

[1] Appropriate discussion and counseling is a part of each visit for care and includes age appropriate topics, such as oral hygiene, including brushing and flossing; fluoride, diet and nutrition; early childhood caries prevention; injury prevention; speech/language development; piercing; substance abuse (e.g., smoking).
[2] Every six months in an office setting. Includes assessment of pathology and injuries.
[3] Occurs at the PCP and Dentist visits.
[4] Referral to a dentist is recommended routinely by age 1, or earlier as medically necessary.
[5] For caries susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

EXHIBIT A: IL CHILD TANF

Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Diagnostic Services					
D0120	Periodic oral evaluation, established patient	0-20			1 per 6 months
D0140	Limited oral evaluation, problem focused	0-20		description of emergency and services provided with claim	1 per day. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not payable with D9110.
D0150	Comprehensive oral evaluation, new or established patient	0-20			1 per provider or location per lifetime
D0210	Full mouth radiographic image	6-20			1 of (D0210, D0277, D0330) per 36 months
D0220	Periapical, first radiographic image	0-20			1 per day per provider or location
D0230	Periapical, each additional radiographic image	0-20			6 of (D0230, D0270) per date of service
D0270	Bitewing, single radiographic image	0-20			
D0272	Bitewings, two radiographic images	2-20			1 of (D0272, D0274) per 12 months
D0274	Bitewings, four radiographic images	10-20			
D0277	Vertical bitewings, 7 to 8 radiographic images	6-20			1 of (D0210, D0277, D0330) per 36 months
D0330	Panoramic image	6-20			
Preventive Services					
D1110	Prophylaxis, adult	0-20			1 of (D1110, D1120) per 6 months
D1120	Prophylaxis, child	0-20			
D1206	Topical fluoride varnish	0-20			3 of (D1206, D1208) per 12 months age 0-2. 1 of (D1206, D1208) per 12 months age 3-20, (Both codes, D1206, D1208 are NOT permitted in the same 12 months w/in the same treatment setting.)
D1208	Topical fluoride	0-20			
D1351	Sealant, per tooth	5-17			1 per tooth per lifetime. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.
D1510	Space maintainer, fixed, unilateral	0-20			1 of (D1510,D1515,D1520,D1525) per quadrant/arch per lifetime
D1515	Space maintainer, fixed, bilateral	0-20			
D1520	Space maintainer, removable, unilateral	0-20			
D1525	Space maintainer, removable, bilateral	0-20			
D1550	Recementation space maintainer	0-20			

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Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Restorative Services					
D2140	Amalgam, 1 surface	0-20			1 of (D2140,D2150,D2160, D2161, D2330, D2331, D2332, D2335,D2391, D2392, D2393, D2394) per tooth per surface per 12 months
D2150	Amalgam, 2 surfaces	0-20			
D2160	Amalgam, 3 surfaces	0-20			
D2161	Amalgam, 4+ surfaces	0-20			
D2330	Resin-based composite, 1 surface, anterior	0-20			
D2331	Resin-based composite, 2 surfaces, anterior	0-20			
D2332	Resin-based composite, 3 surfaces, anterior	0-20			
D2335	Resin-based composite, 4+ surfaces, anterior	0-20			
D2391	Resin-based composite, 1 surface, posterior	0-20			
D2392	Resin-based composite, 2 surfaces, posterior	0-20			
D2393	Resin-based composite, 3 surfaces, posterior	0-20			
D2394	Resin-based composite, 4+ surfaces, posterior	0-20			
D2740	Crown, porcelain/ceramic substrate	0-20	Y	pre-operative x-ray(s)	1 of (D2740-D2792, D2931, D6210-D6792) per tooth per 60 months.
D2750	Crown, porcelain fused to high noble	0-20	Y		
D2751	Crown, porcelain fused to metal	0-20	Y		
D2752	Crown, porcelain fused noble metal	0-20	Y		
D2790	Crown, full cast high noble	0-20	Y		
D2791	Crown, full cast base metal	0-20	Y		
D2792	Crown, full cast noble metal	0-20	Y		
D2910	Recement inlay, onlay, partial coverage restoration	0-20			
D2915	Recement cast or prefabricated post and core	0-20			Not payable within 6 months of D2954 (prefabricated post and core in addition to crown) by the same provider or provider group
D2920	Recement crown	0-20			Not payable within 6 months of D2740-D2792, D2931- D2932 by the same provider or provider group.
D2930	Prefabricated stainless steel crown, primary tooth	0-20			1 of (D2930, D2932, D2933, D2934) per tooth per lifetime
D2931	Prefabricated steel crown, permanent tooth	0-20	Y	pre-operative x-ray(s)	1 of (D2740-D2792, D2931, D6210-D6792) per tooth per 60 months
D2932	Prefabricated resin crown	0-20	Y	pre-operative x-ray(s)	1 of (D2930, D2932, D2933, D2934) per tooth per lifetime
D2933	Prefabricated steel crown with resin window	0-20			
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	0-20			
D2940	Protective restoration	0-20			Not allowed within any 2000 or 3000 series code.
D2950	Core buildup, including any pins	0-20			
D2951	Pin retention, per tooth in addition to restoration	0-20			
D2954	Prefabricated post and core in addition to crown	0-20	Y	final fill periapical x-ray	

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Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Endodontic Services					
D3220	Therapeutic pulpotomy (excluding final restoration)	0-20			Not reimbursable when performed in conjunction with a root canal, primary teeth only
D3222	Partial pulpotomy for apexogenesis	0-20	Y	narrative of medical necessity, pre-op x-ray(s)	1 per tooth per lifetime
D3230	Pulpal therapy (resorbable filling), anterior, primary tooth	0-20			
D3310	Endodontic therapy, anterior (excluding final restore)	0-20			1 of (D3310, D3320, D3330) per tooth per lifetime
D3320	Endodontic therapy, bicuspid (excluding final restore)	0-20			
D3330	Endodontic therapy, molar (excluding final restore)	0-20			
D3351	Apexification/recalcification, initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	0-20	Y	pre-operative x-ray(s)	1 per tooth per lifetime
D3352	Apexification/recalcification, interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	0-20	Y	pre-operative x-ray(s)	2 per tooth per lifetime payable after D3351
D3353	Apexification/recalcification, final visit	0-20	Y	pre and post-operative x-ray(s)	1 per tooth per lifetime
D3410	Apicoectomy, anterior	0-20	Y	pre-operative x-ray(s)	1 per lifetime, not payable with root canal treatment of tooth
Periodontal Services					
D4210	Gingivectomy or gingivoplasty, 4+ teeth per quadrant	0-20	Y	pre-op x-ray(s), perio charting	1 of (D4210, D4211, D4240, D4241, D4260, D4261) per site/quadrant per 24 months. Pre-operative x-rays and periodontic charting required.
D4211	Gingivectomy or gingivoplasty, 1-3 teeth per quadrant	0-20	Y		
D4240	Gingival flap procedure, including root planing, 4+ teeth per quadrant	0-20	Y		
D4241	Gingival flap procedure, including root planing, 1-3 teeth per quadrant	0-20	Y		
D4260	Osseous surgery (including flap entry/closure), 4+ teeth per quad	0-20	Y		
D4261	Osseous surgery (including flap entry/closure), 1-3 teeth per quad	0-20	Y		
D4263	Bone replacement graft, 1st site per quadrant	0-20	Y	pre-op x-ray(s), perio charting	
D4264	Bone replacement graft, each additional site per quadrant	0-20	Y	pre-op x-ray(s), perio charting	
D4270	Pedicle soft tissue graft procedure	0-20	Y	pre-op x-ray(s), perio charting	
D4273	Subepithelial connective tissue graft procedure	0-20	Y	pre-op x-ray(s), perio charting	
D4274	Distal or proximal wedge procedure	0-20	Y	pre-op x-ray(s), perio charting	
D4277	Free soft tissue graft procedure 1st tooth	0-20	Y	pre-op x-ray(s), perio charting	
D4278	Free soft tissue graft procedure each additional tooth	0-20	Y	pre-op x-ray(s), perio charting	

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Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Periodontal Services (Continued)					
D4320	Provisional splinting, intracoronal	0-20	Y	pre-op x-ray(s), perio charting	
D4321	Provisional splinting, extracoronal	0-20	Y	pre-op x-ray(s), perio charting	
D4341	Periodontal scaling and root planing, 4+ teeth per quadrant	0-20	Y	pre-op x-ray(s), perio charting	1 of (D4341, D4342) site/quadrant per 24 months
D4342	Periodontal scaling and root planing, 1-3 teeth, per quadrant	0-20	Y		
D4355	Full mouth debridement	0-20	Y	pre-op x-ray(s), perio charting	1 per 6 months
D4910	Periodontal maintenance	0-20	Y	pre-op x-ray(s), perio charting	
Removable Prosthodontic Services					
D5110	Complete denture, maxillary	0-20	Y	narrative of medical necessity, pre-op x-ray(s); prior placement date	1 per arch per 60 months
D5120	Complete denture, mandibular	0-20	Y		
D5130	Immediate denture, maxillary	0-20	Y	Full mouth x-rays	
D5140	Immediate denture, mandibular	0-20	Y		
D5211	Maxillary partial denture, resin base	0-20	Y	narrative of medical necessity, pre-op x-ray(s); prior placement date	
D5212	Mandibular partial denture, resin base	0-20	Y		
D5213	Maxillary partial denture, cast metal frame, resin denture base	0-20	Y		
D5214	Mandibular partial denture, cast metal frame, resin denture base	0-20	Y		
D5510	Repair broken complete denture base	0-20			
D5520	Replace missing or broken teeth, complete denture	0-20			
D5610	Repair resin denture base	0-20			
D5620	Repair cast framework	0-20			
D5630	Repair or replace broken clasp	0-20			
D5640	Replace broken teeth, per tooth	0-20			
D5650	Add tooth to existing partial denture	0-20			
D5730	Reline complete maxillary denture (chairside)	0-20	Y	date of denture placement	1 per arch per 24 months
D5731	Reline complete mandibular denture (chairside)	0-20	Y		
D5740	Reline maxillary partial denture (chairside)	0-20	Y		
D5741	Reline mandibular partial denture (chairside)	0-20	Y		
D5750	Reline complete maxillary denture (laboratory)	0-20	Y		
D5751	Reline complete mandibular denture (laboratory)	0-20	Y		
D5760	Reline maxillary partial denture (laboratory)	0-20	Y		
D5761	Reline mandibular partial denture (laboratory)	0-20	Y		
Maxillofacial Prosthetic Services					
D5911	Facial moulage (sectional)	0-20	Y	narrative of medical necessity	
D5912	Facial moulage (complete)	0-20	Y	narrative of medical necessity	
D5913	Nasal prosthesis	0-20	Y	narrative of medical necessity	
D5914	Auricular prosthesis	0-20	Y	narrative of medical necessity	

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Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Maxillofacial Prosthetic Services (Continued)					
D5915	Orbital prosthesis	0-20	Y	narrative of medical necessity	
D5916	Ocular prosthesis	0-20	Y	narrative of medical necessity	
D5919	Facial prosthesis	0-20	Y	narrative of medical necessity	
D5922	Nasal septal prosthesis	0-20	Y	narrative of medical necessity	
D5923	Ocular prosthesis, interim	0-20	Y	narrative of medical necessity	
D5924	Cranial prosthesis	0-20	Y	narrative of medical necessity	
D5925	Facial augment implant prosthesis	0-20	Y	narrative of medical necessity	
D5926	Nasal prosthesis, replacement	0-20	Y	narrative of medical necessity	
D5927	Auricular prosthesis, replacement	0-20	Y	narrative of medical necessity	
D5928	Orbital prosthesis, replacement	0-20	Y	narrative of medical necessity	
D5929	Facial prosthesis, replacement	0-20	Y	narrative of medical necessity	
D5931	Obturator prosthesis, surgical	0-20	Y	narrative of medical necessity	
D5932	Obturator prosthesis, definitive	0-20	Y	narrative of medical necessity	
D5933	Obturator prosthesis, modification	0-20	Y	narrative of medical necessity	
D5934	Mandibular resection prosthesis with guide flange	0-20	Y	narrative of medical necessity	
D5935	Mandibular resection prosthesis without guide flange	0-20	Y	narrative of medical necessity	
D5936	Obturator prosthesis, interim	0-20	Y	narrative of medical necessity	
D5937	Trismus appliance (not for TMD treatment)	0-20	Y	narrative of medical necessity	Not for TMD treatment.
D5951	Feeding aid	0-20	Y	narrative of medical necessity	
D5952	Speech aid prosthesis, pediatric	0-12	Y	narrative of medical necessity	
D5953	Speech aid prosthesis, adult	13-20	Y	narrative of medical necessity	
D5954	Palatal augmentation prosthesis	0-20	Y	narrative of medical necessity	
D5955	Palatal lift prosthesis, definitive	0-20	Y	narrative of medical necessity	
D5958	Palatal lift prosthesis, interim	0-20	Y	narrative of medical necessity	
D5959	Palatal lift prosthesis, modification	0-20	Y	narrative of medical necessity	
D5960	Speech aid prosthesis, modification	0-20	Y	narrative of medical necessity	
D5982	Surgical stent	0-20	Y	narrative of medical necessity	

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Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Maxillofacial Prosthetic Services (Continued)					
D5983	Radiation carrier	0-20	Y	narrative of medical necessity	
D5984	Radiation shield	0-20	Y	narrative of medical necessity	
D5985	Radiation cone locator	0-20	Y	narrative of medical necessity	
D5986	Fluoride gel carrier	0-20	Y	narrative of medical necessity	
D5987	Commissure splint	0-20	Y	narrative of medical necessity	
D5988	Surgical splint	0-20	Y	narrative of medical necessity	
D5999	Unspecified maxillofacial prosthesis, by report	0-20	Y	narrative of medical necessity	
Fixed Prosthodontic Services					
D6210	Pontic, cast high noble metal	0-20	Y	pre-operative x-ray(s), prior placement date (if applicable)	1 of (D2740-D2792, D2931, D6210-D6792) per tooth per 60 months
D6211	Pontic, cast predominantly base metal	0-20	Y		
D6212	Pontic, cast noble metal	0-20	Y		
D6240	Pontic, porcelain fused to high noble	0-20	Y		
D6241	Pontic, porcelain fused to predominantly base metal	0-20	Y		
D6242	Pontic, porcelain fused, noble metal	0-20	Y		
D6251	Pontic, resin with predominantly base metal	0-20	Y		
D6721	Crown, resin with predominantly base metal	0-20	Y		
D6750	Crown, porcelain fused, high noble	0-20	Y		
D6751	Crown, porcelain fused to predominantly base metal	0-20	Y		
D6752	Crown, porcelain fused, noble metal	0-20	Y		
D6790	Crown, full cast high noble metal	0-20	Y		
D6791	Crown, full cast predominantly base metal	0-20	Y		
D6792	Crown, full cast noble metal	0-20	Y		
D6930	Recement fixed partial denture	0-20			Not billable by same provider within 6 months of placement.
D6999	Unspecified fixed prosthodontic procedure, by report	0-20	Y	description of service, pre-op x-rays, and narrative of medical necessity required	
Oral & Maxillofacial Services					
D7140	Extraction, erupted tooth or exposed root	0-20			
D7210	Surgical removal of erupted tooth	0-20			Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.
D7220	Removal of impacted tooth, soft tissue	0-20	Y	pre-operative x-ray(s)	
D7230	Removal of impacted tooth, partially bony	0-20	Y		
D7240	Removal of impacted tooth, completely bony	0-20	Y		
D7250	Surgical removal of residual tooth roots	0-20	Y		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Y	narrative of medical necessity	
D7280	Surgical access of an unerupted tooth	0-20	Y	pre-operative x-ray(s)	To expose crown of an impacted tooth not intended to be extracted. For orthodontic reasons.

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Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Oral & Maxillofacial Services (Continued)					
D7283	Placement of device to facilitate eruption of impacted tooth	0-20	Y	pre-operative x-ray(s)	1 per tooth per lifetime. Allowed only on approved orthodontic cases per lifetime. Pre-op x-rays required.
D7310	Alveoloplasty in conjunction with extractions, 4+ teeth or tooth spaces per quadrant	0-20	Y	pre-operative x-ray(s)	1 of (D7310, D7311,D7320, D7321) per quad per lifetime
D7311	Alveoloplasty in conjunction with extractions, 1-3 teeth or tooth spaces, per quadrant	0-20	Y		
D7320	Alveoloplasty not in conjunction with extractions, 4+ teeth or tooth spaces per quadrant	0-20	Y	diagnostic models	
D7321	Alveoloplasty not in conjunction with extractions, 1-3 teeth or tooth spaces, per quadrant	0-20	Y		
D7450	Removal of odontogenic cyst or tumor, lesion diameter up to 1.25cm	0-20	Y	pathology report required	
D7451	Removal of odontogenic cyst or tumor, lesion greater than 1.25cm	0-20	Y		
D7460	Removal of nonodontogenic cyst or tumor, lesion diameter up to 1.25cm	0-20	Y		
D7461	Removal of nonodontogenic cyst or tumor, lesion greater than 1.25cm	0-20	Y		
D7510	Incision and drainage of abscess, intraoral soft tissue	0-20	Y	narrative of medical necessity, pre-op x-ray(s)	1 of (D7510, D7511) per day, Not allowed on the same date of service as D7140-D7250 (extractions).
D7511	Incision and drainage of abscess, intraoral soft tissue- complicated (includes drainage of multiple fascial spaces)	0-20	Y		
D7610	Maxilla, open reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7620	Maxilla, closed reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7630	Mandible, open reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7640	Mandible, closed reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7710	Maxilla, open reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7720	Maxilla, closed reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7730	Mandible, open reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7740	Mandible, closed reduction	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7810	Open reduction of dislocation	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7820	Closed reduction dislocation	0-20	Y	narrative of med. nec., pre-op x-ray(s)	
D7960	Frenulectomy, also known as frenectomy or frenotomy- separate procedure not incidental to another procedure	0-20	Y	narrative of medical necessity and photos	1 (D7960, D7963) per arch per lifetime
D7963	Frenuloplasty	0-20	Y		
D7999	Unspecified oral surgery procedure, by report	0-20	Y	narrative of medical necessity	

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Code	Description	Age Limitation	Auth. Req.	Documentation Required	Limitations
Orthodontic Services					
D8080	Comprehensive orthodontic treatment of the adolescent dentition	0-20	Y	study model or OrthoCad, x-rays	1 per lifetime
D8660	Pre-orthodontic treatment visit	0-20	Y	study model or OrthoCad, x-rays	1 per lifetime
D8670	Periodic orthodontic treatment visit (as part of contract)	0-20	Y		Maximum of 1 per 45 days regardless of number of visits within 45 day period.
D8680	Orthodontic retention (removal of appliances, construction/placement of retainer(s))	0-20	Y	date of de-banding must be included with claim form	1 per lifetime.
D8999	Unspecified orthodontic procedure, by report	0-20	Y	narrative of medical necessity	1 per lifetime. Only covered if case fails to reach 42 points on the Modified Salzman Index.
Adjunctive General Services					
D9110	Palliative (emergency) treatment of dental pain, minor procedure	0-20			1 per day per provider or location. Not covered with D0140 on same day of service.
D9220	General anesthesia, first 30 minutes	0-20	Y	narrative of medical necessity	Permit B is required. Not allowed on the same day of service as D9230, D9241, D9242, or D9248.
D9221	General anesthesia, each additional 15 minutes	0-20	Y	narrative of medical necessity	4 per day per provider or location. Not allowed on same day of service as D9230, D9241, D9242, or D9248. Permit B is required.
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	0-20		narrative of medical necessity	Not allowed on the same day of service with D9220, D9221, D9241, D9242, or D9248.
D9241	Intravenous sedation/analgesia, first 30 minutes	0-20	Y	narrative of medical necessity	Permit A or B is required. Not allowed on same day of service as D9220, D9221, D9230, or D9248
D9242	Intravenous sedation/analgesia, each additional 15 minutes	0-20	Y	narrative of medical necessity	4 per day per provider or location. Not allowed on the same day of service with D9220, D9221, D9230, or D9248. Permit A or B is required. Narrative of medical necessity required.
D9248	Non-intravenous conscious sedation	0-20	Y	narrative of medical necessity	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same day of service as D9220, D9221, D9230, D9241, or D9242.
D9310	Consultation	0-20		narrative of medical necessity	
D9610	Therapeutic drug injection, single administration	0-20	Y	narrative of medical necessity	Name of drug and amount administered required.
D9630	Other drugs and/or medicaments, by report	0-20	Y	narrative of medical necessity	Name of drug and amount administered required.
D9999	Unspecified adjunctive procedure, by report	0-20	Y	narrative of medical necessity	Description of service and narrative of medical necessity required

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SERVICES PERFORMED IN A SCHOOL SETTING					
Code	**Description**	**Age Limitation**	**Auth. Req.**	**Documentation Required**	**Limitations**
Diagnostic Services					
D0120	Periodic oral evaluation, established patient	0-18			1 per 270 days in a school setting
D0601	Caries Risk Assessment and documentation, with finding of low risk	0-18			Effective August 1st 2014 1 of (D0601, D0602, or D0603) MUST be submitted with all school based claims for the provider to receive payment. If one of the D060x codes are not submitted the claim will be denied.
D0602	Caries Risk Assessment and documentation, with finding of medium risk	0-18			
D0603	Caries Risk Assessment and documentation, with finding of high risk	0-18			
Preventive Services					
D1120	Prophylaxis, child	0-18			1 per 270 days in a school setting
D1206	Topical fluoride varnish	0-18			1 per 270 days in a school setting, (Both codes, D1206, D1208 are NOT permitted in the same 12 months w/in the same treatment setting.)
D1208	Topical fluoride	0-18			
D1351	Sealant, per tooth	5-17			1 per tooth per lifetime in a dental office or school setting Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.

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EXHIBIT B: ADULT TANF

LIBERTY Dental Plan currently administers the adult dental benefit for multiple health plans in Illinois. For a specific plan's covered benefits, limitations and authorization requirements please verify member eligibility.

Code	Description	Member Responsibility	Auth Req.	Limitations
Diagnostic Services				
D0140	Limited oral evaluation, problem focused	$0		
D0150	Comprehensive oral evaluation, new or established patient	$0		1 per lifetime per provider or location
D0210	Full mouth radiographic image	$0		1 of (D0210, D0277, D0330) per 36 months
D0220	Periapical, first radiographic image	$0		1 per day per provider or location
D0230	Periapical, each additional radiographic image	$0		maximum billable of 6 of (D0230, D0270) per date of service
D0270	Bitewing, single radiographic image	$0		
D0272	Bitewings, two radiographic images	$0		1 of (D0272, D0274) per 12 months
D0274	Bitewings, four radiographic images	$0		
D0277	Vertical bitewings, 7 to 8 radiographic images	$0		1 of (D0210, D0277, D0330) per 36 months
D0330	Panoramic image	$0		
Restorative Services				
D2140	Amalgam, 1 surface	$0		1 of (D2140,D2150,D2160, D2161, D2330, D2331, D2332, D2335,D2391, D2392, D2393, D2394) per tooth per surface per 12 months
D2150	Amalgam, 2 surfaces	$0		
D2160	Amalgam, 3 surfaces	$0		
D2161	Amalgam, 4+ surfaces	$0		
D2330	Resin-based composite, 1 surface, anterior	$0		
D2331	Resin-based composite, 2 surfaces, anterior	$0		
D2332	Resin-based composite, 3 surfaces, anterior	$0		
D2335	Resin-based composite, 4+ surfaces, anterior	$0		
D2391	Resin-based composite, 1 surface, posterior	$0		
D2392	Resin-based composite, 2 surfaces, posterior	$0		
D2393	Resin-based composite, 3 surfaces, posterior	$0		
D2394	Resin-based composite, 4+ surfaces, posterior	$0		
D2740	Crown, porcelain/ceramic substrate	$0	Y	1 of (D2740-D2792, D2931) per tooth per 8 benefit years
D2750	Crown, porcelain fused to high noble	$0		
D2751	Crown, porcelain fused to metal	$0		
D2752	Crown, porcelain fused noble metal	$0		
D2790	Crown, full cast high noble	$0		
D2791	Crown, full cast base metal	$0		
D2792	Crown, full cast noble metal	$0		
D2910	Recement inlay, onlay, partial coverage restoration	$0		
D2915	Recement cast or prefabricated post and core	$0		Not payable within 6 months of D2954 (prefabricated post and core in addition to crown) by the same provider or provider group

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Code	Description	Member Responsibility	Auth Req.	Limitations
Restorative Services (Continued)				
D2920	Recement crown	$0		Not payable within 6 months of D2740-D2792 by the same provider or provider group
D2931	Prefabricated steel crown, permanent tooth	$0	Y	1 of (D2740-D2792, D2931) per tooth per 8 benefit years
D2932	Prefabricated resin crown	$0	Y	1 per tooth per lifetime
D2940	Protective restoration	$0		Not allowed within any 2000 or 3000 series code
D2950	Core buildup, including any pins	$0		
D2951	Pin retention, per tooth in addition to restoration	$0		
D2954	Prefabricated post and core in addition to crown	$0	Y	
Endodontic Services				
D3310	Endodontic therapy, anterior (excluding final restore)	$0		1 per tooth per lifetime
Removable Prosthodontic Services				
D5110	Complete denture, maxillary	$0	Y	1 per arch per 10 benefit years
D5120	Complete denture, mandibular	$0		
D5130	Immediate denture, maxillary	$0		
D5140	Immediate denture, mandibular	$0		
D5510	Repair broken complete denture base	$0		
D5520	Replace missing or broken teeth, complete denture	$0		
D5610	Repair resin denture base	$0		
D5620	Repair cast framework	$0		
D5630	Repair or replace broken clasp	$0		
D5640	Replace broken teeth, per tooth	$0		
D5650	Add tooth to existing partial denture	$0		
D5730	Reline complete maxillary denture (chairside)	$0	Y	1 per arch per 24 months
D5731	Reline complete mandibular denture (chairside)	$0		
D5740	Reline maxillary partial denture (chairside)	$0		
D5741	Reline mandibular partial denture (chairside)	$0		
D5750	Reline complete maxillary denture (laboratory)	$0		
D5751	Reline complete mandibular denture (laboratory)	$0		
D5760	Reline maxillary partial denture (laboratory)	$0		
D5761	Reline mandibular partial denture (laboratory)	$0		
Maxillofacial Prosthetic Services				
D5911	Facial moulage (sectional)	$0	Y	
D5912	Facial moulage (complete)	$0	Y	
D5913	Nasal prosthesis	$0	Y	
D5914	Auricular prosthesis	$0	Y	
D5915	Orbital prosthesis	$0	Y	

Code	Description	Member Responsibility	Auth Req.	Limitations
Maxillofacial Prosthetic Services (Continued)				
D5916	Ocular prosthesis	$0	Y	
D5919	Facial prosthesis	$0	Y	
D5922	Nasal septal prosthesis	$0	Y	
D5923	Ocular prosthesis, interim	$0	Y	
D5924	Cranial prosthesis	$0	Y	
D5925	Facial augment implant prosthesis	$0	Y	
D5926	Nasal prosthesis, replacement	$0	Y	
D5927	Auricular prosthesis, replacement	$0	Y	
D5928	Orbital prosthesis, replacement	$0	Y	
D5929	Facial prosthesis, replacement	$0	Y	
D5931	Obturator prosthesis, surgical	$0	Y	
D5932	Obturator prosthesis, definitive	$0	Y	
D5933	Obturator prosthesis, modification	$0	Y	
D5934	Mandibular resection prosthesis with guide flange	$0	Y	
D5935	Mandibular resection prosthesis without guide flange	$0	Y	
D5936	Obturator prosthesis, interim	$0	Y	
D5937	Trismus appliance (not for TMD treatment)	$0	Y	Not for TMD Treatment
D5951	Feeding aid	$0	Y	
D5953	Speech aid prosthesis, adult	$0	Y	
D5954	Palatal augmentation prosthesis	$0	Y	
D5955	Palatal lift prosthesis, definitive	$0	Y	
D5958	Palatal lift prosthesis, interim	$0	Y	
D5959	Palatal lift prosthesis, modification	$0	Y	
D5960	Speech aid prosthesis, modification	$0	Y	
D5982	Surgical stent	$0	Y	
D5983	Radiation carrier	$0	Y	
D5984	Radiation shield	$0	Y	
D5985	Radiation cone locator	$0	Y	
D5986	Fluoride gel carrier	$0	Y	
D5987	Commissure splint	$0	Y	
D5988	Surgical splint	$0	Y	
D5999	Unspecified maxillofacial prosthesis, by report	$0	Y	
Fixed Prosthodontic Services				
D6930	Recement fixed partial denture	$0		Not billable by same provider within 6 months of placement
D6999	Unspecified fixed prosthodontic procedure, by report	$0	Y	Description of service and narrative of medical necessity required
Oral & Maxillofacial Services				
D7140	Extraction, erupted tooth or exposed root	$0		
D7210	Surgical removal of erupted tooth	$0		Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.
D7220	Removal of impacted tooth, soft tissue	$0	Y	
D7230	Removal of impacted tooth, partially bony	$0	Y	
D7240	Removal of impacted tooth, completely bony	$0	Y	
D7250	Surgical removal of residual tooth roots	$0	Y	
D7450	Removal of odontogenic cyst/tumor, lesion diameter up to 1.25cm	$0	Y	

Code	Description	Member Responsibility	Auth Req.	Limitations
Oral & Maxillofacial Services (Continued)				
D7451	Removal of odontogenic cyst/tumor, lesion greater than 1.25cm	$0	Y	
D7460	Removal of nonodontogenic cyst/tumor, lesion diameter up to 1.25cm	$0	Y	
D7461	Removal of nonodontogenic cyst/tumor, lesion greater than 1.25cm	$0	Y	
D7510	Incision and drainage of abscess, intraoral soft tissue	$0	Y	1 of (D7510, D7511) per day. D7510 Not allowed on same date of service as D7140-D7250
D7511	Incision and drainage of abscess, intraoral soft tissue- complicated (includes drainage of multiple fascial spaces)	$0	Y	
D7610	Maxilla, open reduction	$0	Y	
D7620	Maxilla, closed reduction	$0	Y	
D7630	Mandible, open reduction	$0	Y	
D7640	Mandible, closed reduction	$0	Y	
D7710	Maxilla, open reduction	$0	Y	
D7720	Maxilla, closed reduction	$0	Y	
D7730	Mandible, open reduction	$0	Y	
D7740	Mandible, closed reduction	$0	Y	
D7810	Open reduction of dislocation	$0	Y	
D7820	Closed reduction dislocation	$0	Y	
D7999	Unspecified oral surgery procedure, by report	$0	Y	
Adjunctive General Services				
D9110	Palliative (emergency) treatment of dental pain, minor procedure	$0		Not covered with D0140 on same day of service
D9220	General anesthesia, first 30 minutes	$0	Y	Permit B is required. Not allowed on the same day of service as D9230, D9241, D9242, or D9248
D9221	General anesthesia, each additional 15 minutes	$0	Y	4 per day per provider or location. Not allowed on same day of service as D9230, D9241, D9242, or D9248. Permit B is required
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$0		Not allowed on the same day of service with D9220, D9221, D9241, D9242, or D9248
D9241	Intravenous sedation/analgesia, first 30 minutes	$0	Y	Permit A or B is required. Not allowed on same day of service as D9220, D9221, D9230, or D9248
D9242	Intravenous sedation/analgesia, each additional 15 minutes	$0	Y	4 per day per provider or location. Not allowed on the same day of service with D9220, D9221, D9230, or D9248. Permit A or B is required
D9248	Non-intravenous conscious sedation	$0	Y	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same day of service as D9220, D9221, D9230, D9241, or D9242
D9310	Consultation	$0		

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Code	Description	Member Responsibility	Auth Req.	Limitations
	Adjunctive General Services (Continued)			
D9610	Therapeutic drug injection, single administration	$0	Y	Name of drug and amount administered required
D9630	Other drugs and/or medicaments, by report	$0	Y	Name of drug and amount administered required
D9999	Unspecified adjunctive procedure, by report	$0	Y	

Allowable Procedure Codes for Pregnant Woman

Guideline:
MD or DDS notes of pregnancy and expected delivery date required for claims payment

Code	Description	Member Responsibility	Auth Required	Limitations
	Diagnostic Services			
D0120	Periodic oral evaluation	$0		1 per 6 months
	Preventive Services			
D1110	Prophylaxis	$0		1 of (D1110 or D4355) per 6 months
	Periodontal Services			
D4341	Periodontal scaling & root planing, 4+ teeth/quad.	$0		1 per site/quad per 24 months
D4342	Periodontal scaling & root planing, 1-3 teeth/quad.	$0		
D4355	Full mouth debridement	$0		1 of (D4355 or D1110) per 6 months

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Exhibit C - FQHC Denture Billing

Complete and Partial Dentures (FQHCs only)

For an approved complete or partial denture, a FQHC provider may be reimbursed for procedure code D5899 a maximum of three (3) times per plate. Partial dentures are limited to children age 2 through 20 only. Complete dentures are allowed for both children and adults. Procedure code D5899 will not reimburse separately when billed with another covered procedure.

Procedure code D5899 is to be used for visits for denture impressions and denture adjustments prior to the denture being placed and for necessary adjustments, repairs, or relines during the six (6) month period following the delivery of a new prosthesis. Providers must provide a narrative of the services performed at the time procedure code D5899 is billed.

Providers should submit payment for completed denture (Procedure Codes D5110, D5120, D5211, D5212, D5213, or D5214) at the time the prosthesis is delivered.

Removable Prosthodontic Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitation(s)**	**Documentation Required**
D5899	Unspecified removable Prosthodontic procedure	None		Yes	Maximum of three visits per approved denture.	Narrative of service performed

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